



# The American Board *of* Oral and Maxillofacial Surgery



A History



## About the Authors

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Dr. MacIntosh is a graduate of the Marquette University School of Dentistry, undertook graduate studies at Georgetown University and the University of Pittsburgh, and gained his surgical training at Walter Reed General Hospital in Washington, D.C., the University of Pittsburgh, Henry Ford Hospital in Detroit, and the University of Zurich. In his educational emphases on ablative and reconstructive surgery, he has endorsed the philosophies and surgical principles of his mentors, Robert B. Shira, Fred A. Henny, and Hugo L. Obwegeser. In his role as Clinical Professor in the Department of Oral and Maxillofacial Surgery at the University of Detroit Mercy, he has been Coordinator of Residency Education at that institution, as well as Section Chief of Oral and Maxillofacial Surgery in the Department of Oral and Maxillofacial Surgery/Hospital Dentistry at Sinai Hospital of Detroit, and Program Director in Oral and Maxillofacial Surgery at Henry Ford Hospital. He has served as a career-long consultant to the United States Army and various teaching institutions, and sat as the 45th President of the American Board of Oral and Maxillofacial Surgery from 1998 to 1999.

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# Prologue

History, it is said, is the guide that illuminates the way ahead. This recording of the events in the first six decades of the American Board of Oral and Maxillofacial Surgery (ABOMS) recounts the *raison d'être* of the Board, its mechanics of operation, and its adaptation to both societal changes and maturation of the specialty. The lessons learned and the issues addressed will doubtless remain pertinent over the next six decades.

The establishment of the ABOMS was a reflection of the growth of the specialty of oral and maxillofacial surgery, a growth given great impetus by the Second World War. Certainly, a generally recognized distinction between the practice of even dentoalveolar surgery and the rest of dentistry existed long before that, and, by the 1930s certain training centers made it evident to the thoughtful observer that there would one day be a sub-group of dentists dedicated solely to surgical endeavors. It was the participation of dentists in the management of trauma, infectious disease, anesthesia, and, to some degree, reconstruction during the 20th century's greatest conflict that prompted recognition and support by the American Dental Association for the development of a recognized dental specialty board to establish training and performance standards for the practice of the dedicated specialty first established in 1918.

The ABOMS achieves its professional recognition from the American Dental Association and its Council on Dental Education and Licensure, distinguishing it from unrecognized, self-designated "boards." The ADA's recognition structure requires that the Board have a sponsoring organization, originally the American Society of Oral Surgeons and Exodontists, now, since 1978, the American Association of Oral and Maxillofacial Surgeons. Further, formal interaction of the Board with other agencies entails appointment of Board directors to seats on the Residency Review Committee of the Commission on Dental Accreditation, and on the AAOMS Committee on Residency Education and Training. The occasional lack of coordination and the disagreements arising from the differing missions of these various organizations constitute many of the essential elements of the Board's history to be described in these pages.

Since its inception, and certainly over the latter decades of the 20th century, the ABOMS has served as the pacesetter and the inspiration for the other eight recognized dental boards. Chiefly because of their modes of practice, recognition of the importance of board certification for several of the other dental specialties was late in coming. Because oral and maxillofacial surgery is a dental specialty whose training and practice is immersed in the medical environment, the American Board of Oral and Maxillofacial Surgery has had to navigate waters roiled by inter-specialty and interdisciplinary conflict. While the significance of ABOMS certification is acknowledged by many hospital staffs, medical licensing and accrediting agencies, and third party insurers, it has never been acknowledged by the American Medical Association or the American Board of Medical Specialties, the latter the ultimate authority in medical specialty recognition.

The Board's relationship with AAOMS as its sponsoring organization forms an important part of the history that will be described in these pages, as the Board has made every effort to maintain its independence. As will be seen, it has labored consistently to ensure the integrity of its director election process, strongly endorsing the policy of providing the nominees from the Examination Committee for election by the AAOMS House of Delegates, the representatives of specialty members at large. While there have been periodic reassessments of this election process, and suggestions that the Board's independence would better be served by conducting the election itself, the reader will see that the existing process has served the Board well over its first sixty years, and has resulted in Board directors and officers coming to service from every quarter of the nation.

In honoring its responsibilities to the public of qualifying, certifying, and, in the recent few years, re-certifying practitioners of its art and science, the Board has instituted examination policies commensurate with those of other certifying agencies, in accord with educational and evaluation methodologies of the times. From the era in which subjectivity perhaps held precedence, to the present day in which uniformity and objectivity have become the watchwords for ensuring a fair and thorough process, the Board has maintained its dedication to introspection and adaptation in performing its primary function. The age of computerization and the increasing sophistication of psychometrics have found their places in the qualifying and certifying processes, and the Board has passed through various phases of one-day examinations, two-day examinations, same-day written and oral examinations, mandated format, selective format, and, currently, a move toward off-site computerized examination. The Board's original charge of conducting examinations to certify individuals practicing the specialty has expanded in recent years to include in-service examinations for trainees, self-assessment programs for its diplomates, and a process for certification maintenance.

Whether the Board in its evaluation of candidates should examine solely the realities of current practice or should also represent the ideal standards of the specialty, even to the point of being avant-garde, has been a debate within the Board since its inception. Three forces, in particular, fueling the debate have been the monumental increase in activity and scope of the specialty beginning in the late 1960s, the progressive development of both inpatient and office general anesthesia, and the shift in emphasis of all surgical disciplines to the outpatient theater.

The Board cannot serve as an arbitrator of clinical practice, nor pass judgment on the ethics of its candidates or its diplomates. It can and does, however, remain alert to evidence of ethical compromise leading to patient harm in the candidate examination material it judges, and, through the conduct of its examiners, directors, and officers, encourages the principles of proper professional decorum and wholesome patient management. In adhering to these precepts, and to those of honest and thorough evaluation of the 7068 diplomates it has certified to this point in its history, the Board hopes to have had, in ways tangible and intangible, beneficial influence beyond the specialty, to all of dentistry, to medicine, and to society at large. These pages will serve as a record of those noble efforts.

# Presidents

* Howard C. Miller	1946-50	Chicago, IL
* James R. Cameron	1951-56	Philadelphia, PA
* Don H. Bellinger	1955-56	Detroit, MI
* J. Orton Goodsell	1956-57	Saginaw, MI
* Thomas Connor	1957-58	Atlanta, GA
* P. Earle Williams	1958-60	Dallas, TX
* Daniel J. Holland	1960-61	West Newton, MA
* Athol L. Frew Jr.	1961-62	Dallas, TX
James R. Hayward	1962-63	Ann Arbor, MI
* Gustav O. Kruger	1963-64	Washington, D. C.
* J. Lorenz Jones	1964-65	Bishop, CA
* Donald E. Cooksey	1965-66	Los Angeles, CA
* Claude S. LaDow	1966-67	Philadelphia, PA
* R. Quentin Royer	1967-68	Los Angeles, CA
* O. Lee Ricker	1968-69	Grand Rapids, MI
Robert V. Walker	1969-70	Dallas, TX
Charles A. McCallum	1970-71	Birmingham, AL
* Lowell E. McKelvey	1971-72	San Antonio, TX
* Jack B. Caldwell	1972-73	Austin, TX
* Harold E. Boyer	1973-74	Louisville, KY
* Robert B. Shira	1974-75	Silver Spring, MD
* Fred A. Henny	1975-76	Detroit, MI
Philip T. Fleuchaus	1976-77	Ormond Beach, FL
Thomas W. Quinn	1977-78	Newcastle, NH
* Marvin E. Revzin	1978-79	Detroit, MI
* Irving Meyer	1979-80	Longmeadow, MA
* Dan E. Brannin	1980-81	Tulsa, OK
Frank Pavel	1981-82	San Diego, CA
* Philip J. Boyne	1982-83	Loma Linda, CA
* Charles C. Alling, III	1983-84	Birmingham, AL
John J. Lytle	1984-85	Altadena, CA
Bill C. Terry	1985-86	Chapel Hill, NC
Lionel Gold	1986-87	Philadelphia, PA
John N. Kent	1987-88	New Orleans, LA
Robert E. Huntington	1988-89	North Tustin, CA
Leon F. Davis	1989-90	Omaha, NE
James E. Bertz	1990-91	Scottsdale, AZ
Donald M. Hagy	1991-92	Sacramento, CA
* Leete Jackson, III	1992-93	Dallas, TX
Douglas P. Sinn	1993-94	Dallas, TX
J. David Allen	1994-95	Stone Mountain, GA
John P. W. Kelly	1995-96	Boston, MA
Thomas W. Braun	1996-97	Pittsburgh, PA
Thomas P. Williams	1997-98	Dubuque, IA
Robert Bruce MacIntosh	1998-99	Detroit, MI
Paul A. Danielson	1999-00	S. Burlington, VT
R. Dean White	2000-01	Granbury, TX
David E. Frost	2001-02	Chapel Hill, NC
James R. Hupp	2002-03	Jackson, MS
Edward Ellis III	2003-04	Dallas, TX
James Q. Swift	2004-05	Minneapolis, MA
William J. Nelson	2005-06	Green Bay, WI
Kirk L. Fridrich	2006-07	Iowa City, IA
Eric T. Geist	2007-08	Monroe, LA
B. D. Tiner	2008-09	San Antonio, TX
* Deceased		



# Common Abbreviations

AADE – American Association of Dental Examiners  
AAOMS – American Association of Oral and Maxillofacial Surgeons  
ABMS – American Board of Medical Specialties  
ABOMS – American Board of Oral and Maxillofacial Surgery  
ABOS – American Board of Oral Surgery (1946-1978)  
ACGME – Accreditation Council of Graduate Medical Education  
ACOMS – American College of Oral and Maxillofacial Surgeons  
ACS – American College of Surgeons  
ACT – American College Testing agency  
ADA – American Dental Association  
ADEA – American Dental Educators Association  
ADSA – American Dental Society of Anesthesiology  
AGD – Academy of General Dentistry  
AMA – American Medical Association  
ASDA – American Society of Dentist Anesthesiologists  
ASOS – American Society of Oral Surgeons (1946-1978)  
ASOSE – American Society of Oral Surgeons and Exodontists (1921-1946)  
ATPC – Advanced Training Program Committee of the ABOS, 1950  
CDA – Canadian Dental Association  
CAQ – Certificate of Added Qualification  
CM – Certification Maintenance of the ABOMS  
CODA – Commission on Dental Accreditation of the ADA  
CDE – Council on Dental Education of the ADA  
CDEL – Council on Dental Education and Licensure of the ADA (after 1997)  
CGT – Committee on Graduate Training of the ABOS, 1948  
CRET – Committee on Residency Education and Training of the AAOMS  
CHDS – Council on Hospital Dental Service of the ADA  
CNDB – Commission on National Dental Boards of the ADA  
EAMFS – European Association of Maxillofacial Surgery  
HOD – House of Delegates of the AAOMS  
HEW – U.S. Department of Health, Education, and Welfare  
IAMFS – International Association of Maxillofacial Surgeons  
JCAH – Joint Commission on Accreditation of Hospitals  
JCAHO – Joint Commission on Accreditation of Healthcare Organizations  
MRA – Measurement Research Associates  
MOC – Maintenance of Certification  
NBDE – National Board of Dental Examiners of the ADA  
NCDCO – National Council of Dental Credentialing Organizations  
OCE – Oral Certifying Examination of the ABOMS  
OMSF – Oral and Maxillofacial Surgery Foundation  
OMSITE – Oral and Maxillofacial Surgery In-Training Examination  
OMSNIC – Oral and Maxillofacial Surgery National Insurance Company  
OMSSAT – Oral and Maxillofacial Surgery Self Assessment Test  
RE – Recertification Examination of the ABOMS  
RRC – Residency Review Committee of the CODA  
RCS – Royal College of Surgeons  
USDE – United States Department of Education  
WE – Written Examination (later, WQE of the ABOMS)  
WQE – Written Qualifying Examination of the ABOMS

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*\* Leslie M. FitzGerald  
Founding Member, First Executive Secretary  
and Only Honorary President of the Board*

# Chapter I

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## Development of the American Board of Oral and Maxillofacial Surgery

### Forebears

There dwells in the consciousness of those dedicated to the healing arts the desire to define, improve, and expand their disciplines for the benefit of those they serve. Jourdain, writing in 1778 in his *Surgical Diseases of the Mouth*, noted that surgery was so expansive that no one man should attempt to deal with the whole field. He recorded, at that early date, that the work done in surgery by dentists, even Pierre Fauchard, was not fully adequate, and was not undertaken with a sufficiently broad surgical view. Jourdain based his opinions on his experience with clefts, salivary gland pathology, and bone infections, among other oral and maxillofacial maladies.

Fewer than 50 years later, however, the surgical view of dentists had broadened considerably. Simon P. Hullihen had graduated as a physician from the Washington Medical College in Baltimore at age twenty-two and, practicing in the two decades before the Civil War, applied his more expansive knowledge to the practice of dentistry, most particularly oral surgery. For these efforts, he was granted an honorary dental degree from the Baltimore College of Dental Surgery in 1843.

James E. Garretson also subscribed to the advantages of a broader educational base and, after graduating in medicine from the University of Pennsylvania, obtained his dental degree from the Philadelphia College of Dentistry (later, the Temple University School of Dentistry) to focus his career on surgery of the mouth. He was the first to suggest the term Oral Surgery and so might rightfully be considered the father of the specialty. Garretson brought great honor to dentistry in general, served as professor of anatomy and oral surgery at the Philadelphia College, and subsequently became its dean in 1880.

### Early Efforts

The inspiration and discipline exhibited by these and other early pioneers brought the practice of surgery of the mouth to the status of a growing specialty within dentistry, so that, following discussions within the ranks of the National (later, American)



Dental Association in 1916, the American Society of Exodontists was established in 1918. Expanded education and scope for practitioners within this group gained early emphasis and in 1921 the group felt emboldened to change its name to the more expansive American Society of Oral Surgeons and Exodontists (ASOSE). By 1928, the Society's desire for better definition of educational requirements and parameters of practice led to appointment of a committee to "...formulate standards of specialty practice."

The same sentiments led, in 1932, to the appointment of an additional Committee to Formulate Plans for a National Board. This group took its lead from Harry M. McFarland, president of the ASOSE, who, in his 1936 presidential address, recommended the "establishment of a board to raise the standards, requirements, and efficiencies of those interested in the specialty." The committee was inspired by the American Board of Orthodontics and the American Board of Ophthalmology, under whose certificates the standards of teaching and practice in those specialties had been raised. By 1937 the committee had defined the chief activities of the proposed board as: the establishment of standards of fitness for practitioners of the specialty; the investigation of the fitness of dental schools and private instructors to properly train in oral surgery and exodontia; the arrangement, control, and conduct of examinations to test the qualifications of those who would desire to practice oral surgery and exodontia; and appropriate certification of those who met the established standards. While the committee endorsed the foundation of such a board as a "good thing," it felt that 1937 was "not the time" for adoption of the plan, and recommended that the matter be considered for a period of one year.

In 1938, the committee again procrastinated in taking a firm stance. The concerns within the ranks of the ASOSE responsible for the delay were several: uncertainties as to medicine's attitude toward the establishment of such a board; the threatened fractionation of ASOSE members into one group that had proved itself board-certified and one that hadn't; and questions as to whether or not the specialty, in general, was sufficiently developed to warrant a board examination. A fortuitous counterbalance to ASOSE concerns was the American Dental Association's (ADA) establishment of an Advisory Board of Dental Specialties. This panel carried representation from the ADA Council on Dental Education (CDE), the ADA Judicial Council, the American Association of Dental Schools (AADS), the American College of Dentists, and the specialty groups in orthodontics, prosthetics, pedodontics and the ASOSE. Two significant benefits derived from the Advisory Board, the recognition of the specialty groups and the board's own entrenchment as an annual advisor to the Commission on Dental Accreditation (CODA) of the American Dental Association. These actions, in effect, held the door open for the ASOSE and its specialty board, if ever organized, to have direct access to the ADA's ruling authority, the CODA, in discussions of educational standards and board recognition.

In 1939, Dr. James A. Blue of Birmingham, Alabama, was in his third year as chairman of the ASOSE Committee to Formulate Plans for a National Board. His 1937 committee

had been composed of Dr. D. C. McRimmon of Ft. Worth, Dr. D. P. Snyder of Columbus, and Dr. Harry McFarland of Kansas City, MO. In their original recommendation for establishment of an American Board of Oral Surgery and Exodontia, the committee had suggested that the ASOSE be the sponsor, and that nominations for positions on the board be made by the Executive Council of the ASOSE. The committee also suggested that the board-to-be offices be in Richmond, VA, for reasons that are today unclear.

The issue of board establishment languished throughout 1937 and 1938. In an effort to exact a decision from the ASOSE at its July 1939, meeting in Milwaukee, Dr. Blue presented his committee's extensive blueprint entitled, "The American Board of Oral Surgery and Exodontia, Origin, Aims, and Procedures," and entered a resolution before the Society that the plan be adopted. Rather than exposing the resolution to a vote, the Executive Council of the ASOSE retained the proposal for overnight consideration. With the dawn, the Executive Council again mounted the previously stated concerns, and also noted that, were the ASOSE to sponsor, control, and operate such a board, the Society membership might take offense at the successful certification of some individuals whom they did not want as members. The Executive Committee decided to take "a month or six weeks" to further study the resolution.

The hesitance and uncertainty of the ASOSE to this point in establishing an examining board, despite extensive well-meaning and thoughtful discussion within its ranks, may be ascribed to the immaturity and uneasiness of a relatively small professional group trying to find its way in the world. Beginning in 1940, however, and extending through the greater part of the next five years, ASOSE deliberations on board establishment became truly comedic. At the 1940 meeting of the ASOSE, Dr. Blue again noted that his committee had reaffirmed American Board of Oral Surgery and Exodontia in preference to National Board nomenclature, to provide continuity with other already-established dental specialty boards and all those in medicine. Dr. Blue also emphasized that his committee had gone about as far as it could in its organizational efforts, and he again moved, in the House of Delegates, that the board concept be adopted.



Dr. Blue's motion for adoption carried, but, in subsequent discussion, the membership became confused and adopted another motion to reconsider. Dr. Blue repeated his motion, a motion to table Dr. Blue's motion failed, and his original motion was adopted again. This having been accomplished, members returned to the earlier discussion of whether it was necessary that the Society control or operate such a board, reflecting a general mood that the board be kept a politically independent and separate entity.

*\* Howard C. Miller ... 1946-50*

With the establishment of a board now Society policy, the Executive Committee went into session to develop a slate of directors for the new American Board of Oral Surgery and Exodontia, and subsequently presented a roster of Howard C. Miller of Chicago, Frank W. Rounds of Boston, Aubrey L. Martin of Seattle, Frank P. Hower of Louisville, and Athol L. Frew of Dallas. The membership accepted all these individuals, and thus was born, seemingly, the first American Board of Oral Surgery and Exodontists.

This did not end the matter, however. Later in the same session, Dr. George Christiansen of Detroit, not convinced of the necessity for a board, found sufficient support for his motion to have the Executive Council again review the report of the Committee to Formulate Plans for a National Board, and expose it to further study. At this point, the Society did and did not have a board, and though a slate of directors had been heartily adopted by the Society, whether or not the board was really wanted had not absolutely been determined.

Perhaps gratefully, there was no meeting of the American Society of Oral Surgeons and Exodontists in 1941, for reasons unclear. At the 1942 session, Frank W. Rounds, who had been appointed chairman of the National Board Committee (the designation of “American” seems to have been momentarily forgotten), reflected the dedication of his committee by asking several pertinent questions and offering specific solutions. The confusion at this point was reflected in the fact that Rounds, who did not even know he had been appointed chairman, offered the opinion that the overall uncertainty demonstrated the Society’s being not overwhelmingly in favor of such a board. He also pointed out that four states—Michigan, Oklahoma, Illinois and Tennessee—already had specialty boards in oral surgery, and that these states, in the absence of a national certifying body, might well determine the course of the specialty nationally. He sensed a potential schism within the ranks of the specialty forged by those who chose, for whatever reasons, not to be members of the ASOSE but who still wanted to take the board examination, and within the ASOSE itself between members who were board certified and those who were not.

In addition to these potential professional differentiations, Rounds and others within the group could foresee potential Society political influences on the board, prompting Rounds to suggest that the American Dental Association be responsible for the board. Rounds’ suggestion harked back to the 1939 sentiments verbalized by E. B. Kelly, a member of the original Committee to Formulate Plans for a National Board, when he stated that, to keep the examination body a politically independent and separate entity, it might be necessary that the ASOSE itself not control or operate the Board. The uncertainties in all these issues led Aubrey Martin, one of the original board members appointed in 1940, to comment frustratingly at the end of the 1942 session, “We have a board, but it is not functioning.”

In 1943, Rounds, still chairman of the appointed Board, reported no activity for his group, and lamented that his review of recent years’ ASOSE minutes did not clearly state that an ABOS (American Board of Oral Surgery) had, in fact, been established.

Leslie M. FitzGerald, an oral surgeon from Dubuque, was, in 1944, chairman of the National Board of Dental Examiners. FitzGerald, who had been dedicated to the establishment of a specialty board for several years, suggested that the ASOSE address the ADA to request that it be authorized to sponsor and organize an American Board of Oral Surgery under the authority of the ADA Council on Dental Education. This recommendation found sympathy within the ranks of the ASOSE, but, once again, no definitive action was taken.

The Society did not meet in 1945 due to travel restrictions imposed by World War II, but, by the meeting in 1946, interest in bringing the Board to full activity had gained momentum. By then, four states, as mentioned, had developed their own specialty examinations. In the post-World War II return to civilian priorities and the upsurge in sophistication of medical care fostered by war-time experience, professional and governmental agencies strove increasingly to better define the parameters of good patient care. The American College of Surgeons (ACS), the American Hospital Association (AHA), and the Veterans Administration (VA) all suggested that non-board certified practitioners could work in approved hospitals only as assistants. This dictate, of course, referred only to the medical specialties, but leaders within the ranks of the ASOSE were well aware of the implications, and, in effect, could see the handwriting on the wall. FitzGerald voiced that awareness when he stated, “It seems that the time has arrived when an American Board of Oral Surgery should.....become active.....It is going to be a requirement in the Class A hospitals recognized by the American College of Surgeons that men operating must be diplomates of the specialty boards.” FitzGerald also stated, perhaps too expansively,

**“to keep the examination body a politically independent and separate entity, it might be necessary that the ASOSE itself not control or operate the Board”**

that it would be the aim of the American Board of Oral Surgery that applicants for admission to all oral surgery groups in the future be board certified, and, perhaps more realistically, “.....that the heads of the Oral Surgery Departments at hospitals and at teaching institutions in all government services be required to be certified.”

Certification as a prerequisite for leadership in the specialty’s training institutions, governmental or otherwise, became an aspiration of the specialty. Carl Waldron, at the University of Minnesota, was, by the late 1940s, a long-recognized leader in the specialty. Having attained both dental and medical degrees and training in otolaryngology and oral pathology, he emphasized that, “Hospitals across America are simply clamoring for some yardstick for the measurement of competence in oral surgery.....,” and that, “If we raise our standards of graduate training and our requirements for national recognition by means of board certification, we have nothing to fear; if we don’t, we have a lot to fear.....”

These enthusiastic endorsements encouraged the



Executive Committee of the American Society of Oral Surgeons (which name had become effective in 1946, evolving from the American Society of Oral Surgeons and Exodontists) to finally take definitive action. The Board, as defined by FitzGerald, would be, "...a separate corporation, separate body..." but always in association with "an organized group such as the ASOS." Once formulated, the Board would no longer be a committee of the ASOS, but the ASOS Executive Council would nominate ABOS director candidates, and the ASOS membership would elect them. The Board's first challenge would be to design plans for an examination, and its second charge, almost equally urgent, would be to formulate and promote the essentials of formalized training in the specialty. These decisions became policy of the ASOS in February 1946. The actions were approved on April 9, 1946 by the American Dental Association Council on Dental Education, by authority of the ADA House of Delegates.

### **The First Board**

The momentous February, 1946, meeting of the board committee with the ASOS Executive Council had led to the reformulation of the Board directorship into seven members, comprised of Howard C. Miller, Carl W. Waldron, James R. Cameron, Athol L. Frew, Frank B. Hower, Leslie M. FitzGerald and Aubrey Martin. Dr. FitzGerald was to serve as secretary of the new Board; as one of his first administrative acts, he asked the ASOS Executive Council for \$1,000 operating expenses.

The now-active Board conducted its first official meeting on May 25, 1946, at the Stevens Hotel (after 1978, the Conrad Hilton) in Chicago. It established its headquarters in Dubuque, as a convenience to Dr. FitzGerald, and mapped the parameters for its first examination, dividing potential candidates into two groups:



#### Group A:

Individuals who had restricted their practices strictly to oral surgery for a period of fifteen years, who would be given diplomate certificates on the basis of their seniorities.

#### Group B:

Individuals in practice fewer than fifteen years who would be required to write a three thousand-word thesis on a topic in the specialty, provide five case reports for review (which, on request, an examiner might evaluate in the candidate's own office or hospital),

and complete an oral examination that would include elements of micropathology. The Board established an initial examination fee of \$100. It also selected a panel of seven examiners, which it chose to call the Advisory Board: Drs. Don Bellinger of Detroit, Orlan K. Bullard of San Diego, Malcolm W. Carr, of New York, Thomas Connor of Atlanta, J. Orton Goodsell of Saginaw, Stephen P. Mallett of Boston, and Douglas Parker of New York.

At this same meeting in February, the Board also began plans to incorporate in the State of Illinois, probably to maintain proximity to the offices of the American Dental Association. In the Articles of Incorporation filed on March 19, 1946, the Board outlined its objectives: “To receive and pass upon applications for examination of graduates in dentistry or medicine, who are legally licensed to practice dentistry or medicine, as to fitness and competency in the practice of oral surgery...,” and “...to perform such other acts and duties as will advance and promote the science of oral surgery.... The board does not confer a degree, but issues a certificate to those candidates whom it finds qualified.” Subsequently, the Board, recognizing the inadvisability of certifying individuals without dental training, directed an amended filing to the State of Illinois on November 9, 1946, deleting the phrase “or medicine” from the final Articles of Incorporation duly registered later that month.

Article VII of the Articles of Incorporation stipulated that, “The affairs and management of the corporation shall be vested in a board of seven directors who shall be nominated by the Executive Council and elected by the members of the American Society of Oral Surgeons at the annual meeting of said society.” The Board also stressed that it would not recommend for reappointment to the Board any director who had already served an elected term of seven years. The light of decades reflects the astuteness of those early leaders in recognizing potential political problems in these regards. The Board carried these directives to the Executive Council of the ASOS at a joint meeting on October 8, 1946, to reiterate the ABOS allegiance to the ASOS and the ABOS’ determination to avoid a policy of self-perpetuation. Recognizing, however, that many in the American oral

surgery community did not belong to the American Society of Oral Surgeons, FitzGerald stated the Board’s position that, “Membership in the American Society of Oral Surgeons will not be required as a pre-requisite for [certification by] the American Board of Oral Surgery. We do not want to leave the impression that they must be so closely tied up with our group. Of course, we hope that any man that has oral surgery at heart will be wise enough to seek admission into this (ASOS) group.....” Secretary FitzGerald also emphasized that, “We have tried to keep oral surgery



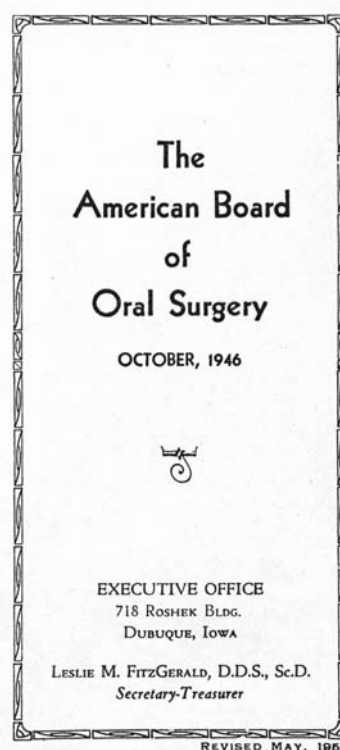
*\* James R. Cameron ... 1951-56*

a part of dentistry....that is one of the reasons that the American Board of Oral Surgery has been established. The other reason is because we want to try to influence the schools to establish a suitable course in oral surgery.”

Interestingly enough, and reminiscent of earlier years’ inconsistencies, all of the inspiring decisions and interplay contributing to the genesis of the American Board during the years 1944 to 1946 took place at the Executive Council and Board levels, without the endorsement of the House of Delegates of the American Society of Oral Surgeons. This policy prevailed through October 8, 1946, when, during the ASOS Annual Session, the Board of Directors, still without House of Delegates sanction, addressed a formal resolution to the Commission on Dental Accreditation of the ADA seeking official recognition of its activities, just as it had to the ADA Council on Dental Education seven months earlier. Not until three days later, on October 11, 1946, did the ASOS House of Delegates formally approve the establishment of the Board, and make appropriate announcements to all reporting media. At that same meeting, the Board recognized the dedication, initiative, and persistence of James A. Blue, chairman of the first Committee to Formulate a Plan for a National Board, and awarded him a Founder’s Certificate of the finally established Board.

The waning days of 1946, then signaled the end of the misgivings, the uncertainties, and the overall struggles of the ASOS to establish an American Board of Oral Surgery. In December, the Board developed its first advisory brochure to be made available to candidates for the first American Board examination on February 14-15, 1947, in Chicago. The design of the 1947 examination, under the direction of President Howard Miller, entailed each of the seven directors, in coordination with one of the seven members of the Advisory Committee, being responsible for the development and grading of one of the seven examination sections. The seven sections were gross pathology, surgical anatomy, hospital procedures, preoperative and postoperative treatment, oral pathology and anesthesia, tumors (clinical aspects), and radiographic interpretation. In its early sessions prior to that first examination, the Board addressed its fiscal responsibilities by developing a reserve fund of \$5,000, to be established from examination revenues. The Board would add \$500 annually to this fund, and the monies would be invested in United States bonds.

By its second year of operation, the Board recognized the need for more members of the Advisory Board and the president was empowered to appoint these individuals. With an early eye toward fair grading, the entire Board, not just the section leaders, would determine the final grading of the candidate. To



incorporate all avenues of efficiency and fairness in its fledgling operations, the Board included the Advisory Board in its organizational deliberations. In keeping with the other of its basic tenets, the Board in this same year established within itself a Committee on Graduate Training to design an outline of basic residency prerequisites for submission to the American Dental Association.

The Board published its first Roster of Diplomates in 1949, but, interestingly, discouraged the use of the term “Diplomate” on calling cards and stationery. This position probably reflected the Board’s abiding desire to avoid dissension within the ranks of the ASOS, since, even by 1950, the Board was rejecting 34% of applicants for examination, although some 76% of those examined were being certified.

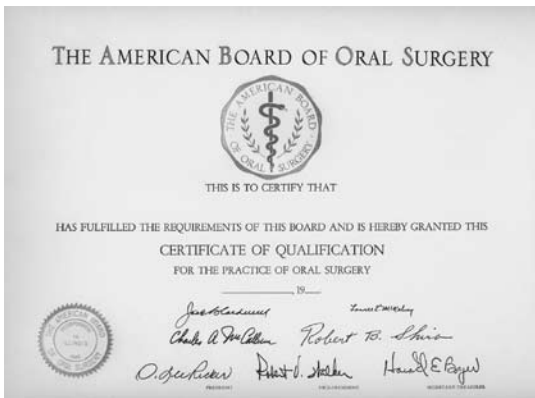
The issue of election to the ABOS Board of Directors followed a somewhat murky course subsequent to the appointment of the first official seven-man board by the ASOS Executive Council in 1946. As noted previously, the importance of holding the Board free of political influence was first suggested by E.B. Kelly, a member of the 1939 ASOSE committee, and by Frank Rounds in his 1942 suggestion that a board, if established, be responsible directly to the American Dental Association. However, in recognizing the perpetual professional ties between the ASOS and the ABOS, the Articles of Incorporation, as noted above, clearly established that the ASOS Executive Council would nominate the candidates for ABOS director and the ASOS House of Delegates would have the responsibility for election. Though the written record for the early years is unclear in this regard, it is evident that neither the ASOS nor the ABOS fully honored this arrangement. In 1946 and 1947, the Board did, in fact, reappoint itself and, in 1948, three members, Drs. Miller, Waldron, and FitzGerald, were re-elected by the Board alone, though Dr. James Cameron seems to have been appointed or elected by the ASOS. The first recorded entry of the House of Delegates duly electing a director appears in 1949 with the election of Dr. Don Bellinger; he had been the only “recommendation” of the Board to the ASOS.

## **Later Board Development**

The course of election, appointment, and replacement remained erratic through 1954, with multiple changes taking place and no clear role of the ASOS. A portion of the record suggests that the policy of Board submission of multiple nominees to the ASOS resulted in the election of Dr. Athol Frew in 1955. Elsewhere, however, documents suggest that the Board forwarded a single recommendation to the ASOS for election until 1959, when a list of three nominees was first submitted. The original Article VII of the incorporating document was amended in 1971 to read that the directors would be nominated not by the Executive Council of the ASOS but by the Board of Directors of the ABOS. This mechanism was further refined in amended Articles of Incorporation adopted in 1985 to stipulate that the nominations would come from the Advisory Committee of the Board, the process which continues to this day.



Throughout almost its first decade of existence, irregularity in terms of service for the directors and their successions to office also prevailed. By its own constitution and bylaws, the Board was empowered to elect its officers as it willed, in no particular order. Early inconsistencies had James Cameron being elevated to president in 1950 after having been elected to the Board only in 1948, and, Earle Williams serving two years as president of the Board from 1958 until 1960, when Leslie FitzGerald relinquished his position on the Board per se to remain as its first salaried executive secretary-treasurer. Refreshingly, FitzGerald proved a laudable constant, serving the Board as secretary, secretary-treasurer, or executive secretary for some two decades following its inception. In 1974, Harold Boyer served as both president and secretary-treasurer.

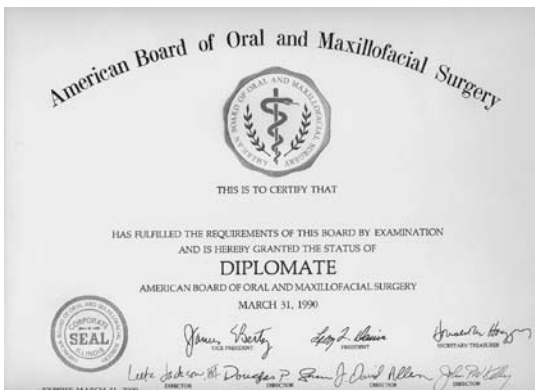


The Board, in its ongoing development, accepts certain modifications to its year-in/year-out operations, and rejects others. In 1973, as a reflection of the burgeoning expansion in the scope of the specialty and the increasing number of candidates for examination, the Board entertained—and rejected—the awkward suggestion that it be increased to nine directors, and that the tenure be reduced from seven to four years. Twenty years later, as the time

commitments and responsibilities of Board service increased, discussion of reduction in period of service again took place and was again discounted. The dramatic changes in the face of the specialty over the decade of the middle 1960s through the 1970s also prompted the Board to call for assistance from the Advisory Committee in revising the scope of the examination to better reflect the nature of training and practice of the time.

In 1978, the Board adopted the designation of American Board of Oral and Maxillofacial Surgery (ABOMS), following the lead of the American Association of Oral and Maxillofacial Surgeons (AAOMS) one year earlier and that of the American Dental Association five years earlier, the latter permitting individuals to announce limitation of

practice to “... ‘oral and maxillofacial surgery’...because... ‘oral surgery’ is frequently misinterpreted by other members of the health professions and the lay public as relating only to the treatment of oral disorders by surgical means.” In 1977, the ASOS had encountered difficulties in adding “maxillofacial” to its name because that designation had already been adopted by the American College



of Oral and Maxillofacial Surgeons (see Chapters V and VI). Dr. Gerald Laboda, representing the ASOS, had written to the Board encouraging it to adopt the title of American Board of Oral and Maxillofacial Surgery, both because, in his words, “... the timing is perfect....,” and because ASOS members were seeking hospital privileges in “oral and maxillofacial surgery” but could only demonstrate board certification in “oral surgery.”

In June 1977, ABOS President Philip Fleuchas had directed the Board’s attorney to research the possibilities for the name change, and in January 1978 the Articles of Incorporation were appropriately amended to designate the American Board of Oral and Maxillofacial Surgery. Interestingly, in February of that year the official seal of the Board was returned to the manufacturer for correction of the misspelled “maxillofacial.”

The Board’s original precepts, that it develop an appropriate examination to determine the fitness of the specialty’s practitioners, that it help determine the parameters of good training in the specialty, and that it recognize by certification those worthy of the public’s trust, have remained essentially intact. The Board consistently attempts to steer a course in its examinations between the extremes of demanding the ultimate in knowledge on one hand, and accepting performance at the lowest acceptable denominator on the other. In its early years, it professed the determination of *competence* as one of its goals, but has learned by experience that this is all but impossible to determine on the basis of written and oral examinations alone; it has, however, come to recognize that appraisal of candidate *judgment* is a workable goal within those modalities. Challenges to its purview and operations have arisen periodically, and are discussed in subsequent chapters.



\* *Don H. Bellinger ... 1955-56*

# Chapter 2

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## Directors and Examiners

### Size Of The Board of Directors

With occasional exceptions, the Board of Directors of the American Board of Oral and Maxillofacial Surgery has enjoyed general stability in its composition and successions over its first six decades. In the early months of the Board's existence, the Executive Council of the then-American Society of Oral Surgeons increased the Board's initial number of directors from five to seven, with the anticipation that each director would serve a full course of seven years. Accordingly, the original Articles of Incorporation of the Board stipulated a "Board of seven directors." In 1974, the Board first considered, then rejected, the notion of increasing its panel from seven to nine members, the maximum allowed by the ADA Council on Dental Education for all dental specialty Boards. Later, in 2003, the Board considered reducing its size to six directors to shorten the time of service after having discarded, in 1995, the proposition of maintaining a seven-member Board whose members would serve for fewer years. The first increase in Board tenure was instituted in 1961 when the directors elected to have the immediate past president retained for one year as an examination consultant for the Oral Certifying Examination, but this policy was short-lived. In 2008, however, the Board of Directors was officially expanded to include the immediate past president. *\*see Addendum P4*

### Director Seniority and Succession

Order of succession through the director ranks has been occasionally disrupted, sometimes by voluntary action of the Board and sometimes by necessity. In the fledgling years, Howard Miller, the Board's first president, was asked to serve through 1950, but unexpectedly died that year. James R. Cameron then assumed the presidency from 1950-1955. In early 1976, Fred Henny, because of an acute illness, relinquished the rest of his presidential year to Phillip Fleuchaus, who then subsequently took his turn as president through 1977, as well. Director Michael Buckley took a leave of absence in 2002, and within a few months resigned his position. Wisely, the Board, in 1970, had amended its

bylaws to accommodate such a vacancy by calling for the then-ASOS House of Delegates to elect two directors at its annual meeting (see Election Process below). This policy was reaffirmed by Board and the AAOMS in 2002 to accommodate Dr. Buckley's departure.

As the activities of the Board grew over the years, both collectively and for the directors individually in their varied other professional responsibilities, the possibility of multiple director loss, particularly through air travel, became evident. In 1997, the Board again amended its bylaws to accommodate such misfortune. This amendment directed that, in the event of multiple losses, temporary replacements in the Board would be drawn from the past presidents in ascending order of seniority until the AAOMS House of Delegates could fill the vacancies through the established electoral process at the first subsequent session of the house.

The most interesting internal personnel scenario centers on the long tenure of Leslie M. FitzGerald. FitzGerald was a founding member of the Board, served as its secretary for more than a decade beginning in 1947, and maintained his position of director over that interim. In 1959, the Council on Dental Education deigned that each dental specialty board would have an executive secretary, an individual who could not serve simultaneously as a director. FitzGerald therewith resigned his position on the Board, but assumed the new position of executive secretary; in essentially an ex officio role, he retained the responsibilities of Board treasurer, as well.

In 1961, the Board voted FitzGerald a salary of \$300/month to offset the obligations of his position as executive secretary. Dr. FitzGerald relinquished those responsibilities in 1968, at which time he was named consultant in administrative and financial affairs. He was voted a salary of \$3,000 a year, an annuity, a per diem, and the costs of two trips to Board functions per year. Director Harold Boyer assumed FitzGerald's former tasks in the newly combined offices of secretary and treasurer, and served in that capacity until 1973. FitzGerald retained his position as consultant for only a short while; he was named honorary president of the ABOS by his Board fellows in 1970, and in 1971 he died. He had served 22 year as secretary, treasurer, executive secretary, and consultant. FitzGerald's death left Carl Waldron as the last founding member of the ABOS.

Harold Boyer, after serving almost five years as secretary-treasurer and superb recorder of events, ascended to the presidency in 1974. Following retirement from that position, he agreed to stay associated with the Board as consultant on administrative affairs for two years, essentially taking on Leslie FitzGerald's earlier responsibilities as executive director.

The Board adopted the policy of limiting the tenure of its secretary-treasurer to a three-year term in 1980 in an effort to ensure progressive ascendancy. In 1984, it formulated its Executive Committee, stipulating that this body preferably be composed of the three most senior directors, to include the president, vice president, and secretary-treasurer, the latter, however, even if he or she were not one of the three most senior. Since that



time, ascendancy through seniority has been consistent on the Board, with each member serving four progressive years as director, then moving through the offices of secretary-treasurer and vice-president to the presidency, and, since 2008, remaining an additional year as immediate past president. *\*see Addendum P5*

## Director Election Process

Integrity in election to directorship on the American Board of Oral and Maxillofacial Surgery has always been central to the Board’s credibility as a fair and impartial body in its dealings with candidates and in its responsibilities to society at large, and mandatory in ensuring that proper individuals are elevated to that position. Earlier pages in this history have described the hesitance, repetition, and sometimes irregularity in the Board’s proceedings as it tried to determine its status and appropriate course. To some degree, the evolution of the election process reflects the same uneven development.

In its infancy, the Board was increased in membership from five to seven members by ASOS action, and that number was specified in the Articles of Incorporation as first filed in 1946. Article 7 of that document stated that the directors would be “...nominated by the Executive Council and elected by the members of the American Society of Oral Surgeons.” This Article was first amended in 1971, to stipulate that the nominations would be made by the “Board of Directors of the Board,” and again in 1985 to state that the nominees would be determined by “...the Advisory Committee of the Board...,” later known as the Examination Committee.

From the beginning, it was understood that one director would be replaced per year but how the candidates would be chosen, how many would be submitted to the ASOS for election, and who exactly these candidates were for the first several years of the Board’s existence, is unclear from the written record. By 1955, however, the Board in its bylaws had incorporated the principle of the annual election of one new director to replace one retiring director. For the subsequent three years, only one candidate was submitted by the Board to the ASOS, and each of these candidates was duly elected by the House of Delegates. In



1959, the Board established the policy of submitting the names of three candidates to the Executive Council of the ASOS for forwarding to the House of Delegates. It appears that, throughout this evolution of the director nominating process, the names of the candidates originated with the Board, whether from its Board of Directors or its Advisory (Examination) Committee, even though the formal nominations were made by the ASOS Executive Council (later, Board of Trustees) to the House of Delegates for election.

*\* J. Orton Goodsell ... 1956-57*

In 1967, the ASOS requested a substitute for one of the Board candidates, since he, Merle Hale, was shortly to be inducted as a trustee of the ASOS; this policy of avoiding any political influence or conflicts of interest on the part of ABOMS directors has remained as principle since that time (See Chapter IV, Administration). In that 1967 instance, the Board substituted the name of Harold Boyer for Hale, and Boyer was duly elected. In only one other recorded instance, in 1992, has one of the director nominees not stood for election, in that case due to the voluntary withdrawal of a candidate with his substitution by an alternate. The naming of two alternates in addition to the three designated candidates had been Board policy since 1971. By 1968, the Board had begun submitting curricula vitae of all candidates and alternates to the ASOS Board of Trustees by May 15 of the year of election, several months prior to the ASOS annual meeting.

The late 1960s and early 1970s marked a time of strained relations, and even confrontation, between the ABOS and ASOS, a fact illuminated further in Chapters V and VI. Certain of the issues current at that time involved the director electoral process, and are pertinent to discussion here. In 1968, two Board diplomates, Harry Archer of Pittsburgh and Herbert Bloom of Detroit (who had served briefly as an examiner), put forth a proposal that the officers and directors of the American Board should be elected by the diplomates themselves in a written vote at the time of submitting their annual registration fees. The proposal was submitted to the American Dental Association, which rejected the notion, stating that the electorate for the American Board should represent the parent sponsoring organization. The ADA's Council on Dental Education, however, had no written requirement in this regard. Evidence suggests that neither the Board nor the ADA, despite their negotiations and agreement in 1946, had codified such a policy. The ADA therefore formally instituted such a requisite, and then stated in 1969 that the ABOS election process was not in compliance, because ".....appointment to the Board is not through the nomination and election by the constituency of the parent organization." Note was also taken at that time that institutional oral and maxillofacial surgery was, perhaps, over-represented on the ABOS Board of Directors.

Discussion on the Archer-Bloom proposal spread throughout the specialty community nationally and provoked an overall discussion of the Board electoral process within the ASOS Executive Council. The society emphasized the long-established principle that director nominees could be named from the floor of the House of Delegates, reflecting the mutual ABOS-ASOS sympathies of the 1940s and 1950s. However, perhaps as a reaction to the Archer-Bloom proposal, the ASOS began to insist that such nominees would not need to have Board examiner experience as a prerequisite. The ABOS Board of Directors rejected this notion, and the disagreement led to the formation of a liaison committee comprised of the senior officers of the American Board and the American Society to sort out the issues. As a result, in 1970 the Board agreed to formally incorporate in its bylaws the allowance for candidates being nominated by the ASOS House of Delegates, again, an understood policy since 1946, but with the expressed stipulation that any such nominee would necessarily have examiner experience. This seemed to satisfy the ADA, and strengthened its refutation of Archer-Bloom.

Over the next year, the American Board reaffirmed its dedication to objectivity and democracy in the naming of director candidates, probably as a response to the unrest of the preceding two to three years. It solidified the three-candidate mandate for submission to the ASOS (which had been established as long as sixteen years previously), and, further, re-confirmed the Board's Advisory Committee as the body selecting the director nominees, with no contribution from the Board of Directors. The Advisory Committee would choose five candidates, submitting the top three to AAOMS for election, with two alternates in rank order to replace any nominees unable to stand for election. This 1970 communication to the ASOS stipulated that eligibility for director nominees would require service as an examiner for four years of the previous ten; in the following year the mandated length of service was reduced to three. In addition to the ABOMS candidates, additional nominees were to be permitted from the floor of the House of Delegates. The ASOS, however, raised the question of whether or not the specific three-year minimum experience as a Board examiner should pertain to a director candidate nominated from the House of Delegates. The American Dental Association Council on Dental Education responded that it had no such requirement for any of its authorized Boards. The American Board did not force the issue, since, to that point, 1971, there had never been a House of Delegates nominee. In a mood of compromise, the Council on Dental Education stipulated that any director nominee from whatever quarter "should" have at least three years experience as an examiner on the American Board of Oral Surgery. This ruling was a far cry from the Archer-Bloom group which had insisted on "shall." The ASOS then agreed to a policy stipulating that any candidate nominated by the House of Delegates would have to be endorsed by five active ASOS members and "should" have a minimum of three years as an ABOS examiner.

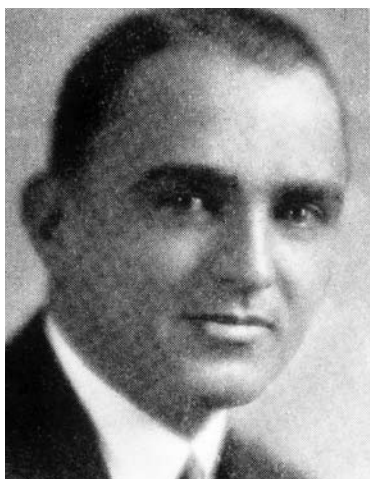
In those same months, however, the ABOS Board of Directors sought legal opinion regarding its prerogative for sole nomination of its own directors without participation of the Society in the process. The consulting attorney reported that the American Board of Oral Surgery, ".....operating as an autonomous organization, pursuant to its own Articles of Incorporation and Constitution and Bylaws...." did, indeed, have the prerogative of nominating candidates for its own directorship. The Board duly entered this stipulation into its rewritten constitution and bylaws in 1972. Not until 1974 did the ASOS formally amend its bylaws to mandate the requirement for a minimum of three years of Board examiner service for any candidate nominated through its House of Delegates. Only once since that date, in 1976, has a candidate been nominated from the floor of the House and elected as an ABOS director.

The stormy seas through which the electoral ship pitched and rolled in the early 1970s abated somewhat by the end of that decade. In 1977, the Board developed a standard curriculum vitae form for all director nominees, codifying the 1968 policy, to maintain consistency in submitted information to the ASOS for public distribution. At one juncture in that same year, the Board took a disinterested stance when the proposal was resurrected that only Board diplomates in the House of Delegates should be eligible to vote in the Board director election, an issue reflecting the dying wake of the Archer-Bloom unrest of

ten years earlier. The Board opined that who voted for director within the ASOS House was a political matter for the ASOS to decide, reiterating its insistence on remaining as apolitical as possible. In 1981, the Board amended its policies to reflect this attitude.

By 1985, the Board again sensed an increasing political restlessness within the now-AAOMS leadership regarding Board affairs. The association again questioned the appropriateness of the three-years-in-ten rule, an issue supposedly laid to rest more than a decade earlier. This specific issue engendered minimal discussion among the association membership and found an early demise. Continuing uneasiness on the part of the Board, however, by 1989 prompted internal discussions regarding the possibilities of taking the director election completely out of the AAOMS House of Delegates. There was no consensus within the Board of Directors, but “straw votes” taken among the examiners at the time of the Oral Certifying Examinations in 1989 and 1990 demonstrated an all but unanimous preference for the move. The proposed options were those of having the Examination Committee elect the new director on an annual basis, or polling all diplomates nationally from a slate of candidates proposed by the Examination Committee, a method of election then in use by the American Board of Periodontology. This latter proposal also echoed an essential element of the 1968 Archer-Bloom proposal, a point not lost on the Board of Directors or the ranks of the ABOMS past-presidents, some of whom cautioned against such action, recalling the dissension ensuing from those activities. The overall concern of the Board, however, was that the electoral process was becoming too politically influenced by forces within the AAOMS hierarchy, and, to some degree, within the ranks of ABOMS officers, directors, or examiners themselves, former and current.

The Board again sought legal counsel in this regard in 1990, and was advised directly that it could, indeed, conduct its own director election, since ultimately the American Dental Association, and not necessarily the AAOMS, was its sponsoring organization; it could simply advise the AAOMS of its change in policy. The Board did not embark on this change, but AAOMS awareness of these sentiments led to significant consternation and a new era of generally unproductive relationships between the two bodies, initially on the issue of director election but later more generally.



In 1994, the Association moved to require Association fellowship as a prerequisite for nomination as Board director, a move directly counter to a principle established at inception of the Board in 1946. Further, the Association, in 1995, proposed that director nominees be required to follow the protocols of candidates for political office within the ASOS, enlisting campaign advocates and making appearances at the district caucuses before and during the AAOMS annual session with campaign speeches. The Board vigorously resisted

*\* Thomas Connor ... 1957-58*



these overtures, and the disagreement resulted in a somewhat acrimonious confrontation at the AAOMS Annual Meeting in Toronto that year. This issue, as well as the Archer-Bloom proposal, is discussed further in Chapter VI.

Subsequent days, reflecting the salving effects of time, attention to more pressing agenda demands, and, perhaps, changes in personalities, saw both organizations retreating to their more characteristic ameliorative approaches to their differences. The Board did not attempt to take the election out of the House of Delegates, and volunteered to supply the AAOMS with standard biographies of their director nominees, not just variegated curricula vitae as had been the policy since 1977, for dissemination to the House of Delegates well in advance of election. Over the next several years, the only issue regarding the electoral process that required consideration by both bodies occurred in 2002 when a sitting director resigned his position. The Board, in consultation with the AAOMS Board of Trustees, established in its bylaws the policy of election of two directors by the House of Delegates at the annual meeting, one to serve six years and the other a full seven-year term. With this act the Board reaffirmed a policy that had already been in place since 1970.

## **Examiner Appointment Process**

The appointment of examiners has always been the prerogative of the Board of Directors. When the national specialty community was in its infancy, the directors appointed examiners on the basis of personal familiarities, generally accepted criteria of experience, recognized standing in the specialty, contributions to the literature and education, and, to some degree, geographic distribution. An equitable balance between practitioners in the private sector, in academia, and in the federal services has been a long-standing goal of the appointment process. The directors themselves served as examiners in the early decades, but this policy was formally discontinued in 1974 with the proviso that the directors would continue to serve as examination section consultants.

Expansion of Board certification among the practicing specialty and maturation of the examining body itself are demonstrated by the facts that from 1960 to 1980, 30% of the examiners were less than five years from their own certifications, but by 1984 this percentage had shrunk to 0%. In that year, the Board established a five-year minimum certification period for appointment, with exceptions allowed only under rare circumstances.

By 1971, the numbers of graduating trainees and applicants for examination demanded a larger cadre of examiners. The Board of Directors in that year elected to include the Advisory (Examination) Committee in the nomination and selection of new examiners (an action the Board emphasized in its dealings with the ASOS at the time), and instituted the position of regional consultant, an individual presumably more familiar with potential candidates from any given geographic area than the directors might be, to further democratize the selection process in terms of regional apportionment. The

original regional consultants were also active examiners, to better ensure familiarity with the current needs of the Board. In later years, the consultants were recruited from the ranks of retired examiners.

A particular impetus for the establishment of regional consultants derived from a complaint from the president of the New York Society of Oral Surgeons that his state had only one examiner on the examination committee. The complaint was delivered directly to Dr. Charles McCallum, then president of the American Board, who carried the issue to his directors and added it to the growing sentiments for the establishment of regional consultants. Regional distribution of examiner appointments would be based on the number of Board diplomates in each of the geographical districts of the American Society of Oral Surgeons. The importance of regional distribution has been debated periodically by the Board over succeeding decades, and, in 1993, it recorded that regionalism was to be only a secondary consideration for appointment, less important than professional criteria. This position was reinforced by further arguments for the priority of other considerations in 1995.

In its ongoing efforts to select the best of the specialty for its Examination Committee, the Board initiated a policy in 1972 of tracking the top 10% of examination performers to establish a cadre of potential future examiners. A year later, the Board formally codified the theretofore generally recognized minimum attributes for appointment. In 1975, the regional consultants were instructed to begin the use of a standard curriculum vitae form for examiner candidates; a policy reiterated and productively revised in 1987. By 1984, the Board adopted the stipulation that any appointed examiner be a citizen of the United States and have an American dental license. This posture was not incorporated into the policies of the Board, however, and, in at least four instances as of 2008, qualified Canadian diplomates have served as honorable examiners. The policies do record that an examiner must be a diplomate, and a diplomate must be currently licensed to practice the specialty in the jurisdiction of his or her practice.

At inception and for its first fifteen years, the examining body carried the denotation of Advisory Board. In 1961, the name was changed to Advisory Committee and in 1993 to Examination Committee to more accurately reflect its role. Despite changes in nomenclature, its responsibilities have remained the same: to examine candidates and to counsel the Board of Directors. It was comprised at inception of six and then, almost immediately, seven members, and over its first five years had expanded to only eleven members. By 1967, the Advisory Committee had grown to thirty members and required a milestone change in its organization into five separate teams, each with a section chairman. By the end of the 1990s, the roll of the Examination Committee had expanded to almost sixty members.

A major concern of the Board at the turn of the century was the quality of its examiners and, through them, the Board of Directors itself. The paradoxical decrease in scope of practice, despite the specialty having established privileges and expertise of great

dimension over the years of the Board's existence, posed a challenge to the Board in recruiting team members with the maturity and expertise to sit in rightful evaluation of junior candidates. By the late 1990s, this concern had become a matter of discussion at every Board meeting and culminated in 2002 in a recruitment brochure to encourage individuals of recognized accomplishment to participate in the examination process. Any diplomate of the American Board has the long-standing privilege of applying directly or through his/her regional consultant for appointment as an examiner and guardian of the specialty. *\*see Addendum P5*

## **Responsibilities of the Examiners**

The advisory role of the Examination Committee has great significance in construction of the examinations and director candidate selection. This role gains periodic reinforcement as, for example, in the early 1970s when the number of candidates and the size of the examining body began to expand significantly.

Paramount in its duties is the responsible examination of candidates, including the prompt submission of material for inclusion in both the Written Qualifying Examination and Oral Certifying Examination. Performance in these tasks ranks chief among the criteria for reappointment to the Examination Committee. By the middle 1970s, examiners came under Board review and evaluation immediately following the completion of the Oral Certifying Examination, and in 1978 the Board began to employ a mechanism to evaluate examiners in relation to both the quality and timeliness of their material submitted for the WQE. By 1991, a discriminator in examiner performance, termed the examiner difficulty factor, was introduced into OCE scoring, in recognition of the variability in examiner effectiveness (see Chapter III). Five years later, to help refine new examiner selection, a computerized database recorded his/her expertise, computer competence, and organizational participation. In 2000, the functioning examiner's examination style, attitude toward candidates, quality of his/her submitted examination material, and rating by examination candidates, were also entered into the database. After another two years, the Board voted to maintain this material on a permanent basis to provide on-going substantiation of examiner performance. By 2004, Measurement Research Associates, the psychometric agency retained by the Board for consultation in all its testing functions, authored an Examiner Evaluation Report, which awarded twenty-eight of the examiners perfect performance scores by their scales, and only one with a lower than expected performance score. At various times during the first sixty years of the Board's existence, examiners have failed reappointment due to tardy submission of examination materials, inadequate performance, or unprofessional conduct at examination times.

“Board review” courses, “Board preparation” courses, “mock Board examinations” – educational devices constructed to enhance the readiness of candidates for Board examination -- have long been employed by institutions and professional organizations throughout the United States. Participation of ABOMS examiners or directors in these courses has been a matter of controversy throughout the Board's history. The obvious concerns are breaches of confidentiality, the potentials for misrepresentation of intent or

content of these sessions, and the misperception of official Board endorsement. In 1978, the Board ruled that an examiner or regional consultant could take part in such review courses, but only with the advertised caveats that he/she did not represent the American Board, and that his/her participation did not imply American Board endorsement of the course. This stance was reaffirmed in 1981, but in 1986 was amended to disallow examiners from being examiners in such courses, though they could continue to serve as course lecturers. The Board's position was again revised in 1994 when it prohibited participation of a current examiner or director in such educational efforts under any circumstances; a retired director or examiner, however, could take part in these programs.

In recent decades, preparation and orientation of new examiners has taken place in a special advisory session at the annual meeting of the American Association of Oral and Maxillofacial Surgeons and again, more intensely, of both new and experienced examiners in the days immediately preceding the annual Oral Certifying Examination. The Board of Directors, with the assistance of outside consultants in educational methodology and psychometrics, has counseled the examiners in proper WQE item writing, appropriate OCE techniques, and the execution of a complete examination. At various times, educational tapes generated within the Board itself have proved useful in orientation and, by the late 1990s, the Board had been integrating mock examinations into these preparatory sessions, with experienced examiners demonstrating proper examination techniques for new appointees to the Examination Committee. All of the examination material is thoroughly reviewed and critiqued by the members of the examination sections during this two-day undertaking prior to the oral examination. At one point, in 1986, the Board of Directors debated the employment of a psychologist as part of this orientation, but discarded the notion as being unnecessary. Historically, the performance of the Examination Committee would seem to substantiate that decision.

**“All of the examination material is thoroughly reviewed and critiqued by the members of the examination sections...”**

As the time for initiation of the Re-certification Examination neared in the late 1990s, the Board urged all active directors and examiners, even those not required to re-certify because of seniority, to volunteer early for examination as a gesture to the professional community of their individual currencies, and an encouragement of their fellows to do the same. Admirably, many of the Board answered the call.

The intensity and, one might argue, the rigidity of the mandates imposed on the Examination Committee might seem, to the outside eye, intimidating and discouraging to potential candidates for examiner. Quite the contrary has been the case. The honor of the appointment, the importance of the position, and the integrity of the process, have been more than enough to attract a continuum of eager applicants.

*\*see Addendum P5*

## Regional Consultants

As related earlier, the position of regional consultant was born in a time of friction with the American Society of Oral Surgeons over the issue of director election, and has remained an intermittently uncomfortable topic since.

In 1971, in the midst of the Archer-Bloom maelstrom, the suggestion arose that the ASOS should elect or select the new examiners every year. The Board of Directors immediately rejected this notion and instead, as noted earlier, initiated a policy of designating a regional consultant from each of the ASOS districts and one from the federal services, derived from the membership of the sitting Examination Committee. The Board would then choose the examiners from a consultant-derived cadre of examiner applicants. The consultant's role would be to advise the Board as to the suitability of the candidates from his or her district, based on knowledge gleaned from professional associates within the district regarding the applicant's scope of practice, ethical standing, maturity, etc. The regional consultants would serve one- to three-year terms, and no one consultant could serve more than two maximum terms.

In 1974 the American Society of Oral Surgeons suggested that the ASOS House of Delegates should nominate and elect the regional consultants. This suggestion was rejected by the ABOS, but resulted in an ASOS/ABOS liaison committee to derive a harmonious compromise. This committee defined the qualities to be sought in an effective examiner (the criteria already in place) and endorsed representation of private practice, academia, and the federal services in the candidates for examiner (also an already long-standing policy). Initially, it was agreed that the Board would select the consultants from each district for three-year terms; later in the year, the policy was modified and mutually accepted by both the ASOS and ABOS to mandate that the Board would select a slate of three consultant candidates whenever a consultant vacancy occurred in any district, and the ASOS Board of Trustees would then choose one of the three candidates as consultant for a three-year term. Each consultant would submit five examiner candidates per year for consideration by the Board of Directors.

This policy functioned generally harmoniously for the better part of a decade, but in 1983 was discontinued by mutual agreement, not because of conflict, but, seemingly, because of indifference by both parties. The simple reality seemed to be that the role of the regional consultant was never a position of contention, and was of little utility. Board diplomates from any quarter could apply for appointment as examiners directly to the Board, and in most cases did so, simply bypassing the

*\* P. Earle Williams ... 1958-60*





regional consultants. Nonetheless, the issues raised regarding regional consultants in the early 1970s arose intermittently in subsequent decades, always with some sort of mutually accepted compromise effected, and usually with the same equivocal result. For example, in 1989, the Board agreed to submit its chosen regional consultant candidates to the American Association for “mutual agreement,” but in 1994 the two entities agreed that the Board alone should appoint these individuals. The position of regional consultant has proved to be a redundant formality at certain periods in the Board’s existence, but by 2003 became, under the Board’s sole responsibility, an effective tool in examiner recruitment and appointment. Six regional advisors were named at that time, distributed geographically in accord with the AAOMS political districts. *\*see Addendum P6*

## Director and Examiner Amenities

The responsibilities of ABOMS principals and the discipline under which they labor have been recognized by the Board of Directors since the Board’s inception, and appropriate rewards are integral to Board operations. The Board has absorbed travel costs and per diem expenses since the early years (see Chapter IV). The first per diem allowed for the Board of Directors and examiners was established at \$25 in 1959 for their activities during the Oral Certifying Examination in Chicago. An additional allowance for ground transportation was introduced in 1991, and these stipends have been expanded to include reimbursement for all Board of Director meetings throughout the years. In concert with the ever-increasing costs of travel and hotel lodging, both the per diem and ground travel allowances were increased considerably in later decades.

The Board has authorized only economy travel for its examiners and Board of Directors throughout its existence, and formally rejected a suggestion for first class travel in 1973. Accommodation and meal charges at examination time are similarly covered, but neither the examiners nor the directors have ever received salaries or reimbursements for the costs of preparation of examination materials. The only time a presidential stipend was raised as an issue came in 1991 and it was rejected out of hand.



By the 1960s, the Board of Directors began to host a presidential dinner for its retiring chief officer at the annual meeting of the American Association of Oral and Maxillofacial Surgeons. This affair was designed to honor and recognize all current examiners, as well, and past examiners within the limits of accommodation. This had become established practice by 1968. Examiners having served three years are recognized at these affairs,

*\* Daniel J. Holland ... 1960-61*

as are those who have served six years. In 1996, the Board initiated a dinner honoring the three candidates for new director on the eve of their standing for election before the AAOMS House of Delegates.

Beginning in 1978, the Board established continuing education credits for all directors and examiners for their efforts during the week of the Oral Certifying Examination. At the beginning of the 2000s, the Examination Committee co-chairmen were receiving sixty continuing education hours, and the other examiners forty such credits. Additionally, recertification candidates were offered thirty continuing education credits. A suggestion to also offer OCE candidates sixty continuing education credits failed to gain support when suggested in 2003.



As a matter of honor, and for good counsel as well, the Board of Directors in 1976 initiated a luncheon with its past presidents at the annual meeting of the ASOS. In that same year, it enrolled the officers and directors as members of the International Club of the Drake Hotel as a bonus for the responsibility of their offices; this was subsequently ruled an unnecessary expense and the practice was discontinued.

Beginning in 1984, the retiring president was authorized a jeweled pin of recognition and by the middle 1990s a presidential ring was struck and made available to all past presidents at their own expense. Since that same period, a variety of pins, neckties, and other memorabilia have been made available to all officers, directors, and examiners, past or present. *\*see Addendum P6*

# Chapter 3

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## Evolution of the Examinations

The history of the American Board of Oral and Maxillofacial Surgery over its first six decades demonstrates that most of its administrative effort, professional acumen, in-house organization and financial outlay have been directed toward its major goal, ie, the development, execution, and continuous review of a legitimate certifying process. The Board has labored consistently to develop examinations that reflect the training and practice of the specialty, treat the candidates fairly, and provide safeguards to the public. The elements of examination design, the qualifications of both examiners, and examinees and the calibration of results have been under continuous evolution since 1946 and, as a reflection of changes in training, the scope of the practice, and the needs of society, will continue to be so.

### Development of the Oral Certifying Examination

#### The Early Years (1940s – 1960s)

As Chapter I outlined, the purpose of the Certifying Examination as anticipated in 1946 would be to advance the science of oral surgery and elevate its standards, to educate and protect the public, and to attest that the successful applicant was fit and competent to practice the specialty.

While current readers most likely associate the certification process with both a written and an oral examination, the initial examination was designed to be strictly an oral exercise and remained so through 1954 when a written component, to be discussed later, was added.

Throughout its formative years, the Board followed James A. Blue's admonition dating from the late 1930s that "...the examiners be broad-minded." This attitude is demonstrated in the early eligibility requirements for certification, slightly modified from those first outlined in 1946: Any announced specialist trained prior to 1947 who had fifteen years of practice experience and was of good standing within the profession, particularly if he had made contributions to the specialty, would be certified without examination; individuals in practice over the previous seven-fourteen years were required to submit a list of ten

“major surgery” case reports, and, at the discretion of the directors, might be required to take an oral examination; those in practice fewer than seven years would take an oral examination, and might be asked to submit cases. A photograph and a \$50 registration fee were the only further requirements.

Candidates trained after 1947 submitted their training credentials to the Credentials Committee, a subcommittee of the Board of Directors, and were required to submit, at first, five case reports (soon increased to ten and then fifteen, but by 1953 reduced again to ten) to the Credentials Committee and, in addition, a three thousand-word thesis on an assigned topic. Once these prerequisites had been satisfied, the candidate underwent an oral examination which reviewed didactic knowledge on “all phases” of oral surgery, to include micropathology. A member of the Board, in some cases, carried out this latter examination in the private office of the candidate. By 1955, the submission of case reports had proved too cumbersome and expensive, and the requirement was terminated after that year. It was supplanted by a required list of major oral surgery cases, satisfying a prescribed list of diagnoses and verified by hospital authorities.

The first oral certifying examinations were offered in February and November of 1947 in Chicago, and in July in Boston. The early examinations were conducted by the directors, each assisted by one of the original seven Advisory Committee members. Each team examined every candidate. The directors supplied their own examination materials, and grading was spontaneous and subjective. By November in Chicago, however, the examination had been somewhat refined to cover seven major practice areas: gross pathology, surgical anatomy, hospital procedures, pre- and postoperative therapy, outpatient surgery and anesthesia, clinical aspects of tumors, and radiographic interpretation.

The examination process and the examination itself became increasingly formalized and more objective over the subsequent ten years. By 1958, the examiners were no longer introduced by name; they were identified only by number to lessen any sense of intimidation in the candidates. By the end of the decade, Written Examination and Oral Examination Committees had been formalized within the structure of the Board. Attempts were underway to eliminate the need for the examiners to bring their own examination materials, and the examining body, termed the Advisory Committee at that point, had grown to ten individuals, relieving the Board of Directors themselves from a portion of examination responsibility. In 1963, with an Advisory Committee now numbering twenty, the Board retained one past president each year as an observer of the Oral Certifying Examination in order to better ensure continuity of the process. Additionally, repeat candidates were examined early in the week and early in the day, to lessen fatigue on the part of both examiner and examinee in those instances in which the stakes were unusually high.

By 1961, the eligibility requirements had been made more stringent. The candidate for examination had to demonstrate three years of formal training, which had to include

one year's didactic preparation satisfying thirty credit hours and two subsequent clinical years in both inpatient and outpatient surgical training. In 1965, the didactic requirement was modified to allow the thirty hours credit to be distributed over the entire three-year period. In addition, the candidate of the early 1960s again had to present fifteen hospital cases carried out within a period of three years subsequent to training, to include five fractures (with at least three open reductions), five infections requiring incision or excision of processes beyond the alveolus, and five corrections of malformations which could include fistulas, clefts, temporomandibular joint disturbances, or jaw anomalies.

The need to further standardize the examination gained impetus during the middle 1960s. In 1965, the examination sections covered anesthesia, pathology, trauma, hospital procedures, and anatomy. A director from the Board served as a consultant to each section, and the examiners examined only in one of these five categories. This policy was intended to help develop more uniform examinations and was reaffirmed in later years. By 1967, the Advisory Committee (examiners) had tripled in five years to thirty individuals, and beginning in 1968 the examination format was redesigned in moves that were termed, at the time, "milestone changes." Each candidate was examined in two sessions of one and one-half hours, with the examinations conducted by three examiners in each section; five examinations were conducted simultaneously in different rooms. This was a departure from the prior methodology of examining in five sessions of twenty-five minutes each for each candidate.

The Board recognized that additional modification of the examination was necessary to accommodate new training circumstances and the monumental change that was taking place in the practice of the specialty. A paradox had developed: many candidates potentially eligible for examination could not satisfy the post-training requirement of fifteen major cases (prompting the Board to allow this requirement to include the two clinical years of training). At the same time, because of increasing hospital activity in the training institutions by the late 1960s, the Board increased its examination emphasis on the hospitalized patient, in particular on preoperative evaluation, post-surgical management, and attention to complications. Similarly, while the Board's traditional twenty-year emphasis on anesthesia



continued, it did so with a change in stress from techniques to pre- and postoperative patient evaluation, pharmacology, and management of complications. Refinements throughout the process prompted the first use, in 1968, of consistent photographic slide sets by each examining team during the Oral Certifying Examination. This advance resulted from consultation with various medical boards, especially the American Board of Orthopaedics, to gain further insight into examination standardization techniques. The liaison with orthopaedics was spearheaded by the Board's Dr. Robert Walker.

*\* Athol L. Frew Jr. ... 1961-62*



## Later Decades (The 1970s – New Century)

The tidal change that occurred in the American specialty of oral and maxillofacial surgery in the 1970s and early 1980s stemmed from the explosion of activity in orthognathic and pre-prosthetic surgeries with techniques introduced to the American community by Hugo Obwegeser in 1966. The full impact of these influences was not realized until later in the 1970s, but it redirected emphases within the Board in the immediate years, and has conditioned Board responsibilities and adjustments every year since.

Refinement and standardization efforts initiated in the 1960s continued into the 1970s. In 1969, the Board adopted the policy of offering both the Written Examination and the Oral Examination during the same period in February. One group of candidates took the Oral Examination before the Written, and the other group after the Written, but all within the same one-week period. Hence, the Written Examination was no longer a “qualifying” examination that was required before undertaking the Oral “Certifying” Examination.

A Board task force undertook responsibility for developing new oral examination material, particularly in the area of patient management and oral pathology. The two sessions of approximately ninety minutes each covered five examination groupings. Into four of these groupings, a thirteen-minute problem-solving scenario would be inserted, one dealing with defense of treatment, another with diagnostic problems, a third with emergency management, and a fourth with complications. Into the fifth grouping, a thirteen-minute analysis, observation, and interpretation scenario would be inserted. The examination emphasis was obviously changing to interpretation and management, and away from immediate recall knowledge and the mechanics of surgery. The directors considered canvassing the diplomates to determine a national “core” or “critical incidence” activity of the specialty in light of the many new cases going to the operating rooms in its training centers. It then rejected the idea, admittedly being concerned with the possibility of disappointing findings. The Board was thus frustrated in its desire to represent the scope of specialty practice as reflected by the leading training institutions.

In 1969, the Board had examined 180 candidates. In an effort to ensure maturity and experience in its applicants for examination, the Board incorporated a mandate of five years of practice post-training as a parameter for eligibility as of 1970, a mandate that significantly decreased the applicant pool. The Board, therefore, again revamped its eligibility requirements in 1971 to allow a candidate to submit his/her application for examination immediately at the end of the three-year training period, and to take the combined written and oral examination after only one year’s practice following training. (see Written Examination, below) The candidate would become “Board eligible” as soon as he/she had submitted an acceptable application for examination. This made it possible, for the candidate who could meet the case experience requirements, to complete both examinations and become fully certified during his/her fifth year following graduation from dental school, since the application deadline for the combined examination to be given in February was several months subsequent to completion of the mandated one year’s practice following training.

To standardize the examination environment, the examination moved from the Blackstone to the Ambassador East Hotel in 1968, where accommodations allowed a more relaxed atmosphere for the candidates. The examination remained at the Ambassador through 1975.



The drive to standardization led in 1972 to another new mechanism, which the directors referred to as “homogenization.” One identical twenty-minute examination was to be given in each segment, with the same questions at the same time to each candidate, in an effort to reduce subjectivity on the part of the examiners and remove the variables of

time of day, place in the case sequence, etc. The move proved unpopular. The Board of Directors and the examiners saw merit in establishing uniform criteria and questions, but felt that this mechanism stifled spontaneity and lessened the ability of the examiners to extract – and the candidates to express – full dimensions of knowledge and judgment. The experiment was discontinued after a one-year trial, but, as will be seen, was to come to fruition in even more defined form some thirty years later. The Board assembled a workshop for directors late in 1972 to consider methods of improving the examination, and for 1973 determined that analysis and interpretation would be the only criteria for grading examinees, and any emphasis on precise recall would be deleted.

The directors in these years continued to take counsel from the Advisory Committee, which had expanded to seven examination teams in 1972 and to nine (fifty-four examiners) by 1975. This five-fold increase in thirteen years reflected the expanding scope and activity of the specialty, and the increasing recognition by newly-trained individuals of the need for Board certification as hospital activity expanded. The percentage of Board diplomates within the ASOS ranks correspondingly increased at an impressive rate.

The debriefing of candidates at the end of their Oral Examinations had been in place for several years by the middle 1970s, and, as the breadth of the examination and the number of candidates increased, the Board also took special heed of the examinees’ appraisals of the process.

In 1965, the Board of Directors had sought consultation with Mrs. Grace Parkin, secretary of the Council of National Dental Boards, to evaluate the structure of the Written Qualifying Examination (see page 41). Parkin retired in 1976, and in that year the Board retained Dr. Etta Berner of the University of Illinois Medical Learning Center to review the entire examination procedure, both written and oral. Dr. Berner’s early evaluations

suggested a comprehensive study, and the Board allocated \$4,000 toward that effort. Berner's recommendations resulted in a realignment of oral examination groupings: a new Section A was to cover management of the hospitalized patient, surgical techniques, and infections; Section B would cover anesthesia, intraoral surgery, and pathology. The too-often mediocre performance of candidates on the anesthesia portion of the examination prompted the Board to urge the ADA to strengthen the requirements for anesthesia training in the ADA-approved oral and maxillofacial surgery residencies, since some approved programs offered very little such exposure.

In that same year, 1976, the issue of a standardized examination was revisited. The emphasis in 1976 was inspired by the earlier-mentioned efforts of President Robert Walker in establishing liaison with the American Board of Orthopaedics in 1968. This contact culminated in Dr. Philip Fleuchaus' visit to the American Board of Orthopaedics examination in Chicago in 1975 and his observations resulted in significant standardization improvement in the oral examination for the subsequent year. For that 1976 examination, each examiner supplied five-ten clinical cases that were edited by the section leaders. Within each section, each candidate was examined on the same selected cases, but spontaneity and improvisation by the examiners was maintained, obviating the criticisms of homogeneity that had plagued earlier standardization attempts. That year's examination was also the first at the Drake Hotel, to which the Board had moved to provide a more candidate-friendly environment.

By 1977, candidates were having fewer problems satisfying the fifteen-case requirement for the oral examination, primarily as a result of the continually expanding activity of the specialty in the domains of orthognathic, pre-prosthetic, and reconstructive surgeries. By this time, additionally, a growing number of training programs, including those in the U.S. Air Force, had voluntarily extended their training periods to four years. The Board, therefore, agreed to interpret its 1971 policy mandating three years of training and one year of practice for eligibility as allowing the fourth year of training in these expanded programs to count as a post-training year of experience. A year later, oral examination eligibility included the requirements of Basic Cardiac Life Support (BCLS) certification and familiarity with EKG interpretation.

Dr. Etta Berner, the examination consultant first retained in 1976, reported now, two years later, that the oral examination was much more standardized and improved overall, but recommended that weighting in grading be designed to reflect the relative emphasis of the different examination components to actual practice. She also suggested that mock examinations be instituted for the examiners themselves prior to

*James R. Hayward ... 1962-63*



the oral examination, and this instrument was, in fact, put in place that year. An example of the weighting principle was that of audible heart and lung sounds being inserted into the 1980 examination segment on management of the hospitalized patient, carrying a grading value of 10%-15% within that section.

Expanding practice was reflected in the renaming of the intraoral surgery section to intraoral surgery and associated structures in 1980, to include diseases and surgery of the salivary glands. The Board's attempt to keep abreast of the widening specialty is reflected in the fact that between 1981 and 1985 the format of the oral examination was changed three times. General physical evaluation was incorporated as one of four otherwise surgical sections in 1981, and in 1983 the physical evaluation section was joined with comprehensive care as one of five new sections, the others being anesthesia, pathology, surgery I (chiefly ambulatory) and surgery II (chiefly inpatient). In 1985, the five sections were reduced to four, three of them being chiefly surgery, and the fourth a section on anesthesia and medical management. Both candidate and examiner dissatisfaction with the quality of the heart and lung tapes introduced three years earlier led to their discontinuance after the 1983 examination.

By 1985, despite the evidence of greater activity of oral and maxillofacial surgeons in the operating room, the Board of Directors recognized, paradoxically, a decrease in activity in maxillofacial trauma. Further, in comparison with four years previously, they noted an increase in the number of inadequate cases submitted by candidates, both in number and in quality, especially in the fields of preprosthetic and reconstructive surgery. In those years, the Board rejected a number of candidate applications, and recorded that some 40% of all applicants had credentialing deficits, many of them reflecting inadequate case numbers or variety of scope.

Recognition of this disparity between training and scope of practice was one of the prompts that, in 1982, motivated the Board to again study the correlation of the written examination (recall) and oral examination (judgment). Computer analysis of scope vis a vis training experience continued, as did consideration of further possibilities in computerization of the examination. Additionally, an outside testing consultant was again brought in to observe the OCE, and, as a result, difficulty factors were introduced to the scoring of the candidates to eliminate bias resulting from differences among examiners and between one set of examination scenarios and another. The difficulty factors were used only to help the candidate who had an examiner who was more difficult than the average experienced by his peers; an "easy" examination or examiner did not penalize the test taker. The success of applying the difficulty factor of each examiner to the candidate's score prompted the Board in 1987 to evaluate the candidate's performance in relation to time of day, day of the week, sequence of examination sections, etc., as possible determinants in his/her performance. No significant correlations were found in these reviews.

In a throwback to earlier emphasis on spontaneity in the examination, the 1983 oral examination was designed to include a single five-minute test case prepared by each examiner for use in that examiner's thirty-minute oral examination segment. This measure found only limited favor with the Board and the examiners, and was retained for only two years.

Sympathy for the discrepancy between training and practice in the early 1980s was reflected in the Board's 1983 decision that the candidate did not have to pass all sections of the oral examination for success, but did have to pass either surgery I or surgery II. At this point, the examination was described as consisting of four surgical sections: surgery I continued to represent chiefly outpatient procedures, surgery II, more extensive inpatient procedures, surgery III, pathology and clinical reconstruction, and surgery IV, anesthesia and medical management of the surgical patient.

In 1988, for the first time, an oral pathologist joined the examination preparation team, both to ensure legitimacy of the pathology examination material and to offer an independent view of the OCE process in general. Dr. Henry Cherrick of the University of Nebraska was the first such consultant retained. He was followed by Dr. Alan Abrams of the University of Southern California in 1989, who was the first to actually participate in the pre-examination examiner calibration sessions. Both of these individuals offered severe but constructive criticisms of the pathology portion of the oral examination: the cases were too diverse, certain of the examiners were not fully qualified to examine on the material, certain of the visual material was inadequate, and there was too often a rush by examiners and/or candidates to complete the allotted cases in a one-hour examination. The Board took the oral pathologists' recommendations seriously, and, over the subsequent fourteen-year tenure of an oral pathology consultant, the quality of this section was continuously improved. Dr. Gilbert Lilly of the University of Iowa represented the field of oral pathology in oral examination preparation from 1993 through 2000, when Dr. Michael Rohrer of the University of Minnesota assumed this responsibility. Dr. Rohrer retained this role until the policy was discontinued after the 2003 examination.

On-site, mock examination training sessions for examiners immediately preceding the oral examination were strengthened by the middle 1980s. These were first presented in the video tape medium, but this approach was discontinued by 1988 because of its being too structured and not reflective of the two examination model. The Board, in 1987, continued its pursuit of examiner evaluation and preparation by initiating a pre-examination orientation meeting for new examiners at the AAOMS annual meeting, in the year prior to their first responsibilities.

That year, 1987, also marked the Board's first consideration of the inclusion of cosmetic surgery in the oral examination, a subject area subsequently incorporated into the 1989 OCE, and given the same weight as cleft surgery in the scoring. This inclusion represented the Board's ongoing adaption to scope of training and practice, and led to the increasing dilemma of how to balance scope vs. depth of questioning in the time allowed in the examination. To ensure internal integrity in addressing this quandary, the Board, by the



turn of the decade, demanded more of the examiners in the preparation of submitted material. Further, it sharpened its pre-examination review of material to be included in the OCE, the orientation sessions of its examiners, and the effectiveness of its examination teams. It also began a statistical comparison of the quality and difficulty of one year's examination with that of previous years.

Externally, the Board again sought the views of its processes from other professional evaluative groups. In 1987, it extended invitations to the certifying boards representing plastic and reconstructive surgery, general surgery, orthopaedic surgery, and otolaryngology, to observe its OCE sessions. These invitations did not immediately come to fruition, but a 1989 invitation to Mr. L. D. Finch of the Royal College of Surgeons resulted in his designate, Mr. John F. Gould, consultant of oral and maxillofacial surgery at the Royal Infirmary of Edinburgh, attending and offering a critique of the ABOMS Oral Examination in 1990. In 1991, Dr. Thomas Krizek, a plastic surgeon and chairman of the Department of Surgery at the University of Chicago, representing the American College of Surgeons, offered a meaningful, positive, evaluation of the 1991 oral examination. Interesting among his summary comments was his statement that, ".....histopathology on an oral examination is a daunting challenge." Krizek's commentary was ironic, because Dr. Albert Abrams, serving his last year as oral pathology consultant to the Board, in preparation for the 1991 examination had expressed his sense of a decreasing emphasis on pathology by the examiners in his section. This perhaps reflected the fact that over 60% of the examiners in 1990-91 were private practitioners.

### *The Case Defense Era*

By the early 1990s the Board again became concerned by the possibility of too much standardization and too much structure in the oral examination design. Beginning in 1990, the Board sought the written critiques of its examiners at the end of the oral examination in regard to quality of the examination material, its scope, its sampling, and its consistency from one section to another. It also instituted an immediate review by the section co-chairmen at the end of the examinations.



As a result of the information gleaned from these efforts, and in recognition of the changing practices of practitioners in the wake of specialty expansion, the Board, in 1990/91, made two noteworthy changes: it erased the difference between inpatient and outpatient operations in its major case category, reflecting the fact that an increasing number of practitioners were carrying out extensive cases on an outpatient basis, while maintaining the standard of sixteen such cases as a prerequisite for examination; and, second, it gave candidates the opportunity for

*\*Gustav O. Kruger ... 1963-64*

spontaneity and self-expression of their actual practice activities through the device of case defense, an exercise later re-termed case presentation.

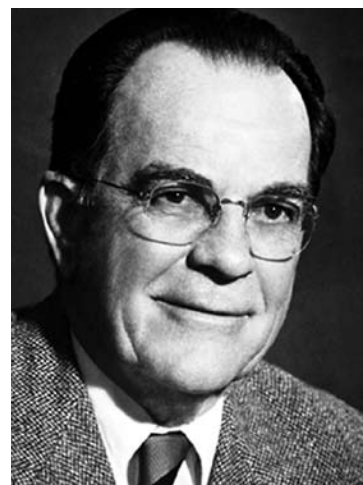
The case defense model took inspiration from the American Boards of Orthopaedics, Urology, and Plastic and Reconstructive Surgery, which had used the device for several years by that point. Interestingly, Michigan, one of the few states requiring successful completion of a specialty examination for the practice of oral and maxillofacial surgery, had incorporated case presentation for decades. In 1991, its first year of inclusion on the American Board examination, case presentation was designated section IV, of equal stature in grading with section I (dentoalveolar surgery, clefts, temporomandibular joint and pre-prosthetic procedures, sinus disease, infections, microvascular surgery, and anesthesia), section II (trauma, orthognathic, esthetic and craniofacial surgery), and section III (pathology, medicine, and reconstructive surgery). Case presentation (three cases) shared equal time with the other sections (one hour); the case presentation score was combined with the scores of the other sections to derive the comprehensive examination score, but case presentation performance represented 50% of that score. A failure on the comprehensive score required only that the candidate retake the sections failed.

In preparation for case presentation, the candidate was required to document sixteen inpatient cases, one of which had to have been a complication, and at least eight in which he or she had been the senior operating surgeon. The Board reviewed the sixteen cases, selected five that seemed most appropriate and so advised the applicants who then presented for examination three of those five of their own choosing. Probably due to the rigorous additional preparation required for case presentation, in 1992 only 142 of a potential 235 new candidates applied for examination; of 189 candidates already eligible, only 76 applied; only 60%, therefore, of all eligible candidates appeared for examination.

Interestingly, however, in that same year it was not case presentation that had the lowest average candidate score, but rather section I in which the average score was below the passing level.

By 1994, it was evident that the required documentation of the submitted cases for case presentation, particularly in regard to clinical photographs, was an increasing problem for candidates, as was the scope of cases to be submitted. These factors, plus overall mediocre performance by candidates and questions regarding the ability of case presentation to discriminate between qualified and unqualified candidates forced the Board to review the efficacy of this modality as an examination vehicle. The weight of case presentation in overall scoring was lessened.

*\* J. Lorenz Jones ... 1964-65*



While other Boards had included issues of ethics (Did the candidate actually serve as senior surgeon in his cases? Was the case undertaken in accord with true indications, or only to satisfy a Board requirement? Did the supportive materials actually match the case presented? Was coding appropriate?) in their grading, the ABOMS chose not to make ethical judgments in the examination process. Suspected violations were to be evaluated independently in accord with the stipulations of the Board's Constitution and Bylaws.

By 1997, case presentation was discontinued as a separate examination section and became integrated into 25% of the examination time of each of four newly formulated sections, the first three remaining as previously constituted, and a new fourth section on medicine and anesthesia. The candidate was now required to submit ten cases for review, four of which, one appropriate to each of the four examination sections, were selected for examination. Case presentation at this point represented 25% of the examination time, but not necessarily, and no higher than, 25% of the grading weight. Despite these changes, the quality of submitted cases continued to deteriorate. Though the Board continued to emphasize that case presentation could help the candidate more than hurt him/her, the candidates' agonies with this method of examination remained considerable. The combination of poor material submissions, calibration difficulties, and a decrease in the number of candidates, led to total discontinuance of case presentation as an instrument after the 1998 examination. When case presentation was discontinued, candidate failure appeals almost ceased.

Despite perennial discussions regarding candidate performance on the microscopic slide portion of the pathology examination, and despite Dr. Abram's 1991 sense of decreasing emphasis in this regard, the Board undertook a cataloging of its microscopic slide material in 1992. By 2002, however, microscopic identification had been removed from the oral examination and transferred to the written examination, as is discussed under the section on the Written Qualifying Examination.

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### *The Psychometric Era*

In its perpetual endeavors to promote objectivity in the Oral Certifying Examination, the Board authorized \$12,000 in 1998 for an ongoing evaluative study by Mary Lunz, chief executive officer of Measurement Research Associates, a psychometric consulting organization. Measurement Research Associates (MRA) had replaced the ACT as psychometric consultant for construction of the Written Examination in 2000, and from that point had been responsible for its encoding. Lunz lauded the Board's integrity and objectivity, but urged

incorporation of newly established evaluative measures into the OCE. Specifically, she suggested an increase in numeric data evaluation, a rotation of examiners from one section to another, and a rotation of cases between the sections. As a result of this 1999 appraisal, the Board, in 2000, initiated horizontal rotation of selected examiners to move through the various examination teams in their sections, so as to decrease any tendency toward habitual grading and to better statistically equate the scoring between sections. In the early years of the new century, vertical rotations of selected examiners through the four different sections with the same goals were also enacted. In addition, a case difficulty factor was added to the analysis of the examination, to augment the long-established examination and examiner difficulty factors. In 2002, efforts to establish an overall section difficulty factor were initiated. The Board had also retained a consultant from the American Board of Medical Specialties, Dr. David Nahrwold, to evaluate its objectivity. He, too, stressed that the Board needed a psychometrically prepared and graded examination to be in line with contemporary evaluative techniques.

The new century also marked ongoing and even expanding difficulties with candidate eligibility. Potential examinees were experiencing increasing difficulties in gaining case experience as a result of a plethora of surgeons being trained, a decreasing spectrum of insurance coverage, and practitioner emphasis on office procedures. These factors resulted in some candidates being unable to satisfy the requirement of being primary surgeon in a variety of cases reflecting the spectrum of the specialty. The number of cases necessary for submission had been decreased to ten by 2000, but this still proved problematic, particularly in relation to pathology and reconstructive cases and in the less stressed requirements for clefts, cosmetics, etc. Many of the candidates' so-called reconstructive cases referred to implant placement. Because of the overall deficiency in submitted cases, the Board was inclined to allow these submissions if adequately complex. The mandated ten cases had to cover at least seven of the thirteen defined categories, with no more than three in any one of the seven categories, and not more than two in any one subcategory of the major categories. The candidate was required to submit operative notes only on those patients operated in the hospital. This liberalization of the case requirements, however, still excluded routine dentoalveolar case reports.

The thirteen categories at this point were divided into section I (dentoalveolar, temporomandibular joint, implants, infections), section II (orthognathic surgery, trauma, esthetics), section III (pathology, reconstruction, and clefts), and section IV (anesthesia, medicine, and perioperative management). The dilemma of testing the candidate with inadequate training and experience in some of these categories (in cancer, esthetics, major reconstruction, as examples)

*\* Donald E. Cooksey ... 1965-66*



prompted the Board to consider testing only in subspecialty categories, i.e., domains in which the candidate could legitimately express personal experience. Additionally, in the spring of that same year, 2003, the Board considered shortening the oral examination sessions and combining the four current sections into three, reflecting the reality that the examination could only include a sampling of the entire scope of the specialty in either case. The potential advantages were those of more examinations being delivered in the same period of time, a decrease in the number of examiners, and overall cost saving. Despite these considered advantages, this plan was not adopted..

The histopathology visual material on the 2003 Oral Examination had proved problematic for candidates in successfully making a diagnosis, and the Board elected to discontinue this long-standing facet of the Oral Examination beginning in 2004, relying solely on the Written Examination for testing of this domain. That year's examination was designed to encompass four fifteen-minute cases in each of the four surgical sections, and section III would be slightly redesigned to discuss cases in cleft/obstructive sleep apnea, reconstruction, pathology, or oral medicine. Postoperative pain control as a domain was transferred to section II, and infections had been moved from section IV to section I in 2003. That latter examination contained 30-40% new material varying slightly from section to section, and the candidate had been graded in each of four "skill areas" on each case in each section of the examination. Data gathering and diagnosis were combined into one of the skill areas. Anatomic skulls and drawing boards were discontinued as examination aids in that same year.

Consideration of new examination construction and the costs to effect this new pattern was exhaustive. To help in these deliberations, the Board sought counsel from the American Board of Internal Medicine regarding the potential adaptability of its long-established Certificates of Added Qualification (CAQ), of which the ABIM had twenty-five, to the needs of the ABOMS. This device had been suggested by the AAOMS in particular consideration of developing a CAQ in esthetic surgery. The Board learned that most of the ABMS boards offered certificates of added qualification, and in developing these, the medical specialties considered the number of potential applicants, the number of training programs available in the particular discipline, and the public interest in such subspecialization emphasis. The Board in its deliberations on this subject elected to take no action until the AAOMS developed a definite opinion on the matter, at which point the ABOMS would make a decision as to whether or not to proceed with CAQ development. No such decision by the AAOMS came forth. The Board took the ABIM information under advisement in its effort to keep the Oral Certifying Examination pertinent to the realities of training and practice at the turn of the century.

The ABOMS incorporated several changes in the execution of the examination in these years, as well. Its long-established mock board examination for orientation of the examiners, which had been conducted extemporaneously, was proving to be ineffective. Earlier orientation labors with video tape had been similarly frustrating, and so the Board elected in 2000 to adopt a scripted mock examination during its orientation days. Section



II, in 2001, was the first to incorporate a computerized PowerPoint™ examination, eliminating the use of slide carousels and projectors; by 2003, this modality was adopted for all four sections. Further logistical changes came about with the move to the Dallas testing site where the variety of test conditions afforded by the use of hotel rooms was replaced by rooms identically equipped for all candidates and examiners.

The AAOMS, in 2000, petitioned the Board to consider helping to organize and contribute to an International Board of Oral and Maxillofacial Surgery. This proposal found conceptual sympathy among the Board of Directors, but overall operational uncertainties prompted them to defer on any such activity for the moment.

Self-policing efforts of the Board resulted in the lack of reappointment of three examiners because of failure to fulfill their responsibilities for submission of suitable examination material in 2000; the 1990s had witnessed the discharge of at least four earlier examiners for the same reasons. *\*see Addendum P7*

## **Development of the Written Qualifying Examination**

### **The Early Years (1940s – 1960s)**

The original written requirement for certification was not actually an examination. As mentioned in Chapter 1, by the time of oral examination in 1946-47, the candidate was to have provided the Board with a three thousand-word written thesis and five written case reports, unless the oral examination was to be given in the candidate's private office. In the years that followed, the thesis mandate disappeared. The case report requirement had increased to fifteen, but by 1953 was reduced to ten. It was in that year that a decision was made to inaugurate a formal written examination as the first step in the certification process. This examination could be taken immediately upon completion of the then minimum three-year training period.

By 1956, the case report requirement had also been rescinded, and a two-part certification process was established. The first step, the Written Qualifying Examination (WQE), was to emphasize the basic sciences as they related to oral surgery, and would be given in several geographic areas, as many as twenty-one, with proctors appointed by the Board of Directors. This WQE requirement was waived for candidates who had finished training prior to 1946.. In 1958, the Board established a policy of supplying the training institutions with examples of earlier Written Qualifying Examination questions for distribution as study aids to graduating trainees.

In 1959, the Board established a designated Written Qualifying Examination Committee, and, a year later, this committee, along with a similar committee for the Oral Certifying Examination, was formalized. By the middle 1960s, the Board became concerned with the appropriateness and the efficacy of the WQE. Since its inception, the function of the written examination, in part, was to serve as a screen for candidates proceeding on to

the Oral Certifying Examination, but it appeared that it was not doing so. Despite the fact that, in 1967 for example, only seventy-three candidates passed the OCE and forty-nine failed (a 60% success rate), the Board had no mechanism for correlating candidate performance on the WQE with his/her success rate on the OCE, but the suspicion remained that the WQE's inability to identify poorly prepared candidates was manifested by their low success rate on the OCE.

By this time, the Board had reaffirmed its stance of offering only one Written Examination per year to encourage candidates to focus intently on this exercise, and had established a relatively stress-free working format of three hundred questions presented in two three-hour periods. As had been earlier determined, the candidate was allowed three failures on the Written Examination before he/she would be disqualified for the Oral Certifying Examination.

The Board was determined in 1964 to establish a mechanism for correlation between Written and Oral Examination performance. The next year, it enlisted Grace Parkin, secretary of the Council of National Dental Boards of the American Dental Association, to assist in formulation of its examination questions, and in 1967 it also sought outside professional evaluation and advice regarding administration of the test. The security of the WQE became an issue by the middle 1960s, so to ensure better control of the Examination by the Board, the venue of the Written Examination was changed to Chicago alone, to be given at the time of the OCE. Leslie Fitzgerald and, in turn, Donald Cooksey, Robert Walker, and Marvin Revzin, worked with Grace Parkin to effect this change. The Board administered the Written Examination at multiple sites for the last time in 1968; beginning in 1969, the examination was administered at only one site, Chicago, a day before or after the OCE. The Written Examination no longer "qualified" the candidate to take the OCE; the two examinations carried equal grading weight and a combined score determined the overall fate of the candidate. An overall failure, regardless of candidate performance on either half of the examination, required repeating the entire process. As will be seen, this policy was changed in subsequent years.

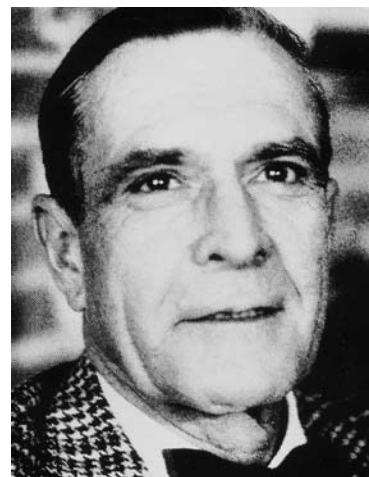
### **Later Decades (1970s – New Century)**

A further indication of the Board's continuing efforts to make the Written Examination more pertinent to the Oral Certifying Examination is evidenced by the fact that in 1969 only twenty of the three hundred WE questions were of the "problem-solving" variety, the remainder being of the "recall" form; by 1971, 30% were deemed problem solving, and by 1972, 50% were so categorized. The emphasis on problem-solving questions seemed to be beneficial, and by 1971 the passing rate on the combined written-oral one-day format rose to 72.6%. Nonetheless, the Board, in 1970, had formed three task forces, one to develop new OCE material, one specifically to address material on patient management problems for both examinations, and a third to develop up-dated material for the Written Examination. One significant Written Task Force recommendation called for continued

harvesting of questions for the Written Examination from the Advisory (Examination) Committee, and, to ensure quality, submission of usable questions to be made mandatory for examiner reappointment. The Advisory Committee had already been submitting questions for several years prior to 1974.

By 1974, President Fred Henny again called for outside evaluation of the written material, and Grace Parkin, who had been first enlisted almost a decade earlier, was again retained for an opinion. She lauded the Board for its emphasis on problem-solving. After again serving both the Written and Oral Examination needs of the Board for some two years, she was to retire, as noted in the section on the OCE, in 1976. In 1977, an observer from the Commission on Dental Accreditation was enlisted for assistance in the construction of the examination. The Board defined distinct percentages for the domains of the WE, further ensuring correlation with the OCE. Specifically, 20% of the questions were to relate to anesthesia, 20% to pathology, 30% to clinical care, 15% to diagnosis, 10% to infectious disease, and only 5% to basic sciences. This apportionment would remain essentially intact for a decade.

Ongoing determination of the Board to emphasize the pertinence and renewed significance of the WE resulted in 1983 in the Board once again separating the Written from the Oral Examination, and offering it on a regional basis. In other words, the Board reverted to the system used prior to 1969 and the Written Examination became once again a qualifying step required prior to the OCE. In the original fourteen-year combined scheme, the WE had been given to all candidates prior to the Oral Examination during examination week but, by 1972, the written exercise was scheduled in the middle of the examination period so that some candidates had their oral examinations before the written and some had them after they completed the written portion. While the arrangements were designed to emphasize to the candidates the independence of the two examinations, the joint scoring had de-emphasized, in the eyes of some directors and examiners, the independent significance of the WE. Despite its increasing orientation toward clinical matters and problem-solving, the WE still depended heavily on didactic training, and, in 1982, consideration had been given to offering the WE to trainees during their last months of residency. This notion was subsequently dismissed because of the potential prolongation of time between the two examinations for certification and because of a desire to emphasize that completion of accredited training was the first requirement of eligibility for certification.



*\* Claude S. Ladow ... 1966-67*

By 1983, the WQE again stood alone with separate grading and no influence on the OCE grade. To better validate its content in terms of consistency and reliability, the Board considered, but then deferred, transfer of the WQE to a professional testing agency. By 1986, computerized grading had been employed, and, indeed, disclosed multiple weak areas in the question pool. This resulted in the lowest passing rate since 1982. The content percentages had changed little since 1976, with only anesthesia and pathology losing slight representation, and basic science and clinical management gaining slightly. In another validative effort, the Board, in 1986, enlisted four of their most effective examiners to take the WQE and render an opinion; this measure had been first undertaken in 1972 when a larger body of the examiner corps had been enlisted for the same purpose.

Despite its best efforts and attempts at progress and consistency, by the late 1980s the Board, though satisfied with the integrity of the OCE, recognized that the overall quality of the WQE continued to suffer. Director Douglas Sinn described the WQE as being “in shambles”: its questions were not pre-tested; it suffered from an erratic filing and organization of its questions; the directors alone made all the decisions regarding the suitability of questions; and the system lacked the contribution of updated psychometrics. The Board recognized that a chief failing lay in the fact that the item writers drafted from the Examination Committee were disciplined neither in the documentation of the items they submitted nor in consistency of form. To remedy this shortcoming, the Board initiated an item-writers’ workshop to train the submitters in the skills of writing examination items. Simultaneously, cataloguing and cross-referencing of items was performed along with statistical analysis of the items’ difficulties and discriminating values.

Computerized indexing of submitted items and supportive photographic material began to take form and in 1989 the Board consulted with Resources Incorporated, a nationally recognized testing service that validated all three hundred Written Examination questions in terms of psychometric norms of quality and design. At the same time, the statisticians of the American Dental Association deemed the WQE 0.93 reliable but judged twenty-four of the three-hundred questions to be weak in either content or construction, i.e.,

ambiguous or having more than one correct answer.

An advisory group from the Examining Committee was enlisted to improve item writing and in 1990 a question-writing workshop was added to the orientation sessions of the OCE examination week in Chicago.



The composition of the Written Examination continued under the direction of the WQE Committee of the Board, which, by 1990, undertook the development of more formalized cataloguing of

*\* R. Quentin Royer ... 1967-68*

question material, stocking of appropriate backlogs of questions to be used in the future, and insistence on a stricter selection process for submitted material. For many years, the Written Committee had been mandatorily composed of four directors, but a 2003 stipulation changed its roster to “at least three” directors. Directors Thomas Williams and Paul Danielson were particularly energetic in strengthening the WQE in the 1990s. Appointed Board members had proctored the WQE at the four cities in which it was given in 1989 (later reduced to three because one site was under-utilized). This measure was undertaken to increase the security of the examination; by that date, the Board had adopted sophisticated models to detect dishonesty, consistent with the practices of other large testing organizations, including the National Board of Dental examiners. The latter’s data indicated that, in cases of suspected dishonesty, any two answer sheets with 80% or more similar answers, and with more identical answers than wrong answers, were probable evidence of malfeasance. To date, no such instances have been detected.

The end of the 1980s witnessed the inclusion of cosmetic surgery in the Written Examination, and ever-improved coordination of WQE content with the OCE examination sections. By 1990, fifty pre-test items (devices to test the validity of a question but not to be included in a candidate’s score) were added to the three-hundred question WQE. The examination was being conducted in two three-hour sessions, with a one-hour pause over midday between the sessions. A newly developed WQE format included examination in two comprehensive surgical sections of one hundred-seventy five questions, which included a pathology section of fifty questions, and an anesthesia/perioperative management section of eighty questions. To keep current with changes in training and practice, this blueprint was revised in 1992, 1994 and again in 1998.

The item writers’ workshop was proving generally effective, particularly when brought under the guidance of the American College Testing agency, which had been retained in 1991 both to guide the Board in its assembly of questions and to critique the material submitted. The costs of the workshop, however, were considerable; the original estimates, to include the ACT consulting services, the housing of a considerable number of item writers for an extra day in Chicago, the attendant hotel costs, etc, ranged between \$22,000 and \$78,000 on an annual basis, and the ultimate costs fell midway in between. Experience under consultant guidance resulted in the Board appointing a special twenty-member segment of the Examination Committee to be responsible for new questions on an annual basis. Each member was charged with submitting five examination items on an assigned topic, all appropriately referenced.

**“...the Board had adopted sophisticated models to detect dishonesty, consistent with the practices of other large testing organizations...”**



In the mid-1990s, the Board supported the efforts of the workshop mechanism by retaining a psychometrician, Mary Lunz (see section on the OCE), whose influence brought significant changes to the formats of both examinations, including modifications in the WQE grading system (see section on Grading). By 1994, the Board was considering moving the histopathology material of the OCE to the WQE. The first attempt at this method of administration was carried out through slide projections of microscopic specimens on the 1996 WQE, proctored by assigned directors at all WQE sites. This attempt proved little short of disastrous due to poor quality of the projected slides, poor lighting control in the various examination sites, time considerations, etc., and so was removed entirely from the scoring calculations for that year, and abandoned. The next year, microscopic visuals were utilized in the WQE through the medium of high quality printed material in the individual examination booklets.

By the end of the 1990s, the Board had brought the WQE from the doldrums of a non-discriminating first step toward certification that nearly everyone passed to the more discriminating role of serving as a well-controlled screen for those candidates progressing to the OCE. In addition to addressing the long-standing desires to determine any correlations between WQE and OCE candidate performance, it also began to investigate any correlations between the OMSITE (Oral and Maxillofacial Surgery In-Training Examination administered by the AAOMS to trainees) and WQE scores. Further, at this time, the ABOMS sought ACT guidance in its consideration of bringing the entire composition and production of the WQE in-house. These undertakings would be further defined in the new century.

Indeed, 2000 marked the first in-house production of the WQE, i.e., it was a product of the Board's own organization, assembly, and fabrication. Computerization of the Board's office played a significant role in its ability to take over this process, but a major motivation for the measure was cost, which had become increasingly significant in producing the examination through outside agencies. Also, because assembling written material from appointed item writers had become unrewarding, the Board brought the responsibility for question construction back under the auspices of the WQE Committee. By 2003, however, the item writers' workshop mechanism was back in place, with the participants assembling questions for the Written Qualifying Examination as well as for the Recertification Examination and the OMSITE (OMSSAT), to be discussed in later paragraphs. The workshop at that time was being conducted by Mary Lunz of Measurement Research Associates, the ABOMS' guiding psychometric consultant. First-, second-, and third-year examiners were selected to submit examination questions along with the otherwise AAOMS-appointed OMSSAT Committee. Consideration was given to combining the WQE and OMSSAT data banks, but the notion was rejected on the grounds of security since the OMSSAT was a self assessment tool and not a secured examination. The Angoff system of criterion-referenced grading remained in place into the early years of the 21st century. In 2004, the WQE demonstrated a 79% passing rate in a year in which the examination was deemed more difficult than those in immediately previous years. In 2004, the Board adopted a new policy of providing the failed candidate

information regarding his/her performance in the domain of the examination that he/she had failed. This latter action was taken to assuage failed candidates' complaints of not being able to study appropriately for re-examination. Candidate numbers in the early years of the new century maintained or even surpassed the numbers of earlier decades, despite an apparent shift from hospital-based major surgery to a largely office-based mode of practice. Particularly in light of its awareness of the specialty's decreasing activity in trauma care, the Board continued to reaffirm the emphasis on full scope of practice in the certification process to all candidates for examination.

In 2003, for the first time, the Written Examination was given in a computerized format online, directed by the Board under the guidance of Measurement Research Associates. Candidates were offered a two-week period of opportunity during February to take the examination at Pearson Professional Testing Centers at any of a number of designated sites throughout the country. *\*see Addendum P8*

## **The Recertification Examination**

A persistent question of the late twentieth century asked how society could be assured that any health practitioner had maintained current specialty-level knowledge and skills, even though he/she at one time in the past might have successfully passed a certifying examination. This was recognized as legitimate uncertainty by American medical specialties as early as the 1930s. In that earlier decade, the American Academy of Pediatrics seems to have been the first medical specialty to inaugurate a periodic recertification examination for its diplomates. By 1973, the American Board of Medical Specialties had endorsed recertification for all the specialties in medicine, and by 1997, twenty-three of the twenty-four specialties had incorporated the process, the American Board of Anesthesiology being the only exception.

The American Board of Oral and Maxillofacial Surgery first began discussions on recertification in 1968. By the early 1970s, the issue prompted constant discussion by the Board, as medical boards nationally and certain state agencies began to inquire of the ABOMS whether or not oral and maxillofacial surgery had a policy in this regard. The Board carried the discussion to the American Dental Association and learned that the ADA had taken no stance on the issue. The ADA's Council on Dental Education, however, had established an ad hoc Committee on Standards of Oral Surgery Practice and Requirements for Recertification to evaluate the concept. The CDE went on record as wanting at least documented continuing education as an annual requirement for maintenance of diplomate status. These years marked general concern with the possibility of governmental involvement in American health care, and the fear of federal imposition of recertification standards energized the Board's attention to the issue. Whether or not continuing education should be a part of recertification, how the Board's independent decision on the challenge would affect its relationship with the American Dental Association legally or procedurally, and the palpable unpopularity of the issue among its diplomates were considerations postponing a decision by the Board in the first part of the

1970s. In the late 1970s, the ABOMS, in its presentation of recertification to the specialty community in its open forum at the ASOS annual meeting, learned again, to no one's real surprise, that the concept was still heavily unpopular with those who might be required to recertify.

Finally, in 1978, the Board charged an ad hoc committee of its directors to suggest a firm position on recertification. A year later, more than a decade after it first undertook discussions, the Board endorsed recertification and undertook discussions as to its application. A voluntary examination process, an open-book exercise, and an educational format rather than a testing format, were among the early options debated.

Another decade would transpire before the first ABOMS Recertification Examination would come to fruition. In 1987, the Board consulted the American Board of Medical Specialties and the American Board of Surgery, and attended the ABMS Conference on Recertification, all in efforts to better define its own aims and format. In 1989, the Board reaffirmed its 1979 dedication to recertification, and in 1990 determined that certificates awarded in that year would require recertification in ten years. The first opportunity for those diplomates required to recertify would be given three years prior to their certificate expiration dates in order to allow any failed candidates to repeat the effort prior to termination of their original certifications. A diplomate who proved unsuccessful in his/her recertification attempts by the expiration date of his original certification would have two additional years to be re-examined; in this instance, he/she would have to document at least 30 hours of Category I continuing education credit in at least three facets of oral and maxillofacial surgery within the twelve months prior to re-applying. If he/she did not reapply within this two year period, certification would be forfeited and the individual would become a resigned diplomate.

As the Board worked its way toward its first recertification examination in 1997, it stressed to the community nationally its goals of demonstrating to society the continued competence of its diplomates, and encouraging diplomates to avail themselves of continuing education. It suggested five sources as preparatory reference material, the *Journal of Oral and Maxillofacial Surgery*, the *International Journal of Oral and Maxillofacial Surgery*, the *European Journal of Oral and Maxillofacial Surgery*, *Oral Surgery*, *Oral Medicine*, and *Oral Pathology*, and the *AAOMS Oral and Maxillofacial Surgery Knowledge Updates*. To be eligible for recertification, the diplomate was required to submit two letters of reference from other diplomates, copies of his/her current medical and or dental licenses, a tabulation of his/her twelve most recent inpatient or



\* O. Lee Ricker ... 1968-69

surgicenter surgical cases, and documentation of his/her continuing education credits over the twenty-four months immediately prior to examination. Foreign diplomates were excused from presenting copies of their licenses. To avoid the necessity for recertification, many Board-eligible candidates hurried to take the examination in 1989, swelling the ranks of examinees for that year.

In its first deliberations, the Board considered using the WQE for recertification, at least for the first three exercises in 1997, 1998, and 1999, but this plan was subsequently discarded. The blueprint for the first examination was approved in 1996, and followed the general outline of the Written Qualifying Examination. It carried entirely different questions, however, and was focused primarily on the clinical practices with which an experienced practitioner would be most familiar. The examination material was supplied by the item writers' workshop, whose members at that time were still responsible for providing the questions for the WQE.

Within two years' experience with the Recertification Examination, the Board became immersed in methods to improve its efficacy and validity. Discussions of the test being a self-study endeavor, the possibilities of core and elective modules being offered, and even virtual reality testing, filled the recertification agenda in the years leading to the new century. Indeed, in 2001 the Recertification Examination did become modular, with twenty-five mandatory questions in each of three modules (medical/surgical management and assessment, anesthesia/pain control, and dentoalveolar surgery), and twenty-five mandatory questions from each of three modules chosen from six options (trauma, reconstruction, cosmetics, orthognathic/cleft/craniofacial surgery, pathology, and temporomandibular joint surgery/pain control). By 2002, the examination incorporated case-based scenarios with visuals, and in 2003 the Board adopted computerized online testing for recertification, just as it had for the Written Qualifying Examination and the self-assessment tool for residents (see below). The examination was offered, as were the others, at Pearson Professional Testing Centers nationwide. Recertification performance was also standardized by the psychometric process of equating, with the 2000 examination established as the comparative base. Over the first years of the new century, successful passing rates ranged consistently over 90%.

The first time-limited original certificates, those granted in 1990, expired on December 31, 2000, so the number of diplomates applying for recertification mushroomed in that year. From first embarking on recertification, the Board has encouraged all diplomates, including all of its directors and members of the Examination Committee, to take the examination, as a gesture of confidence to the specialty and demonstration of the competence of its examiners. In that first year of examination, 1997, few, if any of the Examination Committee, would have been certified as late as 1990, so taking the examination was an entirely voluntary effort for that body. Past President Leon Davis, during whose presidency recertification had been enacted, was the first to take the examination voluntarily in 1997, among a total of only twelve examinees. All passed.

By 2004, thoughts regarding demonstration of continuing competence in American health practitioners had gone beyond recertification solely of the younger practitioners. In the eyes of many, “grandfathering” of many practitioners failed to meet the public need for establishing current competence and expertise. As a result, the American Board of Medical Specialties promoted the concept of Maintenance of Certification, a process that would apply to all certified practitioners. By way of example, The American Board of Plastic Surgery (ABPS) subscribed to this principle of Maintenance of Certification (MOC) and initiated an assessment of practice currency requiring not only completion of an examination but demonstration of ongoing hospital privileges, current medical licensure, three peer endorsements, and membership in one of twenty-one recognized plastic surgery specialty groups. The ABPS inaugurated the MOC in 2006 as a replacement for its long-standing recertification examination. The ABOMS, cognizant of the stance by plastic surgery and aware of similar moods elsewhere, adopted a similar tack in 2007 by replacing its established recertification process with a process for Certification Maintenance (the term Maintenance of Certification, or MOC, had been trademarked by the ABMS!), to be implemented in 2009. This policy mandated that the diplomate with an expiring time-limited certificate demonstrate fulfillment of four criteria to maintain certification:

1. Demonstration of good professional standing, evidenced by possession of a valid unrestricted license permitting the practice of oral and maxillofacial surgery;
2. Evidence of life-long learning and self-assessment; evidenced by completion of 60 hours of continuing education, 30 of which were in the preceding three years and, additionally, completion of a newly-designed ABOMS self-assessment tool;
3. Demonstration of cognitive expertise, demonstrated by successful completion of the Recertification Examination; and
4. Evaluation of performance in practice; gained through successful participation in the AAOMS office anesthesia evaluation or an alternative program made available to those who were ineligible for the office anesthesia evaluation. *\*see Addendum P9 & P10*

## **Grading of Candidate Performance**

Of equal importance to ensuring the relevance and validity of its examination material is the Board’s integrity in evaluating candidate performance. The successful candidate takes great pride after the fact in recounting the scope of material on which he/she has performed credibly, but his/her most intense concern in entering the certification process is that he/she will be judged objectively and honestly. It is, therefore, no surprise that adjudication of candidate performance, especially in differentiating among the marginally qualified candidates, has been one of the most time-consuming and intensely debated issues on the Board’s agenda. Variations in emphases between and within the Written and Oral Examinations, modified by ever-changing energies in both training and practice, have marked the Board’s evaluative exertions over its first six decades. Identifying the clearly superior performer is easy, as is naming the profoundly deficient. As with all panels responsible for weighing academic performance, the ABOMS has dedicated by far the greatest portion of its evaluative time to determining the fate of the narrow spectrum



of marginal candidates. The Board's decision affects the candidate's self-esteem, stature in the eyes of his fellows, the role he/she will play within the surgical community, and the validity of the certification process itself.

Fairness in re-examining the status of the failed candidate has been an item of emphasis. As early as 1973, the Board ensured that unsuccessful OCE candidates would not be tested again by the same team in their re-examination efforts. In 1984, it established its policy of three OCE failures mandating a total loss of eligibility for re-examination, but resolved equally strongly, in these instances, to investigate thoroughly for any flaws in the failed examinations themselves.

### **Oral Certifying Examination**

For the first eight years of the Board's existence, certification depended solely on an oral examination. Scoring in that period was entirely subjective, with the ultimate decision at first in the hands of the Board of Directors themselves, and in the first few subsequent years, within the small appointed Advisory Committee, with opinions supplied by the Board when needed. Until the middle 1960s, candidates were graded in different variations of letter scores, usually A-F. The marginal candidate posed the chief problem, and, in deciding whether such candidates would pass or fail, the Board often took into consideration the reputation and effectiveness of the candidate's examiners. By 1964, to facilitate their calculations, the Board began to investigate data processing possibilities first coming into usage elsewhere in society. Two years later, it began computerizing its data and by 1969 had adapted to this method of grading and storing examination results.

The Board brought refinements to the grading grids in the late 1960s and, in 1969, again adopted a policy of having the Written and Oral Examination grades carry equal weights in determining one combined grade. This was in the period that the Written and Oral Examinations were given in the same week. This computerization channeled the candidates into the categories of clearly passing, marginal, or clearly failing, and brought the Board more quickly to its ultimate rulings on those candidates classified as marginal. Failure on either part of the examination mandated repeating the entire examination, with no options for partial retesting.

By 1972, this failure mandate was modified. If, on a grading scale of 1-10, a candidate scored between 5-10 and had no section failures, he/she automatically passed; a score of 6-10 with one section failure also allowed the candidate to pass, as did a score of 6.5-10 if the candidate had two section failures. This principle of passing the examination despite failures in some sections persisted for the next several years,

*Robert V. Walker ... 1969-70*



although in 1973 the numerical values of the sections in the OCE changed when each of the six examination categories was given a value of 2, for a perfect OCE score of 12. This was then combined with a perfect WQE score of 8 to make 20 the perfect score on the combined test.

Differential weighting of subject areas within the OCE had been initiated in 1968, then eliminated in favor of the above-mentioned equalization in 1973. By the middle of the 1970s, almost a decade's experience with computerized tabulation of test results endorsed the validity of the automated system, and the grading sheets again were revised as were the examination sections, into a classification of surgery I, which carried 25% of the grade, surgery II, 25%, medical treatment of the surgical patient, 20%, anesthesia, 15%, and pathology, 15%. A passing grade was set at 6 out of a maximum of 10, and, though the candidate did not have to pass all sections, he/she was required to successfully pass at least one of the surgery sections. At this same time, scrutiny of more easily recoverable data from the previous fifteen years disclosed that candidates who remained in single training programs throughout their residencies did predictably better in their OCE efforts than did those who had trained at multiple sites, and, further, that the failure rate on the OCE increased linearly with the time since their completions of training.

By 1984-1985, all grading and sophisticated dissection of test results were computerized, utilizing a Louisiana State University program under the guidance of Board Director Jack Kent. As a result of these analyses, the Board was better able to review raw scores, difficulty factors, section weights, etc. The Board next elected to transfer the entire program and its responsibilities from LSU to the ADA facility but, by 1987, computer grading was proving to be more of a problem than giving the examination. Though the Board had determined that the examination difficulty factor and the examiner difficulty factor were sound and of consistent integrity, the ADA experienced trouble in determining and correlating these factors. The Board consulted the American Boards of Pediatrics and Internal Medicine for help in this regard because of their long-standing experience with computerized grading. The information gleaned from them helped temper the confusion.



By the late 1980s, the previous five sections of the OCE were combined into four, and cosmetic surgery was added to the topics to be tested, carrying the same weight as cleft surgery, which had been added in the years immediately prior. A 1-10 scoring grid was employed in each section at this time; 5 was an absolute failing score, reflecting the Board's efforts to eliminate equivocation in marginal candidate evaluation. The candidate was interviewed by two examiners in each section, resulting in eight evaluations. A candidate could fail any one of the four sections completely and still pass the examination;

*Charles A. McCallum ... 1970-71*

therefore, any two examiners could not deny the candidate's certification, but four failing scores among the eight grades mandated automatic failure. Despite these allowances, thirty-six candidates in 1989 requested a review of their OCE scores, whereas only two had requested such attention the year before. This significant increase in appeals undoubtedly reflected, as noted above, difficulties in calibrating the computerized analyses. In addressing these challenges, the Board advised appellants that the scores would be reviewed and a summary of findings provided, but no numerical information would be disclosed.

The introduction of case presentation (originally termed case defense) in 1991 again necessitated realignment of the oral examination sections. The new designations, as noted earlier, were sections I, II, III, and IV, IV being case presentation, representing 50% of the total OCE score. All four scores were combined into a comprehensive OCE grade. By 1993, case presentation was graded only as pass/fail, but in 1994 this scoring was terminated and case presentation was evaluated on a 25-point scheme. In the years shortly thereafter, as noted in the section on the Oral Examination, the Board became progressively uneasy with the whole concept of case presentation, and, in 1997, it lost its distinction as an individual section and became integrated into the other three. At this juncture, case presentation, while still representing 25% of examination time, did not necessarily represent 25% of the grade. After 1998, this segment of the examination was discontinued and did not enter further into candidate scoring.

The years of poorest OCE performance corresponded generally to the years of case presentation. During the 1990s and into the new century, there was also concern among candidates that the increasing inclusion of cosmetic procedures, malignant disease, cleft correction, etc, surgical areas not strongly represented in the training of many residents, would carry a strong influence on their OCE evaluations. In actuality, however, none of these activities ever carried any more than 2-2.5% of grading weight and would not be the sole source of a candidate's failure.

At the beginning of the new century, the drive toward objective psychometrics became more intense and was directed increasingly toward OCE scoring. Within its own ranks, the Board agonized over the role of hard numbers in the evaluation of subjective performance, versus the examiners' exercise of individuality and spontaneity in their appraisal of candidate response. Tighter objective grading was suggested by the consulting psychometrician, nonetheless, and, beginning in 2000, the candidate was evaluated in regard to his/her data gathering, diagnosis and treatment planning, patient management and treatment, and variations/complications. In each



*\* Lowell E. McKelvey ... 1971-72*

of these categories in each examination section, the examinee was graded as being unacceptable, insufficient, satisfactory, or excellent. The numerical and alphabetical scales of grading were eliminated, and the examiner graded the patient on the new performance scale in “bubble sheet” fashion. This approach eliminated the possibilities of examiner mathematical error; it also minimized interpretive comments by the examiners, and delivered the examiner from the lone decision as to whether the candidate passed or failed. By 2003, the Board had reinforced its dedication to computerized grading in the OCE with its affiliation with Measurement Research Associates (MRA), and was anchoring candidate performance to a computer-derived benchmark scale derived in 2000. In this new evaluative process, certain numbers of both examiners and cases were “anchored,” a maneuver designed to ensure even greater consistency and objectivity. The criterion-referenced grading system in place at this time demonstrated an 84% OCE passing rate in 2003 and an 88% passing rate in 2004, indicating higher candidate performance than several years previously. The number of “skill areas” on which the candidates were graded in these years had been slightly reduced, seemingly without detriment to candidate performance.

While all these measures emphasized objectivity, uncertainty to some degree remained in the minds of certain directors and the Examination Committee as to whether or not complete objectivity always accrued to the benefit of the potentially qualified candidate. As Board President Charles Alling had noted as early as 1983, despite the various format and grading systems used up to that point, the passing rates on the Oral Certifying Examination had remained fairly consistent over the years, suggesting that objectivity alone might not be the full measure of determining whether or not a candidate were worthy to achieve status of certification in the specialty. This issue would continue to be debated as the Board progressed into the 2000s.

**“...a decade’s  
experience with  
computerized  
tabulation of  
test results  
endorsed the  
validity of the  
automated  
system...”**

The previously discussed issue of determining any correlation between WQE and OCE performance had been exposed to Pearson’s correlation co-efficient scrutiny in 1989, which determined that, indeed, there was no consistent relationship between the two performances. The Board revisited the issue in 1993, and in later years noted an overall improvement in OCE passing rate when the passing rates of the WQE became more stringent and that examination truly functioned as a “qualifying” examination, sending better prepared candidates to the OCE. The potential correlation continues to be a subject of great interest.

### **Written Qualifying Examination**

The decision to develop a Written Qualifying Examination as the first step in the certifying process was born in 1953. Its incorporation into the process allowed a decrease in the number of necessary case

report submissions from fifteen to ten. Actual incorporation of a Written Examination did not occur until 1956. Its emphasis in the early years was heavily on the basic sciences, reflecting the basic science didactic year required of trainees at that time.

Material for the WQE was generated by the directors themselves and their designees from the Examination Committee. The test was scored by hand, and the results calculated by the Board itself. Imperfections in this system became more prominent as the number of candidates for examination increased, and, in 1965, as previously noted, the Written Committee of the Board worked with Grace Parkin, secretary of the ADA's Council on National Dental Boards, to improve the composition and organization of its question matter.

As reported earlier, the Board undertook initial computerization of its examination materials for both the OCE and the WQE in 1966. It further pursued this approach in 1967, perhaps propelled by the less than 60% passing rate on the WQE that year. These nascent computerization efforts helped stabilize the WQE scoring through the late 1960s, the formative years of the combined same-week Written and Oral Examinations. During this period, the Written and Oral Examinations carried equal weight in deriving a single combined score. Into the early 1970s, computerization had standardized WQE scoring and, because of its being a longer and generally more comprehensive test, the Board considered, but rejected, giving the Written Examination more scoring weight than the Oral Examination. Into the middle 1970s, the Written Examination represented only 40% (8 of 20 possible points) of the combined score. The Board also deliberated the potential for optical scoring of the Written Examination in these years, but deferred on this notion, as well. Into the middle of that decade, however, full computerization of WQE grading had been in place for five years, and seemed to be functioning well in contributing to a legitimate combined score of the WQE and OCE.

As sophistication in objective testing increased beyond the boundaries of ABOMS' capability and the scope of surgery to be examined in the OCE continued to enlarge, the Board discussed the potential gains to be realized in consistency, reliability, cost saving, and its own time apportionment, by separating the two Examinations again, and consulted a testing agency regarding execution of the WQE. As previously noted, the Board, in 1983, did again separate the Written Examination from the OCE in order to make it a true qualifying step in the certification process. The Written Examination was graded strictly on a bell curve at that point. Subsequent computerized grading identified multiple weak areas in the question pool, and, after three years of employing the Board's new methodology, the retained testing agency's application of strict psychometric principles to its scores resulted in the lowest passing rate in five years. Four examiners were appointed to take this WQE to test its appropriateness to even experienced surgeons; the Board could reach no conclusion, however, as to whether the low passing rate represented a less qualified candidate pool or a more difficult or imperfect examination.

By 1991, the Board was again sufficiently concerned with the validity of its Written Examination grading to retain John Bowers, formerly with the American College Testing



service, to suggest systems for improving the quality of the process. Bowers outlined different statistical methods for determining the passing score on the WQE:

1. Norm referencing. An analysis in which the percentage of candidates to pass or fail an examination is set in advance, such as the top 70% to pass or the lower 30% to fail. The individual's fate depends upon the overall group performance.
2. Criterion referencing. An analysis in which the absolute score for passing an examination is set in advance by content experts, i.e., experienced individuals using their judgments to establish the likelihood that a 'qualified' candidate would get an answer correct. The competence of the group has no effect on individual performance.
3. Equating. This analysis considers variations in examination difficulty from one year to the next, and makes the passing rate of one year and the passing rate of the next of the same value, despite different examination questions and different candidates.

Up to that point, the Board had essentially been using norm referencing in determining its WQE passing score, but in 1991, Bowers suggested that criterion referencing would carry greater validity, and suggested additionally, that equating be employed. The Board honored Bowers' recommendation and adopted criterion referencing for its 1993 examination. In particular, it employed the Angoff method of criterion referencing, in which the Board of Directors itself served as the content experts charged to determine individually for each examination question the likelihood of a minimally qualified candidate answering the question correctly. The average of scores compiled by the directors was then established as the passing score, i.e., the performance for a minimally qualified candidate on the WQE for that year. In 1998, to broaden the base of Angoff evaluators, the three director nominees and the co-chairmen of the OCE sections were appointed to serve in this capacity with the seven directors.

While all of the mathematical computations in the various statistical analyses suggested by Bowers refine and bring consistency to a grading system, in any of the techniques of referencing the judgment of the content expert still remains the standard against which candidate performance is appraised.



By 1996, after four years of equating, the overall average score necessary for passing the WQE stood at approximately 77. Failed candidates over the first eight years of equating on the WQE were given information on the domains on which they had been unsuccessful, to assist them in their re-examination preparation. In 2004, Angoff scoring indicated that that year's WQE was more difficult than that of previous years, and eighteen examination items were eliminated due to poor performance statistics.

*\* Jack B. Caldwell ... 1972-73*

## Recertification Examination

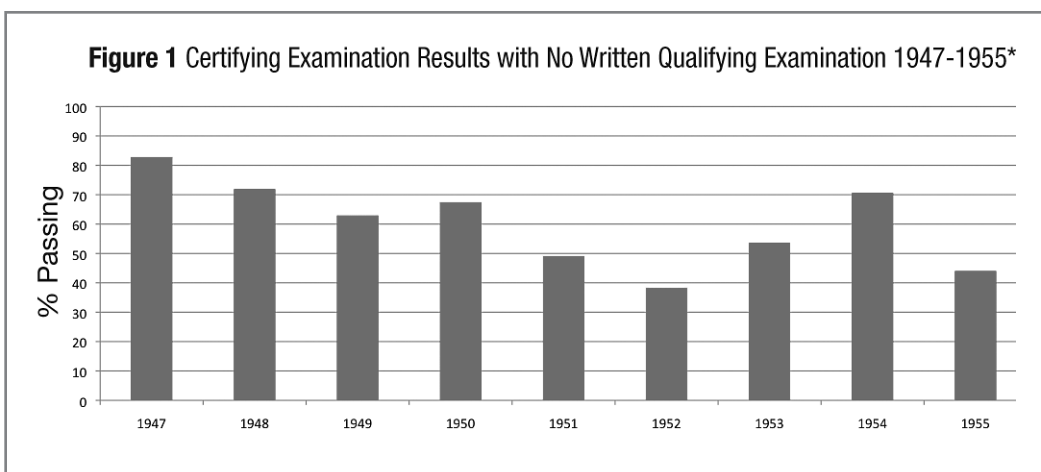
By 2007, the Board had gained a decade's experience with the Recertification Examination, which had become mandatory for all diplomates certified from 1990 onward, as noted in earlier paragraphs. Recertification Examination performance was exposed to the same criterion reference grading via the Angoff method as employed for the Written Qualifying Examination. Obviously, there were different expectations of qualifying performance for experienced practitioners than for takers of the WQE. The benchmark yardstick was established in 2000 and re-established in 2004, as experience with the examination grew. By 2005, some thousand diplomates had undergone the recertification process and had recorded success rates of consistently more than 90%.

## Passing/Failure Rates

It is ironic that although the primary function of the ABOMS has always been the certification of practitioners in the specialty, the written record suffers in only sporadic recording of candidate performances on either the Written or Oral Examinations during the first two decades of Board activity. While the archives illuminate the general course of events, and refer to the Board's satisfaction or dissatisfaction with candidate performance, actual tabulation of performances in the earlier years is inconsistent. Not until the inception of the combined WQE/OCE examination process in the 1960s does the record describe candidate performance on a regular basis.

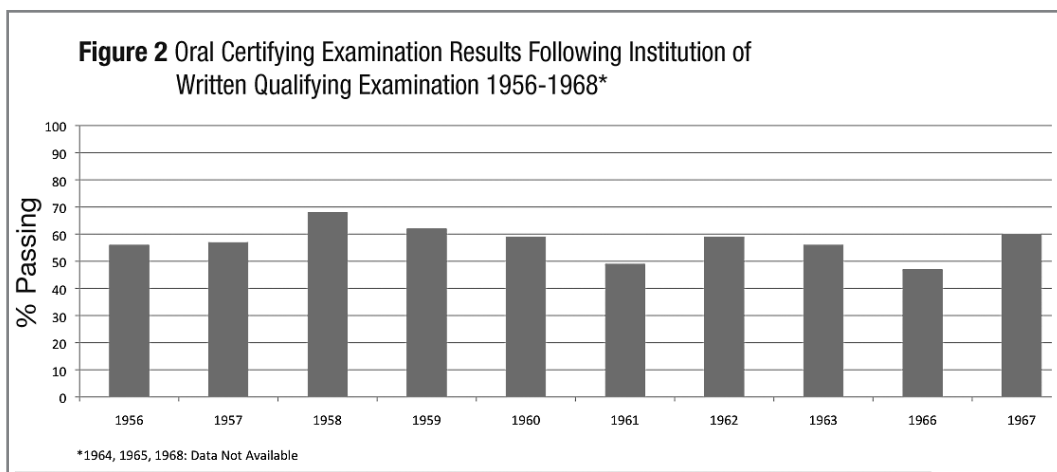
## Oral Certifying Examination

Interestingly, the very first performance on the very first Oral Examination given, that in 1947, is part of the written record; in that first examination, 60 of 63 candidates, or 95%, were successful. The average for the three examinations given in that first year was 83% (122/147 examinees). The performances of the early years are shown in Fig. 1.

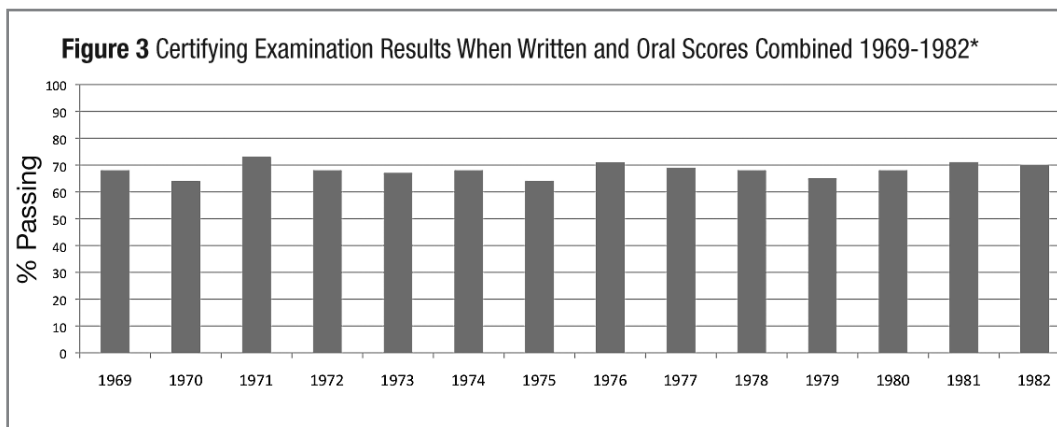


It is probably unjustified to assume that the Board was satisfied with candidate performance on the OCE during that period, with the percentage of successful candidates by the early 1960s hovering between only 50%-60%. As mentioned in an earlier segment, in

1964 the Board recorded its dissatisfaction with the WQE as a screening instrument for candidates advancing for certification testing. As of 1966, i.e., after some twenty years of examinations, there were only 835 diplomates; because, by the late 1960s, success on the OCE sank as low as 50%, the Board sought remedies to the examination process, one of which was the earlier noted conversion to a two-day combined WQE/OCE session in 1969. (Fig. 2).



Candidate performance in the first year under the combined format was poor, with a success rate of only 68%. The remaining years of this fourteen-year experience demonstrated only moderate progress in candidate performance, reaching 73% in 1971, and 71% in 1976 and 1981. This gain may have reflected increasing sophistication or discrimination in the examinations themselves, or, perhaps, better preparation, didactically and clinically, on the part of the candidates, since this decade and a half marks the great expansion in scope of practice and training, chiefly since through orthognathic and pre-prosthetic surgical activities. (Fig. 3)



The 1980s recorded a generally increased OCE success rate, with highs of 76% in 1984 and 1985, and a low of 69% in 1986. The feature most vividly marking the OCE in the 1990s was the introduction of case presentation. Interestingly, in 1990, the year before the introduction of case presentation, the OCE success rate plummeted to 63%; this

performance was one of the motivations for providing the candidate the opportunity to positively influence his/her destiny through the case presentation mechanism. Unfortunately, this did not transpire, and in 1991 the passing rate declined further to 56%, but by 1996 had risen to 87%. Despite case presentation, a record number of candidates, 275, appeared for the OCE Examination in 1992. To some degree, this represented an influx of reserve and active duty military candidates whose availability for examination had been interrupted by the 1990-91 Persian Gulf Desert Storm operations.

By 1998, the last year of its inclusion in the OCE, case presentation represented no more than 25% of the combined OCE grade, and the overall success rate in that year stood at 84%. The early years in the new century were somewhat erratic in terms of OCE performance; the success rate was 88% in 1999, 76% in 2000, 89% in 2001, 8 points lower in 2002, and in comparable range through 2008.

### Written Qualifying Examination

For the first decade following its inception in 1955, the passing rates for the Written Qualifying Examination seemed to have fallen within acceptable margins in the eyes of the Board. By 1964, however, as noted previously, it appeared that the screening intention of the Written Examination was failing in its effectiveness of allowing only qualified candidates to proceed further. In 1961, only 59% (68/115) candidates who passed the WQE subsequently passed the Oral Examination. It was at this point that the Board first attempted to correlate performances on the Written and Oral Examinations. Examination results in 1967 revealed a WQE average of 59% and an OCE performance of 60%, a finding that, in addition to WQE security concerns, may have spurred interest in combining the two examinations. This was undertaken, as noted, for the first time in 1969 and employed for the next fourteen years.

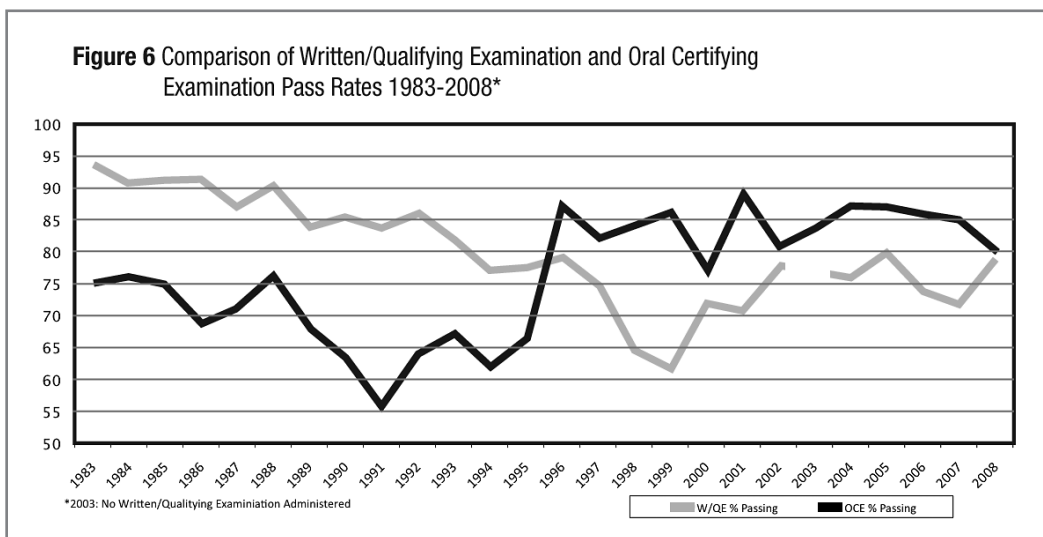
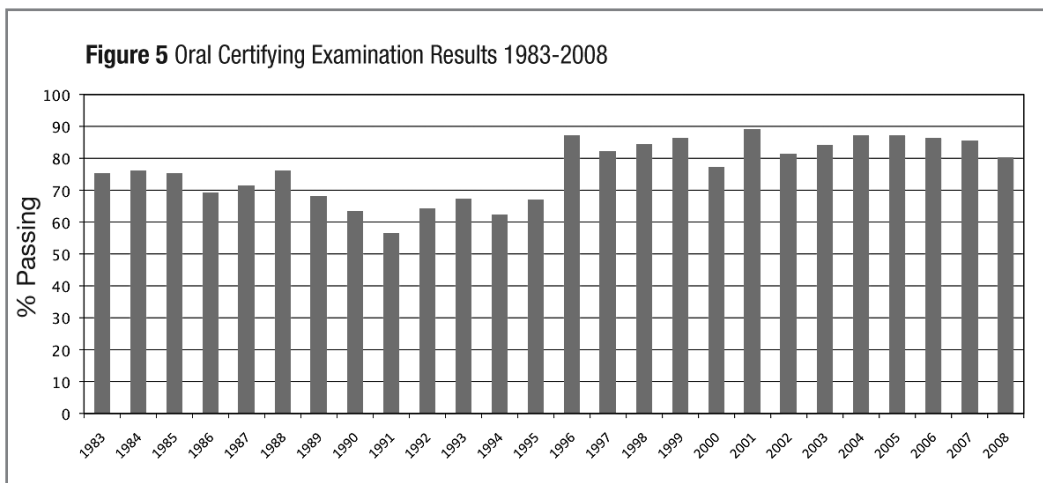
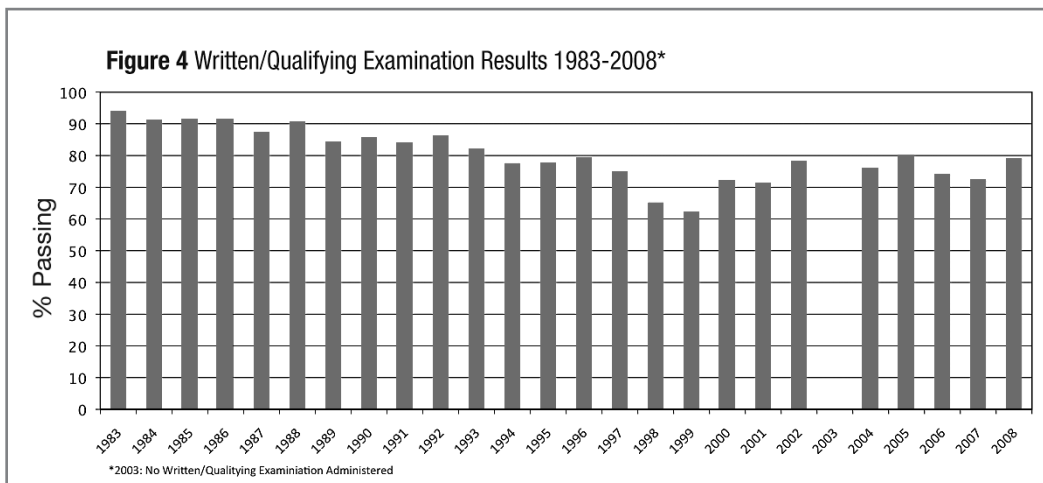
The first year of the combined scoring process was marked by the disturbingly low rate of 52%; two years later, a high of 73% was attained. Though both examinations were given equal weight in determining the combined grade, the overall combined percentage average of mid-to high 60s during this period more closely approximated the OCE rates for the years before and after, than it did the higher WQE rates for the same periods.

Interestingly, once the WQE was re-established as an independent undertaking, its passing rates for the next twenty years fell below 70% only twice, with highs of 91% in four different years over that span, and an absolute high of 93% success in 1983 (See Fig. 4). In this same period, as noted above, the OCE reached lows of 60% for several years, and a dismal 56% in 1991, the lowest rate since 1968. By the early 2000s, however, the



*\* Harold E. Boyer ... 1973-74*

rate had improved, to 87% in 2004 (See Fig. 5). While no formal statistical analysis was performed, the trend suggested that a more discriminating WQE led to higher success rates for candidates on the OCE a year or two later (See Figs. 6 and 7).

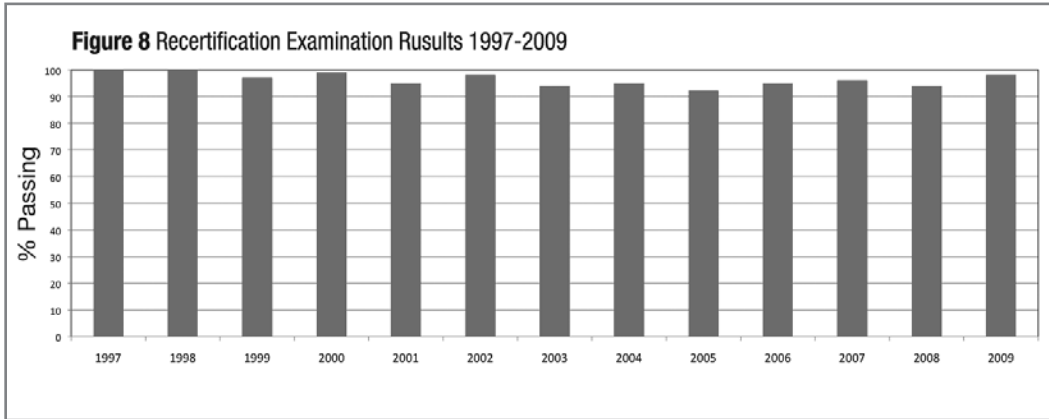




<b>Figure 7 Oral Certifying Examination Results Over Time 1947-2009</b>		<b>% Passing</b>
<sup>a</sup> 1947-1955	Strict criteria for acceptance of application Oral Certifying Examination only Small number of candidates	66
<sup>b</sup> 1956-1968	Written Qualifying Examination instituted	57
<sup>c</sup> 1969-1982	Written/Oral Examination scored together	68
<sup>d</sup> 1983-1996	Written Qualifying Examination Pass Rate 86%	70
<sup>e</sup> 1997-2009	Written Qualifying Examination Pass Rate 73%	84
<sup>a</sup> The earliest candidates first had to get past a strict hurdle of acceptance of their credentials in order to sit for the examination at all; they each submitted case reports and/or a thesis in order to qualify for the examination.		
<sup>b</sup> Institution of a Written Qualifying Examination in place of Case Reports resulted in a low certification rate.		
<sup>c</sup> Combining the Written Qualifying Examination with the Oral Examination led to an overall increase in the certification rate.		
<sup>d</sup> Reinstitution of the Written Qualifying Examination as a qualifier for the Oral Certifying Examination produced little change in the Oral Certifying Examination success rate when the standards of the Written Qualifying Examination were relatively lenient.		
<sup>e</sup> When the Written Qualifying Examination standards were made more selective, the performance of those candidates taking the Oral Certifying Examination improved.		

### Recertification Examination

Candidates first certified in 1990 or thereafter received limited certifications requiring recertification by examination every ten years. All such diplomates were allowed the options, however, of taking the Recertification Examination within the three years prior to expiration of their certificates. The first Recertification Examination was given, therefore, in 1997. In that first year, only fourteen candidates took the Examination, but all fourteen were successful. The passing rates from that first examination through 2009 have ranged from 92-98%. The number of diplomates presenting for recertification and their success rates are shown in Figure 8.



*\*see Addendum P11*

## Oral and Maxillofacial Surgery In-Training Examination (OMSITE)

As early as 1970, under the leadership of President Robert Walker, the Board undertook discussions on the potential relevance of an examination of residents during their training years. Its discussions were carried out in consultation with the American Society of Oral Surgeons and the training program directors. Within a year, agreement was reached with the American Society to establish such an examination under the aegis of the Society's Committee on Residency Education and Training. By 1976, the examination, termed the Oral and Maxillofacial Surgery In-Service Training Examination (OMSITE), had been established. The ABOMS had no role in the preparation or administration of the OMSITE at that time.

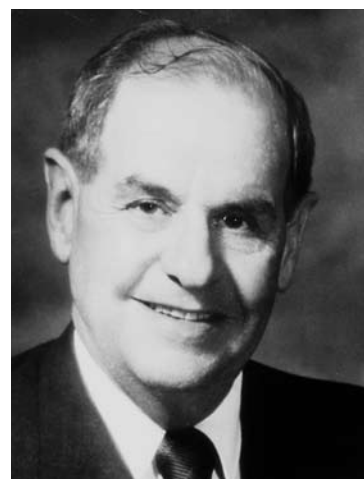
Over the following two decades, the utility, validity, and relevance of the OMSITE evoked discussion within oral and maxillofacial surgery educational ranks, and within the administrative corridors of the by-then AAOMS and ABOMS. As noted earlier, one of the considerations regarding the OMSITE that fell within the purview of the Board was whether or not OMSITE performance had any relevance to the trainees' subsequent performances on the Written Qualifying Examination and whether the former could substitute for the latter. By 1994, potential methods of assessing this relationship took space on the Board's agenda. Questions of confidentiality and security of the examination, the earnestness of attention to the OMSITE on the part of program directors and/or residents, and the scope of training in the individual programs immediately arose as potential qualifiers in determining any such relationship. Ultimately, however, the Board and AAOMS authorized an evaluation of the relationship between the OMSITE and the WQE, the results of which were published in the *Journal of Oral and Maxillofacial Surgery* in December, 2000 (Vol 58:1401-1406) under the guidance of Director Edward Ellis. This review recorded the performance of all residents in their final years of training between 1992 and 1998 and their subsequent performances on the WQE. This analysis of 765 comparisons demonstrated a highly positive correlation between good performance on the final-year OMSITE and success in first-time performance on the WQE. No further such comparisons have been executed since that time.

Cost considerations and the Board's increasing facility with computerized testing prompted the AAOMS in 1996 to approach the Board on the feasibility of assuming sole responsibility for the OMSITE. Several years' discussion ensued, but by 2002, the Board felt confident enough in its administrative and grading efficiencies to formally accept the transfer of the examination. Significant changes in the philosophy and intent of the examination had developed by that time, however. Initially, on a suggestion evolved within the AAOMS, then with general agreement by the ABOMS, emphasis was lifted from the importance of testing residents in training and transferred to *offering* them the opportunity for self-assessment. On this premise, then, the exercise was relaunched as the Oral and Maxillofacial Surgery Self-Assessment Tool (OMSSAT), remaining a conjoint effort between the AAOMS and the ABOMS. The OMSAAT Preparation Committee would have an AAOMS-appointed chairman who would select section editors, approved

by the ABOMS, responsible for organizing the examination questions. The chairman would have oversight over ABOMS activity, but would be responsible to ABOMS for the content and the management of the material itself. The Board would neither write the questions nor appoint the OMSSAT item writers, but would conduct an item writers' workshop and would administer the examination. The interested parties in overseeing the entire process would be the AAOMS, the ABOMS, and the AAOMS Faculty Section. These three entities would have a single representative on the guiding committee, the composition of which would be completed by the chairman and the eight section editors. The eight subject areas would be derived from the ABOMS' blueprint, and its composition and evaluation would be under the direction of Mary Lunz of Measurement Resources Associates. The tool would be administered through the Pearson Professional Testing Centers throughout the country in the fashion designed for the Written Qualifying and Recertification Examinations.

The first OMSSAT under the sole administration of the Board was offered in 2004 for a \$130 fee, \$106 of which went to the testing centers. There were 819 examinees, 39 of whom were diplomates of the Board. The Board deliberated later in that first year the possibility of accepting other dental and even medical specialists for OMSSAT evaluation, and referred the consideration to the AAOMS for an opinion. Only one Canadian training program participated in that first year, to some degree because of distances away from the testing centers, but by 2008 nearly all the Canadian residencies were participating during the assigned testing period of two weeks in April. The costs of the program were shared by AAOMS, ABOMS, and the training programs (or, in rare cases, trainees themselves) who paid registration fees to participate.

Beginning with the 2010 examination, the process again reverted to a secure examination and reassumed the name OMSITE or Oral and Maxillofacial Surgery In-Service Training Examination, this time with the ABOMS responsible for all phases of the activity.



*\* Robert B. Shira ... 1974-75*

In its early days as OMSITE, grading was carried out by AAOMS; there were no “passing” scores, but trainees and program directors were apprised of their performance statistics. Similarly, when the exercise existed as a self-assessment tool, and scoring became the Board’s responsibility, scoring relative to a candidate’s training-year peers and the entire group of trainees was provided. The system of evaluation was different from that of any other Board mechanism in that, as an evaluative tool rather than a test, no criterion-based pass/fail references were established. The Board maintained a tally of the number of examinees during the first five years of the OMSSAT’s existence; some eight hundred residents presented for examination. Interestingly, as noted earlier, certified diplomates were represented in examinee ranks, as many as thirty-nine in 2004. *\*see Addendum P12*

# Chapter 4

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## Administration

The ultimate administrative authority of the American Board of Oral and Maxillofacial Surgery lies in the majority vote of its Board of Directors. In that the Board is a licensed corporation, with all the legal, financial, reporting, and moral accountabilities inherent in that structure, the guidance and execution of its decisions depend mightily on a responsible administrative framework. Over its first six decades, the Board has been well served in that regard.

### Staff and Staff Needs

For the first two decades of its existence, Leslie M. FitzGerald, under one title or another, served the Board as its secretary. From 1947-1958, FitzGerald served as a perennial voting director of the Board but in 1959, in accord with an ADA Council on Dental Education ruling that an administrative secretary of any board could no longer serve on that Board's voting directorate, FitzGerald relinquished his position on the ABOS Board of Directors and assumed the administrative role of executive secretary. In 1961, the Board authorized him a \$300 annual salary and other unspecified monies for part-time secretarial help.

In 1968, the Board decided to move its administrative offices from FitzGerald's private practice in Dubuque, Iowa, to Chicago the following year and elected to hire its first full-time staff member. Judith Wiley was hired as administrative assistant, remaining only until relieved in 1969. Also in 1968, in accord with the administrative changes inherent in the impending move of the offices, Harold Boyer, an elected director, assumed the office of board secretary and FitzGerald became its non-director treasurer. In the year after the move to Chicago, the duties of secretary-treasurer became vested in one director, Harold Boyer, and Leslie FitzGerald was named consultant in administrative and financial affairs, on call at the request of the president or secretary of the Board. In 1969, the American Society of Oral Surgeons dedicated its annual meeting to Leslie FitzGerald, and, from 1970 until his death in 1971, FitzGerald served as honorary president of the American Board of Oral Surgery.



Boyer brought notable service to his role as secretary-treasurer. In his first year he developed a method of coding meeting minutes by month and year to overcome the Board's difficulty in recalling or recovering its previous activities. Boyer continued to serve as secretary-treasurer through 1972. He ascended to the presidency in 1973, at which point the Board elected a new secretary-treasurer from its ranks. At the completion of his tour as president, Boyer was retained by the Board to serve as consultant on administrative affairs for an additional two years.

Boyer's roles overlapped the Board's hiring of its first assistant secretary, Roberta ("Bobbi") Leggett, as it settled into its Chicago offices in 1969. Miss Leggett was to serve in that full-time capacity for the next eighteen years. In 1972, a part-time typist was employed to lighten Leggett's growing duties. Two years later this latter individual resigned and an administrative assistant to the "central office secretary" (another designation of Bobbi Leggett's position) came on board.

Bobbi Leggett's titles seemed to vary in the early years of her tenure, but she was given check-writing authority in 1975. Her service under whatever title was obviously appreciated, as reflected in progressive salary increases throughout her tenure. The secretary (alternately termed the administrative assistant) to Leggett hired in 1974, a Miss Glaum, was retained with a full-time salary until 1979. By 1982, the Board had hired a new administrative assistant to Leggett, who now carried the title of executive secretary. The new post was re-termed assistant executive secretary in 1983, but a year later the individual in that designation resigned, and the position was discontinued; in her place, a secretary was hired to assist Leggett. In that same year, Leggett's title of executive secretary was reconfigured to executive director, and she was authorized a 15% increase in salary. The array of titles from the end of the 1960s to the middle of the 1980s, though confusing, reflected the Board's recognition of the need for a full-time lay administrator and a junior person in support.

Leggett remained in her role until 1987. Upon her resignation, Susan Rohe was hired as executive secretary. Susan Rohe, who became Susan Holzer during her tenure, served the Board admirably until 1994, when, in September of that year, she resigned to focus on her growing family responsibilities. In that same year, Christine Reynolds, Holzer's assistant, suffered physical impairment and also had to leave her position.



Following Susan Holzer's resignation, the Board undertook an intense replacement search and selected Cheryl Mounts as its new executive secretary.

*\* Fred A. Henny ... 1975-76*

Mounts met the full Board for the first time at the 1994 AAOMS Annual Meeting in Denver, Colorado. Within two years, to accommodate the expanding administrative responsibilities in the Chicago office, the Board named Marina Blakeman as assistant executive secretary to Mounts. Within another year, the Board had appointed a third individual, Jenny Greenlimb, as administrative assistant. By the year 2000, though the titles of assistant executive secretary and administrative assistant were retired with the departure of those individuals because of family and educational considerations, the Board continued to support Mounts' responsibilities with a junior staff of three members, Karen Doerr, Caroline Filas and Shonda Oliver. In 2003, Cheryl Mounts exchanged the title of executive secretary for that of executive director, and her staff came to consist of two managers of educational services, Karen Doerr and Caroline Filas, and an administrative coordinator, Shanda Oliver. A year earlier, the Board formalized procedures for succession in case of executive director loss.

Early in the development of its administrative staff, the Board addressed the issue of employee welfare. In 1973, it designed its first program of employee benefits under its policy of employment benefits for full-time employees of the ABOMS. This policy included an annuity, life insurance, medical insurance, and an income protection plan. The pension plan was updated in 1988 for all staff having served one year of employment and, in 1989, the Board authorized maternity leave. The costs of these benefits have been considerable; as an example, the Blue Cross-Blue Shield medical insurance premiums for the staff increased 69% in one year, 1990, but the Board elected, as did many employers at the time, "for the good of the corps," to retain the insurance despite the negative financial impact in doing so.

The move from Dubuque to its new offices in the ADA Building in Chicago in 1969 had coincided with a marked increase in Board activities and responsibilities, as a reflection of the overall increase in number of individuals seeking certification in the specialty. Accordingly, the administrative office demanded regular updating and remodeling and, by 1973, its administrative activities mandated the development of an *Administrative Procedure Manual*. The manual was completely revised in 1984.

In 1986, the Board made its first foray into in-house computerization with its purchase of a Wang computer. This was followed by the 1989 purchase of an IBM PS-2 computer. Interestingly, in that same year, the Board decided not to purchase a facsimile machine because the \$2,396 price was deemed too expensive! By 1995, however, its grasp of the costs of business mechanization had broadened, and it authorized \$17,000 for improvement of its computer capacity. A year later, it dedicated \$75,000 to consultation, hardware/software, and overall computerization updating for its administrative and grading purposes. As a result of this investment, it initiated, in 1997, a three-year program of computerized integration of all Board functions.

To facilitate staff preparation of its examination visual material, the Board, in 1989, invested in slide duplicating equipment to unify the presentation of materials in all examination sections, and, by 2001 had authorized the staff to begin replacing 35 mm slide projection with LCD projection equipment. By the end of the 20th century, it had directed staff to develop a Web site describing all Board policies and activities, to complement its first effort initiated in 1996.

As early as 1976, the Board had established a standing library at its ADA headquarters through the encouragement of a generous donation from Drs. Andrew Tolas and R.V. Walker. This library moved with the headquarters to the new Michigan Avenue site and was significantly updated in 1992. Five years later, it was expanded to include educational video tapes and compact discs. *\*see Addendum P13*

## **Seats of Administration**

Among James A. Blue's early formulations for an American Board of Oral Surgery and Exodontia in 1937 was his suggestion that its first administrative office be established in Richmond, Virginia, for reasons not elucidated in the written record. In any event, the first Chicago ad hoc headquarters was established in the Stevens Hotel (which became the Conrad Hilton in 1978) during the Oral Examination deliberations in 1946. Establishment of a fixed headquarters, however, was determined in that same year, and would reside in the private practice of Leslie FitzGerald in Dubuque, Iowa, from 1947 until the 1969 move to the American Dental Association headquarters building in Chicago. Interestingly, however, all financial operations of the Board were retained in the Louisville, Kentucky, offices of Harold Boyer until 1974. This circumstance was testament to the efficiency and dedication that Harold Boyer brought to the office of secretary-treasurer. The financial records ultimately were relocated to the new Chicago address in 1975.

The Dubuque to Chicago move was authorized in 1968 and effected in 1969. After two years in its new quarters, the office moved to a directly adjacent larger space in the ADA Building, and in 1980 relocated to even larger quarters in the building. Though the Board negotiated a new five-year lease with the ADA in 1981, its relationship with its hosts was not entirely harmonious in those years and, in 1987, the Board made its decision to retain new offices in Chicago outside the confines of the ADA Building. Accordingly, it moved its headquarters to 625 North Michigan Avenue in 1988, which allowed it more space, greater autonomy, the enjoyment of fourteen months free rent, and a rental rate of \$16/square foot, as opposed to the ADA charges of \$18/square foot.

The Board became frustrated from time to time with its new landlord. As an example, in 1990 the lessor attempted to charge the Board for air conditioning, in direct contravention to the lease agreement, and in the same year the Board's secretary discovered several irregularities in other financial charges directed to the Board. Board frustrations mounted to the point of its considering a move to Wacker Drive in Chicago in 1991. It took no action at that point, but four years later again considered moving from Michigan Avenue

because of increasing costs and overall dissatisfaction with the landlord. Between 1993 and 1997, the office rent had doubled, but, in that latter year, the Board came to general reconciliation with its lessor and, in fact, elected to expand and renovate its office site. By 2004, the Board was in earnest negotiations with its Michigan Avenue landlord, Mainland Properties 625 NMA LP, and, in 2006, extended its lease through February, 2015. In that same year, it expanded into new accommodations on the same floor at 625 North Michigan Avenue.

## Board Meeting Sites

As early as 1955, the Board had established a policy of conducting a business meeting at ASOS annual meetings, chiefly to facilitate liaison with the sponsoring organization. The policy of conducting business in Chicago or at the ASOS annual meeting was not wholly exclusive, however, and by 1972 the Board had held off-site meetings in Las Vegas, Atlantic City, New York City, and New Orleans. However, in 1974, the Board adopted an annual routine of a Chicago meeting during the Oral Certifying Examination week, one additional Chicago headquarters meeting, an Oral Examination evaluation meeting, and a summer general business session, the latter two of which by the 1980s were often held outside Chicago. By the 1980s, the Board Credentials Committee regularly conducted its business at the Chicago headquarters in the fall. Other Board committees, such as the Written Examination Committee, also conducted business at the Chicago headquarters at various times of the year. As early as 1991, the potential for video conferencing had become a topic of repeated discussion by the Board, but had been deemed insufficiently interactive and still too expensive to replace the face-to-face assembly of all directors. Intermittently, and rather intensely in 1995, the Board considered reducing the number of meetings, but so far in its history has been unsuccessful in that regard. By 2003, however, the Board had determined that, under Illinois law, conference calls could substitute for in-person conferences, even if that stipulation was not specifically mentioned in its bylaws or articles of incorporation. *\*see Addendum P14*

## Constitution and Bylaws

The frameworks that reflect the legitimacy, provide the guiding principles, and explain the day-to-day operations of any organization are its constitution and bylaws. These cornerstones derive from the philosophies and intentions of the founders. They are exposed to continuing revision by subsequent leadership in response to societal and professional community change, and must at all times satisfy legal oversight.

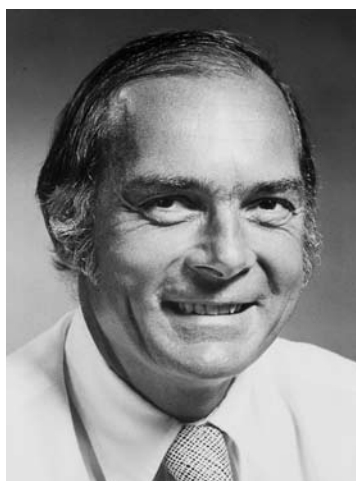


*ADA Building*

The constitution is essentially a philosophical document explaining the *raison d'être* of an organization and the general principles it intends to honor in its operations. The bylaws describe the practical guidelines that the organization must honor in carrying out the principles of its constitution. The policies describe the mechanisms the organization will employ in honoring the mandates of its bylaws. The policies are subject to rather frequent change; alterations of bylaws and, certainly, of the constitution, generally require intense and often protracted deliberations. For his superlative efforts in helping to establish the original constitution of the American Board of Oral Surgery, as well as bringing it to recognition by the American Dental Association, James A. Blue was awarded the first Founders Certificate by the ABOS in 1946, saluting his ten-year effort to that point.

The need for flexibility in Board policies was quickly recognized, and changes were fairly common as the Board adapted the principles of its constitution and the stringencies of its bylaws to everyday functions. In 1957, for example, the Board enacted a momentary policy change to its bylaw mandating three nominees for director election, in order to accommodate the fact that only one nominee would be provided that year; Dr. Gustav Kruger was readily elected by the American Society of Oral Surgeons. The issue of director election required significant attention to and modification of the bylaws and policies in later years, as is described in later paragraphs. A notable bylaws change in 1969 was that which accommodated a consultant in administrative and financial affairs, to keep Leslie M. FitzGerald active following his retirement, as noted in earlier pages.

In the early 1970s, the Board stressed in its constitution and bylaws that its role in the profession was the certification of candidates to the public as having completed accredited training, demonstrated periods of experience in the specialty, and succeeded in a series of examinations of their knowledge of the specialty. It did not specifically outline its role in influencing education, though its permanent representation on the Advisory Committee of the Commission on Dental Accreditation gave it a role both in the establishment of training standards and in the determination of which programs met those standards.



Because of the importance of certification to the individual candidate, his/her ability to appeal a failing score on examination was duly recognized by the Board, and procedures for providing such candidates due process of appeal were codified in the bylaws and policies. For several years prior to 1975, the failing candidate was allowed to examine his/her results upon written request. In 1977, this somewhat informal stance was inserted as a formal amendment to the policies, and a definite step-by-step mechanism for appeal was instituted. For some twenty years after

*Philip T. Fleuchaus ... 1976-77*



this, formal appeals of failed candidates occurred only infrequently. However, in 1989 thirty-six candidates requested reviews of their scores, though only two had requested this consideration the year before. The Board honored these requests and submitted a summary of their findings to those thirty-six without specific numerical information. Only a few subsequently embarked upon the formal appeal procedure. In 1990, the Board adopted a new policy for appeals, stipulating that the president would appoint three directors to arrange a hearing with the appellant at the next following AAOMS annual meeting, to evaluate his/her appeal, review the examination grades, and render a decision to either uphold or refute the failing score. In 1995, in the middle of the case presentation era, seven formal appeals were entertained, two of which resulted in reversals of the failing grades.

The early 1970s witnessed a significant amendment to the ABOS Bylaws, when, as discussed in Chapter II, the Board received notification from the ADA that it stood in violation of the ADA guidelines for the specialties which stipulated that, “...appointment to the Board must be made through the nomination and election of the constituency of its parent organization...”, because it had no formalized policy in this regard. This issue had been brought to the ADA by the founders of the American College of Oral and Maxillofacial Surgeons (ACOMS) who complained that the Board was self-perpetuating, on one hand, and, on the other, had its directors elected from the ASOS House of Delegates, the majority of whom were not Board diplomates. This issue is discussed further in Chapter V. In any event, in response to the ADA’s recommendation, the ABOS codified its bylaws to state that the three nominees selected by its Examination Committee, would be forwarded to the ASOS president for presentation to the ASOS House of Delegates. This had been the apparently unwritten policy in decades past. The now-stipulated bylaw, in effect, made the Board nominees the ASOS nominees, and the House vote satisfied the ADA mandate. Additional nominations from the floor of the House of Delegates would also be allowed, but any such nominees would have to carry five endorsors, and would have to meet all the eligibility requirements for service as a director. The ASOS amended its bylaws in the same year to establish the same guidelines. The ASOS president at the time, Dr. Elmer Bear, emphasized that it would be understood by the ASOS that the three nominees presented to the House would be those delivered in advance to the ASOS president by the ABOS. The issue of director election gains additional brief mention below under Legal Considerations.

This 1972 director revision was accompanied by a second new provision in the bylaws of both the ABOS and ASOS to accommodate the need to elect two directors in the same year in the event of an unexpected vacancy on the ABOS. Should this occur, the House of Delegates would be charged with



*Thomas W. Quinn ... 1977-78*

electing two directors from an ABOS-submitted slate of four nominees. This policy was restated in 2002 to accommodate that exact circumstance, when a director, after being on a leave of absence for some six months because of medical considerations, resigned at the end of that period.

By the late 1960s, the Board, recognizing the increasing complexity of its policies, initiated a two-year effort to develop a ready reference for its activities. The changes of this period in the early years of the 1970s were incorporated into a complete revision of the ABOMS Constitution and Bylaws in 1972 and, as noted previously, the development of its first procedure manual for administrative personnel, published in 1973 and revised in 1984. The Board undertook a general review and updating of its bylaws in 1995.

Concerns with qualifications of both candidates at examination and diplomates at annual registration arose by the 1980s. In the first year of that decade, the Board amended its bylaws to mandate a dental license for both examination and certification, since the specialty, by ADA definition, was a part of dentistry. This issue had arisen in the overall debate of general education and licensure, as discussed later under Examination Considerations.

The fraudulent use of “diplomate” increased in the middle 1980s and into the early 1990s, as commercial advertising in the profession and specialty became more common and sometimes blatantly misleading. The Board developed a set policy to respond to the misuse of “diplomate,” “board certified,” etc. The policy stipulated that the president would personally speak with any violator, and the Board would notify in writing the chairman of the AAOMS Commission on Professional Conduct, the authorities of the violator’s local dental society, the president of his/her state oral and maxillofacial surgery society, and all the ABOMS diplomates in the violator’s area. Finally, the violator would be obliged to verify in writing to the Board that he/she had notified all his/her patients and associated hospitals of his/her misrepresentations. After the general review and updating of its bylaws in 1995, the Board in 1999 inserted very strong language into its policies concerning ethics in general, on the part of both candidates and diplomates.

At various junctures, the Board has demonstrated efforts to maintain its integrity and neutrality. In 1988, the policies were amended to reflect that AAOMS officers could not serve as examiners, and, three years later, distanced itself from other organizations with a policy change stipulating that no director or examiner might serve as a trustee on the boards of the AAOMS, ACOMS, ADA, OMS Foundation, or OMSNIC (Oral and Maxillofacial Surgery National Insurance Company). Also in 1991, the Board reflected in its bylaws its rejection of a presidential stipend.

Other policy changes during the 1990s included the insertion of a requirement for foreign graduates to perform one year at the senior level in a CODA-accredited program (see Eligibilities below) to qualify for examination consideration. In 1999, the Board enacted a policies amendment to mandate that the Board Reserve Fund be equal in size to the “normal” annual operating expenses. Previous measures regarding financial affairs had

not always been stipulated in the bylaws, thus the inclusion of this 1999 amendment in the policies. An additional policy change in this last year of the century directed that the Board not report to, or inquire of, the National Practitioner Data Bank. Finally, in 1999, in accord with the national trend among all educational and many business institutions, the Board incorporated a mission statement into its constitution and bylaws.

In 2002, the established responsibilities of the directors were re-emphasized in the negation of a proposed bylaws change to reduce the number of directors to six. In 2008, as noted in Chapter II, the Board amended the constitution to include the immediate past president as a fourth officer of the American Board of Oral and Maxillofacial Surgery.

## **Financial Affairs**

The financial affairs of the Board have always commanded significant time and thought of the officers, directors, and administrative staff. The principal considerations have been garnering candidate fees, establishing realistic operating and reserve funds, determining annual budgets, honoring all business and administrative costs, maintaining a sound investment policy for reserves, and financial oversight.

## **General Responsibilities**

Throughout the first two decades of its activities, Board operations were funded solely through candidate fees and diplomate annual registrations. In subsequent years, this policy was adjusted as Board activities occasionally overran these sources of income on the one hand, and additional sources of revenue augmented the treasury on the other. As early as 1947, the Board established a \$5,000 reserve fund designed to keep the Board functioning for a period without income, and to ensure examination of candidates already registered should the Board for any reason become insolvent. This fulfilled a requirement of the American Dental Association's Council on Dental Education for recognition of specialty certifying boards. The fund in 1961 was strengthened to equal two years of the operating budget at that time. In 1974, this requirement was rephrased slightly to establish the reserve fund balance at twice the annual expenditures for each given year, which by that time was reflected in a fund of \$160,000. The sums involved had grown sufficiently to mandate a thoroughly reviewed and detailed annual financial report, which was first produced in 1970. Within a few years, the potential demands on the reserve fund (which became the official title, relieving it of the "investment fund" terminology that had been informally used intermittently in previous years) required that the monetary reserves equal 2.5 times the "normal annual operating expenses." By the end of the century, however, the operating expenses had become sufficiently large to force the Board to amend the reserve policy to require a more realistic reserve fund balance equal to only one year's annual operating expenses. Arguments to reduce expenses and preserve the higher reserve fund levels did not carry the day. By 2002, the Board had adopted a "revenue neutral" stance regarding the WQE, OCE, and RE, requiring that these examinations pay for themselves without requiring support from the reserve fund. Rising examination preparation costs, the cost of committee meetings, and the cost of living adjustments for the administrative

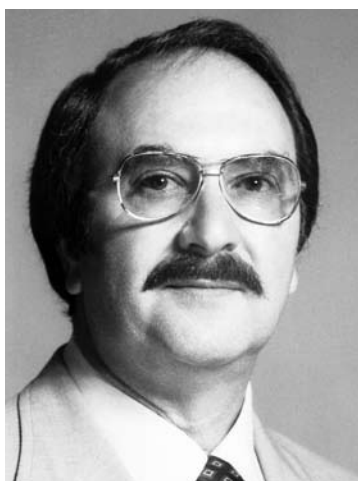
staff were the underlying reasons for this posture. Not unexpectedly, this policy resulted in significantly higher candidate fees, as noted below. Because of ever-increasing expenditures, the Board wisely amended its policies in 2004, to require full Board approval of any expenditure 15% or more above budgeted amounts.

Occasionally, the Board has elected to fund special projects such as the establishment of the aforementioned reference library in 1976, a \$5,000 contribution to the Oral and Maxillofacial Surgery Foundation PEER Campaign (Professional Excellence in Education and Research) in 1988, and the funding of a study to compare candidate performance on the OMSITE and WQE, which was published in 1998.

The Board has demonstrated diligence in the disbursement of its monies in day-to-day operations, as attested by its obtaining group airline rates for the directors and staff, its constant review of its headquarters' lease (discovering in 1990, for example, significant overcharges by its landlord) and in its rejection of the notion of a presidential stipend in 1991. In the early 1980s and again in the 1990s, tight financial control of the budget was reinforced with a policy of the secretary-treasurer receiving a detailed financial statement from the executive director on a monthly basis. Despite these efforts, however, and primarily because of its being the dental board with the greatest activity, the *1989 Report on National Certifying Boards for Specialty Areas of Dental Practice* announced that the costs of certification in oral and maxillofacial surgery were the highest in dentistry, followed most closely by those in pediatric dentistry and periodontics. \*see *Addendum P15*

## Examination Fees

The first Board of Directors in 1946 had hoped to keep the examination fee for the one-part certification process, the Oral Examination, at \$75, but subsequently determined that the fee for the first examinations in 1947 would be \$100. This almost immediate fee change reflected the realities of financial equilibrium that the Board would be compelled to face at frequent intervals. By the early 1950s, the Board found it necessary, for example, to initiate a \$35 application fee as a prerequisite before the examination fees were assessed. The application fee was increased significantly over the next twenty-five years, but later, perhaps to avoid discouraging potential candidates from applying, necessary increases were shifted to the examination fees and away from the application fee.



By 1990, the Board was gaining a significant per-candidate profit from the WQE, which offset a somewhat lesser per-candidate loss absorbed by the Board for the OCE. The details of these calculations

\* *Marvin E. Revzin ... 1978-79*

are unclear from the record, but they do reflect the fact that there were at that time, and have been since, significantly more candidates per year taking the WQE than the OCE. This variance in the number of candidates for the two examinations in any given year has made it difficult for the Board to set the fees in such a way as to deliver “revenue neutral” examinations. The problem was confounded in the latter 1990s by a decrease in WQE examination fee revenues as the number of applicants decreased. In 2001, the Board formally adopted a “revenue neutral” stance for the WQE and OCE, a policy designed to avoid withdrawals from the reserve fund to produce the examinations. This posture resulted in significant increases in the fees for both examinations.

Another consistent source of revenue for the American Board has been that of the annual registration obligation of the diplomates, as required for recognition of the Board by the Council on Dental Accreditation. This registration fee for maintaining an authentic current roster of ABOMS diplomates was first established in 1959 at \$3 per annum. As the costs of maintaining and distributing the roster rose over the decades, so did the annual registration fee, so that fifty years after its inception it had increased many fold.

The re-examination of candidates who have failed either the WQE or OCE has carried a re-application fee since the early days of the Board. Up until the early 1970s, this fee was the same as that for the OCE, \$250. The fee for reexamination had kept general pace with the fees charged to those candidates taking either the WQE or the OCE for the first time until the later years of the new millennium’s first decade, when the Board began to require only examination fees of the failed WQE and OCE candidate if there was remaining eligibility on his or her original application. If not, a reapplication fee was required to reinitiate the process.

As recertification became obligatory, the Board established a \$50 application fee for the Recertification Examination, and a \$200 fee for the examination itself. These fees, too, increased notably in the 2001 adoption of the “revenue neutral” stance.

The Board’s activities expanded on several fronts in the final years of the last century. Third-party reimbursement procedures and legal issues became more complex, bringing new burdens to candidate tracking. The number of inquiries to the Board by outside interests came to consume considerable administrative time. In one six-month period in 1996-1997, eight hundred ninety queries were directed to the Board. Consequently, in 1995, a \$5 diplomate verification fee was levied for inquiries from outside interests. By 2003, however, these requests had diminished significantly, and the Board projected a decrease in verification income of some 30%. The change in the number of inquiries was attributed to the fact that verification agencies had come online over the previous decade, which provided blanket verification data for any particular individual to whatever inquiries at whatever time.

Overall responsibility for the Oral and Maxillofacial Surgery Self-Assessment Tool (OMSSAT, formerly OMSITE), was transferred from the AAOMS to the American Board in 2003. The OMSSAT was subsequently abandoned, and the OMSITE re-instituted and transferred to



exclusive Board management (see Chapter III). At the time the OMSSAT reverted back to the OMSITE, the examination fee rested at \$210.

Fee determination has reflected the Board's efforts to be fair to candidates, to scale candidate and diplomate charges to overall societal costs, and to answer the demands of its own budget expenditures. In later years, the Board has based its decisions on the national economic indices. *\*see Addendum P15*

## **Funds/Budget**

The original directors recognized the necessity of having monetary reserves to cover the unexpected. In their 1947 fledgling efforts, they established a reserve fund of \$5,000 to be augmented with \$500 annually. This money was to be invested in United States Bonds. The Board added \$10,000 in US Treasury notes and, for the first time, \$10,000 in certificates of deposit to the fund in 1959. Two years later, as noted earlier, the Board established a policy of holding two years' annual operating costs in reserve, and resolved that the fund would consist only of government securities and certificates of deposit.

Within fifteen years, the overall income of the Board stood at slightly more than 2½ times its budget expenditures, so that the reserve fund at its prescribed ratio remained secure. To protect the reserve fund, however, the Board in 1976 resolved to maintain one year's budget expenses in an operating fund, and to hold the reserve fund (now the correct reference, as opposed to the earlier "investment fund") at 2½ times the strength of that operating fund.

The budget then began to increase remarkably and, by 1980, had reached a quarter of a million dollars while the reserve fund represented only slightly over half that amount. By the end of that decade, the Board had significantly increased the reserve fund, but the budget had also almost doubled. At one point, a five-figure deficit required transfer of reserve fund monies to the operating fund. The records of financial resources for this period are somewhat erratic, suggesting consternation on the part of the Board in addressing its financial adjustments. The general upward trend of expenditures, however, is quite clear. (Fig. 9)

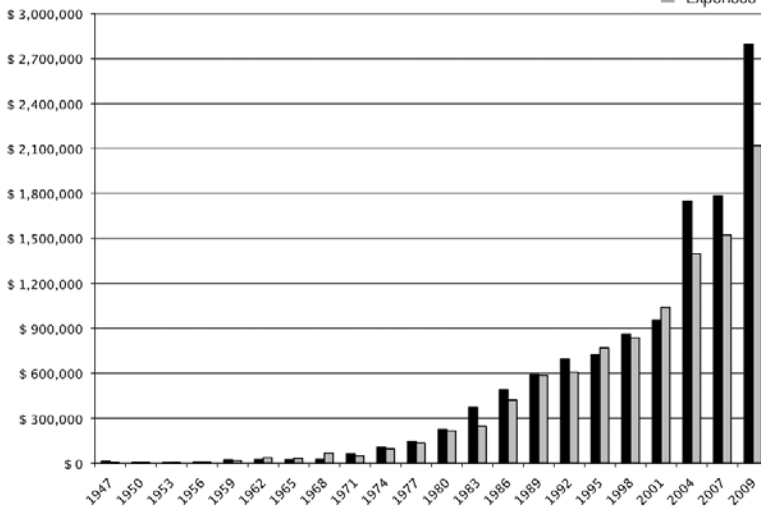
In 1995, the Board's overall resources passed one million dollars for the first time, some 78% of which was represented by the reserve fund. By the end of the decade, the Board's overall monies continued to increase significantly, but not proportionately as much as had the budget expenditures (which now stood at some 60% of the reserve fund), so that the fifteen-year policy of holding 2½ times the annual expenditures in the reserve fund had become clearly unworkable. Consequently, in 1999, by which time the reserve fund had amassed over one million dollars, the Board amended the bylaws to require that the reserve fund equal only one year's operating expenses despite its monetary resources having doubled over the previous decade. By 2003, however, increasing concerns with potential litigation and legal costs led the Board to revise the 1999 amendment and require the reserve fund to total 120% of a year's expenses.

The Board has always maintained liquidity in its operating fund to answer both its planned and unexpected obligations. For example, when the conveniently manageable money market instrument became popular in the 1980s, the Board shifted all but a small fraction of its operating fund into that type of account. *\*see Addendum P15*

### Costs

The majority of costs in the Board budget over the years beyond those relating to the examinations have been normal business expenses, such as rent, staff salaries, office supplies, and the sundry items of administrative overhead.

**Figure 9 Revenue/Income\* & Expenses/Expenditures\*\* 1940's-2000's** ■ Revenue ■ Expenses



#### \*Revenue/Income

Encompasses examination fees, annual registration fees, investment income, verification of certification fees, etc.; it does not include investment value or other Board assets, and relative values of the factors have varied significantly over the decades.

#### \*\*Expenses/Expenditures

Encompasses chiefly office overhead, staff benefits, insurance, and costs of examination preparation and execution of the elements of which have varied in emphasis over the decades.

One of the items particular to the functioning of the Board has been the per diem expenditures for the officers, directors, and examiners. The per diem offered the directors during OCE week and for all other special meetings with members of the examining committee has always been kept equal to that offered the examiners. By the 1950s, when gasoline in the United States sold at thirteen cents a gallon and the average annual American household income was some five thousand dollars, the Board established a per diem allowance of twenty-five dollars per day. This doubled within a decade and, in 1975, an allowance for ground transportation was added. These sums remained in place for twenty years, but by the middle 1990s the Board, in recognition of the marked increase

in both air and ground transportation costs, substantially increased these allowances. In 2001, for the first time, the directors allowed themselves single room accommodations for all Chicago headquarters sessions. However, the Board held steadfastly to its policies of non-salaried status for all officers, directors, and examiners, and scaling of per diem reimbursement to national cost of living indices.

Occasionally, unusual expenditures have required the Board's attention. In 1968, three thousand dollars was allowed for moving the Board files from Leslie FitzGerald's office in Dubuque to new headquarters accommodations in the ADA Building in Chicago. By 1985, the Board's dissatisfaction with the ADA site was inflamed by a more than 100% increase in the annual rent, from twelve thousand to twenty-seven thousand dollars, helping to prompt the move to its independent facilities three years later. In 1976, as mentioned earlier, the Board funded the establishment of an in-house reference library in its new quarters. Careful monitoring of its expenditures disclosed the previously noted 1989 overcharge of some twelve thousand dollars by the Drake Hotel for accommodations and amenities attendant to the OCE, and in subsequent months the Board rejected the idea of establishing an annual stipend for the Board president. The Item Writers' Workshop, designed to assist and standardize the methods by which the WQE was constructed, demanded the Board's special attention in 1991. The estimated expense to retain a guiding consultant and bring the designated writers to Chicago for a three-day training and working session ranged between twenty-two thousand and seventy-eight thousand dollars; the ultimate cost fell within the lower half of these estimates and the incomes from the OCE and WQE fee structures at that time allowed the Board to cover this charge comfortably.

Special expenditures to introduce current technology to the Board's operations have already been described. Part of this improvement in computer abilities was employed in the Board's comparison of candidate performance on the OMSITE and WQE Examinations, funding for which it also undertook at the end of the 1990s. *\*see Addendum P16*

### **Investments**



The Board recognized early in its existence that income from examinations alone could not underwrite all its functions and thus determined that the reserve fund monies were to be put to work in interest-bearing investments. By the middle 1970s, the Board of Directors had an established investment policy of preserving the principal of its accounts with investments at minimal risk, and placed its resources into US Treasury securities, certificates of deposit, and a savings account for short-term purposes,

*\* Irving Meyer ... 1979-80*

formalizing a stance that had effectively been in place since the late 1950s. The Board originally adopted this guiding fundamental at the time its financial activities were housed in Louisville, Kentucky, under the guidance of Secretary-Treasurer Harold Boyer. In 1974, it directed Boyer to consult investment advisors in that city to help design potential programs for its adoption. It sought similar advice again in 1983. During this period of the early 1980s, it continued to honor its investments in treasury bills and certificates of deposit, but, as mentioned earlier, as money market accounts became popular, the Board closed its savings account and transferred the monies to this new instrument.

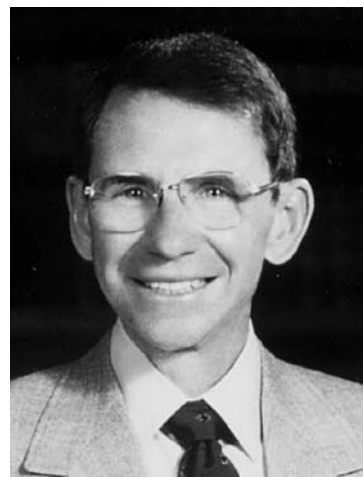
In the early years of the next decade, the Board transferred its immediately available monies to the operating fund and adopted a slightly modified investment principle for its reserve fund. The change recorded that “...all monies in the ABOMS Reserve Fund shall be held in optimal interest-bearing insured accounts, or certificates of deposit.” The Board entrusted most of its invested monies to a managed account with Invesco, a securities investment firm. The Board retained Invesco as its counselor for several years, but, by the end of the 1990s, had transferred investment responsibilities to Smith-Barney Associates. In the first years of the 2000s, it transferred its investment responsibilities again, this time to Raymond James Associates, who reported, despite the general economic downturn in the first decade of the new century, generally positive Board earnings. Until these early years of the century, however, certain sums remained invested in certificates of deposit.

*\*see Addendum P16*

## Audits

Throughout its existence, the Board has been responsible for an annual accounting of its finances, but for the first thirty years relied chiefly on its own in-house audit. By the mid-1970s, reflecting the expansion of the specialty, monetary transactions expanded in all quarters and the Board employed an independent accountant to evaluate its practices. The consultant made substantial suggestions for improvement, all fully acceptable to the Board. In the early 1980s, Bansley & Kiener was retained to handle the annual independent audit and still held this responsibility three decades later. By 1990, auditing costs had risen to four thousand eight hundred dollars a year and increased to a five thousand dollar average in subsequent years. One of the interesting expenditures noted in the 1982 audit was the cost of a gold pin to be awarded to the president at the end of his tenure during the AAOMS annual meetings. Interestingly, in 1977, the Board had rejected the idea of awarding rings of office to the president or any other officer, but by 1990 authorized a design study for a director’s ring, which, in fact, became available to the directors at their own expense four years later.

*\* Dan E. Brannin ... 1980-81*



In 2003, after more than fifty years of operating under a January-December fiscal year, the Board shifted its operations to a July-June fiscal year to accommodate multiple changes in both state and federal reporting guidelines. *\*see Addendum P16*

## **Legal Considerations**

Early in its developmental years, the American Board of Oral Surgery recognized its legal obligations and its vulnerabilities. As societal sympathies for litigation against the professions began to swell in the late 1960s, the ABOMS purchased its first “all-risk” liability and property insurance. In 1971, it retained its first standing legal counsel, Attorney Harvey Sarner in Chicago, who, in one of his first advisories, answered the Board’s question of its own authority to appoint committees and nominate its directors, by finding that the Board, “.....is presently operating as an autonomous organization pursuant to its own Articles of Incorporation.” This was deemed a favorable report legally, and the Board directed Mr. Sarner to insert these rights of nomination and election into its articles of incorporation and constitution and bylaws appropriately. This issue was revisited in 1982, with the same position forthcoming. It arose again, in 1990, when legal counsel advised the Board that it could handle the entire nomination and director election process in house if the ADA was considered the sponsoring organization, in which circumstance the Board need only advise AAOMS in writing of its actions. These decisions resulted in the ABOS/ABOMS interfacing with the ASOS/AAOMS over the years on the director election policies, and culminated in the process mentioned in earlier pages.

The Board had retained Mr. Sarner with a five hundred dollar per annum fee, but elected to return to its earlier fee-for-service relationship in 1973, a policy observed to the present time.

Four years after its initial 1969 acquisition of liability insurance, the Board revisited the matter in terms of its individual and collective vulnerabilities. Within two more years, the early 1970s, appropriate coverage had been revised by legal counsel. The monetary limits of coverage were extended again in the late 1970s and, by 1986, individual coverage was increased from five hundred thousand dollars per director to one million dollars. By the end of that decade, legal counsel advised that gaining increased liability insurance would entail too many exclusions, including considerations of libel, slander, and pass/fail situations, all of which were considered “bad risks.” Uncertainty regarding coverage continued into the 1990s, when the Board decided to discontinue its relationship with its then-carrier, the same one retained by the ASOS and the orthodontic and endodontic specialty boards, because that carrier’s coverage was deemed insufficient to cover the Board’s potential liabilities. It obtained a new carrier (CNA), which accepted appropriate risks and maintained the protection at one million dollars per director. By 2003, this coverage had been increased to provide three million dollars per director.

Maintaining confidentiality of candidate performance has always been recognized as paramount among the Board’s responsibilities. However, in 1975, the Board did respond to a Maryland court’s subpoena to provide the examination grades of a diplomate involved in



litigation. The judge in this instance had assured absolute confidentiality and honored his pledge. Subsequently, the Board reaffirmed its policy of retaining individual examination grades in confidence and of notifying even candidates only of overall passing performance.

In the same year, however, the Board approved a Release of Information Statement for requesting diplomates, allowing distribution of their Board performances to third parties. The challenge to release of information arose again in 1988 when the ABOMS attorney counseled that pass/fail information should not be released to any unauthorized third party in the absence of “pressing need.” He insisted again, in 1990, that the Board did not even have to answer a Pennsylvania subpoena for the certificate status of two oral and maxillofacial surgeons involved in litigation in that state. Shortly thereafter, the Board adopted the policy that only the president would give depositions in regard to any Board matters, including the requirements for certification, an individual’s eligibility, etc.

Over the years, legal counsel has aided the Board in developing policies of revocation of diplomate status. In 1990, the Board incorporated absolutes in this regard, stipulating that revocation would be automatic if the diplomate had lost a state license to practice, had voluntarily surrendered a state license to practice, or was suspended or expelled from a professional organization for unethical or immoral conduct. The legal position on revocation of a diplomate’s certificate was voiced by counsel James Rankin of Kirkland and Ellis that year. He advised that a specific bylaws protocol was not necessary for revocation tendered on moral grounds, but that the bylaws did require a hearing protocol for pending revocation on the basis of patient care deemed unacceptable by the Board. Twelve years later, this policy was strengthened through a rewording of the policies, which allowed a hearing for a diplomate prior to revocation of certification under any circumstance except loss of license. In this same period, legal counsel reminded the Board that certified status was information in the public domain, but the details of individual candidate performance were not. This meant that the Board was free to release information on the first circumstance, but could not concerning the second.

By the late 1970s, sympathies had increased for inserting “maxillofacial” into the title of the American Board. This reflected the almost explosive expansion of clinical activity within the specialty in the preceding decade, and was a matter of discussion within the corridors of AAOMS and throughout the specialty nationally. There were interprofessional and legal concerns with the use of “maxillofacial,” primarily because no specialty within either dentistry or medicine could legitimately claim full or exclusive use of the term, and there was nothing to exclude spurious or self-defined groups from adopting it. By 1983, the certifying agency for several years had been the American Board of Oral and Maxillofacial Surgery, and in that year its official seal was copyrighted.

The following year, the American College of Oral and Maxillofacial Surgeons copyrighted its seal, giving that organization exclusive rights to its use. This indirectly strengthened the ABOMS logo by removing any visual or other confusing competition. A copyright has different implications than a trademark, however, and as late as 1990 neither the seal

nor the title, American Board of Oral and Maxillofacial Surgery, had been trademarked. In that year, legal counsel urged that this be done as quickly as possible to defend against the misuse of “board certified” by devious individuals knowingly referring to any unrecognized board. Interestingly, in 1991, the US Office of Patents and Trademarks rejected the trademark application of the American Board of Oral and Maxillofacial Surgery, ruling that the name was too similar to the American College of Oral and Maxillofacial Surgeons. The ABOMS application was resubmitted in November of that year and, in 1992, the trademark on the ABOMS title was awarded.

In 2003, the issue of the trademark again arose in Board discussions relating to diplomate use of the logo. Reaffirmed policy restricted use of the ABOMS seal to the diplomates’ personal stationaries, letterheads, business cards, office doors, and computer Web sites. Legal counsel advised the Board on the niceties in differentiation between a service trademark, which relates to protection of impersonal action, and a *certification* trademark, which relates to actions involving individuals, and advised that the Board retain its certification trademark. In that same year, the Board, on petition, allowed the US Army to use the Board logo in an Army promotional video supporting advanced education programs in oral and maxillofacial surgery.

New federal guidelines of increasing complexity mandated additional legal counsel in 2003. Mr. James Rankin, now well into his second decade as advisor to the ABOMS, reassured the Board that the recently instituted confidentiality restrictions of the Health Insurance Portability and Accountability Act (HIPAA) regarding age, gender, race, medical history, etc., did not relate to the Board’s certification of candidates, the information being recognized as mandatory for Board confidentiality and security. Mr. Rankin further advised the Board of the necessity to comply with the Americans with Disabilities Act in the execution of its examinations. Compliance with the mandates of the Act became pertinent in the examination of a particular candidate in 2008.

The Board noted in 2002 that legal fees had increased substantially for the first time in years, primarily due to legal opinions rendered on policy issues such as revocation, disclosure of Board status, etc.

*\*see Addendum P16*

## Examination Considerations

### Sites

As noted in earlier chapters, the first ABOS examinations for certification were given at the Stevens Hotel in Chicago on February 14 and 15, 1947. The



*Blackstone Hotel*

examination was then held until 1954 at the American Society of Oral Surgeons' annual meetings. By the middle 1950s, the Board separated the examination from the ASOS session and established it at mid-winter in Chicago, to take advantage of the central location and the less expensive meeting and room rates at that time of year. From 1955-1967, the examination was ensconced at the Blackstone Hotel, a site listed in the National Register of Historic Places.

By the late 1960s, the Board reviewed its site selection criteria for the Oral Certifying Examination, and reaffirmed ease of transportation, adequate hotel space, and ability to reserve accommodation at least three years in advance as priorities. It considered the possibility of airport and university sites, as well as other cities, but decided to continue in Chicago. In 1968, after thirteen years at the Blackstone Hotel, the Ambassador East Hotel became the new venue for the examination because of its greater capacity and more consistent accommodations.

In 1976, accommodation and rate considerations forced relocation of the OCE to the Drake Hotel in Chicago, with a commitment through 1982. Within a few years, difficulties in the agreement with the Drake Hotel and escalating travel costs for examiners and examinees led the Board to consider regionalization of the Oral Certifying Examination, but such thoughts were for the moment rejected. Nonetheless, the Board looked beyond the termination of the contract with the Drake, and investigated other Chicago hotels as possible venues, including the Knickerbocker, the Hyatt Regency, the Bismarck, the Ambassador East, and the Continental Plaza. At the expiration of the 1982 contract, however, the Board initiated a policy of year-to-year dealings with the Drake Hotel. In 1986, the Drake increased room rates significantly, and in 1989, the Board discovered a twelve thousand dollar overcharge by the hotel. Despite the many amenities at the Drake, and overall personal satisfaction with its facilities by the Board, the examiners, and the examinees, by 1995 the Board was again considering moving its test site because of concerns with expenses and overall services. Ultimately, the ABOMS ended its agreement with the Drake Hotel, and conducted its last certifying examination there in 2002. In 2003, in response to an offer of standardized rooms, a general room upgrade, and the attraction of less street noise, the Board moved its examination operations to Chicago's Fairmont Hotel. Nonetheless, the Board maintained conversations with the Drake at that time, anticipating the possibility of returning following expiration of its contract with the Fairmont in 2008.



Examinees reported to Chicago's Fairmont Hotel in February for the next five years, but, following the 2007 examination, the process was transferred out of Chicago completely,

to an established testing facility in Dallas, Texas. The move to Dallas was made in favor of a dedicated board-testing facility established by the American Board of Obstetrics and Gynecology, a facility of which other medical boards had already taken advantage. This facility provided an entirely consistent, easily controlled testing environment, and offered nearby housing accommodations for candidates with coordinated transportation. The transfer of testing to Dallas did not affect the maintenance of the ABOMS administration headquarters in Chicago, however. *\*see Addendum P16*

## **Eligibilities**

The evolution of the examinations and the candidate eligibility requirements have been discussed in Chapter III. Administratively, the Board, over the decades, has been challenged to investigate and/or validate applicants' information regarding their eligibilities. As early as 1950, the Board reiterated the mandate of two formal training years being necessary, with preceptorships disallowed. In 1972, the Board re-emphasized the minimum of one year of practice post-residency being necessary prior to registration for the OCE. In that same year, because of the increasing number of four-year programs, the Board agreed that the graduate of a four-year program could take the OCE in his/her first year of practice, if he/she had passed the WQE in the interim. This allowed the four-year graduate to keep pace with the three-year graduate. As late as 1981, the Board reiterated its observance of ADA policy stating that the eligibility of candidates depended on their graduations from ADA-accredited programs after January 1, 1967, except for those who had completed ADA listed programs prior to January 1, 1967, and who had been ethically in limited practice since that date.

Administrative problems peculiar to the military have occupied the Board from time to time. In 1974, it recognized that, because many of the military hospitals and clinics restricted the administration of general anesthesia to the operating room, the eligibility of many military candidates was compromised because of their limited experience in the administration of outpatient general anesthesia. Additionally, some surgeons in uniform were stationed in positions of research, clinic administration, or, less frequently, in duties requiring general dental care, all of which interfered with the Board's stipulation of the candidate restricting his/her practice to exclusive oral surgery activities. The Board adopted a policy of evaluating each military candidate individually in such circumstances. In 1991, the Board allowed extensions of eligibility limits to those military candidates who had been unexpectedly called to duty at the time of the first Persian Gulf Desert Storm engagements. Extensions for similar activities were authorized again during the subsequent Iraq and Afghanistan military activities. The Board formally endorsed a policy change in 2004 that not only allowed eligibility extensions but also suspension of annual registration fees for federal service diplomats deployed in combat zones, and their release from the limitation of practice clause defining specialty activities when such individuals were militarily deployed in circumstances that might require their contributing in professional activities other than oral and maxillofacial surgery.

In 1986, the Board established policy that re-applicants, i.e., those practitioners who had exhausted an initial period of eligibility and were beginning again in the examination process, might take the earliest OCE after passing the WQE, meaning they did not necessarily have to demonstrate again one year of active practice between the examinations. Nine years later, the Board also mandated that the re-applicant who had failed an earlier examination had to have twenty-five hours of Category I or Category II continuing education credits in at least three facets of the specialty within the twelve months prior to re-application. This codified the prior requirement that re-applicants demonstrate further training and education following their earlier unsuccessful examinations.

The basic elements of application to begin the certification process stayed fairly consistent for the three decades prior to and into the twenty-first century. By 2003, the requirements included proper candidate identification, substantiation of appropriate training, payment of the application fee, and a Record of Operating Experience (ROE) as operating surgeon during the final twelve months of residency training. The definition of “operating surgeon” in the WQE candidate application brochure and application form has proven problematic from time to time, however. In 1991, the Board recognized that the resident is never the operating surgeon in the responsibility sense, since he/she always operates under the supervision and responsibility of an academic mentor. The Board addressed this dilemma at that time with a decision that “operating surgeon” should be understood by the candidate to be the individual of major resident responsibility. Essentially the same issue arose again in 1996 as post-training fellowships became more popular in American training. Despite the reality that the surgeon in fellowship has finished his/her formal mandated training, the cases operated in fellowship were still disallowed for satisfaction of the requirement for cases done in the twelve months prior to application, since the fellow is still not recognized as the ultimately responsible surgeon for those patients. If, however, the candidate were a duly licensed dental practitioner in the state of his/her fellowship, the cases were allowed.

In that same year, the Board decided administratively to allow long-time practitioners who belatedly applied for Board certification to document those hospital cases done only in the immediately recent twelve months of practice rather than having to search out the twelve cases done during their final twelve months of residency, if those late applicants had been out of training for ten years or more.

A major quandary in eligibility requirements in the last decades of the twentieth century concerned those candidates studying for the medical degree. As early as 1969, the Board began to receive requests for eligibility extensions based on the delay in entering



*Frank Pavel ... 1981-82*



practice brought about by medical school studies. Over the subsequent twenty years, the Board developed a policy of automatically offering extensions for documented medical school studies. In 1987, the Board was asked to establish a stance on the role of the medical degree, which was assuming an ever-greater prominence in oral and maxillofacial surgery education at the time. It elected to take no position on the issue, honoring its charge of evaluating educationally qualified candidates solely on the bases of knowledge and performance regardless of supplementary or parallel educational accomplishment. An associated problem dealt with those candidates who held both dental and medical degrees but were practicing strictly on medical licenses. This problem became acute by 1980 because of the number of such candidates and, in that year, the Board considered a bylaws change to mandate that such candidates have dental licenses. By 1988, this stipulation had found a place in the bylaws, but, even at that late date, the Board was still responding to persistent inquiries by emphasizing that a dental *degree* was, in itself, not sufficient for eligibility, and that the candidate also had to possess a dental *license*. The issue would not disappear, however, and by the late 1990s the Board redefined its stance by reiterating the mandate for the dental degree but also by accommodating the increasing number of those candidates with both dental and medical degrees who chose to practice on their medical licenses alone. The new requirement for examination eligibility mandated that:

1. A candidate with a *dental degree*, or with both *dental and medical degrees*, who practices on a *dental license*, must limit his/her practice to oral and maxillofacial surgery and/or any other specialty for which he/she is educationally qualified by virtue of his/her completion of a specialty training program accredited by the ADA Commission on Dental Accreditation, or by demonstration of having received such training in the acquisition of the necessary surgical skills to enable that candidate to perform procedures as allowed by the appropriate state dental licensing authority;
2. A candidate with both *dental and medical degrees* who practices on a *medical license* must limit his/her practice to oral and maxillofacial surgery and/or any other specialty for which he/she is educationally qualified by virtue of his/her completion of a specialty training program accredited by the ADA Commission on Dental Accreditation, the Accreditation Commission on Graduate Medical Education, or by demonstration of having received such training and the acquisition of the necessary surgical skills to enable the candidate to perform procedures as allowed by the appropriate state *medical licensing* authority;
3. The candidate must submit evidence of a current *license* from the appropriate authority enabling the individual to practice the specialty of oral



\* Philip J. Boyne ... 1982-83



and maxillofacial surgery independently within the location of the individual’s practice, or certification of being on active duty with the US federal services; limited licensure which permits practice only under supervision (such as a “resident license”) is not sufficient to satisfy this requirement. This policy has served the Board well since its adoption.

An equally perplexing dilemma facing the Board of Directors, one far removed from any consideration by the fathers of the Board at its inception, was that concerning applicants trained in foreign countries. The Board first began to consider those surgeons as a result of the influence of an internationally recognized Swiss-trained surgeon, Professor Emil Steinhäuser, who had taken an academic position on the faculty of the University of Minnesota in the late 1960s. Despite that particular individual’s stellar qualifications, the Board, in 1969, though it decided to review individual circumstances on a per-case basis, rejected foreign training per se as acceptable qualification for examination, staying consistent with the policies of specialty certifying boards in medicine and surgery. It reiterated this stance in 1970 and again in 1977, by mandating that any candidate must have completed an ADA-approved training program in the specialty.

The dilemma was further complicated by an instance in 1983 in which a surgeon with both foreign medical and dental degrees and a US medical license was practicing oral surgery, but without a US dental license. The Board addressed this circumstance by allowing the candidate to take the Written Qualifying Examination, but deferred his eligibility for the OCE until he would have obtained an American dental license. By 1990, the Board had modified its stance on this question by declaring that a foreign-trained applicant who had credentials acceptable for admission to advanced standing in an ADA-approved US program in oral and maxillofacial surgery, and who would serve at least twelve months as a resident in such a program, would be potentially eligible for examination by the American Board providing he/she held an American dental license, and was able to fulfill all other eligibility criteria. This stance was similar to decisions made by the American Board of Orthopaedics, the American Board of Otolaryngology, and fellow dental American Boards of Orthodontics, Pediatric Dentistry, and Periodontology. In 1999, the bylaws were appropriately amended to include this provision, stating that any such foreign graduate must serve his/her twelve months at the senior level of training in the American program; there was no allusion to serving as chief resident.

The Board of Directors, still vigilant in protecting the integrity of its certifications, stated in the applicant brochure that, “The Board reserves the right to further investigate the applicant’s educational background and training, if deemed necessary.” This stipulation was meant to be empirical and, though

*\* Charles C. Alling, III ... 1983-84*



inspired by the foreign graduate dilemma, was not directed to that cadre of applicants specifically. Because the issue did not disappear entirely, and probably never will in light of increasing internationalization in all professional spheres, an ad hoc committee of the Board of Directors was appointed in 2001 to establish explicit guidelines for advanced standing in eligibility. This Committee's deliberations and protracted subsequent discussions culminated in the Board deferring to the training programs for determination of candidate educational validity and, therewith, Board examination eligibility. The Board concluded that, because ADA-accredited oral and maxillofacial surgery programs had the authority to permit advanced standing of a candidate to their programs, and because the programs were answerable to the ADA for their actions in this regard in their program accreditation process, it would not establish a policy of determining a candidate's advanced standing in its review of his/her application for Board examination, but rather would simply stay diligent in monitoring the actions of the training programs with this evolving issue. In 2007, the Board's policy was changed again to permit a foreign-trained individual practicing the specialty in this country with appropriate licensure and credentials to pursue certification and become a diplomate.

In accord with the overall relationships between the United States and its northern neighbor, the question of Canadian candidate eligibility has stood apart from the overall deliberations on "foreign candidates." As early as 1951, Canadians were deemed eligible for affiliate certification. By 1969, however, uncertainty prevailed regarding evaluation of Canadian candidates because none of the Canadian training programs had passed through the sieve of the American Dental Association and, indeed, the Canadian Dental Association at that point was only in the beginning processes of accrediting its programs. The Board did not feel qualified to pass judgment on Canadian training efforts because of its not being an accrediting agency. In 1972, the Board accepted for examination a Canadian graduate from the only program certified by the Canadian Dental Association, but later that year deferred acceptance of any further Canadian candidates until the ADA Council on Dental Education would endorse a policy of reciprocity with the Canadian Dental Association. By 1973, the two associations had agreed on a policy of reciprocation and the Board continued to accept applications from the one program in Canada certified by the CDA.

The Board recognized early the issues of defining "Board eligible" and the possible misuse of the term. By 1968, the definition mandated that the candidate must have applied for the Written Qualifying Examination and have had his/her credentials examined. The Board inserted this definition and that of "Board qualified" into the Board bylaws that year, and emphasized those definitions again in 1982. In 1992, the ADA Council on Dental Education suggested that "Board eligible" be used to define a candidate being "... then actively engaged in the certifying process who must complete the process within five years once initiated." This definition carried the general qualifier of the candidate having completed an ADA-approved residency. This new clarification was designed to cover the growing misuse of "Board eligible" by those candidates who, on the basis of simply having completed an approved residency or having at one time applied for Board examination, misrepresented themselves in perpetuity to outside agencies as being Board

eligible without ever pursuing certification. In that same year, 1992, the American Board of Medical Specialties discouraged the use of “Board eligible” in general, because of the recognized violations. Ten years later, the ABOMS did discontinue the use of “Board eligible” as a descriptive term, and would advise inquiring outside agencies simply that a subject was or was not in the process of certification. *\*see Addendum P17*

## **Examiners/Candidates**

Over the years, the Board has had to wrestle administratively with the evaluation of intangibles, such as performance and conduct on the part of both candidates and examiners. Fortunately, examiners have rarely lost their appointments for the careless submission of poor examination material although three examiners did suffer this fate in 1990, as did four more a few years later.

The Board of Directors wrestled mightily with the issues of morality and ethics in the mid-90s, especially during the era of case presentation in the Oral Certifying Examination. Should a candidate be penalized for exposing a patient to unwarranted surgery simply to satisfy Board requirements, e.g., extirpating a salivary gland when removal of a calculus would be adequate, or opening a non-displaced nasal fracture simply to satisfy certain trauma requirements? Similarly, questions arose regarding review of the candidate’s insurance billing practices in evaluating the ethics of his/her practice. Ultimately, the Board declined to become the arbiter of ethical questions and deferred to other organizations and authorities in such matters.

Candidate exit surveys following their OCE experiences came into being in 1995, in which the examinees, after the fact, were given the chance to comment anonymously on the examination experience. One of responses requested in this encounter was a prioritizing of the reasons for taking the examination. Interestingly, three intangibles emerged predominant by wide margins, i.e., self assessment, encouragement by peers to take the examination, and community recognition. Review of the same survey data in 2004 showed the same results; regulatory body or insurance company requirements and hospital staff regulations had minimal influence on the motivation to seek certification.

Periodic evaluation of examiners has been a responsibility of the Board since its inception, with different yardsticks employed. Maintenance of quality and legitimacy in the examination team was reflected in the Board’s 1972 tracking of the careers of the top 10% of successful certification candidates to determine a potential pool of future examiners. In 2000, a new examiner evaluation form was instituted by which the directors scaled style, attitude, submitted material, and ratings of candidates; posited against this grid, several examiners were found deficient.

**“Periodic  
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the Board since  
its inception...”**

In the mid-1970s, the Board endorsed the position of regional consultant to aid in the selection of qualified examiners (see Chapter III). The regional consultants were practitioners who had previously served as board examiners, and were named by the Board to identify potential examiners in their geographic districts. In its early years, this mechanism had delivered disappointing results, either through the inactivity of the regional consultants or reluctance to volunteer by potential examiners. Despite emphasizing the importance of the regional consultants to all diplomates in 1980, the Board discontinued the position in its then-constituted form in 1983. In an ostensible effort to strengthen the position, the American Association of Oral and Maxillofacial Surgeons insinuated itself into the selection process for regional consultants, and a joint effort in selecting the consultants was devised. The ABOMS Directors and the AAOMS Trustees would both review a panel of examiner candidates generated by their jointly selected regional consultants in the AAOMS Districts, and recruit a new cadre of examiners from those lists. Over the ensuing decade, the role again regressed in importance and, in 1993, Board action deemed the position of regional consultant meaningless and it was discontinued. In keeping with attitudinal oscillations on the subject, however, the position of regional advisor was re-established in 1997.

The Board, in its annual newsletter to all diplomates and to all candidates at the time of the OCE, has actively promoted the opportunity for individuals to become examiners, and in 2002 instituted a computerized database of all examiner applicants to be reviewed for currency by staff on an annual basis. An applicant's name is kept permanently on file unless he/she asks to be removed from consideration.

As noted in other chapters, the ABOS in 1971 initiated an open forum at ASOS annual meetings. This mechanism remains intended to keep the entire national community, not just diplomates, advised as to ABOMS activities, and opportunity for appointment as a Board examiner is consistently emphasized. *\*see Addendum P18*

### **Logistics**

Board activities and responsibilities, as noted earlier, had expanded substantially by the early 1970s. The number of standing committees had grown to those of Administration, WQE, OCE, Credentials, Constitution and Bylaws, American Board/American Society Liaison, and Appeals Review. The number of candidates to be examined also reached an all-time high at that point, and concerns arose regarding the examination teams' ability to test all the candidates at one time. There were one hundred thirty-three accredited training programs in the specialty in the early 1970s, forty-one of them dental-school based, and ninety-two of them hospital-based



*John J. Lytle ... 1984-85*

(including twenty in federal hospitals), which represented two hundred forty-six training positions and a total of seven hundred sixty-five residents. By the middle 1980s, the number of candidates and the expense of travel necessitated that the WQE be given at four sites; in 1983, for example, in Chicago, Philadelphia, New Orleans, and Los Angeles. By the latter years of that decade, plans were underway for inauguration of the Re-Certification Examination, with initial anticipation that it would be delivered at the times and places of the WQE.

All these activities initiated an interest in computer technology as early as 1966 and by 1983 the filing of all candidate information had become computer-based. In a first effort, an analysis of the 1982 OCE results was executed to be compared for consistency with previous results scored with non-electronic methods. All diplomate information, i.e., their training institutions, years at their institutions, degrees, examination performances, etc., was transferred to the computer and, by 1985, the Board resolved to place “all valuable papers” into its developing computer data bank. By 1995, more than five thousand diplomate records had been microfilmed and entered into the digital database.

Candidate online application was first discussed by the Board in 1997 and, after gaining experienced advice for this process from the American Association of Medical Colleges, the Board made this opportunity available to candidates for the first time in 2001. Grading of the OCE was being done by computer on the Excel program by 1997. Also in that year, laptop computer use by the directors was initiated.

The national trend of primary source verification for credentialing and periodic re-credentialing led to a new Board responsibility – and source of income – in the mid-1990s, as the number of outside inquiries from insurance companies, hospitals, and legal entities as to practitioner certification status increased. The Board felt that the burden of these verifications justified a five dollar fee, and, within two years, almost one thousand nine hundred verification requests were being entertained by the Board every six months.

The ever-changing character of the specialty in scope and emphasis dictates constant revision of the examination process on the part of the Board. In the late 1980s, the Board improved the consistency of its OCE slide material through the purchase of the Polaroid Turbo-palette graphic accessory kit and a 35 mm Express Graphics kit to ensure quality duplication. Less than a decade later, the textual slide material of the OCE was transferred to compact discs, and just after the turn of the century all visual material had been transferred to LCD projection.

The WQE is also subject to ongoing change. In 1996, the Board became concerned with the costs of producing the WQE through outside agencies, and began to consider its in-house production. It did so for the first time in 1998 and, in 2001, it placed a sample of the WQE on its Web site for candidate orientation; it did not, however, release old examinations, either WQE or Re-Certification, to prospective candidates.

As early as 1966, thoughts of evaluating training programs in light of their graduates' performances on the WQE occupied the Board's agenda. Nearly thirty years later, the Commission on Dental Accreditation adopted a standard that stated that the success of a training program's graduates in their board certification process would be one measure of the quality of the program. At that same time, the Board sought to compare candidates' OMSITE and WQE performances in reflection of the same interest. At that point, the Board also began to computerize WQE applicant data, which included detailed lists of procedures performed in the final year of training, on-service/off-service activity, unbundling in procedure reporting, and regional training differences, and then correlated variations in these factors with OMSITE, WQE, and OCE performances. In the first year of the new century, the Board discussed using this database for determining the true surgical activity of the specialty in two statistical frameworks: first, by descriptive statistics on candidates' surgical experiences, such as types of surgery, strengths/weaknesses in their activities, and the numbers of patients operated, with the purpose of delivering this information to the AAOMS Committee on Residency Education and Training to assist in determining the standards for the specialty training programs; and second, by inferential statistics to determine whether or not the recorded surgical experiences did, indeed, lead to better Board performances, i.e., did WQE and OCE scores correlate to training activity. An additional long-term objective of collecting the case lists was to determine the evolution of individual practice patterns by comparing case lists in training, case lists from the early years in practice at the time of OCE application, and case lists ten years later at the time of recertification. A further anticipated derivative was the determination as to whether or not the medical degree in training played a role in performance or practice patterns. Ultimately, all such information would be reported confidentially to all program directors. Unfortunately, the burden of producing these case lists outweighed the perceived value of the information gained, and the data collection was abandoned. Nonetheless, the Board continues, on an annual basis, to inform the CODA-accredited oral and maxillofacial surgery programs of the successful completion of the certification process by their former residents.

The directors' intermittent self-evaluation is testament to their dedication to the integrity of their examination and certification obligations. In 1987, the Board appointed a Long Range Planning Committee to discuss such items as how the Board affects the scope and future of the specialty, and whether it is obliged to set the pace in avant-garde fashion or to certify only the minimums of clinical performance. The committee posed the question of whether the ABOMS should endorse the medical degree as a standard training goal. As noted earlier, the Board chose not to make an endorsement, opining that this issue would be resolved in the education marketplace. Further, it considered the possible requirement of seventy hours of continuing education being required for maintenance of diplomate status, as both the American Dental Association and the American Medical Association had recommended. Finally, the committee encouraged the Board's seeking recognition by both the American College of Surgeons and American Board of Medical Specialties; the former has since occurred (for ABOMS diplomates with medical degrees seeking ACS



fellowship), while the latter, to date, has not. Eleven years later, in another exhaustive self-analysis session, the Board reviewed its responsibilities to public agencies, the particulars of examination mechanics, its role in the evaluation of specialty education, and its relationships with other professional organizations. It reviewed its constitution and bylaws exhaustively in that session, it revisited the value of re-certification, it took measures to further validate the Oral Certifying Examination, and it embarked on improvements in archiving visual materials and in its other technological activities. Its subsequent 2001 strategic planning session discussed many of these same elements, but focused particularly on computerized testing and remote site testing for the WQE. *\*see Addendum P18*

## **Educational Affairs**

As recorded in earlier chapters, one of the Board's primary challenges in its formative years was determining who was qualified to be examined, which necessarily carried the corollary determination of which training programs were bona fide. In 1948, the Board's Committee on Graduate Training formulated guidelines for adequate training, and submitted these to the American Dental Association (see Chapter I). This petition received a sympathetic hearing by the ADA. In 1950, the name was changed to the Advanced Training Program Committee and, by 1951, it had measured twenty-three training programs nationally against its own criteria and approved sixteen of them. Over the subsequent decade, the American Dental Association reserved most of that authority for itself (literally adopting the Board's standards and methodology for its initial accreditation process), but in 1964 and even later, the Board still had an ad hoc committee to review graduate programs in the specialty. Two years later, one of this committee's recommendations to the ADA was a requirement that all certified training programs be under the charge of a full-time American Board-certified director.

In 1970, the ABOMS was awarded a seat on the ADA reference committee studying the feasibility of mandating a four-year training period for accredited oral and maxillofacial surgery programs. Burgeoning scope brought the need for broader clinical preparation, but only a small minority of oral and maxillofacial training programs had adopted the optional four-year curriculum by that point. The Board had completed the first cycle of its own training program evaluations by 1970, with some reference to trainee performance on the Written Qualifying Examination. The Board's 1980 activities in this regard considered the length of training, the on-service time, the off-service rotations, and the stability of the training faculty. Fifteen years later, the ADA and the appropriate agencies of the by-then AAOMS asked the Board to join in a review of the essentials of the still-active three-year programs, and to monitor the development of the new, fully endorsed

four-year programs.

By the late 1970s, concerns arose among oral and maxillofacial surgery training programs — and complaints were generated from other quarters — concerning the expansion of general practice residencies, which included increasingly broader activities in dentoalveolar and other outpatient domains of the specialty. The Board was asked to join efforts to restrict what was perceived as inappropriate, even presumptuous, activity by these programs, but refused to do so. This rejection may have reflected the directors' own sensitivity to the decades-long history of arbitrariness in education directed toward their specialty by academic or economic competitors.

The privileged perspective of the American Board of Oral and Maxillofacial Surgery on the strengths and weaknesses of the graduating trainees provided it with the opportunity to appraise the effectiveness of the specialty's training programs. Even within the first two decades of its activities, questions arose within and without its own ranks as to whether or not program effectiveness could be equated with candidate performance on the WQE. The Board first undertook an appropriate review in 1966, as noted earlier, and completed its first cycle of such evaluations in 1970. As the debate regarding the efficacy of increasing the training period to four years gathered momentum, the American Board in 1973 began to computerize its findings on the WQE success of graduates from the three-year residencies. By 1975, however, the Board reported that it had inadequate data in this regard to extract any beneficial information.

For the next twenty years, the relationship of training quality to examination performance resurfaced as a focus for the Board, and in 1995 it resolved to undertake a review of ten-year data and report accordingly to the Commission on Dental Accreditation. This project ultimately took the form of a meaningful paper documenting a comparison of senior trainee OMSITE scores to subsequent WQE performance, which was published in the *Journal of Oral and Maxillofacial Surgery*. The findings suggested that there were, indeed, parallels between program content, program scope, and WQE candidate performance. By 2000, the Board was relaying its accumulated database of surgical

activity, as demonstrated by candidate submissions, to the residency training directors. This liaison reflected the policy instituted more than a quarter century earlier of open exchange with the program directors and prospective applicants, the latter through continuous review of the examination application brochure.

As early as 1970, the Board, in coordination with the then-American Society of Oral Surgeons, had undertaken discussion on the indications and potential efficacy of an in-training examination for all residents.

*Bill C. Terry ... 1985-86*

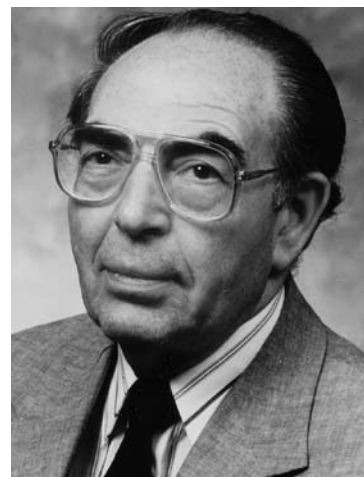


Other pages have described the ultimate development of the OMSITE within the AAOMS, that organization's beginning request to the ABOMS in the early 1990s to assume the responsibility for the examination, this transfer ultimately being consummated in 2003, and the first OMSSAT being offered in 2004 (see Chapter III).

Discussion in earlier pages dealt with particular educational concerns in candidate eligibility. Interestingly, in an action that reflects interprofessional attitudes of the times, the Board in 1950 rejected the application of an oral surgical candidate for examination because his major practice was deemed to be plastic surgery. The issue of candidates with medical degrees gained prominence by the 1970s, and the Board emphasized that the medical degree per se did not allow waiver of any part of the requirements for Board examination. Specifically, it was not a substitute for the requirement of two years of practice for eligibility. In 1978, at the request of Walter Guralnick, director of the Harvard/Massachusetts General Hospital training program, the Board undertook a comparison of examination performances of candidates with and without medical degrees. The initial report found numbers too low to be statistically valid for conclusions, but the Board resolved to continue the study in future years. To date, however, no such review has been undertaken. Interestingly, in the 2008 exit survey of candidates immediately following completion of their OCE, slightly more than half of the candidates with medical degrees thought the degree offered an advantage in taking the examination while only 32% of the non-medical degree group were of that opinion.

The Board has tracked the number of programs offering the medical degree and, in 1986, this number stood at fourteen of one hundred programs, at eighteen of one hundred in 1988 (which represented a 250% increase over 1983), at twenty-eight of one hundred programs in 1990, and at forty-six of one hundred programs in 2005. In 2008, the number fell to forty-three of one hundred programs, indicating that 48% of all residents were enrolled in dual degree training.

Throughout its history, many of the directors and examiners have been academicians actively immersed in the training of residents and in the continuing education of diplomates. In jealously guarding the integrity of the evaluative process, however, the Board has traditionally maintained an arm's length relationship with any educational effort that might appear to be Board-endorsed, or at all implying special access to examination emphases. As the thirst for continuing education in all professions burgeoned in the 1970s, the Board, in 1973, announced to all training programs and the practicing community



*Lionel Gold ... 1986-87*

nationally its independence from any and all so-called “Board preparation” courses, forbade the use of any reference to the ABOS in the promotions, and prohibited all Board-associated personnel from participating in such undertakings. Two years later, however, the Board decreed that officers, directors, consultants, or examiners associated with the Board could participate as individuals in continuing education courses which carried distinct disclaimers of any relationship of the course to Board orientation/preparation. These policies were re-emphasized in a written communication to all program directors in 1982. In 2001, the Board lifted its restrictions on examiners participating in “Board preparation” courses, but prohibited their participating in any “mock board examinations” associated with such courses; it maintained its strong censure of officers or directors even participating in such review sessions. And, in the single such episode in its history, in 1979 the Board mandated that an examiner desist immediately from further serving as a sales representative for a surgical instrument company at the AAOMS annual meetings.

In 1988, at the time it first established liaison with the American Board of Medical Specialties (not withstanding James Hayward and Leslie FitzGerald’s courtesy visit to the then-American Committee of Medical Specialties in 1954), the Board developed sympathies for having the Commission on Dental Accreditation sit independently of the American Dental Association, in a position analogous to that of the Accreditation Council for Graduate Medical Education (ACGME) for medicine. These feelings developed from the Board’s periodic frustration in not gaining support from the ADA Council on Dental Education in furthering oral and maxillofacial surgery training parameters that the Board felt appropriate (see Chapter 1). The directors saw an independently functioning CODA as being a more responsive and efficient agency. The intensity of Board focus on this concern varied over the next fifteen years, but in the first decade of the twenty-first century, the AAOMS had undertaken an in-depth review of the CODA’s actions vis-a-vis the specialty, and had approached the ACGME for consideration of transferring OMFS training program accreditation to that agency. The ABOMS played only the role of interested observer in these discussions; by 2010, no substantive policy changes had been achieved.

*\*see Addendum P19*

## **Diplomate Relations**

Liaison of the Board of Directors with their cadre of diplomates is maintained primarily through the administrative staff which, on a weekly basis over the years, has received the inquiries, relayed the policies, recorded the financial transactions and, in general, offered administrative counsel to the Board’s certified practitioners throughout the nation. After its first twenty years of operation, the Board had certified eight hundred thirty-five individuals; by the middle 1970s, this number had risen to some one thousand seven hundred and, by 1995, five thousand diplomate records had been tabulated and microfilmed. By 1970, 40% of the American Society of Oral Surgeons membership was Board certified, and by 1990, this had risen to 63%.

The Board published its first roster of diplomates in 1949, after its first three years

of certifying experience. Interestingly, however, it discouraged the use of the word “diplomate” on professional cards and stationery, reflecting the still-present uneasiness with which the whole consideration of certified approbation rested in the practicing community. Years later, in 1992, the Board restricted dissemination of the diplomate roster to diplomates only, and attached a charge for the service.

By 1973, the Board was circulating abstracts of its meetings to its diplomates as well as an annual report and copies of the annual budget. Within a few years, it adopted a policy of semi-annual reporting to the diplomates, including a roster of the newly certified individuals. This policy remained in force until the 1990s, and included dissemination to residents in training; economic considerations at that time limited this latter distribution to the spring circulation only. ABOMS policy has always been very protective regarding which outside interests might have access to either candidate or diplomate records. In 1977, however, the Board advised its diplomates that they might review their own examination records on written request.

Three years later, in the era of intensifying educational and social interests in cardiopulmonary resuscitation, the Board first considered and then rejected a suggestion that basic certification in resuscitation be a mandate for annual diplomate registration. In the early 1990s, by which time an increasing number of trainees, and even certified diplomates, had embarked upon formal medical school studies, the Board deferred the annual registration fee for those diplomates who had momentarily interrupted their practices and incomes to undertake this course, until the completion of their studies.

During the 1970s, the Board’s relationship to its diplomates was otherwise interesting. Because of the expansion in scope of practice, national debate on the use of the word “maxillofacial” describing the specialty was rife. In 1974, the Board allowed its diplomates to legitimately use the term on their stationeries and business cards, despite the Board itself not including maxillofacial in its title. This policy was endorsed by the American Society of Oral Surgeons, as well. In 1978, however, “maxillofacial” had become incorporated in the nomenclature of both organizations, and the Board issued new certificates to both old and new diplomates carrying “maxillofacial” in both the logo and title.

Up until 1990, though the record is somewhat incomplete, it appears that some two hundred seventy-five diplomates had served as examiners. The most accurate compilation derived from reliable records indicates that as of 2009, three hundred sixty-five diplomates have served in this capacity.



*John N. Kent ... 1987-88*

Intensified social scrutiny of the professions in the 1980s and 1990s, well perceived by the ABOMS directors, prompted a policy of notifying all diplomates' hospitals of their good standing, upon receipt of their annual registration fees. By the turn of the century, it became evident to the Board that an increasing number of diplomates had lost or voluntarily given up their hospital privileges. The question of hospital status, therefore, became incorporated into the annual registration questionnaire, both to monitor any disciplinary actions and to track emphases and scope in practice. Late in the new century's first decade, new Board policy mandated maintenance of hospital privileges as a condition for both OCE examination and certification maintenance. *\*see Addendum P19*

## Recording of History

As early as the 1950s, the Board recognized the utility and the importance of incorporating its activities in an ongoing written history. It first assigned the task to Leslie FitzGerald, but, in the flurry of his other administrative responsibilities, he was unable to initiate the project. By 1969, when he left active Board responsibilities, his declining health precluded his accepting any such responsibility. The Board's 25th Anniversary in 1972 re-energized its interest in recording its history, and in 1975 it invited Director Lowell McKelvey to accept the responsibility. McKelvey assumed the charge, and announced that he would be able to assemble the history in a "factual approach," i.e., a simple chronological listing of events as extracted from the written record; his project would also include photographs of past Board members. By the end of 1978, McKelvey had completed his task, and Directors Henny and Hayward were assigned to review the effort.

McKelvey's compilation has remained one of the foundations for all subsequent efforts. In 1982, the Board declared that, "...a history shall be maintained and updated appropriately...." and assigned resumption of the task to Director Donald Cooksey. Cooksey demurred, and the challenge was passed to Director Irving Meyer. Meyer first accepted, then subsequently resigned the task.



*Robert E. Huntington ... 1988-89*





The responsibility was then transferred to Past President Charles Alling. Alling added to the compiled record chiefly through his efforts in extracting information from AAOMS sources. Alling's contribution was added to that of McKelvey to support all subsequent efforts.

In 1996, the Board celebrated its 50th Anniversary, noting the celebration on specially designed stationery for that year. Recognition of that event rekindled enthusiasm for resuming Alling's 1982 effort, and, in 2000, the Board authorized underwriting for the resumed effort and within two years named Past Presidents Bruce MacIntosh and John Kelly to assume responsibility for the present volume. *\*see Addendum P20*

# Chapter 5

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## Relationships With Other Organizations/Entities

The execution of its responsibilities brings to the Board enormous influence in the lives of educators and trainees and in its relationships with other professional bodies, both within dentistry and extramurally. Certainly, the legitimacy of its existence derives from its recognition by the Council on Dental Education of the American Dental Association, but its earliest liaison, and throughout its history its most intimate, has been the body from which it was derived, the national organization of practitioners of its specialty.

### Relationships with the American Association of Oral and Maxillofacial Surgeons

#### The First Twenty-Five Years

As early as 1928, the American Society of Oral Surgeons and Exodontists established a committee to formulate the standards of specialty practice within the United States. The toil of this early committee resulted in 1937 in the ASOSE “creating and sponsoring” an organization initially to be known as the American Board of Oral Surgery and Exodontia. The Executive Council of the ASOSE at that time determined that, if such a Board were to be formed, nominations to the Board would be made from within the Council’s own ranks. Progress in this regard was somewhat confounded by the beginning of the Second World War, but by 1944 the now-American Society of Oral Surgeons authorized its provisional American Board of Oral Surgery to petition the American Dental Association for a hearing regarding its founding and recognition.

The following year, the ASOS acted to accelerate action on the part of the ADA in recognizing the ABOS. As noted in earlier chapters, the American Board of Oral Surgery was finally incorporated in 1946, after which it no longer was a Committee of the American Society of Oral Surgeons. Its members, however, were still to be elected by the ASOS House of Delegates. This system seems to have worked harmoniously for the first decade of the Board’s existence, even in 1956 when James R. Hayward was the only candidate forwarded by the American Board to the American Society and was promptly endorsed.

Interestingly, it was not until 1961 that the American Board first reported annually to the American Society as the American Board and not as The Committee of the American Board of Oral Surgery, though it had been recognized as an independent entity some fifteen years earlier.

By the early 1960s, the ABOS Board of Directors and the ASOS Board of Trustees were meeting at intervals and had suggested an annual luncheon meeting as standard protocol. The two Boards were also meeting with Committee B of the ADA Council on Dental Education to discuss the scope of advanced basic science training in oral surgery residencies and, in 1964, the three bodies joined to form the Review Commission on Advanced Education in Oral Surgery whose charge it was to evaluate the specialty training programs overall.

In 1967, another oddity in the ABOS Director nominee protocol with the American Society ensued when the American Society requested that the Board replace one of its original nominees, Merle Hale, with another examiner because of Hale's other commitments to the American Society; this the Board agreed to do and the electoral process proceeded uneventfully with the election of the new nominee, Harold Boyer. Another unique event in the election process occurred in 1976 when a nominee from the floor of the House of Delegates, Philip Boyne, won the election over the three candidates nominated by the American Board. The only digression from normal election proceedings occurred in 2002 when, as necessitated by the resignation of a sitting director, the House of Delegates, in accord with mutually agreed American Board/American Association protocols, effected the election of two directors in the same year.

By agreement in 1968, the list of all Board director nominees was to be forwarded to the American Society by May 15. At the same time, the two bodies began discussions to develop a requirement of Board certification for ASOS fellowship. Further, the two organizations conferred regarding the construction of a joint American Board/American Society Written Examination, since, at that time, the American Society required successful completion of its own examination for membership. The Society's examination was shortly thereafter judged to be redundant and was discontinued. Discussions of the content of the Board examinations at that time also addressed the issue of ethics evaluation; no definite guidelines were established. The matter was deemed to be ultimately an American Dental Association responsibility, but the ethics debate has resurfaced in Board deliberations over the decades since.

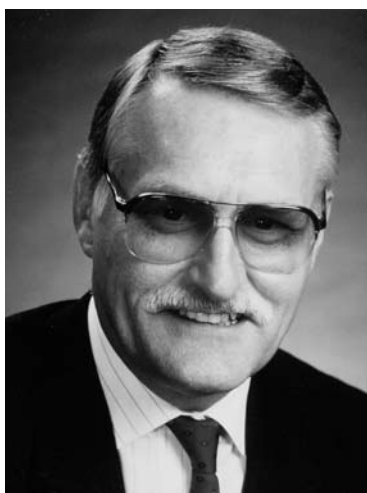
Relations with the American Society of Oral Surgeons at the end of the 1960s were mixed. In 1969, the Association honored the Board by dedicating its annual meeting to one of the Board's foremost pioneers, Leslie M. FitzGerald, and in the following year the two organizations conferred on the development of a resident in-service training examination in cooperation with the training program directors. Also, the ASOS president accepted the Board's invitation to serve as an observer to the 1970 Oral Certifying Examination. Several months later, however, the Board forwarded its revised and up-dated constitution and

bylaws to the American Society of Oral Surgeons for review and approval and the Society requested a change in the electoral process not acceptable to the Board: that nominations of individuals with no experience as American Board examiners could be made from the floor of the ASOS House of Delegates. The Society subsequently retreated from its position, but the disagreement resulted in the development of an ABOS/ASOS liaison committee made up of the presidents, vice presidents, and their executive secretaries, which was to meet on a semi-annual basis with the goal of developing “stronger lines of communication.” Additionally, since confusion persisted as to whether the Board was to report independently as a Board or as the ABOS Reference Committee (an issue thought to have been resolved a full decade earlier), the two organizations agreed that the Board would develop an open forum format for an airing of Board business to the entire membership at the annual ASOS meeting. This device would replace the policy of the Board reporting as a committee to the American Society.

### **The 1970s – 2000**

In this period, the American Board of Oral Surgery confirmed its interest in education by supporting the ASOS move to amend the ASOS Essentials in Oral Surgery Residency to require thirty-six months of coordinated training. The new requirements included integrated instruction in the biological sciences, replacing the previous policy of one year of preparatory basic sciences, and mandated three to six months of exclusive in-patient anesthesia training rather than the previous twelve months. Further, the two Boards joined in recommending to the American Dental Association that oral surgery consultants be appointed to the Council on Dental Education, which transpired in 1971. The abiding interest of the two bodies in anesthesia was reflected a year later when the Board assured the ASOS Trustees of the continuing emphasis of general anesthesia on the Board examination, an assurance prompted by the cancellation of an ASOS member’s malpractice insurance centering about his general anesthetic activities.

Cooperation between the two bodies was further evidenced in 1971 when the American Society directed that, henceforth, Board certification would be necessary for active membership in the ASOS, therewith enacting the decision made three years earlier. This collegiality was contradicted in that same year, however, as the ABOS became uneasy with certain of the attitudes expressed by the ASOS executive director. The Board retained an attorney, Harvey Sarner, to determine whether or not the Board was entitled to freedom in its actions, independent of the ASOS. Sarner reported that the Board’s Articles of Incorporation relieved it from any dictates of the ASOS. The ABOS continued to submit a lengthy annual report to the American



*Leon F. Davis ... 1989-90*

Society, nonetheless, as well as to its diplomates. The Board's Open Forum at the ASOS annual meetings, designed to relay the Board's activities to the entire membership, drew only sparse attendance.

These issues prompted the Boards of Directors and Trustees to sit together in 1973 to discuss the overall relationship of the two organizations. By this point, 1,313 of the 2,587 members of the American Society of Oral Surgeons, 50.8%, were Board certified. The Board had again invited the officers of the ASOS to observe the annual Oral Certifying Examination. The two organizations once more discussed appointing regional consultants, individuals selected to recruit and suggest potential Board examiners who would be elected by the ASOS House of Delegates. Opinions on this proposal varied strongly and the matter was tabled but the issue would resurface periodically in subsequent years.

At the instigation of the ADA, the American Society also suggested the Board form an independent review committee to study the Board "in toto" in regard to "many criticisms that have lingered over the years." This recommendation, which the ABOS readily accepted, was prompted in part by the American Board's travails with the recently formed Association of Diplomates, an issue discussed in more detail in later pages. Part of these difficulties stemmed from the new Association's charge of "in-breeding" on the part of the American Board in selecting its examiners.

Despite the uneasiness perceived by all parties in the early 1970s, however, the ABOS worked with the ASOS in determining a policy for the appointment of regional consultants, stipulating that the Board would submit its suggested candidates to the ASOS for selection. In an associated matter, the ASOS amended its bylaws to require a minimum of three years of service as an examiner for any ABOS director candidate, making the two organizations' policies concordant. Further, the two agencies worked together in supporting the American Dental Association's petition for a seat on the Joint Commission for Accreditation of Hospitals (JCAH), and in endorsing the use of "maxillofacial" in the designation of the specialty, though neither group at that point included the term in its official designation. Additionally, the ASOS Board of Trustees, in the ASOS *Forum*, one of its official publications, acknowledged in July of 1975 that the American Board received, indeed, its ultimate authorization from the ADA Council on Dental Education.

While the liaison between the two Boards in these years had been ongoing on a scheduled basis, the ASOS chose by 1974 to have the American Society/American Board liaison committee function on an as-needed basis rather than by set schedule. Within a year, that committee was dissolved entirely and, instead, the joint decision was made to have the entire Boards of both organizations and their executive directors meet at the American Society annual meetings.

Despite drawing only indifferent attention in early years, the open forum at the 1974 ASOS Annual Meeting was notable in two regards. First, it provided the earliest Board and Society discussion of the feasibility of a recertification examination. Secondly, the Board

announced its receipt of a letter from two representatives of the newly-formed Association of Diplomates, Drs. Herbert Bloom of Detroit and Harry Archer of Pittsburgh, with allegations against the integrity of the Board. Very little comment was elicited from those in attendance. As mentioned earlier, however, and as will be discussed in greater detail in other paragraphs, the actions of this new association did generate increased tensions between the American Board and the American Society leadership. The pressure exerted by the Association of Diplomates on the American Society prompted the latter to appoint a committee to review the activities of the ABOS in 1976, as had been agreed three years earlier. Discussions within and around this committee resulted in the exposure of the ASOS executive director's annoyance with the independence of the Board on one hand, but the Board's ameliorative agreement on the other hand that the ASOS was, indeed, the parent organization of the American Board of Oral Surgery. The abiding coolness in the relationship was evident a year later when the American Board refused to send justification for its increase in annual registration fee to the American Society, reserving that information to itself as an autonomous corporation. In those same months, it designed a new standard curriculum vitae form for all director nominees to be forwarded to the ASOS prior to election, and it advised the ASOS that which members of the ASOS House of Delegates could vote for the director was an ASOS concern, not one for the Board to determine. This latter action came in response to the charge made by the Association of Diplomates that the Board was a self-perpetuating body.

The American Board's independence and non-involvement in the political affairs of the American Association of Oral and Maxillofacial Surgeons continued into the early 1980s. (By now, both organizations had incorporated "maxillofacial" into their official designations).

**“This desire to avoid political issues prompted the Board to again seek legal opinion regarding its freedom to operate independently.”**

In the first year of that decade, the Board deemed the issue of board certification being a prerequisite for AAOMS active membership, enacted in 1971, as “not pertinent for the Board to review,” and was, in other words, a problem for the Association to solve for itself. The Association therewith established the fellowship category for those of its members who were ABOMS certified. This desire to avoid political issues prompted the Board to again seek legal opinion regarding its freedom to operate independently, a stance again reaffirmed by counsel.

The issue of regional consultants to the Board reappeared on the organizations' agendas. The AAOMS reiterated its interest in the naming of these consultants, which the Board rejected. The whole question of the effectiveness of the consultants was then debated and, in 1982, a working agreement was derived by which the consultants would be



appointed by the Board if, indeed, the consultant position was deemed to be worthwhile. The inefficiency of and/or indifference to the consultant position was an abiding problem. After a short period during which the Board, entirely independently, appointed the regional consultants, agreement was reached with the AAOMS in 1983 on a policy by which the Board would select its new examiners from lists derived by regional consultants appointed by the Board from each of the AAOMS geographical districts. A joint American Association/American Board Grievance Committee, previously constituted to hear the complaints of surgeons not selected as examiners during the period when the regional consultant concept had been discontinued, was dissolved as a result of this new approach in naming regional consultants. During this period of great attention to the regional consultant issue, the AAOMS also asked the Board to join in a request to the Commission on Dental Accreditation to appoint private practitioners as site visitors to the training programs. The Board rejected this notion, deeming the request outside the purview of its responsibility.

More minor points of disagreement characterized this period. In 1983, the Association revisited its earlier request to the Board for information on candidate passing rates as they related to the individual training programs and on other associated operational matters. The Board denied the request, citing over-burdening of its staff, its legal counsel's concern with matters of candidate privacy, and the fact that the Commission on Dental Accreditation had most of the requested information readily available. Two years later, the AAOMS questioned the Board's policy on requiring at least a three-year service as examiner within a ten-year period as eligibility standard for its director candidates, reporting that this had not been written into AAOMS policy, though the record indicated that it had been in 1974. The Board responded that it was, in any case, within its own policies, and so would continue to be applied. At one juncture, the Board refused to send a requested copy of its Policy Manual to the American Association, replying that it was an internal document, had little pertinence to ABOMS/AAOMS relations, and, in any case, was available on request to all diplomates.

These continuing disagreements prompted both bodies to again form a joint committee to study interfacing policies, and suggest changes for greater cooperation. At the same time, 1985, the Board engaged a new law firm for ongoing counsel, one with no affiliation to AAOMS so as to avoid any conflict of interest. And, throughout this period of repeated contention, even confrontation, the Board maintained its invitation to the officers of the American Association, as well as to representatives of the American Dental Association, the Council on Dental Education, and the Commission on Dental Accreditation to its luncheons during the OCE Sessions in Chicago. In addition, the Board joined with the



*James E. Bertz ... 1990-91*

AAOMS in supporting the four-year training period newly proposed to the Commission on Dental Accreditation. It also furthered increasingly productive discussions with the Association on recertification, the issue first brought to open airing almost a decade earlier. At this point, the two groups were discussing primarily voluntary recertification,

In 1986, the two Boards joined in mailing notifications of the Association-designed SCOPE Conference to all Association members and state boards of dentistry. These sessions were to prove monumental in determining the future directions of the specialty. In 1988, the Board teamed again with the Association in compiling a statement endorsing dual medical/dental degree training programs as a standard, a resolution resulting from informally constituted conferences involving international specialty leaders held at Tenerife (Canary Islands) and Bermuda, that were convened in an attempt to establish uniform international training guidelines.. This position encountered significant resistance within American corridors, however, and the joint statement was later rescinded.

The two organizations joined forces again in emphasizing to the Commission on Dental Accreditation the need for permanent specialty representation on the CODA to review site visit reports. The proposal suggested that the review be performed by one committee instead of two, to review uniformly both school-based and hospital-based training programs. The Board also enlisted the American Association of Dental Schools in this effort. It also adopted an unofficial policy at this time encouraging all directors to participate actively in AAOMS affairs, but only as individuals and not as representatives of the ABOMS. It reinforced its official policy of prohibiting its directors from serving on the AAOMS Board of Trustees, or any other elected office of the Association. In this same period, the American Association invited the Board to assume new headquarters space in the Association's new building in Rosemont, Illinois; the Board considered the option but ultimately declined, primarily because it was offered no equity in the building, and chose to remain in the downtown Chicago area.

The fluctuating relationships between the Board and the Association that characterized the 1980s were exemplified again by the mid-decade AAOMS argument against Board directors serving as educational program site visitors, a position that both the Board and the Commission on Dental Accreditation ignored. Further, the Board undertook internal considerations in 1989 of moving the election of Board directors out of the AAOMS House of Delegates. The issue was put to a "straw vote" of the Examination Committee at the 1989 Oral Certifying Examination in Chicago, and was all but unanimously endorsed. Neither were discussions with the Association in the latter months of that year concerning matters of accreditation, fraudulent advertising, or scope of the specialty always harmonious. Further, conversations begun a year earlier regarding Board representation on the Association's Committee on Residency Education and Training, if it were not otherwise independently represented by a director, were not always collegial. On the other hand, as early as 1987 the Board officially supported the OMS Foundation's PEER (Professional Excellence in Education and Research) campaign in principle, but not with the requested \$25,000 donation, citing its desire to remain professionally supportive but financially independent

of the effort. In 1989, the Board and the Association agreed to approach the American College of Surgeons with a request for fellowship for its diplomate members holding both medical and dental degrees, and for membership for those holding dental degrees only, although the College had no such distinction in its existing structure. The two organizations were also united in petitioning the American Board of Medical Specialties for recognition of the ABOMS, though the AAOMS was somewhat upset that the Board gave its own recognition primacy over acceptance of any other oral and maxillofacial surgery agency. These joint initiatives were expanded to include addressing the ACGME (Accreditation Council of Graduate Medical Education) regarding that body's potential accreditation of oral and maxillofacial surgery training programs.

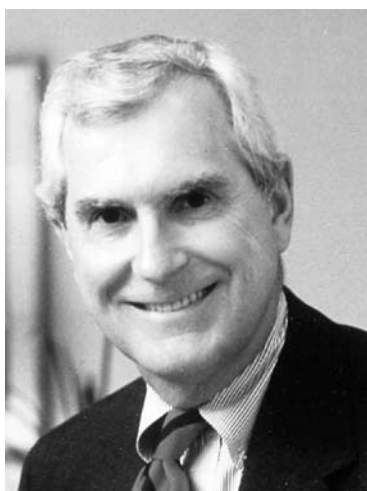
The new decade witnessed cooperative liaison with the American Association. In the first year of the 1990s, the two organizations directed a joint communication to all state dental boards describing the newly defined scope of the specialty. This new definition was delivered to the Commission on Dental Accreditation and to the American Dental Association House of Delegates, as well, who, in their 1990 Annual Session officially adopted it. The definition reads that, "The specialty of oral and maxillofacial surgery is that part of dental practice which encompasses the diagnosis, the surgery, and the adjunctive treatment of diseases, injuries, and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region."

The two Boards also agreed to review jointly their individual lists of nominees for site visitors, and would then jointly direct the selections to the Commission on Dental Accreditation for appointment. This arrangement settled, for the moment, the contentious relationship regarding the Board's freedom to submit its own site visitor list to the Commission. The Board and Association also issued a joint communication to the American Dental Association opposing the move to establish anesthesiology as a recognized specialty within dentistry, and directed this official opinion to the American Society of Dentist Anesthesiologists, the body of individuals promoting such recognition.

The earlier discussed approaches to the American College of Surgeons, the American Board of Medical Specialties and the Accreditation Council of Graduate Medical Education, had generated arguments as to who should take primary responsibility for representing the specialty in these contacts. In 1990, AAOMS Executive Director Mr. Bernard Degen suggested that a combined Association/Board task force be directed to formulate parameters for these approaches. This issue, plus those relating to CODA site visitors and the Board's rejection of the Association's suggestion that the WQE be designed to replace the OMSITE, provoked discussions, again, regarding the Board's autonomy and its potential desire to take its director election out of the AAOMS House of Delegates. The two agencies conferred regarding this latter proposal. During those sessions, the AAOMS executive director agreed that, because of the seemingly endless dissension on the matter, the election, indeed, should be taken out of the House of Delegates, and transferred to a defined electoral process of the Board. No such action was formulated, either at that time or since.

In 1991, having abandoned its request that the Board substitute the Written Qualifying Examination for the OMSITE, the American Association transmitted a request for the Board to assume joint responsibility for the production and conduct of the in-service examination. The Board recorded its willingness to assume sole responsibility for the OMSITE, but demurred on conjoint management with the AAOMS. The Board also took no action on the Association's suggestion that it incorporate the OMSITE into the newly enacted recertification program. The AAOMS Special Committee on Strategic Planning issued a statement in this same year suggesting continued dialogue with the ABOMS on the content of all ABOMS examinations, particularly as they related to the evolving scope of oral and maxillofacial surgical care. The Board agreed to further dialogue, but discounted any contribution from AAOMS on the scope or content of the examinations. Persisting in this vein, the Association informally suggested a joint committee to review all examinations, those of the Board plus the OMSITE, for content. The Board rejected this notion, as well, and the AAOMS never formalized the request.

Matters of education assumed importance in 1991, as well. The AAOMS became concerned with the lower OCE passing rate and its possible relationship to the training program accreditation process. The ABOMS felt that the discouraging rate was due more to the rather poor candidate pool of dental students applying for oral and maxillofacial surgery training. The two Boards joined forces in registering their opposition to the CODA's proposed revision of program directors' certification statuses. Both the AAOMS and ABOMS supported the proposal that all programs be under the direction of Board-certified individuals, applying this to anyone appointed after January 1, 1984. The CODA took a less stringent approach to "grandfathering" and stipulated that only after January 1, 1994, would new program directors have to be Board-certified, and it would allow programs already under the direction of non-Boarded directors to maintain their accreditation. In other words, the CODA allowed a much larger cadre of non-certified program directors to hold their posts than either the AAOMS or ABOMS would have desired.



The AAOMS and ABOMS Boards developed an AAOMS/ABOMS statement on "Training and Scope of Practice of the Oral and Maxillofacial Surgeon," which reflected the new definition of the specialty as adopted by the American Dental Association and disseminated to the state boards of dentistry a year earlier. The AAOMS executive director advised the Board at this point of a meeting between representatives of the American Medical Association, the American Society of Plastic and Reconstructive Surgeons, the American Academy

*Donald M. Hagy ... 1991-92*

of Otolaryngology, and the national dermatology groups regarding the issue of surgeons of various disciplines advertising their qualifications in, and practice of, cosmetic surgery. He emphasized his conviction that the meeting had been called because of the joint AAOMS/ABOMS publicized statement of 1989 regarding its endorsement of dual degree training, and the consequent interests in cosmetic surgery. In part due to their not having been invited to this session, a six-member liaison committee of the ABOMS and AAOMS directors was dispatched to consult with the American Board of Medical Specialties in February, 1992, regarding their petition to the ABMS for recognition of the specialty. This issue was felt even more acutely because the toll-free telephone number provided by the ABMS for patients inquiring about the qualifications of their cosmetic surgeons made no mention of the dental specialty.

The Board's 1988 request for a seat on the AAOMS Committee on Residency Education and Training became a formalized reality in 1992, but only for a single representative. This formalization was perhaps prompted by the Board's advisory to the AAOMS that the Board and not the Committee on Residency Education and Training, was the appropriate agency to report to the training chiefs on the Board examination performances of their graduates. The two organizations did work together in promoting a restructuring of the CODA framework for evaluating training programs. Their suggestion called for an improved evaluative system modeled along ACGME lines, and from these efforts evolved the establishment of the Oral and Maxillofacial Surgery Review Committee comprised of representatives of both AAOMS and ABOMS, functioning under the CODA. Shortly before this effort, a committee of ABOMS directors had met with members of the AAOMS Testing Committee to coordinate and define the policies and roles of the two organizations in execution of the OMSITE, OMAAP (Oral and Maxillofacial Surgery Anesthesia Assistants Program), and ABOMS Examinations.

In late 1992, after only a decade, differences between the organizations in the role and appointment of Board regional consultants resurfaced. The AAOMS requested that the Board submit its regional consultant nominees to them for approval, a posture echoing the demands put upon the AAOMS by the Association of Diplomates several years earlier. The discussions with the AAOMS Board of Trustees on this issue became strained, but the matter was diffused by the Board agreeing to forward to the AAOMS trustees its rationale and criteria for regional consultant selection. During this period, the Board was still frustrated in trying to determine the significance of the consultants' role in the best of circumstances. Debates with AAOMS also ensued over the latter's request that examination results be disseminated by the AAOMS to interested parties, a request that the Board denied.

*\* Leete Jackson, III ... 1992-93*





A further item of contention in this period was the suggestion by the AAOMS Trustees that ABOMS Director candidates should follow the same guidelines as AAOMS candidates for election, entering the political process regionally and at the AAOMS meetings prior to director election; this proposal was abhorrent to the ABOMS, but was only a prelude to a more intense debate in the immediately subsequent years. An AAOMS petition that the Board did elect to honor was the insertion of questions on the WQE relating to the newly-established AAOMS Parameters of Care, which had been disseminated to all members and trainees within the specialty. The Board included four non-scored questions on its 1993 Written Qualifying Examination to serve as a monitor of the candidates' awareness of the AAOMS-endorsed guidelines.

The American Association's recognition of the Board's role in monitoring residency training was reflected in its invitation to the Board to send a representative to a 1994 international meeting of OMS educators in The Hague, The Netherlands. The two groups also exchanged thoughts on the difficult matter of evaluating candidate ethics and/or morality in the examination process. The Board advised the Association that it would not score these attributes during the candidate's performance in the much-debated case presentation section of the Certifying Examination. In the same year, 1994, an ABOMS director was invited to sit on the AAOMS Special Committee on Graduate Medical Financing, and in those discussions the issue of candidate Board performance and its relationship to the individual training programs again arose. At that juncture, the Board representative, working cooperatively with the Association, reaffirmed the Board's role in and contributions to program accreditation.

In the middle 1990s the Board responded positively to a request of the Association's Commission on Professional Conduct for a two-year revocation of a diplomate's certification to run concurrently with any penalty assessed by the Commission for violation of its Code of Professional Conduct. Appropriately, the Board established a policy of referring any complaints of unprofessional conduct it might receive directly to the commission.

Unfortunately, cooperation between the Association and the Board did not entirely typify the interactions of the two groups during the last years of the 20th century. In 1994, despite the earlier joint directive to the ADA and state dental boards, the Board removed its name from a proposed joint letter with the Association defining the specialty and its educational status to outside credentialing bodies because the Board did not entirely agree with the Association's views. In that same year, AAOMS suggested that it would sponsor "Board preparation courses" for both the Written Qualifying Examination and the Re-Certification Examinations, a stance that the ABOMS soundly opposed. The proposed course for the WQE never materialized, but, in 1998, the Association indeed did institute a preparation course for the Recertification Examination.

A rather petty issue arose in 1997, when the Board planned to present an informational booth at the AAOMS annual meeting; the Association exhibition design placed the Board's booth in the rather remote "Support Services" area, a move the Board considered



a derogation and it canceled the proposal. A year later, the ABOMS consideration of an endowment program was informally opposed by the AAOMS, ostensibly because of perceived competition with soliciting financial support for the OMFS Foundation, and the plan never came to fruition. In the same period, the Board's request for two seats on the Association's Committee on Residency Education and Training (one seat having been only begrudgingly given, in the Board's view, some five years earlier) met with resistance from the Association.

Three greater issues, however, brought the two organizations to near impasse. The first arose within months of the Association having recognized, seemingly collegially, the Board's role in education when it announced, in 1995, that it now saw the Board's only role being testing and questioned the Board's contribution to education and the accreditation process. The Board countered that in light of its intimacy with candidate performance and its knowledge of and responsibility to the training programs, it was impossible for it not to stand in some proportion accountable to the American Dental Association or to legitimate outside agencies for the educational and training status of the specialty. Secondly, in 1994, the AAOMS requested that three ABOMS directors serve on its Election Reform Committee. In this interplay, the AAOMS moved to impose an AAOMS fellowship requirement on all Board director nominees and, further, reiterated its 1992 wishes that director candidates enroll in the same electioneering process as all AAOMS political candidates, speaking at caucuses, regional meetings, etc. The Board deferred the first move without definitive action, but vigorously rejected the second motion in a major confrontation. Thirdly, because of its frustration with the perceived insensitivity of the Commission on Dental Accreditation to ABOMS opinions and recommendations regarding specialty training, the Board joined with the boards of the other recognized dental specialties in the initial design of an Association of American Dental Specialty Boards, intended, in one of its functions, to coordinate and direct the interests of the recognized specialty certifying boards to the CODA in formal fashion. This is discussed later in this chapter, but it is noted here that the move was considered redundant by the AAOMS and an affront to its authority as the "parent" organization of the Board. The American Board's authority to act independently in this undertaking was given contemporary support by a declaration of the American Dental Association House of Delegates in 1995 which noted, in a review of the role of its Council on Dental Education, that, "The Council on Dental Education and sponsoring organizations monitor the administrative standards and the operations of the certifying Boards." The semantic issue of "parent" vs. "sponsoring" had arisen in less intense confrontations between the two bodies over the previous four decades, but never to the extent that it attained by the late 1990s.



*Douglas P. Sinn ... 1993-94*

The intensity of these three disagreements disrupted the political proceedings of the Association at its 1995 Annual Meeting in Toronto, and prompted intense new deliberations within the Board of Directors regarding the feasibility of functioning independently, free of any managerial obligations to the Association. The Board subsequently adopted a policy of dispatching one of its directors to each of the AAOMS summer district caucuses to ensure proper representation of the Board's stance on any issues of contention that might arise. However in the 1996 District I Caucus, the Board representative was directed by the AAOMS district trustee to excuse himself during the portion of the business proceedings pertaining to Association/Board matters.

## **The New Century**

Throughout this period of contest, and even animosity, between the organizations, elements of civility were maintained. The Board began disseminating formal director candidate summaries and biographies to the AAOMS House of Delegates in advance of the annual meeting, and the senior officers of the Association, as well as its executive director and assistant executive director, continued to participate in luncheons at the OCE sessions. A program of conference calls was instituted by the end of the century wherein the officers of the Board, the American Association, the AAOMS Foundation, the AAOMS Political Action Committee, and the AAOMS National Insurance Company, would speak together on a bi-monthly basis; within a year, however, because of coordination difficulties, and occasional lack of substance, this liaison was discontinued.

The directors continued to attend the AAOMS district caucuses, and in 2002-2004 the American Board engineered an informal encounter between Association trustees and those of the American Board of Surgery by inviting representatives of both organizations to observe the Oral Certifying Examination. In that same year, the ABOMS president and vice president met with the AAOMS trustees at the latter's summer sessions and continued to do so through 2005. This regular interchange between officials of the two oral and maxillofacial surgery agencies continued throughout most of the new century's first decade, though director election remained an agenda item at the joint AAOMS/ABOMS leaders' meetings as late as 2003.

In those early years of the 2000s, the Association, inspired by its international liaisons, asked the Board to consider the feasibility of an international board examination in the specialty. The topic had been considered informally a few years previously, but now received more intense scrutiny. Problems in design, questions in regard to contributors, and uncertainties as to acceptance and recognition plagued the discussions and the Board withdrew from further serious consideration of the notion for the time being.

By 2002, the Board had accepted full responsibility for the OMSSAT, and administered its first examination in 2004. In those same months, the Board of Directors considered the possibility of establishing so-called Certificates of Added Qualification in subspecialty

areas of oral and maxillofacial surgery, inspired by the formula used by certain of the ABMS-recognized medical specialties. The Board itself was somewhat divided on the advisability or efficacy of such examinations and the notion elicited little interest when transmitted to the AAOMS Committee on Residency Education and Training.

The earliest new century uneasiness in relationships with the AAOMS arose in the first year when the ADA House of Delegates rejected the American Society of Dentist Anesthesiologists' (ASDA's) proposal for establishing dental anesthesiology as an endorsed specialty. The AAOMS, anticipating that anesthesiology might one day become a specialty, offered titular approval to the American Dental Society of Anesthesiology (ADSA ) being the sponsor for any future developing board examination, since so many of that group's members were fellows of the AAOMS. The ABOMS, however, took a much stronger stance in these considerations, vigorously opposing any notion of any agency establishing recognized board status in anesthesiology. *\*see Addendum P20*

## **Relationships with the American Dental Association**

### **The First Twenty-Five Years**

Even before the Board's formal inception, the 1938 committee of the American Society of Oral Surgeons and Exodontists charged with development of a board examination undertook organizational conversations with the American Dental Association. This committee worked with the ADA's Advisory Board of Dental Specialties in laying out the definition and recognition of the specialty. The ADA's Council on Dental Education and its Judicial Council, the American Association of Dental Schools, and the American College of Dentists, along with all other specialty groups, were represented in these discussions. Unfortunately, at that point neither the ASOSE committee nor the group as a whole could muster sufficient sympathy for the development of a specialty board. But these early liaisons did lead at least to recognition of the specialty by the American Dental Association and all other interested dental parties. Seven years later, within a year of its official ASOS formulation, the fledgling ABOS petitioned the ADA's Council on Dental Education for approval and recognition, which were duly granted.

Two years later, in 1947, the Board, submitted an outline for approved residency training in the specialty to the Council on Dental Education. Within a year, following acceptance of this outline, the new Board's Advanced Training Program Committee (ATPC) began on-site surveys of potentially acceptable programs, with particular reference to their academic content and training facilities. The ATPC then submitted all its garnered information to the Council on Dental Education and, if a program were then deemed acceptable by that council and the ADA's Council on Hospital Dental Service, the Board would then approve that program's graduates as eligible for examination. At that time, then, the Board found itself with the responsibility of approving or disapproving programs, a function it felt more rightly belonged to the American Dental Association.

The transfer of this ultimate responsibility was, indeed, effected in subsequent years, but the Board's seminal role in the development of educational standards and accreditation criteria for the specialty cannot go unnoticed.

By the spring of 1951, the Board's ATPC (earlier termed the Graduate Training Program Committee) had reviewed and approved fourteen programs and a total of twenty programs by October of that year, two of which were military (Walter Reed Army Hospital and Letterman Army Hospital). As it gained experience in reviewing programs, the Board began to recognize the necessity for increasing length of training, and, in 1953, relayed to the ADA's Council on Dental Education its endorsement of a three-year formal training requirement. The council accepted this recommendation. The increasing complexity of these evaluations culminated in 1956 in the Board and the Council on Dental Education agreeing that the Council would henceforth be responsible for evaluation and approval of programs; the Board would provide consultants to suggest improvements in existing programs and the creation of new ones.

The close liaison between the Board and the Council was tested in 1959 by the Council's dictate that the executive secretary of any specialty board could not also serve as a director of that board. Dr. Leslie FitzGerald had carried both of those responsibilities since the ABOS' inception in 1946. In accord with the Council's new mandate, however, he stepped down as director in that last year of the 1950s, but remained on as executive secretary for several more years (see Chapter IV).

As the Board matured, its interplay with the American Dental Association correspondingly expanded. In 1962, it joined with Committee B of the Council on Dental Education and representatives from the American Society of Oral Surgeons to discuss the scope of advanced basic science training in its approved programs. A year later, the Board offered \$1,500 in support of the ADA's Conference on Graduate Education, and, a year after that, two Board directors, O. Lee Ricker and Robert Walker, served as the first two Board representatives on the newly-established ADA Review Commission on Advanced Education in Oral Surgery, which first reported in March of 1965. Imperfections in the ADA's process of accrediting graduate oral surgery programs became manifest during the five years that Ricker and Walker served in this capacity, and they expressed their dissatisfaction with imprecise standards, inadequacies in site visits, etc. These were the first frustrations with issues that would last for decades.

In that same period, the Board worked with the Council on Dental Education in establishing a requirement that all oral surgery program directors be Board certified. Close integration of the Board with the ADA's agencies was further demonstrated by the Board's monetary support of Review Commission activities, providing \$3,000 in 1967 for meeting expenses, for example, and by sending two directors as representatives to the ADA's Conference on the Dental Specialties in 1968. In that year, the Board also approached the ADA regarding the possibility of transferring its offices from Dubuque to the ADA Building in Chicago.

The decade of the 1970s marked a period of both cooperation and friction with the American Dental Association, primarily in the Board's relationship with the Council on Dental Education and the newly-established, quasi-independent Commission on Dental Accreditation. This new alignment allowed the CDE to focus on its responsibilities of the recognition and function of specialty boards and channeled the CODA into supervision and monitoring of the training programs. The conundrum created by separating the responsibility for measuring outcomes from the responsibility for measuring process was only later recognized. Later pages will detail the Board's difficulties with the new agency in these responsibilities.

In 1971, the ABOS worked with the Council on Dental Education in determining the eligibilities for Board examination of the increasing number of foreign graduates. Those individuals who had attained some advanced education in other countries and then transferred to institutions in the United States often proved difficult to evaluate in regard to their earlier educations and their appropriate positionings in American programs. This was a particularly perplexing issue in regard to Canadian trainees. The Board was inclined to accept them for examination on the basis of some familiarity with training programs in Canada and in the interests of international collegiality, but was unable to do so since the CDE had no mechanism for evaluating the quality of non-United States programs, even those in Canada. In this instance, the Board had to recognize that it had long since ceased to be an accrediting agency, and, despite its inclinations, was forced to disallow Canadian-trained applicants.

Also in 1970, the ADA agreed that the Review Committee on Graduate Training in Oral Surgery could investigate the potential merits of increasing the period of oral surgery residency to four years, and also endorsed the Committee's investigation of an in-service training examination. The next year, the Board's relationship with the Council on Dental Education was frustrated on two fronts. First, the Council would agree that only "the major portion" of any specialty training program had to be under the tutelage of a Board diplomate. This proposal was originally raised by the specialties of Public Health and Oral Pathology, but was strongly opposed by the ABOMS. Secondly, the Council ruled that a candidate for ABOMS director did not of necessity have to have experience as a Board examiner although such an individual "should be given preference." The Council ruled that this ABOMS-mandated qualification was not in compliance with Council on Dental Education requirements. This issue was brought up for discussion by ASOS members affected by this ABOMS restriction.



*J. David Allen ... 1994-95*

Through the alternating indifference of the parties involved and effective argument on the part of the Board, the qualification prevailed, but arose as a debating point once again a decade later.

## The 1970s – 2000

In 1974, responding to the Council on Dental Education’s request, the Board named an ad hoc Committee on Standards of Oral Surgery Practice to review possible requirements for recertification, reflecting a growing interest in recertification throughout the professions. The Council’s preference at that time was an emphasis on continuing education for all dental specialties as a hallmark for recertification.

Within months of working together on this first project, the Board endorsed the ADA’s new effort to gain a seat on the Joint Commission on Accreditation of Hospitals, with the particular goal of gaining history and physical examination privileges for oral surgeons. The Board’s support of the ADA was championed by the Board’s Fred Henny, particularly through his close personal liaisons with Dr. John Porterfield of the JCAH. The mutual support of the ADA and the ABOS in that period was exemplified further by the ADA House of Delegates’ 1973 endorsement of “maxillofacial” in describing the specialty and its practice. This decision was announced officially by the ADA in 1974, with the concurrence of both the American Board and the American Society of Oral Surgeons. The term was not officially incorporated into these organizations’ titles for another four years, however.

Although relationships over an almost ten-year period were generally cordial, as iterated in a joint statement by Board President Fred Henny and ADA Executive Director Harold Hillenbrand and echoed by other Board presidents, certain matters of contention arose. By 1971, the Council on Dental Education had still not honored the Board’s request of five years earlier that the directors of accredited training programs in oral surgery be required to

be Board certified. Additionally, in 1974, a reference committee of the American Dental Association instructed the American Society of Oral Surgeons to study the composition and overall operations of the American Board. As described in earlier pages, this was the result of an initiative undertaken by a small contingent of dissatisfied Board diplomates to challenge certain operational policies of the Board; the issue is further discussed later in reference to the American College of Oral and Maxillofacial Surgeons. This directive of the American Dental



*John P.W. Kelly ... 1995-96*



Association was ultimately rejected by the ASOS Board of Trustees and its executive director, and no such action was undertaken. A year later, the ADA Council on Dental Education advised the Board that its policy requiring diplomates to restrict their practices solely to the specialty ran counter to the CDE allowance for multiple ADA-authorized specialty practices. The ABOMS discussed the issue with the ASOS and, at that point, no action was taken; however, some two decades later, the Board altered its policies to allow such multi-specialty practice for those with the requisite credentials.

The earlier-mentioned difficulties between the Board and the fledgling CODA arose first in early 1974 when the Review Commission on Advanced Education in Oral Surgery, which had been in place for some ten years by that point, was re-titled the Advisory Committee for Advanced Education in Oral Surgery and placed under the aegis of the new administrative body. It was to be composed of two members from the American Society of Oral Surgeons, and two from the American Board of Oral Surgery. One of the initial points of contention between the American Board and the American Society, on one hand, and the new Commission on the other, was the directive that the two specialty bodies would submit lists of candidates for program site visitors, from which the Commission would assume responsibility for appointment. Further, that same year, the Board's frustration with the Commission's indifference to its recommendations regarding training programs – an echo of voices of some nine years earlier – was reflected in the Board's complaint that some CODA-approved programs, according to site visitors' reports, had inadequate anesthesia training. This was only one manifestation of a larger problem, the fact that neither the CODA's Committee A, which reviewed and passed judgment on dental school-based programs, or Committee B, which reviewed hospital-based programs, maintained obligatory oral and maxillofacial surgery representation. In fact, the Commission itself had no oral and maxillofacial surgery representation for the first twelve years of its existence. This inequity, an expansion of earlier unease on the part of the American Board, would have significant implications in future decades. In 1977, the Board became further frustrated with CODA actions when, after it provided examination results to the CODA to help that body advise program directors of their candidates' performances, the CODA refused to utilize the information, responding that such responsibility was not within its purview.

As the American Board of Oral and Maxillofacial Surgery – its new designation, assumed in 1978 - entered the 1980s, relationships with the American Dental Association and the Commission on Dental Accreditation continued to oscillate between sweet and sour. In 1986, the Board, to demonstrate its allegiance to the American Dental Association, prepared a comprehensive article on all ABOMS activities for publication in the *Journal of the*



*Bobbi Leggett*

*American Dental Association* and the *AAOMS Forum*. This gesture came despite the Board's chagrin with the ADA for having increased the rent on its ADA offices by 100% in a single year, 1985.

Interorganizational difficulties stemmed from the administrative oddity of the CODA itself. Although it was intimately tied to the ADA administratively and financially and functioned as an arm of the ADA's educational role, its authority as an accrediting agency came from its independent recognition by the United States Department of Health, Education, and Welfare (later, the Department of Education). The Board continued its policy of invitational luncheons for ADA, CDE, and CODA representatives at its annual OCE sessions in Chicago, and in 1984 the Board supported the ADA's and the CODA's recommendation for a five-year accreditation cycle for oral and maxillofacial surgery programs. Additionally, in 1986, the Board sent an official supportive commentary to the CODA regarding the new four-year program essentials, endorsing the rotation of OMS trainees in sub-specialty departments during their newly-mandated four-month minimum exposures on general surgery services. Three years later, the Board also supported the CODA's effort to improve the quality and efficiency of its site visitors by sending Board representatives to the Commission's site visitors' workshop.

However, relations between the Board and the Commission on Dental Accreditation remained strained at times. In 1984, the CODA, reversing its stance of several years' earlier, requested certification examination results from the Board to aid them in evaluating training programs. This time the Board refused, fearing that such information, if disseminated, might encourage a candidate's "training only toward the Board examination." In 1989, the ABOMS, frustrated by the lack of specialty representation on the CODA committees performing final reviews of site visitor reports, joined the AAOMS in emphasizing to the CODA the need for permanent specialty representation in this process and suggesting that Committees A and B be amalgamated into a single evaluating group. The CODA did not respond to this appeal and the Board, in frustration, attempted to enlist the American Association of Dental Schools into the debate. A year later, this appeal to CODA remained unanswered.

In 1990, finally, the Board, in concert with the AAOMS, convinced the American Dental Association to dictate that two oral and maxillofacial surgeons would sit on the committees reviewing the site visitors' reports of both dental school- and hospital-based residencies, and, further, the ADA agreed that all oral and maxillofacial surgery training programs would have to be under the direction of a Board-certified individual. Specifically, the original proposal mandated that any director appointed after January 1, 1984, would have to be Board-certified, but directors in continuous service before that date would be exempt from this ruling. In 1991, as noted previously, the CODA delayed the date of mandated program director certification to January 1, 1994 in response to concerns of due process by those non-boarded individuals already serving as program directors after 1984.

These ADA-mandated changes tempered the American Board's 1988 petition to the American Dental Association for a two-tiered training program accreditation process: the first through the CODA and the ADA, and the second through the Accreditation Council on Graduate Medical Education. The latter accredited only post-doctoral medical training programs and functioned as a private agency, independent of the American Medical Association and outside the purview of the US Department of Health, Education, and Welfare (HEW). The CODA, however, needed HEW recognition because of its accreditation of predoctoral programs whose funding depended on being accredited by an agency recognized by HEW, an issue not faced by postdoctoral "residency" programs. Liaison with the ABMS and the ACGME would continue as future Board preoccupations in other contexts.

In the 1980s, on issues such as the director election process, relationships with other specialty organizations, and role of the Board in education, the ABOMS Board of Directors and the AAOMS Board of Trustees had disagreed several times. The issue of whether or not the AAOMS had primary authority over the Board always lay at the heart of these encounters. It had been generally agreed since its inception that the Board was derived from the Association (or, earlier, Society), but the disagreement centered on semantics, i.e., whether the Society/Association was the *sponsor* of the Board or the *parent* of the Board (see Chapter VI). Administrative records gave support to both camps, so in 1981 the Board formally petitioned the American Dental Association for an opinion. The American Dental Association replied equivocally, pointing out that its Council on Dental Education Statement of Policy declared in 1968, and reiterated again in 1973, 1975, and 1976, that, "Each Board shall have a parent or sponsor. . . ." This posture indicated that the ADA chose not to drive to the heart of the disagreement.

In 1988, the Board and the AAOMS again dealt with one another through the ADA when the Association asked the ADA to mandate that OMSITE scores and success on the certification examinations be included in the outcomes assessment of training program quality. The Board commented to the American Dental Association that these monitors were not required in the standards for oral and maxillofacial surgery training programs approved through the Commission on Dental Accreditation. At that time, however, there was a paradigm shift in accreditation circles that emphasized demonstration of outcomes instead of process. To be accredited, an institution could no longer simply show that it provided the educational milieu; it had to demonstrate that its graduates had absorbed and applied their educations. The new language of the accreditation standards stated "performance of the graduates of the programs [in the Board certification process] is one measure of the quality of that program." In its 1988 request, the AAOMS was presumably acting in the interest of its Committee on Residency Education and Training (CRET) in suggesting that the Board should supply its certification information to the CRET. The Board did not comply in that instance but did agree to provide the training programs with pass/fail information on their graduates so that those programs could utilize the information for their own outcomes assessments and enable the programs to meet the new

requirements in that regard. Several years later, in 1995, the Board did agree to transmit program Board performance data, not including individual scores, directly to the Advisory Committee of the CODA, but not to any committee of the AAOMS.

Also in 1988, the ADA, in an effort to assist its Council on Dental Education, asked the American Board to provide an official stance on the proposed specialty of oral implantology. The Board expressed its gratitude for being consulted, but deferred on responding until the AAOMS would record its official stance on behalf of the specialty nationally. The AAOMS ultimately declared its disapproval of the implantology proposal, and the Board concurred. In 1990, the Board joined AAOMS in a letter to the American Dental Association arguing against the legitimacy of the establishment of an approved specialty in dental anesthesiology, as proposed at that time by the American Society of Dentist Anesthesiologists. Fourteen years later, the ABOMS, apparently interpreting the petition as an impotent effort, chose to offer no official comment on the petition to the ADA by a small specialized group to form a recognized specialty in craniofacial pain.

During the 1990s, liaison with the CODA was sometimes in unity with the American Association and, other times, at variance with that body. Inclusion of formal medical school training in oral and maxillofacial surgery residencies was increasing significantly during the 1990s and the Board asked for an opinion from the Commission on Dental Accreditation regarding the time allowed in residency and the potential role such time in medical school might play in the eligibility of candidates. The Commission replied that it could not rule on the content of formal medical education in such programs, but only advise. This left the Board and the AAOMS Committee on Residency Education and Training to address these considerations themselves.

The issue of appointment of site visitors for program evaluation arose twice in this decade, primarily as an issue of disagreement between the Board and the Association. In 1990, because of its concern that AAOMS nominees might be more politically derived than chosen for academic credentials and/or examination experience, the Board submitted

its own list of site visitor candidates to the CODA rather than simply endorsing a roster generated by the AAOMS. Discussions with the AAOMS over this issue became less confrontational over the next couple of years, but by 1994, the Board reiterated its request to the CODA on the issue. At that point, the CODA enacted, as policy, direct submission of candidate listings independently from both the AAOMS and the ABOMS.



*Thomas W. Braun ... 1996-97*

The earlier noted concerns with what both the American Board and the American Association deemed to be shortcomings in training program evaluation and quality enforcement coalesced in efforts to change the CODA accreditation process during the early and mid-1990s. In 1991 the Board, with AAOMS endorsement, approached the US Department of Education to force the CODA to change its policies. A year later, because of the CODA's continuing lack of specialty representation and perceived weakness in training standards enforcement, the two bodies directly approached the ADA with their concerns.

The joint stance of the Board and the Association in 1992, was that the CODA should be restructured to mimic the ACGME, i.e., become free-standing with totally separate processes for predoctoral and postdoctoral programs, and with appropriate specialists to evaluate the respective specialty training programs for all of dentistry. This formulation met with little sympathy within the CODA, but did result in the establishment of a Residency Review Committee for each of the dental specialties that would at least be charged with responsibility for reviewing training site evaluations before they were channeled to Committees A or B for final adjudication. Neither the Board nor the Association completely laid aside the ACGME-model deliberations, however, and latent advocacy of this or similar mechanisms would find expression again in later years.

The relations with the ADA outside the CODA context reflected, on several occasions, the Board's determination to maintain its independence and integrity. The Board maintained its support of ADA policies in general, as evidenced by its 1996 conjoint endorsement of the administration of office anesthesia and conscious sedation by qualified dentists. A year later, however, the ADA House of Delegates, in their Resolution 96H, 5.I.1, adopted a policy that, in essence, allowed and recognized non-ADA approved specialties. In the Board's view, this action compromised the influence of the bona fide specialties and prompted the Board to even more strongly endorse the development of a Dental Specialty Board Association, a posture that, as discussed in a previous section, became a matter of confrontation with the AAOMS.

Interestingly, despite the 1997 House of Delegates action, the ADA, through its new Council on Dental Education and Licensure (CDEL) (formerly, Council on Dental Education), four years later endorsed the Board's promulgation in its own literature that Oral and Maxillofacial Surgery was an ADA-recognized specialty, distinct from "pretender specialties" that were not. The CDEL supported such pronouncements by all other approved dental specialties, as well.

**“... this action compromised the influence of the bona fide specialties and prompted the Board to even more strongly endorse the development of a Dental Specialty Board Association.”**

## **The New Century**

In 2001, the Board recommended to the CDEL that American Board certification be deemed sufficient for licensure in specialty practice in any of the states, The Board's position on certification and state dental licensure had been reflected earlier in its interchanges with the American Association of Dental Examiners, discussed elsewhere in this chapter. A year later, the Board strongly endorsed the ADA's approach to the Joint Commission on Accreditation of Healthcare Organizations for recognition of the ADA and all the dental specialty boards, in the same light as the JCAHO's recognition of the AMA, the American Board of Medical Specialties, and all the ABMS-approved medical specialty boards. *\*see Addendum P21*

## **Relationships with the American College of Oral and Maxillofacial Surgeons**

In May of 1968, a cadre of American Board diplomates dissatisfied with certain policies of the ABOS, and the activities of the Board of Directors, coalesced under the leadership of Dr. Harry Archer of Pittsburgh and Dr. Herbert Bloom of Detroit into an Association of Diplomates of the American Board of Oral Surgery. Both Archer and Bloom were Board certified and Bloom had been appointed an examiner in 1947. The ostensible cause célèbre of this group was the fact that the leadership of the Board was elected by the ASOS House of Delegates, well over half of whom were not diplomates of the American Board. With equal vigor, they charged that the Board, in selecting its own director nominees, was uncontrollably inbred. This new Association wanted the "officers and directors" elected by the diplomates themselves by national mail ballot at the time of payment of their annual registration fees. The Archer-Bloom coalition directed this petition to the American Dental Association, which channeled the request to its Committee B. This latter body rejected the notion, and instead suggested inserting the stipulation that the directors of the American Board of Oral Surgery should be determined by the "Electorate..." of the "...parent (sponsoring) organization." This latter phraseology was correspondingly inserted into the Council on Dental Education requirements for the specialties, where, seemingly, it had not resided to that point. Apparently, this absence was an oversight of the 1946 ADA documents relative to the then-new American Board of Oral Surgery.

Though written correspondence, often direct and not always complimentary, coursed regularly between the American Board and the new Association of Diplomates for the next five years, nothing of substance transpired. The actual surviving correspondence is fragmentary, but the Board minutes make reference to it on a consistent basis. In 1973, however, the ABOMS Board of Directors agreed to meet with Drs. Archer and Bloom to discuss the group's perceptions of Board inadequacies or improprieties. Among the agenda items were the issues of alleged first-class air travel for the ABOMS Board of Directors (of which there is no record in Board annals), the level of annual dues assessments, a deterioration of morals and ethics within the specialty, and, indirectly, within ABOMS itself. The new Association questioned the minimum requirements for examiners and their mode of selection and suggested lessened reliance on the Written Qualifying Examination



for certification. They wanted a sharper emphasis on clinical procedures and a discussion of the value of case report documentation. The Board took exception to certain elements of both the tone and substance of the Association’s case, and the session came to an open confrontation with Drs. Bloom and Archer. Following the Board’s strong admonition to Dr. Bloom, he promised to write a letter divorcing himself from the Association of Diplomates, but Board archives contain no record of this note ever having been received. The Association of Diplomates next took its arguments to the American Society of Oral Surgeons, which agreed to form a review committee of disinterested parties to study the American Board of Oral Surgery “in toto” in regard to “many criticisms that have lingered over the years.” Because of the American Society’s delay in activating this committee and because it procrastinated in including “maxillofacial” in the designation of the organization and the specialty, the Association of Diplomates metamorphosed into the American College of Oral and Maxillofacial Surgeons, and quickly registered its trademark. The promised outside review committee did not report until 1976. In the interim, the leadership of the now-American College of Oral and Maxillofacial Surgeons re-emphasized its charges that the ABOMS was inbred in selecting its examiners, and suggested further that the ACOMS should supplant the AAOMS as the sponsoring organization for the American Board. The ABOMS willingly exposed its operations to the American Society-sponsored review; the Board was able to refute the ACOMS effort to insert itself into Board affairs and the review committee’s findings were bland overall.

With the retirements of Drs. Archer and Bloom, and the general exhaustion of parties over the political interplay, relationships between the American Board and the American College sobered considerably. In subsequent years, the College developed into a chiefly educational forum, and the Board retained its ADA and AAOMS responsibilities. In 1985, the ABOMS president formally addressed the American College in a session that reinforced the tacit agreement to live and let live. By the late 1980s, the Board had established a policy of no official liaison with the American College, and determined that its directors would maintain any such liaison on a strictly personal basis. In 1994, again as mentioned in earlier paragraphs, the Board confirmed its desire to distance itself from intra-specialty contentious issues by adopting its policy disallowing trusteeship in the American College and the other organizations of specialty kinship for its officers, directors and examiners.

The American College became thirty years old in 2006 and, in that year, the AAOMS Board of Trustees accepted an invitation to formally visit the annual academic session of the American College. The American Board remained a sympathetic but disinterested observer to that liaison, and maintains that posture to the present day.



*Thomas P. Williams... 1997-98*

## Relationships With Other National Dental Groups

From the first years of its existence, the American Board of Oral Surgery sought out and responded to dental organizations peripheral to its ADA foundation and ASOS sponsorship, in matters relevant to its own activities and those beyond in which it might have legitimate contributions or responsibilities.

In 1947, its first full functioning year, the Board appointed a liaison committee to consult with the American Board of Oral Pathology, itself a nascent body, regarding matters of examination and administrative conduct. Three years later, the Board's Advanced Training Program Committee sent questionnaires to selected training institutions to establish a data reference of site facility and training capabilities. Almost simultaneously, in 1950, the Board contacted the American College of Dentists seeking funds to underwrite the costs of inspecting those programs deemed potentially suitable for accreditation; this occurred during that developmental period, mentioned in a preceding section, in which the Board carried the responsibility for program certification. Beginning in 1961, the ABOS consulted Grace Parkin, the secretary of the Council on National Dental Board Examinations to design, monitor, and improve its Written Qualifying Examination, a liaison that was to prove fruitful for more than a decade.

Dealings with non-ADA dental professionals became more frequent and intense during the last two decades of the century. By the early 1970s, the Board had cemented good relations with the American Dental Society of Anesthesiology (ADSA), most of whose officers were also certified oral and maxillofacial surgeons. However, early in 1981 the American Society of Dentist Anesthesiologists (ASDA), which included some oral surgeons dedicated to the practice of general anesthesia, first promulgated the formation of an American Board of Dental Ambulatory Anesthesia. The ABOMS at that time spoke against such a movement, feeling it divisive. This posture was reiterated in 1990 when the ASDA petitioned the ADA for recognition of a specialty in dental anesthesia. The issue came to the fore once more in 2001 when the ASDA appealed for the development of board status; the ABOMS for the third time in twenty years expressed its opposition to this proposal. As noted earlier, the Board remained non-committal in 2003 when a small group petitioned the ADA for the formulation of a recognized specialty in craniofacial pain.



*Bruce MacIntosh ... 1998-99*

In 1981, the Chicago Society of Oral and Maxillofacial Surgeons extended an invitation to the directors and examiners for dinner and participation in the Society's educational meeting during the Board's OCE week in February, a standing invitation that the Board honored for some two decades. In 1983,

the Illinois State Board of Dentistry recognized successful completion of the ABOMS Written Qualifying Examination as an acceptable credential for state specialty licensure.

The Academy of General Dentistry approached the Board for an advisory on certification protocols in 1981, but no further correspondence with the Academy was ever effected.

In 1986, the Board developed an informational brochure on its activities for dissemination to all interested parties on request, and in this effort reviewed similar summaries from various medical organizations and the American Academy of Periodontology. This activity in broad professional “public relations” was repeated four years later in the Board’s distribution of the spring issue of the *ABOMS News* to all residents in training and other potential examination applicants. At the same time, it joined with the AAOMS in directing a mailing to all state dental boards containing the official definition of the specialty and information describing the training of oral and maxillofacial surgeons.

Difficulties between the boards of the dental specialties and the difficulties in adjudicating these problems through the Commission on Dental Accreditation became evident in 1990. As part of CODA’s on-going process of re-recognition of specialties, the Board was asked as part of the “community of interest” to comment on the continued recognition of Pediatric Dentistry as a specialty. This was a point in time marked by a decrease in pediatric dentistry trainees and the entry of many pediatric dentists into the realm of what the American Board of Orthodontics interpreted as orthodontic practice, leading some to question whether Pediatric Dentistry should retain its specialty recognition. In that the request for comment came from the Commission, the Board reviewed information from both orthodontic and pediatric dental sectors, but then interpreted the issue as a matter for Commission decision and did not file an official opinion.

This 1990 instance of the need for more effective communication between the CODA and the dental specialties, both the sponsoring organizations and the certifying boards, was perhaps an early impetus for the movement among the specialty boards four years later to form an Association of American Dental Specialty Boards to better present a unified front to the American Dental Association and outside interests in matters of specialty interest. This action was briefly mentioned earlier in regard to AAOMS relations. The first efforts in this direction took place in a meeting of representatives of the ABOMS and the American Boards of Oral Pathology, Periodontics, Endodontics, and Prosthetics, in 1995. This session prompted the Board to proceed with a provisional draft of bylaws for such an organization. The ABOMS effort drew early and



*Paul A. Danielson ... 1999-00*

intense opposition from the American Association of Oral and Maxillofacial Surgeons, since the latter viewed such an organization as redundant and potentially usurping the role of the Association’s responsibilities to the ADA. Repeated conversations between the officers of both organizations failed to convince the Association Board of Trustees that incursion on AAOMS privilege was not the motivation for the intended association. The disagreement reached its ultimate intensity during the 1995 AAOMS Annual Meeting, held in conjunction with the Canadian Association in Toronto.

The ABOMS Board, nonetheless, reaffirmed to AAOMS in the following year its full intention to proceed with the formation of an Association of American Dental Specialty Boards, and to endorse its proposed bylaws. The Board’s stance was invigorated by the aforementioned action of the ADA House of Delegates a year later that, in effect, allowed the formation of non-ADA accredited specialties and their boards. The ABOMS and other recognized specialty boards interpreted this as another instance of their ineffectiveness in influencing the ADA through the Commission on Dental Accreditation on specialty issues, despite their being officially recognized as the ultimate authorities in these matters. By 1998, all of the specialties except the American Board of Orthodontics were in favor of establishing the specialty association; the Board of Orthodontics had been convinced by its sponsoring organization, the American Association of Orthodontists, that a specialty board panel would not significantly improve recognition of orthodontic perspectives. Relations between the dental specialty boards and the Commission became somewhat more temperate over the next few years, to no little degree due to the inter-specialty liaison effected under the aegis of the American Association of Dental Examiners (see below).

The desire of the various specialty certifying boards to meet one another in defined fashion within the structure of a defined organization remained subdued, but not dormant,

and in August of 2003 the specialties met together at a meeting of the recognized dental specialty certifying boards at the invitation of the ADA’s Commission on Dental Education and Licensure. The session took place with AAOMS awareness and apparent disinterest. The AAOMS was asked for comments when this group a year later spoke again of establishing a new dental specialty board organization; interestingly, orthodontics, which had stood apart from the earlier effort in this vein in the mid-1990s, had taken the initiative early in the new century, and had drawn up a set of by-laws for the proposed new organization. The specialties discussed this proposal among themselves prior to their meeting that year, again under Commission on Dental Education and Licensing auspices. These meetings continued into the later years of the first decade of the 2000s, generally with all specialties represented, but without the formulation of a defined specialty board organization.

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In this same period, 2003, the ADA requested the Board’s consideration of a proposal promulgated by the National Council of Dental Credentialing Organizations (NCDCO) to enlist the ABOMS into its ranks. The proposed organization stated as its purpose “to elevate and recognize the standards of dental certifying boards and other entities that offer credentials in dentistry.” The ABOMS in its deliberations met with representatives of the recognized dental specialty certifying boards, and, in joint action, dismissed any consideration of participation in the Council and so advised Dr. Howard Jones, the then-president of the American Dental Association.

ABOMS relationships with other dental agencies during the 1990s were much less turbulent than those with its sponsor and the ADA. In 1997, the Board made special efforts to avoid scheduling its meetings and special sessions at times conflicting with those of the American Association of Dental Schools and the International Association for Dental Research. In 1999, an officer of the American Board of Periodontics was invited to observe the Oral Certifying Examination and, in 2005 the president of the American Board of Periodontology visited again.

A 1999 overture to the American Association of Dental Examiners to send an OCE observer signaled the initiation of a collegial relationship with that organization which, later that year, resulted in an ABOMS representative attending the annual AADE Meeting. The ABOMS subsequently joined the AADE as a consulting member. As noted above, the AADE Executive Committee had formed within its group an association of dental specialty boards; through this agency, the ABOMS was able to maintain liaison with the other specialties without raising objection from AAOMS, since the AADE was a voluntary organization outside the purview of the American Dental Association and the Commission on Dental Accreditation. The AADE, whose long-standing chief function is monitoring the coordination of state dental licensure examinations, through its new liaison with the ABOMS became wholly sympathetic to the proposition that any oral and maxillofacial surgeon with ABOMS certification and a license to practice in any state should be eligible for immediate specialty licensure in any other state. In 2002, the ABOMS directors hosted a meeting of the dental specialty boards under their relationships within the AADE.

In the beginning of the new century, the Board also took new interest in liaison with the American Dental Education Association, encouraging Board officers and examiners involved in education to participate actively on behalf of the specialty in the corridors of the ADEA. At that agency’s annual meeting in 2001, an invited representative of the



*Susan Holzer*

American Board of Medical Specialties discussed the possibility of meeting informally with the ABOMS, the AAOMS, and the ADA, regarding the potentials for ABMS recognition of the dental specialty boards. An account of the Board's interaction with the ABMS is discussed in subsequent paragraphs. *\*see Addendum P22*

## **Relationships with the Oral and Maxillofacial Surgery Foundation**

The Oral and Maxillofacial Surgery Foundation was instituted in 1959 to generate and dispense funds in support of educational and research efforts for the welfare of the specialty. Its financial base broadened impressively in 1987, when it developed its specialty-wide PEER (Professional Excellence through Education and Research) Campaign, soliciting donations from the rank and file of the practicing surgeons and from corporate supporters of the specialty.

In that the activities of the American Board of Oral and Maxillofacial Surgery provided a good monitor of the educational and investigative endeavors of the specialty, it seemed logical that it should be represented on the Foundation Board of Trustees. As late as 1984, however, there existed no clearly defined procedure for naming any such ABOMS representatives. Both the president and immediate past president of the AAOMS had seats on the Foundation Board and, in 1986, the ABOMS submitted a proposal that its president should also participate at that level. Given that the Board's Constitution and Bylaws at that time prevented a Board officer, director, or examiner from serving on the administrative board of several professional agencies, including the Foundation, a bylaws change was required. This was achieved in a 1986 bylaws modification that allowed the Board president to function as a trustee of the Foundation, but only if he/she were already on the Foundation Board through other appointment.

The requested formal appointment of the ABOMS president did not come to fruition, and the frustrations of the Board were compounded in 1989 when the Foundation did, in fact, appoint an ABOMS director, not the president, to its directorate without conferring with the Board. The appointment stood in violation of extant Board Bylaws and the Board therefore announced that the appointed individual could not and would not be recognized as an official ABOMS representative. The Foundation, in turn, altered its bylaws in 1990 to allow the inclusion of one three-year appointment of an ABOMS director to its governing panel, but only on a request of the Board accepted by the Foundation Board of Directors. Later in 1990, when the Foundation again appointed an ABOMS representative without consulting the ABOMS, the Board became convinced that the Foundation really did not want an ABOMS voice on its Board of Directors. Firmly convinced, the Board, in 1994, reaffirmed its bylaws policy of disallowing any officer, director, or examiner to serve on the Board of Trustees of the AAOMS, the ADA, the Oral and Maxillofacial Surgery National Insurance Company, the American College of Oral and Maxillofacial Surgeons, or the OMS Foundation. In 2001, however, as noted elsewhere in this history, the Board removed its examiners from the 1994 restriction, but maintained the constraint on its directors and officers. *\*see Addendum P23*



## Tangential Non-dental Liaisons

Activities and responsibilities of the American Board of Oral and Maxillofacial Surgery over its first six decades have, of necessity, brought it into contact with outside interests. Most of these less intense relationships have concerned legal, regulatory, insurance, or educational entities.

As early as 1948, during the period of its having responsibility for developing guidelines for training, the Board invited a two-man committee of the United States Veterans Administration to visit the Board for discussions regarding possible residencies in oral surgery. The specific items to be discussed were the curriculum, admission criteria, and length of study, and Dr. James Cameron was appointed to head a Board subcommittee to study these issues. In these endeavors, the Board consulted with the head of research and education of the Veterans Administration, and with the dean of the University of the Pittsburgh College of Medicine, the latter because of his familiarity with residencies developing in medicine at the time.

Within a decade of the Board's establishment, a number of approved training programs had been identified and the graduates of these programs were being certified by the Board in increasing numbers. At this point, the late 1950s, the Board recognized the importance of notifying the new diplomates' hospitals of their certifications, both to strengthen the posture of the diplomates themselves and to promulgate the importance of Board certification and the scope of the specialty. Three decades later, in 1986, the Board drafted a new letter to all diplomates' hospital administrators emphasizing the same values. By 1991, the ABOMS had initiated a policy of notifying the appropriate administrators of the annual good standing of the diplomates on their staffs, after receiving the diplomates' annual registration fees. As mission statements came into vogue by the 1990s, the Board of Directors composed a statement for the American Board of Oral and Maxillofacial Surgery, describing in some detail the purpose and depth of the examinations, their significance, and their equivalence to examinations proffered by the American Board of Medical Specialties; this document was directed to any hospital uninformed of the status of oral and maxillofacial surgery.

As the hospital and surgical activities of oral and maxillofacial surgeons expanded in the middle 1980s, particularly in regard to its hard-won privilege of executing its own history and physical examinations and to the burgeoning activity in cosmetic surgery procedures, inquiries to the Board concerning the scope of the specialty increased. Queries at times reached almost flood stage, coming not only from



*R. Dean White ... 2000-01*

hospitals and medical groups but from within dentistry itself. Unusual examples were two received in 1988: At one extreme, the Crippled Children's Service of North Dakota inquired regarding the scope of the specialty and its examination as it pertained to cleft surgery, to which the Board responded in part by supplying that agency with a copy of the candidate application brochure which described the content of the examination; at the other pole, a dental inquiry requested a definition of the OMS scope of practice in regard to endodontics and periodontics, to which the board responded in general terms, relating the relative lack of prominence of these topics on its examinations and referring the inquirer to the boards in those two specialties. In an effort to deflect questions coming from dental sources, the Board in 1990 developed the aforementioned statement in conjunction with the American Association of Oral and Maxillofacial Surgeons defining the specialty scope, and supplied it to all state boards of dentistry.

By the beginning of the 1990s, various medical specialties, including general surgery, otolaryngology, and dermatology, began to expand their interests in cosmetic surgery, just as oral and maxillofacial surgery had done. Because of this, the American Medical Association had circulated a twenty-eight page document describing "Guidelines for Truthful Advertising of Physician Services," including particular reference to a practitioner's training and abilities in cosmetic surgery. Clinicians in oral and maxillofacial surgery were not recognized as pertinent to the discussion in this publication. In the flurry of debate surrounding this document, the State of California introduced legislation prohibiting the designation of "Board certified" by a practitioner if his/her Board was not recognized by the American Board of Medical Specialties. The ABOMS Board petitioned the governor of California urging him to veto this bill, unless stipulation was made that the certification of the American Board of Oral and Maxillofacial Surgery was of "equivalent requirements."

As part of the cosmetic surgery debate, but also because of its concerns with other fraudulent use of "Board certified" terminology, the Board in 1989 had developed a strict policy regarding the improper use of that term on practice announcements, stationery, etc. In such instances, the first disciplinary step entailed having the Board president correspond directly with the violator, with the demands that the misrepresentation be corrected within thirty days and that the violator notify all his/her patients and hospital authorities of the error. Should this



*David E. Frost... 2001-02*

measure fail, the Board was then to report the misconduct to the AAOMS Commission on Professional Conduct, the presidents of the violator’s state and local dental societies, and all legitimate diplomates in the violator’s geographic proximity.

By the turn of the century, the issue of expanded scope prompted an increasing number of responses by the Board to outside inquiries regarding details of particular practitioners, practices, and requests for review of treatment options, different diagnostic possibilities, etc. These requests quite probably reflected not only the expansion of practice into cosmetic surgery, but also the frustration of interested parties in adjudicating threatened or real malpractice actions. To all such inquiries, the Board immediately made plain its total lack of ability and responsibility in arbitrating case management. Further, the Board adopted the policy of responding to all legal inquiries regarding diplomate standing or examination performance by stating simply whether or not the individual was Board certified.

Though bound by no official affiliation, the ABOMS has maintained a tangential relationship with the Oral and Maxillofacial Surgery National Insurance Company, once known as the AAOMS Mutual Insurance Company, on a cordial and consulting basis in matters relating to Board expertise or responsibility. In 1989, the Board invited AAOMS Mutual Insurance Company President Dr. Jack Bolton to give a detailed presentation regarding the insurance company’s stance on scope of practice, determination of liability, insurability, etc. This contact initiated a policy between the two agencies of inviting one another’s officers to their official dinners at the AAOMS Annual Meetings. In 1996, the AAOMS Mutual requested an official listing of Board diplomates to be used as a reference of qualification for its enrolled clients.

The Board responded by pointing out that its published roster of diplomates lay in the public domain, and was available upon request to any outside interest. Earlier in that year, the Board had sought the Company’s assistance in computerizing certain of its activities, and the Company had responded graciously by allowing its operational expert in this field to counsel and advise the Board. In 2002, the OMSNIC, as a result of its increasing expertise in computerized case registration and as a service to the specialty, offered a case log program to residents in training, free of charge. The Company asked the Board’s opinion of the project, but the Board deferred, feeling that it had no role in endorsing or not endorsing the project. However, Dr. John Kelly, past president of the Board, then worked with OMSNIC to develop a case log program acceptable to the Board. The log included a reporting function that allowed a graduating resident

**“... the Board immediately made plain its total lack of ability and responsibility in arbitrating case management.”**

to complete the case log portion of the ABOMS application in a format commensurate with usual Board procedure. In enabling this feature, the Board cooperated fully with the programmers at OMSNIC.

Consultations, even on incidental bases, have been integral to the Board's operations over the decades. As early as 1961, the Board had developed a practice of inviting all past presidents for a luncheon advisory and consultation at ASOS annual meetings. This policy was re-endorsed fifteen years later, and has remained an event of the AAOMS annual meeting every year since.

In 1976, the Board retained Dr. Etta Berner of the University of Illinois Medical Learning Center as an observer to comment on the quality of the Oral Certifying Examination and offer advice as to its improvement. Later major modifications of the OCE, beginning in the late 1990s and into the new century, have been described in Chapter III on Evolution of the Examination, but further one-time opinion was attained in 2003 when the director of the Intercollegiate Examination Boards was invited as an observer and commentator to the OCE that February.

Monthly conference calls became part of ABOMS Board activities in the late 1990s, during the previously mentioned time of turmoil in intra-specialty organizational relationships. The Board, the AAOMS, the AAOMS National, and the Foundation agreed to discuss policies and mutual interests in an effort to diffuse unnecessary conflict. Scheduling difficulties and a too-frequent lack of substance led to the demise of this endeavor within two years.

Much of the Board's advisory to interested parties over the years, particularly in more recent decades, has dealt with issues of scope and privileges in relation to the policies of the Joint Commission on the Accreditation of Hospitals. The Board has maintained vigilance in regard to the Commission's directives. In 1983, the JCAH, in an attitude remarkably different from its posture of the preceding two decades, recognized the abilities of qualified oral and maxillofacial surgeons to perform admission histories and physical examinations on hospitalized patients and wrote this privilege into the Commission's standards for hospitals. This gain for the specialty was achieved through the diligence and dedication of many people, including those of ABOMS Past President Charles McCallum, who became the first dental representative on the Joint Commission (and subsequently its chair.) McCallum's and dentistry's efforts were aided by the Board's emphases on the particulars and importance of these elements in the certifying process. Also in the 1980s, however, the Commission had striven to restrict hospital specialty staffs to only those individuals certified by ABMS-recognized boards. While this stance had been primarily adopted to resist the efforts of individuals representing self-proclaimed, non-ABMS-approved, medical specialty groups, it indirectly reflected on the recognition and stature of the American Board of Oral and Maxillofacial Surgery. In 1990, the Board registered this dissatisfaction with the Joint Commission, and, in 2002, as noted previously,

it strongly supported the American Dental Association’s approach to the JCAHO seeking Joint Commission recognition of the American Dental Association and its dental specialty boards in the same light as the ABMS and its recognized medical specialty boards.

The Board has supported military representation in the specialty through its policies of accommodating the special programmatic needs of military trainees and the difficulty of scheduling their examination deadlines because of military assignment constraints, and by appointing recognized military leaders to its examiner ranks. Seven oral and maxillofacial surgeons who have distinguished themselves in military practice have become presidents of the American Board of Oral and Maxillofacial Surgery: Presidents Alling, Boyne, Caldwell, Cooksey, McKelvey, Shira, and Terry. In 1987, the Board answered the military’s regard for the ABOMS by sending an invited representative to join the Air Force’s Civic Leader Tour in a series of visits to USAF bases.

Occasionally over the years, the Board has had to assume a negative stance on issues that it deemed compromises to its impartiality or detrimental to the interests of the specialty. In 1976, for example, despite urging from its own president, the Board denied an appeal for financial help from the American Fund for Dental Health because it felt that such support would be unfairly selective when viewed by other worthwhile charitable agencies. Five years later, rather awkwardly, it denied a request by the Academy of General Dentistry to observe the Oral Certifying Examination, after having first acceded to the request; the ultimate decision rested on the opinion that the AGD represented no recognized medical or dental specialty and, therefore, did not share the true interests of the specialties. A decade later, the Board directly rejected the suggestion submitted by the oral and maxillofacial surgery program director at the University of Iowa that a representative of the AAOMS, or its Committee on Residency Education and Training, be seated on the ABOMS Board of Directors. This approach played at least a small part in convincing the Board to adopt its 1994 stance that no ABOMS officer, director, or examiner, would be allowed to serve as a trustee of the ADA, the AAOMS, the OSMNIC, the OMS Foundation, or the ACOMS.

In a regulatory matter, the Board, in 1991, complied with the federal Americans with Disabilities Act by adapting its testing facilities to the needs of such individuals.

**“... Occasionally over the years, the Board has had to assume a negative stance on issues that it deemed compromises to its impartiality or detrimental to the interests of the specialty.”**

## **Liaisons With Medical Organizations**

The American Board of Oral and Maxillofacial Surgery, because of the day-to-day interplay of its specialty with medicine, has gained as much counsel regarding its examination content and execution through its medical liaisons as through its dental.

As early as 1948, when the Board was still responsible for evaluation of residency programs, it came in tangential contact with various medical boards regarding the parameters and other particulars of such evaluations. As the specialty grew, organized medicine became increasingly aware of its presence, due in no small degree to the contributions of its military members in both the Second World War and Korean conflict. The American Medical Association contacted the American Dental Association in 1951, asking for the definition of the scope of practice of oral surgery. The ADA's Council on Dental Education then referred the inquiry to the ABOS for response.

The Board's first direct intense contact with a recognized medical specialty board was that initiated in 1967 with the American Board of Orthopaedics. The ABOS opened this liaison by consulting the Orthopaedics Board regarding the structure of their certifying examination. A year later, a representative of the American Board of Orthopaedics visited the ABOS during Certification Examination week, offering his observations and advice. That same year, the Board accepted the invitation of the American Board of Orthopaedics to have a representative, Dr. Robert Walker, visit the Orthopaedics Certifying Examination. These visits proved fruitful and inspired improved standardization of the ABOMS' OCE. In 1974, the orthopaedic surgeons extended an invitation again, and ABOS President Philip Fleuchaus visited the American Board of Orthopaedics session that year. The relationship with orthopaedics was reaffirmed two decades later when a representative of the Orthopaedics Board arrived as an invited observer to the 1998 ABOMS Certifying Examination.

Though orthopaedics was the first medical specialty with which the ABOMS established dedicated official contact, others followed. In 1984, the Board dispatched Dr. Jack Kent to the American Board of Neurosurgery's Certifying Examination in May. Exchanges with other medical specialty boards continued in the subsequent decade. In 1991, a representative of the American Board of Plastic and Reconstructive Surgery observed the ABOMS OCE Examination and in 1993 an officer of the American Board of Otolaryngology was a guest at the session. The otolaryngologists proffered a reciprocal invitation to the American Board in 1998 and, accordingly, the Board directed Dr. Bruce MacIntosh to attend their certifying session in 1999. At the beginning of the new century, the Board established relationships with the American Board of Surgery so that, in 2002, the two Boards agreed to exchange consulting observers. One year later, the American Board of Internal Medicine and the Director of Research and Psychometric Services of the American Society of Clinical Pathology accepted ABOMS invitations to participate in Certifying Examination construction and evaluation.



In the mid-1980s, in redesigning its own informational brochure, the Board reviewed the descriptive printed materials of the American Boards of Otolaryngology, Plastic and Reconstructive Surgery, and General Surgery, for suggestions in format. Interestingly, some five years later, the International Society of Plastic and Reconstructive Surgery requested a copy of the ABOMS brochure for the same purposes. At about the same time, the non-ABMS recognized American Board of Cosmetic Surgery developed a section of maxillofacial surgery within its own ranks. The Board was advised of this innovation, but remained disinterested and offered no official comment.

Intermittent workings with the recognized medical specialty boards helped develop and maintain a liaison with their certifying agency, the American Board of Medical Specialties. Initial contact developed in 1954-55 when Board officers James Hayward and Leslie FitzGerald accepted an invitation to observe the administrative operations of the American Committee of Medical Specialties (later, ABMS), but no substantive relationship ensued. In 1983 the ABOMS made overtures to the ABMS director of education and research and executive vice president to discuss the possibility of associate membership in that body for the ABOMS. At that point, the Board had actually decided against applying for any such affiliation, but, nonetheless, directed Dr. Robert Huntington to attend an ABMS conference on the topic. Three years later, still pursuing some form of medical recognition, the Board investigated the possibility of the ABMS listing oral and maxillofacial surgery in its Red Book of recognized specialty boards. This approach proved unfruitful.

Within a year, however, the Board became more determined in its posture vis-à-vis the ABMS and began pursuit of full recognition by that agency. Coincidentally, the ABMS was hosting a special conference on recertification that year, and invited the ABOMS to participate. The ABOMS Board's Dr. Leon Davis attended the sessions, taking the opportunity to discuss the item of membership as well as the theme of the conference. The Board learned much regarding the sentiments and the mechanics of recertification from this meeting, but was unable to make any progress toward recognition. (Interestingly, the specialty of Anesthesiology was the only one of the medical specialties who spoke against recertification at that time). Board discussions of 1987 also included proposals for an approach to the American College of Surgeons for both specialty and individual recognition, a liaison discussed in subsequent paragraphs.

Despite the rebuffs of these first approaches, the Board maintained its interest in gaining ABMS recognition for itself and, hopefully, the specialty over the next decade and more. By 1990, the American Association of Oral and Maxillofacial



*James R. Hupp ... 2002-03*

Surgeons, representing the same sentiments, elected to approach not only the ABMS but also the American College of Surgeons and the Accreditation Council of Graduate Medical Education (ACGME) for official acknowledgement of their dental specialty. The Board felt it should be party to this petition, but the American Association did not proffer an invitation. The directors discussed this seeming slight on the part of the AAOMS with its executive director and director of education, but to no avail. Though the AAOMS and the ABOMS were united in their sentiments toward the various medical agencies, the AAOMS was upset by the Board's earlier attempt to establish recognition of at least itself, if not of the entire specialty. The following year, 1991, the Board had the opportunity to review a letter circulated by the ABMS executive vice president denigrating "dentists, although they have medical degrees," who practiced cosmetic surgery. The tone of this letter and the attitude it reflected ran counter to the Board's albeit imperfect but previously collegial relationship with the ABMS and, in the Board's opinion, reflected the ineffectiveness of the AAOMS mission to the ABMS.

This energized the Board's resolve to approach the ABMS directly, seeking "associate/affiliate" membership status. This determination was reflected in two actions, the first an invitation to the ABMS president to observe and critique the 1992 ABOMS OCE, and the second an attempt to establish an ad hoc liaison committee between itself, the ABMS, and the American College of Surgeons. This committee would interface with the American Association of Oral and Maxillofacial Surgeons on an as-needed basis. This initiative resulted, in altered format, in the establishment of a six-member ABOMS/AAOMS committee to meet in February of 1992 with the ABMS.

The resultant consultations were collegial, and reflected both understanding and sympathy for the specialty's position, but produced no substantive commitment for ABMS recognition. This experience, however, prompted the Board to amend its bylaws to define a standing Committee on Dental/Medical Interdisciplinary Relations to be engaged in any future discussions. The ABMS did accept the invitation to the 1992 OCE, and its executive director and director of evaluation and education, Drs. Dockery and Bashook respectively, were present at that session in February 1992. Both individuals participated in active discussions on all facets of the examination, and provided a very serious and complimentary critique of the process. One of the topics discussed was that of recertification, and a tangible result was the subsequent fruitful review of the recertification programs of seventeen of the recognized medical specialty boards. Discouragingly, however, in that same year the ABMS toll-free telephone information service continued to dispense incomplete public information by not mentioning oral and maxillofacial surgery as a specialty, or the ABOMS as a valid certifying agency.

Liaison with the ABMS nonetheless continued. The groundwork spearheaded by Drs. Leete Jackson and James Bertz in the immediately preceding years culminated in a second visit of the ABMS to the ABOMS OCE in 1993, during Jackson's presidency. Dr. Jackson had previously met with the emergency medicine representative on the American Board

of Medical Specialties who had led a thirteen-year effort for recognition of his board by the ABMS. An interesting detail of those earlier conversations had been his suggestion of including case presentation in the ABOMS examination format, a device that was tried and then withdrawn by the ABOMS (see Chapter III). The 1993 ABMS representative to the American Board was the individual of Jackson's earlier acquaintance, Dr. Podgorny, who proved very thorough and candid in his appraisal of both the examination and the chances for ABMS recognition of the ABOMS. As strengths of the ABOMS position he noted that oral and maxillofacial surgery was a recognized specialty of long existence, that it already had a strong place in the American hospital system, had an established accreditation process in place through the Commission on Dental Accreditation, had a certification examination in place of fifty years' standing, and notably, was endorsed by the American Dental Association. The ADA, reportedly, was held in very high regard by the American Medical Association and national political agencies. He cited as weaknesses in the specialty's position the fact that the ABOMS certified non-medically degreed surgeons, which made the process immediately outside the domain of the ABMS, that there were at that time well over one hundred other self-proclaimed medical subspecialty groups applying to the ABMS for specialty recognition, and that oral and maxillofacial surgery would certainly encounter opposition at the ABMS level from otolaryngology and plastic and reconstructive surgery. Podgorny stressed, however, that those two specialties represented only five of approximately one hundred ten votes in the electoral process within the ABMS.

Podgorny's report was interpreted as not discouraging but starkly realistic. In 1994, the Board renewed its dialogue with the ABMS regarding recognition, and invited the American Association of Oral and Maxillofacial Surgeons to join in the petition. Dr. James Bertz, though by then no longer a Board director, had been previously asked to serve as ongoing liaison with the ABMS, and, in that year, Dr. John Kelly was appointed to the same responsibility, to serve even after his Board service expired. Despite intermittent interaction with the ABMS over the subsequent few years, it became evident that ABOMS recognition by that agency was simply not going to transpire. In 1998 the Board officially voted to abandon the effort.

The ABOMS, nonetheless, continued its representation to the ABMS on other planes. In 1999, an ABOMS representative attended the ABMS Conference on Professional Competence and Board Certification, and the ABOMS was invited by the ABMS to do so annually. In 2001, the Board consulted with the American Board of Medical Specialties regarding an enduring challenge for all accrediting agencies, that of methods for ensuring candidate competence. The ABMS correspondent at that point was Dr. David Nahrwold, who suggested professional standing, cognitive expertise, a commitment to life-long learning, self-assessment, and acceptable practice performance as criteria for competence. Subsequent discourse with the American Board of Medical Specialties has remained cordial and receptive to the present day.

Though not as intimately as with the ABMS, the Board has experienced circumstances in which correspondence with other medical agencies has been essential. As early as 1953, the American Society of Plastic Surgeons entertained a resolution by Dr. Reed O. Dingman, a noted plastic surgeon of Ann Arbor, Michigan, condemning the growing scope of practice by non-medically degreed oral surgeons. The measure failed at that time, but four years later was endorsed by the Society of Maxillofacial Surgeons, again at the instigation of Dingman. The Society of Maxillofacial Surgeons was a small group, primarily of oral surgeons with medical degrees and variable periods of formal plastic surgery training. This resolution deprecating oral surgeons and their practices was then circulated to the chiefs of surgery in every hospital in the United States. The “Dingman Resolution” reverberated negatively for the specialty throughout the country for a decade. Ultimately, after its innumerable complaints lodged with the American College of Surgeons, the ASOS, with the support of the American Board, petitioned the American College of Surgeons for a hearing. This request was honored, and the ensuing conversations led to significant amelioration of the effect of the circulated misinformation in surgical circles, and overall improved conditions for the practice of the specialty throughout the country. Much later, at the time of its drive to be recognized by the ABMS, the Board entertained Dr. Paul Ebert, director of the American College of Surgeons, at the 1991 Oral Certifying Examination. In the ensuing years, the College recognized oral and maxillofacial surgery in its listing of surgical specialties, and opened its doors to oral and maxillofacial surgeons with medical degrees.

Earlier pages have recorded the Board’s response to an American Medical Association inquiry regarding scope in 1951. Direct contact with the AMA since then has been sporadic, defined only by the Board’s involvement in particular issues. In 1987, the American Medical Association responded favorably to the Board’s request for Category I continuing education credits for its officers, directors, and examiners’ efforts during the week of the Oral Certifying Examinations. As mentioned in earlier paragraphs, the AMA in 1991 circulated a twenty-eight-page document establishing *Guidelines for Truthful Advertising of Physician Services*, which emphasized the importance of Board certification without

listing the American Board of Oral and Maxillofacial Surgery. This was deemed in certain quarters to have been engendered by surgical groups within the AMA attempting to disparage the increasing scope of oral and maxillofacial surgery, particularly in the realm of cosmetics. The ABOMS Board, however, did not interpret the guidelines as particularly disparaging, and so was not as negative in its response as was the American Association of Oral and Maxillofacial Surgeons. The Board felt that the paper did not specifically exclude the ABOMS as authoritative, but,



*Edward Ellis III ... 2003-04*

rather, simply had not mentioned it. The Board was of the opinion, however, that, because the ACGME was marked as the only legitimate accrediting body for surgical training, the Commission on Dental Accreditation should have been given equal accord. The American Medical Association subsequently demonstrated its recognition of the Board's legitimacy when, in 1994, through its Office of Physician Credentialing and Qualifications, it requested information on the particulars of ABOMS candidate credentialing.

In 1996, the American Academy of Facial, Plastic, and Reconstructive Surgery, the subspecialty group of the national otolaryngology community, approached the American Association and the American Board regarding the possibility of establishing a joint meeting between the AAOMS and the AAFPRS. A Board director was dispatched to represent oral and maxillofacial surgery in these discussions; although informal program exchange was effected, no official joint meeting was established at that time because of scheduling conflicts within both organizations.

As the century ended, and the Board became fully engrossed in its efforts to computerize its operations, it sought assistance from different medical sources, most notably the American Association of Medical Colleges, which it visited in 1999 in regard to organizing its system of on-line candidate applications.

## **Relationships with Foreign Groups**

Neither its basic charge nor any farsighted inclinations suggested that the American Board at its inception play any role in relation to the international community. Indeed, the Board, born in the early months of the post-World War II era, was part of an American social environment that, after four years of foreign entanglement, wanted nothing more than relief from off-shore obligations. Interestingly, the American Society of Oral Surgeons had authorized one of its fellows to represent the Association to their Japanese colleagues as early as 1940, but for the subsequent two decades neither the American Association nor the American Board harbored any inclination toward foreign representations. The founding of the International Association of Oral Surgeons in the early 1960s, however, awakened an interest in things foreign, and proved in many ways the predecessor for much of the international exchange within the specialty that has ensued since.

The American Board's exposure to the specialty outside its borders began when a delegation of the Canadian Association of Oral Surgeons visited the Oral Certifying Examination in the winter of 1969. As professional communication across a common border increased during the subsequent decade, the Royal College of Dentists of Canada, the Canadian body responsible for the equivalent of American board certification, approached the Board to investigate the potential for reciprocity between the two agencies. In 1979, the Royal College officially petitioned for such reciprocity, but the Board, feeling unable to adequately measure the equivalence of the two certification processes, denied their request. Informal interplay between the two agencies persisted intermittently, nonetheless, and, in 1986, the Board began to distribute its Newsletter to members of the Royal College of



Dentists. Continued mutual interest in maintaining and strengthening the integrity of the certification process was evidenced by the American Board sending an invited consultant to the Royal College's workshop on dental specialty certification in 1996. The following year, the Canadian Association of Oral and Maxillofacial Surgeons, almost thirty years after their first visit, again dispatched an observer to the American Board's Certifying Examination, and in 2003 the Royal College of Dentists did the same.

In 1989 correspondence between English-speaking colleagues on opposite sides of the Atlantic resulted in reciprocal invitations between the Royal College of Surgeons of Edinburgh and the American Board of Oral and Maxillofacial Surgery for attendance at each other's certifying operations. The RCS of Edinburgh accepted the opportunity first proffered to the RCS England, which found itself unable to accept for 1990. In that year, Mr. L. D. Finch and Mr. John F. Gould, consultant oral and maxillofacial surgeons at the Royal Infirmary of Edinburgh, served as the RCS observers at the OCE. The American Board found it impossible to reciprocate, however, and no ABOMS observer thus far has visited the Royal College of Surgeons. In an interesting convolution, however, the Royal College of Physicians and Surgeons in 2003 offered to recognize members of the American College of Oral and Maxillofacial Surgeons who were also ABOMS certified, the stipulation being that the Royal College would first want to review an ABOMS Written Qualifying Examination. The ABOMS refused this stipulation, and notified the ACOMS accordingly. Relationships with the English, however, took a positive note in 2004 when Dr. James Swift, representing the Board, accepted an invitation to be present at the Intercollegiate Specialty Examination, essentially a certifying endeavor in England. English-speaking liaisons were furthered when the Board's Eric Geist served as representative to the Royal Australian College of Dental Surgeons' Board of Oral and Maxillofacial Surgery in 2007.



*Cheryl Mounts*

Another overseas accrediting board representative to visit the OCE as an observer was Arie Schteyer, dean of the Hadassah Dental School representing the Israeli Board of Oral and Maxillofacial Surgery Examiners, who came to Chicago in the winter of 1993. Several years later, in 1999, Johann Reyneke of the South African Society of Oral and Maxillofacial Surgeons followed. Official liaison with the continental Europeans commenced in 1992 with a letter from John Sowray, chairman of the European Union of Medical Specialists, suggesting discussions on the feasibility of ABOMS contributions to the establishment of a European board examination.

The European Union at that time was maturing in the interplay between its original nations, and was



entwined in the incorporation of new member states from the East. This activity evoked in responsible sources the need for some sort of international standardization of oral and maxillofacial surgical training and practice. The American Board expressed its willingness to provide whatever counsel would be sought in this regard, and these exchanges resulted in a visit of three delegates from the European Association of Maxillofacial Surgery to review the workings of the ABOMS at its OCE session in 1995. These three, Wolfgang Busch of Germany, Carlos Navarra of Spain, and Blaise Kovacs of Belgium, were charged with the responsibility for developing a European Board. They remained in Chicago for the entire examination week, observing, questioning, and recording the particulars of the American functions. The European Association faced the formidable challenges of reconciling many languages, political systems, and social and professional circumstances in establishing a qualification mechanism. By 1996, however, at the biannual meeting of the EAMFS in Zurich, the new European Board executed its first series of examinations, qualifying twenty-one individuals. The American Board accepted the invitation of the new European Board, and Director Bruce MacIntosh served as its reviewer to that first examination.

Interest on all continents in recent decades has suggested some degree of coordination and even integration of national or regional board qualification. The International Association of Oral and Maxillofacial Surgeons hosted a special session on international educational standards at its meeting in The Hague in 1994. The AAOMS, as a charter member of the International Association, invited a participant from the American Board to support its representation at The Hague. The Board's Douglas Sinn fulfilled this role. Several ABOMS directors participated in an IAMFS regional conference dedicated to the same topic and held in Cartagena, Colombia, in 1997. *\*see Addendum P23*



*James Q. Swift ... 2004-05*

# Chapter 6

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## Challenges And Controversies

The preceding chapters have related the basic structure of the American Board, its duties and activities, and its relationships to other professional entities. The sixty-plus years since its entry into certifying ranks have exposed the ABOMS to remarkable growth in both the scope of its specialty and the number of its practitioners. Education and training amplifications, e.g., the progression from two to three to four to six years and more in residency length, the commonplace integration of the medical degree, and the introduction of fellowships, have transformed oral and maxillofacial surgery into an entity never imagined in 1946. These modifications in the specialty have mandated internal adjustment changes in administrative and examination venue, increases in administrative personnel, and adaptation to automation and psychometric innovations among them. In the ebb and flow of these sometimes tidal changes, the Board has demonstrated, among its greatest attributes, a remarkable flexibility.

Earlier pages have alluded to the episodes in its first six decades that have put the Board's mettle and resolve to the test, as it has prevailed in maintaining its integrity and positive role in the welfare of the specialty. This chapter summarizes those encounters.

### **American Society of Oral Surgeons/American Association of Oral and Maxillofacial Surgeons**

Interestingly, and perhaps not surprisingly, the most protracted difficulties for the Board have arisen in its relations with its fellows responsible for the organizational and political guidance of the specialty nationally, the Board of Trustees of the American Society of Oral Surgeons. These differing perspectives, and even conflicts, have been, perhaps, inevitable. The Association has sought to effect what it sees best for the general welfare of the specialty, all the while having to recognize the magnitude of the peculiar

responsibilities of the American Board and, at times, having difficulty doing so. The Board, from its position, has had to maintain an objective overview of the Association's prerogatives and responsibilities. Unquestionably, from time to time, personal perspectives have competed with organizational perspectives in the dealings between the two bodies.

## **Educational Matters**

One of the recurring themes of disagreement between the two bodies has been that of the American Board's role in the education of oral and maxillofacial surgery trainees. This is somewhat ironic given that a role in education was among the original Board charges designed by the American Society of Oral Surgeons and Exodontists in the years of the Board's formulation, and it was the Board that first defined the elements of adequate training programs.

As early as 1950, the Board's Advanced Training Program Committee was canvassing the specialty's training programs with questionnaires regarding facilities and overall capabilities, and was forwarding its information directly to the Council on Dental Education of the American Dental Association for provisional approval. If the Council acted favorably on the Board's recommendation, that decision was forwarded to the American Dental Association's Council on Hospital Dental Service, whereupon the latter body would inspect the site for final ADA approval. By April, 1951, the CHDS had acted favorably on fourteen of the institutions the American Board had recommended, and by October of that year had endorsed twenty of the twenty-eight programs they had originally surveyed. This initial list of twenty included two military facilities, Walter Reed and Letterman Army Hospitals. Six years into this relationship, the American Board met with the Council on Dental Education at the latter's invitation, to offer recommendations for the process of evaluating training programs, the minimum requirements for the establishment of new sites, and the improvement of existing curricula.

A decade later, and twenty years into the existence of the Board, this relationship with the American Dental Association remained healthy, and the Council on Dental Education advised the Board that certain of the American training programs did not have Board-certified program directors. The Board agreed to assist the Council in designing guidelines to mandate certification for individuals directing programs. The role of the Board in education assumed a new dimension in 1970. By that date, the American Society of Oral Surgeons had turned its interest to education, and the CDE urged the American Board and the American Society, in consultation with the program directors, to begin deliberations in constructing an in-service training examination for all trainees in the specialty.

By the late 1980s, the Commission on Dental Accreditation had been formulated to establish a formal step-by-step accreditation process for all programs involved in dental education, including predoctoral, postdoctoral, and allied professional programs. This process was initially flawed in that the CODA protocols included no mandate for oral and maxillofacial

surgeons to sit on the committees that reviewed the evaluators' reports on the periodically examined training programs. This meant that the fate of a program, though evaluated by oral and maxillofacial surgeons, would not ride with the determinations of members of the specialty at the CODA level. The American Board and the American Society were united in their protests to the CODA over this inequity. Joint action by the two organizations in 1989 resulted in the CODA changing its operational rules and appointing oral and maxillofacial surgeons to decisive positions in the accreditation process.

Within a year, however, the American Association presumed to take responsibility for deciding who of the American Board would serve in this joint responsibility. It suggested that the Board submit two candidates for AAOMS approval to sit on the four-man CODA Review Committee. This 1990 AAOMS action inaugurated a near decade-long confrontation between the Board and the Association on matters relating to education. In that same year, the Board also came into difficulty with the Commission itself over differences regarding Board certification for program directors, an issue originally discussed with the ADA more than thirty years earlier. One of the corollary issues at this later date was the "grandfathering" dates of non-Board certified program directors.

The overall issue of the American Board's representation of the specialty through the CODA provoked another conflict with the American Association in 1990. The Association took issue with the Board having submitted its own candidates to the CODA for appointment as training program site visitors. The Association was of the opinion that it should have primary responsibility for selecting those individuals, and should at least have the role of reviewing the Board nominees.

Further consternation between the Board and the Association concerning the Board's role in education arose over the next three years when the Association's Board of Trustees rejected its own Committee on Residency Education and Training's recommendation that both American Board representatives on the CODA also sit as members on the CRET. The AAOMS at that time also ruled that any AAOMS Faculty Section representative

to the CRET could not simultaneously serve as an ABOMS director. In addition, any proposed ABOMS representative to the CRET must not have already served a full term on CRET at any earlier time. A year later, in 1993, the AAOMS officers proposed that the Association's OMSITE substitute for the Board's Written Qualifying Examination for senior residents in training, the successful completion of



*William J. Nelson ... 2005-06*

which would make these residents “Board eligible” by the completion of their residencies. A corollary stipulation of this arrangement, as suggested by the AAOMS, entailed a joint committee of Association and Board Members being assembled to construct and review the WQE, a notion that the Board rejected categorically.

Two years later, the CODA formed a special committee to study education for the specialties. The Board offered to participate and to define its role in education and program accreditation for AAOMS review. At this point, the AAOMS refuted, in writing, the Board’s overall role in education. By 1997, in an apparent effort to ameliorate contentions between the two national oral and maxillofacial surgery bodies, the CODA ruled that its oral and maxillofacial surgery Residency Review Committee would have two members from each organization selected by the CODA from independently-submitted candidate lists from the organizations; the oral and maxillofacial surgery RRC chairman, in accord with its ruling for all dental specialties, would be the specialty’s representative to the Commission itself, and would be appointed by the specialty’s sponsoring organization, in this case the AAOMS. The ABOMS would have no contribution to, or review of, this appointment. By the end of that year, overall Board relationships with the CODA were recorded as being generally improved, with the issue of the Board’s contribution to Board/Association CODA representation having been settled.

A minor but more protracted educational point of contention persisted, however, until the late 1990s. As early as 1974, the Board had strongly and broadly announced its refusal to endorse “Board preparation/review” educational courses, whether sponsored by the AAOMS or any other agency. In 1991, however, the AAOMS had encouraged recognition of its OMSITE as “preparation for Board Certification or Recertification.” The ABOMS strongly objected to such advertising, and both then and again in 1997 dissociated itself from AAOMS-endorsed Board review courses, and requested that a written Board disclaimer be posted on any announcements of these programs.

### **Electoral Concerns**

The issue of election of Board director taxed the energies of both the ABOMS and the AAOMS for more than a quarter century. In 1971, the American Society insisted that all director nominations be made from the floor of the Society’s House of Delegates. The Board could not agree to this change in its established policies and a liaison committee of the ASOS and the ABOS, consisting of the senior officers of each body, was established to convene twice a year to resolve such conflicts on an ongoing basis. This particular issue came to rest with continuance of the Board’s established policies.

The matter was complicated only a year later, however, when the American Dental Association House of Delegates, considering all dental specialties, decided that only the parent organization of a board (the parent/sponsor terminology debate played no role in this issue) could establish the qualifications for the election of dental specialty board

directors. This, too, contradicted an established ABOS policy, that of mandated three-year examiner experience for all director nominees. The American Society of Oral Surgeons did not seek undue advantage with the ADA ruling at this juncture, and Board protocols for nomination and election of its director candidates remained essentially without change for more than fifteen years.

By 1989 the American Society had again raised the issue of the Board acting independently in determining its director candidates, and the Board, for its part, investigated the scenarios of having the entire election carried out solely by the Board examiners and/or the diplomates nationally, therewith removing the process from the ASOS House of Delegates. The Board's legal counsel in 1990 opined that, in light of the Board's status as an independent corporation it *should* have the sole responsibility for the entire electoral process. The AAOMS reacted by making this posture of the Board a political campaign issue at the 1990 AAOMS Annual Meeting. This initiative by the AAOMS Board of Trustees culminated in the 1991 AAOMS House of Delegates Resolution 27, formulated in the AAOMS District II caucus that year, which directed that the ABOMS director election be moved to the second session of the Annual Meeting to allow Board director candidates to campaign politically, in accord with the protocols for candidates electioneering for AAOMS positions. In a joint meeting with the AAOMS Board of Trustees, the ABOMS officers announced that they would not respect any such ruling, since this was outside the purview of AAOMS. In any event, the resolution failed acceptance by the AAOMS House, and, in 1995, a District I resolution echoing similar sentiments also failed.

That year, 1995, also recorded general AAOMS membership sentiments calling for an overall review of AAOMS election policies. The national organization's Election Reform Committee, after much deliberation of many facets of AAOMS political policy, recommended only AAOMS endorsement of ABOMS director candidates nominated by the ABOMS, with the actual election to be determined according to ABOMS' protocols alone. "Straw votes" taken in those years among ABOMS examiners at the time of the Oral Certifying Examinations had consistently endorsed such a policy, but the ABOMS Board of Directors proved correct in its anticipation that the AAOMS Board of Trustees would not support their own Election Reform Committee's suggestion. With the second defeat of the campaigning issue in 1995, however, the American Board director election has survived harmoniously and essentially unchanged since that time.

### **Appointment Difficulties**

The Board has come into contention with the American Society/American Association over less intense issues that the Board has deemed within its independent privilege. As discussed in Chapter II, the American Board in 1971 developed the position of regional board consultant to assist the directors in selecting examiner candidates from year to year. The position of regional consultant was developed to defuse charges lodged by an uninformed sector of the national community (the Archer-Bloom cadre, see Chapter V) that the examiners were chosen solely by the directors, making the Board a self-perpetuating



entity. By design, the regional consultants were derived from the membership of the sitting Examination Committee on a geographical basis, on the assumption that these individuals would be the most qualified appraisers of candidates from their own districts for appointment as examiners.

In 1974, however, the ASOS Board of Trustees suggested that the ASOS House of Delegates should nominate and elect the regional consultants. The Board rejected this notion as initially proposed, but then agreed to forward to the ASOS, whenever an examiner vacancy occurred, the names of three candidates suggested by its regional consultant for ASOS selection. This mechanism worked generally well for several years, but then, because of general unwieldiness and universal disinterest in the role of regional consultant, it withered on the vine, and the examiner selection process reverted again to the former Board operation.

As recorded in Chapter V, a conflict with the AAOMS developed in the 1990s regarding the Board's independent submission of candidates to the CODA for appointment as training site evaluators. Up until that time, the ABOMS and the AAOMS had submitted an annual joint list of candidates through the AAOMS to the American Dental Association for selection as evaluators by the CODA. By 1990, concerned that the AAOMS might rank political expediency over a nominee's academic credentials or examination experience, the ABOMS Board of Directors determined to send its own roster of candidates independently through the ADA to the CODA, rather than having those candidates first reviewed by the AAOMS Trustees. This action inspired resistance from the Association, but adjudication by the CODA in 1994 resulted, indeed, in a policy of the Commission receiving independently derived evaluator candidate lists from both the American Board and American Association.

Another skirmish on a lesser scale regarding Board representation arose in that same year. The American Association invited "an officer of the ABOMS" to join its delegation to an international education session at the bi-annual meeting of the European Association of Maxillofacial Surgery, assembling in The Hague, and named the officer of their choice. The Board deemed this selection not necessarily unwise, but certainly presumptuous. It derived a compromised acceptance of the invitation, delegating both the requested officer and another director of its choosing to carry the banner of the ABOMS at the Netherlands assembly.

**“...the ABOMS Board of Directors determined to send its own roster of candidates independently through the ADA to the CODA...”**

## Liaison Overview

Certain of the controversies discussed here had generated a sensation of overall uneasiness between the ABOS and the ASOS as early as the 1970s. Consequently, in 1974, the Board resolved to strengthen the importance of the open forum at the ASOS annual meetings to publicly and candidly explain and reinforce its policies to the specialty community, and therewith attempt to defuse tensions with the ASOS Board of Trustees. In these sessions, the Board was to review and clarify its mission, its relationship to the ADA and the American Society, the qualifications for selection of examiners and regional consultants, and to present flow charts of these considerations for review. It also strove to emphasize its apolitical stance in American Society activities. The Board's proselytizing efforts in the 1974 open forum had already been tested in its representations to individual AAOMS district caucuses in 1971.

These good intentions sustained the peace for several years but, by the early 1990s, the relationship with the American Association of Oral and Maxillofacial Surgeons had grown so precarious that the ABOMS Directors requested a meeting with the AAOMS Board of Trustees at the 1993 AAOMS winter meeting. The Board of Trustees rejected this proposal, offering as a substitute an informal session between the presidents and vice-presidents of the two groups. Such a session, indeed, took place, but did little to salve the wounded relations. Two years later, the AAOMS Board of Trustees encouraged each of its district caucuses to define a mission statement outlining the purposes of the American Board. This came in concert with the aforementioned District I resolution of 1995, which urged a political campaigning character on the ABOMS director candidacy. The caucuses deferred on the mission statement and the AAOMS House of Delegates rejected the resolution. The ABOMS director disagreements, the ABOMS role in education, and the ABOMS relations with the CODA signaled a near-total breakdown in ABOMS-AAOMS liaison during this period. Further, the developing relationship (see Chapter V) between the ABOMS and the other dental specialty certifying boards in their desire to develop an Association of American Dental Specialty Boards for more forceful concerted representation of the specialties to the CODA and the ADA, and to

provide a mutual learning experience for the boards on matters of testing methodology, credentialing, etc., further soured the discourse. The AAOMS leadership was determined that the Board not act independently in this regard. The experience of organized medicine some decades earlier in separating responsibility for matters of education, certification, and credentialing from the political process had made individuals within the ADA and AAOMS determined not to let these processes become independent in dentistry.



*Kirk L. Fridrich ... 2006-07*

The ABOMS Directors in the contentious period of the '90s took measures, when it could in good conscience, to diminish the dissatisfactions of the AAOMS leadership. In 1990, it agreed to join AAOMS in formal approaches to the Accreditation Council of Graduate Medical Education (ACGME), the American College of Surgeons (ACS), and the American Board of Medical Specialties (ABMS), though its independent, albeit informal, liaison with these agencies had already been initiated. In 1995, because of American Association hostility, the ABOMS abandoned its efforts at formal incorporation of an aforementioned Association of American Dental Specialty Boards, but established a less formal program of meeting regularly with the other dental specialty boards outside the ADA framework in an effort to formulate common specialty policy.

As early as 1974, the Boards of both the ABOS and ASOS had agreed to renaming the specialty oral and maxillofacial surgery, though neither at that point incorporated the designation into the official title of the specialty; the official change came some four years later. A quarter of a century after that, when the American Society of Dentist Anesthesiologists (ASDA) attempted to develop an officially-designated dental specialty of anesthesiology – and gained tacit ADA approval – the AAOMS, prompted by its membership's strong representation in the American Dental Society of Anesthesiology (ADSA) suggested that, were a board in Anesthesiology ever to be established, the latter would be the appropriate agency for its formulation. The ABOMS, however, refused to offer support of board status for anesthesiology from whatever quarter, on the grounds that the anesthesiology group did not satisfy the ADA requirements for Board recognition, either in size, influence, or legitimacy of its petition.

### **The Ultimate Issue: Parent or Sponsor**

To considerable degree, the contentious positions of the American Board and the American Association in the later years of the last century revolved around the very basic question of whether the American Association did or did not have authority over the activities of the American Board. The debate was reduced to a matter of semantics, i.e., whether the American Association was the “parent” or the “sponsor” of the Board, the implied difference being that a “parent” had inherent responsibility for its offspring, while a “sponsor” provided official endorsement to an entity that subsequently would be responsible for its own actions.

The debating points for the semantic issue first arose long before they were ever intended to be debating points when, in 1937, the then-American Society of Oral Surgeons and Exodontists assumed the responsibility for “creating and sponsoring” an organization ultimately to be known as the American Board of Oral Surgery and Exodontia (Chapter I). Seven years later, the now-American Society of Oral Surgeons authorized its provisional American Board of Oral Surgery to petition the American Dental Association directly for authority for its founding. This latter action implied that the ASOS, which had generated the provisional American Board of Oral Surgery, acted as its sponsor in gaining access to the ADA's ultimate recognition.

At the time of the American Board's great consternation with the Association of Diplomates and its developing American College of Oral and Maxillofacial Surgeons several decades later (below, and in Chapter V), the House of Delegates of the ADA, acting in response to the American College, ruled that "...only the parent organization of a Board can establish qualifications for the election of its Directors..." giving support to the "parent" argument. This was offered in an entirely extraneous context, and not in particular preference to "sponsoring." Frustrating interplay between the Association of Diplomates and the ABOMS continued into 1974. The Liaison Committee established by the American Society and the American Board tasked to resolve the allegations of the fledgling American College, emphasized that the American Society was the "parent" of the American Board to fend off the allegation of the Association of Diplomates that it, too, could serve as the "parent" or "sponsor" of the then-American Board of Oral Surgery, or, in fact, could establish a new one. Two years later, the president of the Board at the time, Dr. Fred Henny, affirmed the stance of the American Society being the "parent," to strongly counter the attempts of the Association of Diplomates to establish its own certifying board.

The Board's position during this debate of the early 1970s was that, although the national specialty organization had spawned the Board and directed it to the American Dental Association for approbation, it derived its authority from, and had responsibility for reporting to, the latter organization. Simmering unrest on the issue over the next decade precipitated the Board's 1981 request for clarification from the American Dental Association. The ADA equivocated in its response, noting that its Council on Dental Education in its Statement of Policy in 1968, which was reiterated in 1973, 1975, and 1976, had recorded that "each Board shall have a parent *or* sponsor." This stance was probably designed to dampen the strong opinions of both parties, which it did to some extent at that time. In 1982, however, the abiding unrest of the Board prompted it to seek legal opinion regarding its ability to function independently in accord with its Constitution and Articles of Incorporation, with the resultant advisory, as noted earlier, affirming that right.

The issue of parent/sponsor receded from prominence for the next several years, but rose again in the vigorous debates between the AAOMS and the ABOMS in the 1990s, as described in previous paragraphs. Until the end of the century, the American Board avoided the use of "parent" in reference to its relationship with the American Association, stood fast by the term "sponsor," and emphasized its ultimate allegiance to and recognition by the American Dental Association. Interestingly, over a half century earlier when the American Medical Association House of Delegates refused recognition of the fledgling American Board of Oral Surgery, presumptuously suggesting instead the title of "Board of Oral – Dental Surgery," it sent its complaint and hopes for re-designation not to the American Society of Oral Surgeons, but, rather, to the Council on Dental Education of the ADA.

## American College of Oral and Maxillofacial Surgeons

The troubling interplay with the American College of Oral and Maxillofacial Surgeons, as outlined above and in Chapter V, led to the greatest challenge to Board legitimacy either before or since. The essence of the problem was not the American College per se, but, rather, the personal differences with its founders and the issues they generated which culminated in the founding of the College.

When the initiative engineered by Drs. Harry Archer of Pittsburgh and Herbert Bloom of Detroit to determine the election of American Board directors by mail ballot of the diplomates at the time of their annual re-registrations was rejected by the American Dental Association, these two individuals with their supportive cadre formed the Association of Diplomates of the American Board of Oral Surgery. The footings of this organization were the demands that only Board examiners should be candidates for directors, that the directors should not be elected by the ASOS House of Delegates (because more than half of the delegates in the House were not Board certified), and the allegation that the American Board of Oral Surgery was self-perpetuating. This was exemplified, in their view, by the Board's method of naming regional consultants, which the Association of Diplomates termed "non-democratic." The group's assault on the Board expanded into allegations of improprieties in its internal workings, and inadequacies in the minimum requirements for appointment as Board examiner.

Because none of its attempts at change within the Board came to significant fruition over the next few years, the Association of Diplomates next undertook a mail survey of diplomates regarding their impressions of Board activities. In that this initiative produced little of substance, the Association next, in 1974, sought action through the American Society of Oral Surgeons. The Society then formulated the aforementioned Review Committee to review the Association of Diplomates' complaints and the overall workings of the Board. The Archer-Bloom group also requested "complete" financial data from the Board in that year; the Board countered by requesting the same information from the Association of Diplomates, and the issue thereupon stalemated. Because of delays in the formulation and reporting of the ASOS Review Committee, and its ultimate benign findings, the Association of Diplomates institutionalized its existence through the formation of the American College of Oral and Maxillofacial Surgeons, hastening to be the first to trademark "maxillofacial" in its name. In an early action, the new ACOMS avowed that it should supplant the ASOS as the sponsoring organization for the American Board.



*Eric T. Geist ... 2007-08*

The Board, in the aforementioned open forum at the 1974 ASOS Annual Meeting, answered the inquiries and charges of the Association of Diplomates. Two years later, subsequent to formulation of the American College, the ABOMS, in an effort to terminate confrontation with the new organization, directed a letter to all diplomates advising them of the Board's recognition of the College, but its intention to continue to function under its own direction without amendment demanded by the new organization.

The American College's last significant contention with the Board was an indirect one. The College threatened to legally challenge the ASOS on the use of "maxillofacial" in its title, when, in 1978, the Society refashioned itself as the American Association of Oral and Maxillofacial Surgeons. The College asserted that it had domain over the use of "maxillofacial," but legal interpretation ruled that this was true only in the term's relationship to the College as an organization, and had no bearing on either AAOMS or ABOMS nomenclature.

In the decades since the upheaval engendered in the wake of the Association of Diplomates' allegations, the Association's offspring, the American College, has sought no further influence on Board affairs, and relationships between the two groups have been those of independence and collegial disinterest. It is of historical note, however, that this decade-long challenge to the overall legitimacy of the Board is the only such attack ever undertaken, and it came from within the Board's own corps of diplomates.

## **Oral and Maxillofacial Surgery Foundation**

The directorate of the Oral and Maxillofacial Surgery Foundation is composed of specialty representatives elected by national vote of the Foundation supporters within the American specialty community, appointees of the AAOMS Board of Trustees, certain past officers of the AAOMS Board of Trustees, and lay members elected by the Foundation's Board of Directors. ABOMS representation on the Foundation Board would seem to be mutually beneficial, but has not been a consistent presence.

By the early 1980s, as mentioned in Chapter V, both the president and immediate past president of the AAOMS had seats on the Foundation, but there was no clearly defined procedure for naming any such ABOMS representatives. In 1986, the Board petitioned the Foundation for an appointment of its president to be included in its directorate, offering to change its own Bylaws to allow such participation (see Chapter V). The Foundation chose not to honor this request, but then in 1989, without Board consultation, indeed did appoint a Board director to its Board. This awkward action prompted the Board to emphasize that any such representation would not be considered official from its standpoint. A year later, the Foundation accommodated by allowing a three-year appointee of the ABOMS to its Board, at the request of the ABOMS. This seemed to solve the dilemma until the Foundation again attempted to appoint its own selection from the ABOMS Board, without consultation with the ABOMS itself. Rebuffed by the Board in this action, the



Foundation then eliminated the three-year ABOMS appointment, announcing that the new Foundation chairman, the Board's previous three-year representative (Dr. Douglas Sinn) could also continue to serve as ABOMS representative. This second affront resulted in the Board, in 1994, reaffirming its bylaws restriction against any of its officers or directors serving on the directorates of any associated oral and maxillofacial surgery bodies, however worthy.

## **Medical Organizations**

Gratefully, difficulties with organizations not intrinsically germane to the Board or its functions have been rare, but, indeed, the first such episode occurred early in the Board's history. In 1952, as discussed earlier in this chapter with different contextual emphasis, the American Medical Association House of Delegates deemed it appropriate to challenge establishment of an American Board of Oral Surgery, suggesting that a title of their choosing, "The American Board of Oral-Dental Surgery," would be more appropriate. The AMA's position, again, was referred not to the Board itself, and not to the American Society of Oral Surgeons, but, rather, to the ADA Council on Dental Education. The ADA responded by bringing the matter to the floor of its House of Delegates, which recommended appointment of a special committee to study the AMA resolution. The American Board was asked to assist in drafting a response. The rejoinder is not part of the written record, but the substance is reflected in the retention of its own designation, and continuance of Board functions. The AMA felt obliged to comment on oral and maxillofacial surgery affairs again in the 1970s in the midst of the almost thirty-year uneasy interaction between the American Society of Oral Surgeons and the Joint Commission on Accreditation of Hospitals. This activity of the AMA did not directly involve the Board at that time, however.

As noted in Chapter V, by the middle 1980s the Board had approached the American College of Surgeons for recognition of its diplomates for fellowship in the ACS. This ultimately came to fruition for ABOMS diplomates with medical degrees, and the liaison also resulted in the listing of oral and maxillofacial surgery in the American College's registry of recognized surgical specialties. The AAOMS ultimately joined in this approach to the ACS, requesting membership, if not fellowship, for dental degree-only AAOMS members, although the decades since have not seen this petition honored.

An unrealized Board aspiration has been its attempt to gain recognition by the American Board of Medical Specialties. Despite protracted intermittent, very collegial, contacts between the two bodies, the ABOMS in 1999, recognizing the formidable obstacles to such recognition, formally abandoned the attempt. The simple realities are that the ABMS does not recognize non-medical entities, and that dozens of medical subspecialty groups also seek ABMS recognition, minimizing the chances for ABOMS consideration. Interestingly, liaison conversations with the ABMS have indicated that any obstructionist votes against an ABOMS petition raised by competing specialty groups would probably not be enough to deny ABOMS recognition were it ever to reach the voting agenda.

ABOMS' interplay with the ACGME (Accreditation Council for Graduate Medical Education) has been chiefly peripheral, but the Board has stood in strong support of AAOMS petitions to this group for recognition of OMS training programs. The discussions between AAOMS and the ACGME became particularly intense by the middle years of the new century's first decade because of the former's ongoing dissatisfaction with the Commission on Dental Accreditation's policies and actions. The Board's role in these discussions remained secondary.

## **In-House Challenges/Controversies**

### **Record Keeping**

One of the most challenging housekeeping issues for the Board in the interests of posterity has been the accurate recording of its proceedings. During the FitzGerald years, official minutes were recorded in handwritten summary fashion, without narrative explanation. Harold Boyer's protracted tenure in secretarial responsibilities signaled significant progress in explanatory recording and date coding of the minutes, beginning in 1969. Accuracy and order in this regard were fostered significantly with Susan Holzer's advent as executive secretary in 1987. Cogent recording of the Board's activities since has assisted mightily in the production of this history. Imperfections in the early years, however, proved formidable for the past presidents charged with formulation of the history, firstly Lowell McKelvey, then Irving Meyer, then Charles Alling, and have proved a challenge for the current compilers.

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### **Board Liability**

The period of perhaps greatest dynamism in the Board's history, the late 1960s into the 1990s, with its issues of eligibility, expanding scope, recertification, hostile legal environment, etc., prompted the Board to have its legal counsel review its liability on all issues, both collectively and individually. Legal opinion in those years assured the Board of Directors of their individual protection through corporate law and its liability policies; this reassurance has been reaffirmed intermittently since.

## Candidate Eligibility

The issue of Board eligibility has demanded continual monitoring, as these pages have described, since the Board's inception. The original parameters seemed to serve satisfactorily for the first years, until, interestingly enough, the question of Canadian candidate eligibility arose in 1951. Candidates north of the border were deemed to be eligible only for "Affiliate Certification" at that time. Some two decades later, in 1970, Board policy authorized the certification of Canadian applicants once the Canadian Dental Association were to develop training program accreditation standards deemed equivalent to those of the Commission on Dental Accreditation. By 1973, the Canadian Dental Association indeed, had adopted the program accreditation standards of the CODA, and the Board then opened its application process to Canadian graduates of such programs; at that time, however, there was only one such program answering the mandated standards.

That same period marked intense concentration of the Board on the dilemma of eligibility for surgeons trained overseas, and resulted in a policy of non-eligibility for such applicants because of there being simply no way for the Board to judge the quality of the foreign training programs. Because of the great increase in scope of the specialty and number of training programs, in those years the Board had devoted significant energy to reinforcing its definition of "Board eligibility" for even United States trainees. This it did in formal fashion in 1969 on the 1968 directive of the Council on Dental Education, which mandated that the "Board eligible" individual must have applied for the Written Qualifying Examination and have had his/her credentials examined (see Chapter IV). In 1992, the ABOMS, in accord with the new ruling of the Council on Dental Education, restricted Board eligibility to that candidate actively engaged in the certifying process and compelled to complete the process within five years. In that same year, the American Board of Medical Specialties discouraged the use of the term "Board eligible" because of its misuse. In 2002, the ABOMS eliminated the term entirely, choosing to define a candidate's status as simply being in or not being in the process of certification (see Chapter IV).

## Case Presentation

Certainly, one of the most vigorous in-house challenges the Board has faced in relationship to the examination process itself was that directed toward case presentation (nee case defense) as a significant bloc in the candidates' Oral Certifying Examination.

*B. D. Tiner ... 2008-09*



Chapter III describes the rationale of this parameter. By 1994, however, following the fourth year of case presentation experience, the number of appeals from failed candidates had risen to nine, a number never previously experienced by the Board, six of which were based on case presentation decisions. The following year, seven appeals, all based on case presentation scoring, were heard, and two of those failures were overturned in the appeal process. These experiences led to intense debate among the directors, some feeling that the demands of case presentation were simply excessive for most candidates and failed to discriminate between the qualified candidates and those who weren't; others took the stance that failure of a candidate in this opportunity to present his or her own wares in vigorous comprehensive fashion was a reflection of the inadequacies of training and/or practice, and was thus a monitor of reality. The concept was ultimately deemed a failed modality, and was removed from the certification process.

### **Scope and Practice**

Issues of scope and practice have otherwise challenged the Board, particularly in more recent decades. By the middle 1990s, inclusion of the medical degree in approved oral and maxillofacial surgery training programs had become well-recognized, comprising some 40% of programs. As the numbers of such candidates for certification continued to rise, the Board strove diligently to make no distinction between candidates, and to ensure that all candidates, irrespective of degree, would answer the same demands for eligibility and certification.

A practice issue that the Board has had to answer intermittently is whether a practitioner with a medical degree and medical license, Board certified in the dental specialty of oral and maxillofacial surgery, may practice his specialty solely on the strength of his medical license if he does not have a dental license. In 1995, the Board took the stance that such an individual may, in good standing, practice solely on that medical license if the particular state medical licensing board allows. This policy did not obviate, however, the need for that individual to have had a dental license in one of the states at the time of applying for ABOMS certification.

Also by the mid-1990s, trainee activity in esthetic or cosmetic surgery had become common. Accordingly, the Board, to an appropriate degree, introduced esthetic surgery into its examinations. As the practice of these procedures expanded, the Board has been compelled to respond to both examination candidates and outside interests regarding the relative emphasis of this domain in the certification process. Inquiries as to the status of esthetics in the examinations are answered directly, within the confines of confidentiality; no information is released regarding individual performances or overall performance statistics. Questions relating to the legitimacy of such practice by diplomates in their communities, particularly queries deriving from insurance interests, legal sectors, or hospital authorities, are deemed by the Board as not within its purview and are redirected to appropriate state boards of dentistry and/or medicine, to JCAHO guideline review, or to individual hospital monitoring agencies.

## Recertification

The early 1970s presented a novel challenge to the Board, that of recertification. This concept was gaining momentum in medical circles because of societal sympathies for ongoing professional accountability and maintenance of standards, encouraged by growing legal contentiousness. The ABOMS began to study this process through an ad hoc committee at the request of the Council on Dental Education, which, in its initial urging, ruled that documented continuing education would be one of the requirements for recertification by any dental specialty board. For the next fifteen years and more, the Board wrestled with the recertification concept, and ultimately began to issue time-limited diplomate certificates in 1990. The Recertification Examination was firmly in place by the middle 1990s, offering the time-limited diplomate the opportunity to undertake his/her recertification testing three years before the expiration of his/her ten-year certificate. If any such diplomate, however, had not availed himself or herself of this opportunity within those three years, or had failed repeated examinations within two years following the expiration date of the time-limited certificate, he or she was compelled to repeat the entire certification process, including the oral certification portion.

## Conclusion

The ABOMS responses to these special issues arising from within and without its own corridors, many peripheral to its main responsibilities, reflect the maturing adaptability of the Board over the decades of its existence.



# Epilogue

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The six-decade performance of the American Board of Oral and Maxillofacial Surgery in deciding who is qualified to undertake the practice of the specialty, and its continuous revision of its processes to maintain currency in the changing environment of education, training, and practice, has established the Board's legitimacy in the eyes of the public and its professional constituency. Direct on-site observation has confirmed the comprehensiveness and reliability of the ABOMS process in comparison to several medical specialty board examinations. It has functioned faithfully in its execution of ADA mandates for specialty examination, and has honored that body's request for its participation in resident education. It has helped establish, and has enhanced, wholesome attitudes toward the specialty within dental ranks. It has demonstrated the legitimacy of specialty training to the nation's dental students, and has reinforced time and again the anchoring of the specialty within dentistry. The Board has significantly influenced the scope of specialty practice and has been a vital monitor of that practice. It has effectively fulfilled its role as counselor and/or ambassador to state and federal governments, to insurers, to training programs, and to the medical community, domestic and distant. How the ABOMS ensures its continuing legitimacy in fulfilling these obligations depends on its responses to multiple challenges.

In the operational context, examination content, testing methodology, and philosophy of mission will remain paramount. In recent years, the depth of examination in pathology and anesthesia, two of the clinically pertinent academic pursuits that have distinguished oral and maxillofacial surgery from other surgical disciplines for decades, has diminished. Whether this is simply a mark of evolution or is truly a compromise of specialty fundamentals remains to be seen. Orthognathic surgery, responsible for the explosive growth of the specialty in the 1960s, has become an elective option for the recertifying examinee. To a great extent, this reflects monetary non-reimbursement, but there are those who fear its diminution in emphasis, either clinically or intellectually, may prove harmful to the specialty or the needs of society. Such issues of content will challenge the foresight of future directors.



There will always be variance in the quality and emphases of residency programs. Since the 1980s, the Board has strived to strike a balance between what should be known and what can be known by those candidates coming from programs less strong in one facet of the specialty or another. In addressing this dilemma, the roles of educational methodologies and psychometrics have come to the fore and have brought the benefit of greater objectivity to the evaluation process. Today, ultimate written performance can be mathematically determined after only a few responses. Oral candidates are each being examined on exactly the same material, in exactly the same periods of time, and exactly the same environment, and randomly rotating examiners lessen the chance for bias or personal influence. Some will contend, however, that the ultimate goal of testing is evaluation of judgment, and, while fortuitous knowledge or even incomplete knowledge can be attractively displayed in a time-restricted format, judgment does not always come in neat packages. Demonstration of spontaneity, imagination, and effective decision making may be thwarted by this emphasis on objectivity. These pages have shown that the Board has struggled with these arguments several times in its first sixty years, and it probably will again. The Board, in 1997, convened a retreat dedicated specifically to educational issues, and anticipated the possibility of interactive, computerized examinations. This approach has since come to fruition in other disciplines, and, despite anticipated costs, may become pertinent to ABOMS activity, as well.

Regardless of the mechanics, the hallmark of examination in the future will continue to be the scope of the specialty. Since the 1990s, the traditional predominance of outpatient oral and maxillofacial surgery practice has become even more pronounced. This strengthened emphasis reflects the explosion in osseointegrated implant surgery, a decrease in both private and governmental insurance reimbursements for much of inpatient surgery, and, quite probably, the general societal tendency in the new century to withdraw from commitment to responsibility and complexity. Perhaps the first indication of this new orientation of specialty practice was the profound difficulty for candidates in answering the demands of case presentation in the 1990s.

In these first years of the new century, the specialty as a community has witnessed a perceived decrease in emergency room activities and maintenance of hospital privileges by Board diplomates. These pages have recorded what some might consider a lessening of stringencies in the certification process, citing the de-emphasis on orthognathic surgery, for example, and the lessening of candidate case requirements since the end of the second millennium. The Board must recognize the potential threat of indifference toward Board certification if the specialty chooses increasingly to confine itself to office practice. To date, this danger has attained no real significance, witness the steadiness of examination candidate numbers, and the rates of annual registration and recertification. Exit surveys of examinees following the OCE continue to record regard of one's confreres as a chief motivation for seeking certification. Nonetheless, a possible future dilemma will be the identification of qualified experienced board examiners, if the scope of oral and maxillofacial surgical practice continues to contract.

The future of the ABOMS would seem to depend, then, not only on the course of the specialty, but also on the directions of medicine and dentistry generically. If dentistry, through its general practitioners or other specialties, develops demonstrated competence in implant therapy and less-involved dentoalveolar care, will outpatient office activity be sufficient to maintain oral and maxillofacial surgery specialty practice? Or, if, on the other hand, the specialty today, practicing with the broadest palette of privileges in its history, abrogates those opportunities and transfers by default its responsibilities in inpatient surgery to medical disciplines, what then for the role of the ABOMS in certification of inpatient qualification?

Ironically, the medical specialties historically in competition with oral and maxillofacial surgery, those of plastic and reconstructive surgery and otolaryngology, have become much more accommodative in their attitudes. If, then, attitudes of objectivity and ecumenism prevail, might there one day be a justification for a Board of Maxillofacial Surgery only, with prescribed educational foundations in both dentistry and medicine? If so, how many such surgeons will society require, and what agency would then represent the public interest in certifying specialty performance in “oral surgery”? In that scenario, would the specialty have weighed anchor in dentistry and its responsibility to the ADA?

Perhaps the American Board of Oral and Maxillofacial Surgery will examine fewer surgeons in the future, and perhaps the candidates will be active in specialized hospital or university environments only. The truth, in any case, will remain the truth, and the truth is that children will still be born with maxillofacial imbalances, that dental disease will not go away, that neoplasia will never be totally erased, and that individuals will continue to injure their faces. Casual education will not satisfy society’s demand that these maladies be treated in sophisticated fashion. Peer certification in prescribed disciplines will be forever necessary, and an American Board of Oral and Maxillofacial Surgery will still remain the best window into the activity of the specialty, whatever its domains.



*ABOMS Headquarters*

## Acknowledgements

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# The American Board *of* Oral and Maxillofacial Surgery



A History: Addendum

2008 through 2010

## About the Author

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### **B.D. Tiner, DDS, MD**

B.D. Tiner practices in San Antonio, Texas and served as President of the American Board of Oral and Maxillofacial Surgery in 2008-2009. He received his dental degree from the University of Tennessee College of Dentistry and his medical degree from the University of Texas Medical School at San Antonio. He completed his oral and maxillofacial surgery residency at the University of Texas Health Science Center in San Antonio.

Dr. Tiner is a Fellow of the American Association of Oral and Maxillofacial Surgeons (AAOMS) and currently serves as its District V Trustee. He is also an Ambassador for the Oral and Maxillofacial Surgery Foundation and currently serves on the Foundation's Board of Directors. He has served as President of the Texas Society of Oral and Maxillofacial Surgeons (2002-2003), and the Southwest Society of Oral and Maxillofacial Surgeons (2010). Dr. Tiner is a Fellow of the American College of Surgeons and the American College of Dentists



# Presidents

* Howard C. Miller	1946-50	Chicago, IL
* James R. Cameron	1951-56	Philadelphia, PA
* Don H. Bellinger	1955-56	Detroit, MI
* J. Orton Goodsell	1956-57	Saginaw, MI
* Thomas Connor	1957-58	Atlanta, GA
* P. Earle Williams	1958-60	Dallas, TX
* Daniel J. Holland	1960-61	West Newton, MA
* Athol L. Frew Jr.	1961-62	Dallas, TX
* James R. Hayward	1962-63	Ann Arbor, MI
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* J. Lorenz Jones	1964-65	Bishop, CA
* Donald E. Cooksey	1965-66	Los Angeles, CA
* Claude S. LaDow	1966-67	Philadelphia, PA
* R. Quentin Royer	1967-68	Los Angeles, CA
* O. Lee Ricker	1968-69	Grand Rapids, MI
* Robert V. Walker	1969-70	Dallas, TX
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* Lowell E. McKelvey	1971-72	San Antonio, TX
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* Harold E. Boyer	1973-74	Louisville, KY
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Philip T. Fleuchaus	1976-77	Ormond Beach, FL
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* Irving Meyer	1979-80	Longmeadow, MA
* Dan E. Brannin	1980-81	Tulsa, OK
Frank Pavel	1981-82	San Diego, CA
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* Charles C. Alling, III	1983-84	Birmingham, AL
John J. Lytle	1984-85	Altadena, CA
* Bill C. Terry	1985-86	Chapel Hill, NC
Lionel Gold	1986-87	Philadelphia, PA
John N. Kent	1987-88	New Orleans, LA
Robert E. Huntington	1988-89	North Tustin, CA
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James E. Bertz	1990-91	Scottsdale, AZ
Donald M. Hagy	1991-92	Sacramento, CA
* Leete Jackson, III	1992-93	Dallas, TX
Douglas P. Sinn	1993-94	Dallas, TX
J. David Allen	1994-95	Stone Mountain, GA
John P. W. Kelly	1995-96	Boston, MA
Thomas W. Braun	1996-97	Pittsburgh, PA
Thomas P. Williams	1997-98	Dubuque, IA
Robert Bruce MacIntosh	1998-99	Detroit, MI
Paul A. Danielson	1999-00	S. Burlington, VT
R. Dean White	2000-01	Granbury, TX
David E. Frost	2001-02	Chapel Hill, NC
James R. Hupp	2002-03	Jackson, MS
Edward Ellis III	2003-04	Dallas, TX
James Q. Swift	2004-05	Minneapolis, MA
William J. Nelson	2005-06	Green Bay, WI
Kirk L. Fridrich	2006-07	Iowa City, IA
Eric T. Geist	2007-08	Monroe, LA
B. D. Tiner	2008-09	San Antonio, TX
Stuart E. Lieblich	2009-2010	Avon, CT
Mark E. Wong	2010-2011	Houston, TX
* Deceased		

*Editors Note: Addendum text succeeds the final paragraph of each section (as noted)*

## Chapter 2

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### Directors and Examiners

#### **Size of the Board of Directors** (Page 17)

Over the preceding few years, it had become quite evident that the demands on the ABOMS Directors for examination content and professional input had increased significantly. Additionally, certification and re-certification issues were becoming more complex. In their discussion, the Board considered a number of options to address their increasing workload demands. They considered engaging current and former Examiners and Regional Advisors for external expertise, but eventually decided that keeping these individuals updated and communicating effectively with them would be difficult. The Directors also considered increasing the size of the Board of Directors from seven to eight. To utilize the skills, expertise, and institutional memory of the Immediate Past President, the Board voted in the Summer of 2008 to increase the size of the Board of Directors by making the Immediate Past President a voting member of the ABOMS Board beginning in 2009. Dr. B. D. Tiner would be the first Director to hold the office of Immediate Past President since the early 1960's. During this meeting, the Board also voted for a bylaws change that would make the term of office a period of eight consecutive years for each elected member of the Board pending approval by the AAOMS House of Delegates. At the AAOMS Annual Meeting in Seattle in the fall of 2008, the House of Delegates passed resolutions that officially expanded the ABOMS Board of Directors from seven to eight with an eight year term for each elected member. At their Long Range Planning Meeting in January 2009, the Board voted to make the Immediate Past President a voting member of the ABOMS Executive Committee. The role and responsibilities of the Immediate Past President were further defined at the 2010 Long Range Planning Meeting. By virtue of his/her experience, knowledge, and institutional memory, the Immediate Past President would serve as a member of the Executive, Credentials, Certification Maintenance and History Committees. Additional responsibilities would include developing a Past President's electronic newsletter, updating the ABOMS history, Chair of the ABOMS Past President's Advisory Panel, and acting as a liaison to the International Academy of Advanced Maxillofacial Studies (IAAMS), the ABOMS Past President's organization.

## **Director Seniority and Succession** *(Page 19)*

Due to the resignation of Dr. Mike Buckley as a Director in 2002, the seven year Director tenure for Dr. Kirk Fridrich and Dr. Eric Geist was shortened to six years to maintain the orderly succession of the Board. In 2003, two new Directors were elected by the AAOMS House of Delegates to return the ABOMS Board to a full complement of seven Directors. Dr. B. D. Tiner and Dr. Stuart Lieblich were elected and it was decided that Dr. Tiner would serve a six year term and Dr. Lieblich would serve a seven year term on the Board of Directors.

## **Examiner Appointment Process** *(Page 25)*

In 2008, the OMSSAT Committee Chairman informed the Board of an ongoing challenge in obtaining quality items in preparing the OMSSAT examination. This was attributed to a limited number of motivated item writers who were properly trained in appropriate item writing techniques. In an attempt to mitigate this, the Board voted in 2008 at the Oral Certifying Examination Meeting in Dallas that applicants for the ABOMS Examination Committee be encouraged to serve as OMSSAT item writers. This newly desired credential for prospective Examination Committee members was disseminated among the ABOMS Regional Advisors, reported in the ABOMS Newsletter, and announced at the AAOMS District Caucuses.

## **Responsibilities of the Examiners** *(Page 26)*

To more effectively counsel members of the Examination Committee with poor consistency ratings or negative evaluations Director observers, the Board developed and instituted an Examiner Counseling Form in 2008. The following year, the Board instituted a policy that would place an examiner on probation if the surgery section consultant deemed their case submissions for the OCE to be sub-standard; they would then be required to submit an acceptable case for the following year's OCE to be reappointed to the Examination Committee.

In 2009, while reviewing the forms necessary to apply for joint sponsorship for continuing education credits for activities associated with the OCE, the Board identified a need for a conflict of interest disclosure statement for the Examiners and Directors. A Conflict of Interest Disclosure Statement and a Speaker Disclosure of Commercial Affiliation Statement were drafted, reviewed and adopted by the Board to fulfill the requirements for granting continuing education credits.

In response to several inquiries from Examiners whether cases previously submitted for potential use on the qualifying examination or the oral certifying examination could be returned to them, the Board in 2010 adopted a policy that all written items and case materials submitted to the ABOMS for examination purposes become property of the Board and will not be returned to the Examiners for other uses.

## **Regional Consultants** *(Page 28)*

The role of the Regional Advisors has been an ongoing discussion among the Board of Directors. In 2004, the Board eliminated the restriction that an individual from the same state as a current member of the Board of Directors could not serve as a Regional Advisor.

At their Summer Meeting in 2007, the Board noted that there were increasing numbers of Examination Committee applicants about whom the Directors had little or no personal information. With the understanding that the Regional Advisors' duty is to gather personal data and thoroughly evaluate the applications prior to submitting their recommendations, the Board voted to enhance the information available when the applications are reviewed. These enhancements included verifying whether the applicant participated in the Certification Maintenance process, successfully completed the Recertification Examination, and served as an item writer for the OMSSAT Examination. A summary checklist and timeline would be developed and provided to the Regional Advisors in a concerted effort to provide greater direction to them. The Regional Advisors would also be recognized at the Annual Banquet and in the ABOMS Newsletter.

## **Director and Examiner Amenities** *(Page 29)*

A major change in Director reimbursements was brought forward for discussion at the Summer Meeting in 2006. Historically, the expenses born by the Directors for the Spring and Summer meeting had met or exceeded the allotted Director per diem. As a result of this, several Directors had incurred additional tax liabilities that impacted their personal finances. To alleviate this burden, the Board adopted a new policy to reimburse Directors for expenses at the Spring and Summer Meeting to include airfare for the Director and spouse, car rental and ground transportation.

Over the years, many Past Presidents of ABOMS had inquired about receiving a duplicate of the President's medallion upon leaving office. Dr. Kirk Fridrich presented information to the Board at the 2007 OCE in Chicago about the development of a bronze medallion master mold for fabricating a replica of the ABOMS Presidential medallion; this medallion would be given to all living Past Presidents and to each outgoing President thereafter. The Board unanimously and enthusiastically endorsed this proposal.

For many years, the President and Vice President of ABOMS were invited to attend the AAOMS Away Meeting each year to meet with the AAOMS Board of Trustees and officers to discuss topics of mutual interest. To further enhance these important relationships, the Board voted in the summer of 2007 to fund the Executive Committee to attend the AAOMS Away Meeting each year.

In 2008, most airlines began charging for checked baggage. Therefore, the Board adopted a policy that the ABOMS would reimburse Directors for baggage charges for up to two checked bags with receipts.

Two years later, the Board revisited the reimbursement policies for Directors and Examiners. After discussion, the Board approved a policy that would reimburse ABOMS Directors for their travel expenses when representing the Board at meetings of associated organizations. If the Director's expenses are paid by the associated organization and are less than the standard ABOMS reimbursement, then the Board would provide reimbursement equal to the amount that would be provided the Director at a regular meeting of the ABOMS. At this same meeting, the Board confirmed the policy that Directors, Examiners or guests who drive to the examination city for the OCE will be reimbursed at the existing governmental mileage rate and for parking fees. No reimbursement for ground transportation will be paid.

Over the years, members of the Examination Committee who had served three years and six years were recognized with awards at the ABOMS annual banquet. With the increase in the size of the Examination Committee, several Examiners were invited back multiple times after completing their initial six years of service to the Board. Consequently several Examiners had reached nine years or more of service to the Examination Committee. Due to this ongoing trend, the Board in 2008 decided to dispense with the three year examiner award and to recognize and award those Examiners with six and nine years of service.

## Chapter 3

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### Evolution of the Examinations

#### Development of the Oral Certifying Examination

##### Later Decades (1970's-New Century) *(Page 43)*

The size of the Examination Committee from 2006-2010 varied from 56 in 2006 and 2007 up to 75 in 2010.

An additional 8 Relief Examiners were added in 2008 and continued in 2009- 2010. The concept of 4 former Senior Examiners serving as mentors to provide guidance in item development and case construction was approved for the 2009 OCE. Each year the size of the Examination Committee was based on the potential number of candidates that could apply for the OCE the following year.

A change in the OCE blueprint occurred for the 2007 OCE when Sleep Apnea was moved from Surgery Section III to Surgery Section II. It was agreed that a Sleep Apnea case would only appear in 4 of the 8 exams and a minor trauma or pediatric trauma case would be placed on the remaining 4 exams. For the 2009 OCE, a major change occurred that reduced the examination time for each Surgery Section from 60 to 45 minutes. This was

done after reviewing a report on the length and format of other surgical specialty boards which suggested that it took less than 60 minutes to determine whether a candidate would meet the minimum requirements for that Surgery Section examination. The Board also acknowledged that decreasing the time for each examination session would also shorten the examination day, freeing up more time for Examiners, Directors and Staff to conduct other OCE business. Prior to the 2009 OCE, Surgery Section III had five cases on their exam and the remaining Surgery Sections each had four cases. To achieve better consistency and equality in weighting among all the Surgery Sections, the Board voted to reduce the number of cases in Surgery Section III from five to four. Another blueprint change occurred for the 2010 OCE when the categorical area of Oral Medicine was removed from Surgery Section III. The new examination time of 45 minutes only lasted one year, after which it was changed to 50 minutes for the 2010 OCE. Several Examiners had expressed concerns to the Board that 45 minutes was not enough time to adequately cover the subject matter for each exam.

After a review of the Co-Chair evaluations of case materials submitted for the 2007 OCE, a proposal was made to report categories of case material excellence to the Examination Committee during the OCE. The Board approved categories for each Surgery Section to include: 1) best case submissions and 2) most improved case submissions. After two years the award for most improved submissions was eliminated.

Simulation technology was first approved for use on the 2011 OCE in the fall of 2010. A request by the Surgery Section IV Co-Chairs to develop simulations for the complication portion of two of their cases was approved. The Directors directed the ABOMS staff to inform the candidates for the 2011 OCE about the additions of simulation technology prior to their participation in the OCE.

## **Development of the Written Qualifying Examination**

### **Later Decades (1970's - New Century) (Page 49)**

In 2007, the Computer Based Testing (CBT) Committee determined that the ABOMS archival software that had been in use for more than 10 years did not have sufficient capability in several areas: allowing item writers to create and edit items online, developing a web based system in support of the CM self-assessment process, communicating expediently between committee members and staff, and creation of a searchable online database of active and inactive items that could be accessed securely and remotely by item writers and CBT Committee members. Data from four technology companies was gathered by the committee for analysis of their capabilities and their software. The companies were Schroeder Measurement Technologies, Applied Measurement Technologies, DataHarbor Solutions and Castle Worldwide. The CBT Committee recommended that the Board allocate monies to purchase or lease software that could be used for item and graphic resource storage and retrieval and support remote item development while providing the delivery of online examinations administered by ABOMS or an alternative testing agency. After a thorough review of the proposals, Schroeder Measurement Technologies from Clearwater, Florida was selected by the CBT Committee and approved by the Board



to develop the new software system that would meet all of the requirements initially identified by the committee and ABOMS staff.

With the assumption of sole responsibility for development of the OMSITE and the addition of the COMSSAT as part of the CM process, the demand for more quality items increased significantly. The Directors agreed in 2009 to bring more resources to the item development and review process by creating two new appointed positions with staggered terms. These new positions would be designated as ABOMS CBT Item Editors. The Directors determined that these individuals would serve as extensions of the CBT Committee. Dr. Jeff Bennett was appointed to serve a four year term as an Item Editor and Dr. Patrick Vezeau was appointed to serve a two year term as an Item Editor. The Board recognized the need to provide support for these new positions to enable them to conduct their business in an efficient and effective manner.

Item Editors would be partially funded to attend the AAOMS Annual Meeting and Item Editors who were not ABOMS Examiners would be funded to attend portions of the OCE each February. They would also receive a technology allowance to offset technology requirements necessary to conduct ABOMS business.

In the fall of 2010, Dr. Patrick Vezeau was reappointed to serve a four year term as an Item Editor commencing in October after successful completion of his initial two year term. To increase the number of items in the Qualifying Examination data bank, the Directors in 2010 agreed that cases previously utilized on a prior OCE and then retired for a period of five years could be released to the CBT Committee for use in developing CBT items. Also, cases submitted but never used on an OCE for a three year period could be released to the committee for the same purpose.

### **The Recertification Examination** *(Page 52)*

In the mid 1990's, the Board adopted a Recertification Eligible status for Diplomates with time-limited certificates who needed additional time to pass the recertification examination. In 2006, the Directors agreed that the status of Recertification Eligible was no longer consistent with the current direction of maintaining certification through a process of continued learning, testing, self assessment and practice evaluation. At the OCE Board Meeting that year, the Board voted to eliminate the Recertification Eligible status beginning with Diplomates whose certificates expired on 12/31/2009. After that date, Recertification Eligible status ceased to exist as a Diplomat category.

To more accurately reflect the contemporary practice of oral and maxillofacial surgery, the recertification examination blueprint was modified in 2008 with the addition of a separate content area for dental implants.

## **Certification Maintenance** *(Page 52 cont.)*

The 24 member boards of the American Board of Medical Specialties in 2000 agreed to change the philosophy of their recertification programs to one of continuous professional development. ABMS Maintenance of Certification (MOC) was chosen as the name of the new recertification program and the term was copyrighted. The MOC program would assure that the physician is committed to lifelong learning and competency in a specialty and/or subspecialty by requiring ongoing measurement of six core competencies adopted by the ABMS and ACGME in 1999. Measurement of these competencies would vary among the specialties but all member boards would use a four- part process that was designed to keep certification continuous. By 2006, all member boards of the ABMS had received approval of their ABMS MOC program.

For many years, the Directors of the ABOMS felt had an unwritten policy that the American Board of Oral and Maxillofacial Surgery would mirror the specialty boards of the American Board of Medical Specialties. This relationship was strengthened in 1987 when the Directors began another discussion on the concept of recertification and attended the ABMS Conference on Recertification. Later that decade, the Board reaffirmed its' commitment to recertification and in 1990 issued the first time-limited certificates.

With the evolution of the ABMS recertification programs into the Maintenance of Certification program in 2006, the Board began to discuss a similar program for the ABOMS. The Board formally requested permission from the ABMS to use their copyrighted term, Maintenance of Certification, for the ABOMS's continuous professional development program. This request was denied; therefore, After consultation with the ABOMS's legal counsel, the Board voted to name the program Certification Maintenance (CM).

At the OCE Board Meeting in 2006, the Board agreed that the Certification Maintenance program would consist of four components: 1) Evidence of professional standing 2) Evidence of commitment to lifelong learning and involvement in periodic self-assessment 3) Evidence of cognitive expertise and 4) Evidence of performance in practice. In 2007, an ad hoc committee was appointed to develop a detailed initiation and implementation plan for the CM process. The Directors acknowledged that the CM process was dynamic and the program would most likely require changes and modifications over time. With this background, the Board voted to establish a new standing committee of the ABOMS to be known as the Certification Maintenance Committee to continue the development and oversight of the CM process.

The following year at the Summer Board Meeting, the new Certification Maintenance Committee made several recommendations to the Board for implementation of the CM program. The COMSSAT was approved as the self-assessment vehicle and would be available to eligible Diplomates each year from January 5th-May 31st. It would consist of 10 domains with 10 items each and 220 new items would be generated each year for replacement purposes. The AAOMS Office Anesthesia Evaluation process was approved

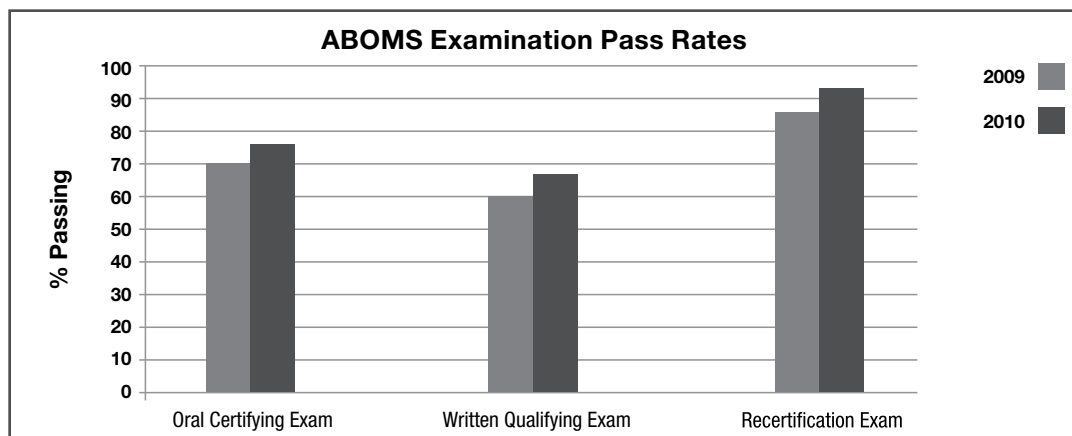
as the satisfactory pathway to demonstrate evidence of performance in practice for the fourth component of the CM program. Alternate pathways for Diplomates who do not participate in the AAOMS Office Anesthesia Evaluation Program or who are not clinically active would be provided by the ABOMS. The Credentials Committee was designated to conduct the annual CM audit of those Diplomates selected for review of their CE credits. Additionally, the Board approved the CM Committee to develop the COMSSAT items and the CBT Committee be responsible for administering the COMSSAT.

To satisfy the second component of the CM program, evidence of commitment to life-long learning, the Board approved 90 hours of continuing education credits be completed within the three years prior to the expiration date on the Diplomate's certificate. These 90 hours would consist of 60 hours of Category I CE credits and an additional 30 hours of Category I or II CE credits. In 2008, the Board further defined Category I and II CE credits.

The Board launched the ABOMS Certification Maintenance Program in January 2009 with 75 Diplomates completing the COMSSAT. As the second year of the CM Program came to an end, the Board addressed the issue of whether Diplomates who live and practice outside the United States would be required to meet all components of the CM process and whether Category I CE credits could be obtained from accrediting sources other than the ADA CERP and the ACCME.

After discussion the Board affirmed that Diplomates who live and practice 100% of the time outside of the United States must complete all the components of the CM process. Alternate pathways to meet the performance in practice component could be utilized by preparing patient information charts and sending them to ABOMS for review by the Credentials Committee. The Board also agreed to accept continuing education credits from other specific agencies that are formally documented by the provider. The documentation must certify participation by the Diplomate in the designated continuing education activity.

### Grading of Candidate Performance (Page 63)



## **Oral and Maxillofacial Surgery In-Training Examination (OMSITE)**

*(Page 66)*

After five years of the oral and maxillofacial surgery training examination being administered as a self-assessment vehicle (OMSSAT), members of the faculty section began to request that the in-service training examination return to a secure examination. Most agreed that the OMSSAT was not being used by residents and program directors in the way it was originally intended. At the Long Range Planning Meeting in January 2009, the Board voted to assume responsibility for the development and administration of a new secure in-service training examination for oral and maxillofacial surgery residents and that the new examination would be named the ABOMS Oral and Maxillofacial Surgery In-Service Training Examination (OMSITE). The Board also approved the first delivery of the ABOMS OMSITE be in April of 2010 and the sixth and final delivery of the OMSSAT be in April of 2009. Integrating timelines for implementation of the OMSITE with existing timelines for the other ABOMS examinations were approved.

On June 29, 2009, a joint AAOMS/ABOMS meeting in Rosemont was convened for the purpose of discussing the decision by the ABOMS to assume responsibility for an in-service training examination for oral and maxillofacial surgery residents. Representatives at the meeting discussed the proposed Letter of Agreement (LOA) between the AAOMS and ABOMS which would detail the areas of responsibility of both parties. Later that summer, after suggestions and amendments by both parties, the Letter of Agreement was signed giving the ABOMS the responsibility of developing and administering the OMSITE. At the Summer Board Meeting, the CBT Committee, informed the Board that OMSITE item writing assignments had been disseminated to all first and second year Examiners. Additionally, items that had previously been submitted and reviewed by the Item Editors and Board Consultants for the 2010 OMSSAT were imported into the data base software for the 2010 OMSITE.

At the AAOMS Annual Meeting in Toronto in 2009, the ABOMS Executive Committee and the Chairman of the CBT Committee met with representatives from eight of the nine accredited OMS programs in Canada to discuss the new OMSITE examination and the availability of the examination to the residents of their programs. The discussion was very positive and the presentation was well received by the Canadian program directors. At that same meeting, the Faculty Section was presented with an overview of the agreement between the AAOMS and ABOMS in which the ABOMS assumed full responsibility for the OMSITE. The presentation provided details about the application and delivery process as well as the proposed statistical analysis that would be available to the participating residents and programs.

## **Oral and Maxillofacial Surgery Self-Assessment Test (OMSSAT)**

*(Page 66)*

In 2006, an addendum to the 2002 Letter of Agreement between the AAOMS and the ABOMS regarding the development and administration of the OMSSAT was

executed. At the February OCE Board Meeting, the Board approved disseminating the 2006 OMSSAT to all participating residents, programs and practicing surgeons in a CD format. The Board entered into an agreement with a vendor to duplicate, package, and mail the CD to all participants, and to make the CD's available to all ABOMS Diplomates and AAOMS members. At the joint meeting between the AAOMS and ABOMS at the 2006 Annual Meeting, the AAOMS Board of Trustees was notified that the AAOMS annual subsidy for the OMSSAT would not be needed for that year mostly due to income generated from the sale of the CD's.

In 2007, it was discovered that two individuals had participated in the OMSSAT who were not residents, interns, Diplomates or candidates of the ABOMS or members or fellows of the AAOMS. When it was developed, there was an underlying understanding that individuals participating in the OMSSAT would be affiliated with a training program, the ABOMS or AAOMS. After discussion, the Board decided to limit OMSSAT participation to OMS residents and interns, ABOMS Diplomates and candidates, AAOMS members and fellows and foreign trained OMS's.

At the Summer Meeting that year, the Board discussed the impact that the annual release and sale of the OMSSAT CD's was having on the ability to reuse items over time. The Directors acknowledged the difficulty in creating an entirely new assessment each year. To make the process more efficient and be able to reuse items that test well statistically, the Board approved a four-year release cycle for the OMSSAT beginning in 2008. The first 2- disk release would be for 2006-2007 and the second 2- disk release would be for 2011-2012.

## Chapter 4

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### Administration

#### **Staff and Staff Needs** *(Page 70)*

At the Long Range Planning Meeting of the Board in 2010, a discussion of Executive Director (ED) succession planning began. Questions were posed concerning the current job description of the ED and whether it was accurate and detailed enough to provide a basis to begin a search for a new ED when Cheryl E. Mounts decided to retire. The Board also pondered whether the current organization of the staff was the most efficient for the current needs of ABOMS, or should there be consideration for a reorganization that would alter the current chain of command and modify or change the roles and responsibilities

of each employee. The idea of creating the position of Assistant Executive Director who could step in and run the central office in the acute absence of the ED was offered for consideration. ABOMS staff were directed to investigate the type of consulting services that might be available to advise the Board with this matter. The Board agreed that the search process could take up to two years and that the current ED would overlap with the new ED for one year. The search committee for the new ED would consist of the ABOMS Executive Committee, three ABOMS Past Presidents and an appropriate organizational representative with expertise in not for profit and certification management. If no suitable new ED was found, the Board would ask the current ED to delay her retirement date or appoint a retired ABOMS Past President as the Interim ED. In the event of an ED taking early retirement or a long- term leave of absence, the Board would appoint an internal candidate, a candidate from another professional organization or a retired ABOMS Past President as Interim ED. The Board also addressed whether internal candidates could be considered for the new ED and agreed that all appropriate and qualified individuals could be included in the interview process.

### **Board Meeting Sites** *(Page 71)*

Prior to 2008, there were no written guidelines for acceptable meeting locations, site visits and ranges for housing and activity expenses. To facilitate meeting planning, the Board developed written meeting guidelines that met the needs of the Board and satisfied the fiduciary responsibilities essential to responsible governance of the organization. With the understanding that site visits may or may not be required for each meeting of the Board, the Board approved the following guidelines for meeting planning:

- 1) No more than one site visit (if required) for the Annual Meeting, the Oral Evaluation, Spring Meeting and the Summer Meeting.
- 2) Acceptable meeting locations include the 50 United States, Canada, Mexico and the Caribbean.
- 3) Expenses will be reimbursed for Director and spouse airfare, up to three hotel nights, up to three days per diem, ground transportation and/or rental car. Additionally, if the ABOMS pays for all site visit expenses then the Director will not receive a per diem.
- 4) ABOMS staff will be solely responsible for negotiating and confirming all contractual arrangements for meetings.

In 2010, it became apparent that written guidelines for selecting Spring and Summer Meeting destinations in a timely manner were necessary so the ABOMS staff could negotiate complex and financially favorable contracts with hotels, transportation and activity companies. To provide staff with a reasonable time for negotiation, the Board established a policy that the location for the ABOMS Spring and Summer Meetings must be determined two years in advance by the Director responsible for the meetings.



When the Board decided to move the OCE to Dallas in 2008, the Crescent Court Hotel was designated as the headquarters hotel for the Directors, Examination Committee members and Staff. By the second year, it became apparent that the facilities offered by Crescent Court were insufficient to conduct the various activities of the OCE that took place outside of the ABOG testing facility. Prior to the OCE in 2009, a site visit was conducted at the Ritz Carlton Hotel in Dallas. After the site visit, it was apparent that the Ritz Carlton met all the needs of the Board that were lacking at the Crescent Court. At the OCE Board Meeting, the Board voted to move all Board and Examiner activities to the Ritz Carlton at the earliest possible date after the expiration of the, Crescent Court contract.

## **Financial Affairs**

### **General Responsibilities** *(Page 76)*

The severe recession in 2009 and the subsequent collapse of the stock market resulted in a significant loss to the ABOMS reserve fund. In 2010, the Board approved a new investment policy that was more conservative than the existing policy. The investment structure for managing assets of the ABOMS would be allocated to 5-10% cash, 20-25% equities and 70-85% short-term investments. Due to ongoing volatility in the stock market, the Board also approved the Finance Committee meet 2-3 times each fiscal year either in person or by conference call. Additionally, in an attempt to be more fiduciary responsible, the Board approved a policy that would require all motions coming before the Board include financial and resource impact information.

### **Examination Fees** *(Page 78)*

In 2006, the Board appointed an ad hoc committee to study the examination application process. The committee reviewed the policies and procedures, examination logistics, the financial impact of any proposed changes and the credentialing impact of any recommended modifications. Following the recommendation of the ad hoc committee, the Board instituted a one-step application process for the Qualifying and Oral Certifying Examinations and approved a single administrative fee for both the QE and OCE. This eliminated a separate application fee for the QE and OCE.

With completion of the development of the Certification Maintenance program in 2008, the Board approved a fee for the Certification Maintenance process that would include the Recertification Examination and the COMSSAT, the internet delivered self-assessment examination.

### **Funds/Budget** *(Page 79)*

Periodically the Board reviews the fees that generate revenues for the ABOMS. After remaining unchanged for several years, the Board voted in 2008 to increase the verification fee from \$25 to \$50 and the annual registration fee from \$100 to \$125.

## **Costs** *(Page 80)*

For 2010, ABOMS generated almost \$2.5 million in revenue, against expenses totaling \$2.4.

## **Investments** *(Page 81)*

During the period from 2006-2008, the annual return on the Board's managed funds ranged from 4-8.37%.

The severe recession and subsequent collapse of the stock market in 2009 severely impacted the ABOMS reserve fund.

Due to the volatility of the financial markets, the Board voted in 2010 to move to a more conservative investment policy and to contribute a minimum amount in the 2011 fiscal year to the ABOMS reserve fund.

## **Audits** *(Page 82)*

During the five years from 2006-2010 the accounting firm of Bansley and Kiener conducted an annual fiscal audit of the ABOMS. For each year, the accountants reported the audit presented fairly, in all material respects, the financial position of the ABOMS and the changes in net assets and cash flow were in conformity with generally accepted accounting principles. The 2009 fiscal audit noted there were points in time where the total of both checking and money market accounts exceeded the FDIC insurance limit. The Directors requested the staff to investigate establishing a separate account in another bank to use as an overflow account so all ABOMS funds would be FDIC insured against loss.

## **Legal Considerations** *(Page 84)*

After the Board voted to include the Immediate Past President as a voting member of the ABOMS Board of Directors, it became necessary to amend the Articles of Incorporation to reflect this change. Early in 2009, legal counsel for the ABOMS made the necessary modifications to the Articles of Incorporation and the Board approved them at the OCE Board meeting in Dallas.

## **Examination Considerations**

### **Sites** *(Page 86)*

From 1955-2007, the Oral Certifying Examination was held in Chicago at four locations. The Blackstone Hotel was home for the OCE from 1955-1967. Then the Ambassador East Hotel became the new home of the OCE until it was moved to the Drake Hotel in 1976, where it remained until 2002. In 2003, the OCE moved to the Fairmont Hotel for five years. The 2008 OCE in Dallas at the American Board of Obstetrics and Gynecology testing center marked the first time the OCE was held outside of Chicago since 1954.

The nearby Crescent Court Hotel was chosen as the headquarters hotel for Directors, Examiners and Staff and the Melrose Hotel was selected to house the candidates. After many months of planning, 201 candidates were examined in the new venue. Candidate exit surveys were overwhelmingly positive for the new location and facility.

## **Eligibilities** *(Page 91)*

An ad hoc committee, appointed in 2006 to study the examination application process, made several proposed changes to the Board during their Summer meeting that year. The Board approved a recommendation that the annual ABOMS Credentials Form include a question regarding the possession of current, active hospital privileges for OMS core procedures. Additionally, the committee recommended that the ABOMS require active hospital appointment with core OMS privileges as a component of the Oral Certifying Examination and Recertification Examination application process. The Board agreed with the committee's recommendation regarding the OCE but defeated the privileging requirement for the Recertification Examination. During the following three years, the issue of maintaining hospital privileges were discussed at length, became a hot topic with the AAOMS and the ABOMS. At their Summer Meeting in 2009, the Board voted to support the resolution generated by the AAOMS Special Committee on Strategies for Hospital Privileges for discussion and action by the AAOMS House of Delegates in Toronto that Fall. At that Summer Meeting, the Board also determined that in order to practice the core scope of the specialty and designated sub-specialty areas, Diplomates with time-limited certificates must maintain admission and surgical privileges in oral and maxillofacial surgery at a hospital or a surgical center accredited by the Joint Commission on the Accreditation of Health Care Organizations or the AAAHC to maintain board certification. This conclusion was based on the tenet that hospital privileges provide safeguards for the public by promoting continuity of care, quality of patient care, mechanisms for auditing clinical competence, quality improvement exercises and continued competence in core oral and maxillofacial surgery procedures. Diplomates who desired to maintain board certification, but could not meet this standard, would be asked to file a formal written request for exemption explaining why they could not meet this requirement 30 days or more before the deadline for Annual Registration.

In 2008, several cases of widespread cheating on national examinations and cheating episodes in dental schools made the national headlines. To the Board's knowledge, cheating on any of the ABOMS' examinations had never been an issue but the Board discovered that they had no written policy concerning cheating by a candidate.

At the Annual Meeting in Seattle, the Board approved a policy that if the ABOMS had verifiable evidence that an individual cheated on any ABOMS component examination, that individual will be prohibited from ever taking or re-taking any ABOMS examination. Furthermore, if this individual was a Diplomate of the ABOMS, their certification would be revoked.

For many years as a part of the Qualifying Examination application process, candidates were required to submit a Record of Operative Experience. Due to the limited value of the record and the inconsistency of its use, the Board in 2010 voted to discontinue this requirement effective with the 2012 Qualifying Examination.

In 2006, the Board began to receive inquiries from foreign-trained oral and maxillofacial surgeons who could not participate in the ABOMS certification process because they did not meet the educational requirements of the two existing pathways for board certification. At the OCE Meeting in Chicago, the Board entered into a lengthy discussion on the educational requirements policy. Current trends in education and practice, the move toward international accreditation of professional programs, and the evolution of curricula in foreign training programs were all considered. The Board also acknowledged the rapid increase in foreign-trained oral and maxillofacial surgeons serving as faculty in OMS training programs and fellowships in the United States. Based on this background information, the Board created a third pathway for ABOMS certification. An applicant who had received training in an OMS training program not accredited by the Commission on Dental Accreditation must provide verification that their oral and maxillofacial surgery training program had an equivalent educational background to those accredited by CODA, and must complete 12 consecutive months as a full-time faculty member in an accredited OMS training program during the past two years which is verified by a letter from the department chairman in oral and maxillofacial surgery.

### **Examiners/Candidates** *(Page 92)*

The submission of substandard cases for the OCE by some Examiners continued to be a problem despite counseling by Co-Chairs and Directors. To enhance the submission of more quality cases for the OCE, the Board in 2008 approved a probation policy. Examiners who submitted substandard cases would be placed on one year probation. If their cases submitted for the following year's OCE were substandard or of unusable quality, those Examiners would not be invited to return to the ABOMS Examination Committee.

In response to inquiries from Examiners and Directors on the possibility of receiving approved continuing education credits for through participation in item writing and the oral certifying examination, the Board voted in 2009 for the Executive Committee of the ABOMS to proceed with the development and submission of materials required for recognition as a joint sponsor of continuing education with the AAOMS.

### **Logistics** *(Page 95)*

With the explosion of technological advancements, it became evident to the Board that the software program being used to categorize and store item banks lacked important functions available in other exam development and delivery products. In an attempt to improve the efficiency of the Computer Based Testing Committee's exam development and delivery, the committee and the staff of ABOMS developed a list of requirements identifying the ideal components of a new software system. At the Annual Meeting in

2007, the Board approved Schroeder Measurement Technologies (SMT) of Clearwater, Florida be awarded a contract to develop a system capable of storage and retrieval of items, on-line development and review of new items, composition of examinations and on-line delivery of examinations or self-assessment exercises. By the Annual Meeting the following year, the remote item development software had been completed and the SMT item bank had been installed on the ABOMS server. The last remaining function of the new software was an analysis of the test delivery component. It was anticipated the completion of this task would be completed by the end of 2008 when the COMSSAT became available for Diplomates involved in the Certification Maintenance program.

In 2010, Dallas received a record February snowfall that significantly disrupted travel into the Dallas/Fort Worth area. By Friday evening, only a handful of the 88 members of the Examination Committee had made it to Dallas. Given the possibility that some Examiners might not make it to Dallas in time to participate in the calibration process, the Board decided to invite former Examiners from the Dallas/Fort Worth Metroplex and surrounding area to meet the examination needs. This group included Dr. Dean White, a Past President of ABOMS. It is believed that Dr. White was the first and only Past President to ever serve as an Examiner after his Presidential tenure. The entire weekend schedule for the OCE including the orientation, calibration sessions and the item writer's workshop were modified. By Monday evening, all but one of the scheduled 88 Examiners had arrived in Dallas and the examination proceeded smoothly.

### **Educational Affairs** *(Page 98)*

In September of 2009, the Executive Committee began working with a consultant to prepare an application for joint sponsorship of continuing education with the AAOMS. As part of this application process, the Directors would be responsible for defining an educational role for the ABOMS and executing disclosure statements. The initial application filed with the AAOMS included three educational programs for which the Board anticipated issuing continuing credits to members of the Examination Committee. These programs were the Case Development of the Oral Examination (20 hours), the Item Writer's Workshop (3.5 hours) and the Oral Examination Calibration and Delivery (30 hours). The 2010 application added the Scientific Seminar to the initial three educational programs. The Board also approved guests attending the Oral Certifying Examination could earn CE credits for participation in jointly sponsored approved programs.

### **Diplomate Relations** *(Page 100)*

The Board voted in 2008 to invite three former Past Presidents each year to observe portions of the OCE as guests of the Board beginning in 2009. It was decided that the invitations would be extended to the most senior Past Presidents until three confirmed that they could attend. Accordingly, the first three invited were Dr James R. Hayward, Dr. Gustav O Kruger and Dr. Robert V. Walker. The following year Dr. Charles McCallum, Dr. Frank Pavel and Dr. John Lytle were invited and in 2010 Dr. Bill Terry, Dr. Lionel Gold and Dr. John Kent were invited to attend portions of the 2011 OCE.

The Board had been discussing modification of the affiliation categories of Diplomates for some time. The Board recognized that there were Diplomates who did not practice but did not wish to be moved into the Retired category. Some of these Diplomates remained professionally active but were not able to provide patient care. At the Annual Meeting in 2010, the Board approved new affiliation categories that designated Diplomates as Active, Clinically Inactive, Retired, Student, Resigned, Revoked or Deceased. Diplomates designated as Clinically Inactive would be subject to all the Certification Maintenance requirements except the Evaluation of Performance in Practice component and the possession of active hospital privileges.

### **Recording of History** *(Page 101)*

Past Presidents Drs. Bruce MacIntosh and John Kelly were appointed to write the first edition of the History of the American Board of Oral and Maxillofacial Surgery. During the writing of this first edition, the authors sent the Board periodic memos to update them on the status of the history project. In the Fall of 2010, Dr. B. D. Tiner was asked to assume the responsibility of researching and writing the first update to the first edition of the ABOMS History, which concluded in 2006. The update would cover the five years from 2006-2010. It was anticipated that an update would be written every five years thereafter.

## **Chapter 5**

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### **Relationships With Other Organizations/Entities**

#### **Relationships with the American Association of Oral and Maxillofacial Surgeons**

##### **The New Century** *(Page 115)*

To strengthen the anesthesia team model used in the delivery of office based anesthesia by our specialty, the AAOMS Board of Trustees in 2006 sent out a request for proposal (RFP) that detailed their intent to develop a computer based, voluntary Oral and Maxillofacial Surgery Anesthesia Assistant Certification Program for clinical allied staff members employed by members of the AAOMS. At the AAOMS annual meeting in San Diego, the Directors discussed the feasibility, advantages, and disadvantages of developing and administering this certification program. The decision was made not to submit a proposal for the program. The rationale for this decision was the activity was deemed



not consistent with the mission of the ABOMS, operational and logistical resources were not currently available to meet the requirements in the RFP, and the establishment of a consistent standard for the level of experience, education and training necessary to credential candidates would be difficult.

Until 2007, invited guests from AAOMS to the ABOMS annual banquet had included the President, Executive Director and the Associate Executive Director for Advanced Education and Professional Affairs. In response to many members of the AAOMS Board of Trustees expressing an interest in attending the ABOMS annual banquet, the Board voted to invite the AAOMS Board of Trustees to attend the annual banquet at their own expense.

In 2008, a new AAOMS Strategic Plan was being developed and the ABOMS Board of Directors was asked for input to the new document. The Board forwarded three recommendations to AAOMS for inclusion in the new Strategic Plan: 1) Promote competency in oral and maxillofacial surgery through pre- and postdoctoral education and training and active ABOMS certification 2) Encourage board certification as an outcome measure for OMS training programs and 3) Urge oral and maxillofacial surgeons to participate in the ABOMS Certification Maintenance process. For reasons unknown, the AAOMS Board of Trustees chose not to include any of the ABOMS recommendations in the new AAOMS Strategic Plan.

The issue of oral and maxillofacial surgeons maintaining a presence in hospitals became a widely discussed topic in 2009. In response to this, the AAOMS appointed a Special Committee on Strategies for Hospital Privileges. The ABOMS was represented on this committee by past President, Dr. Paul Danielson and ABOMS President, Dr. B. D. Tiner. After several conference calls, the special committee proposed a resolution to the AAOMS House of Delegates that would require hospital medical staff membership for fellowship status in AAOMS. The ABOMS Board of Directors supported this resolution but it failed to pass in the House of Delegates.

## **Relationships with the American Dental Association**

### **The New Century** *(Page 124)*

A major change in the structure of the Advanced Specialty Education Review Committees was proposed by an ad hoc committee that had been appointed by the Commission on Dental Accreditation. The committee report recommended the structure of the review committees be changed from five specialty-specific content experts to a committee consisting of a discipline-specific Commissioner appointed by the specialty sponsoring organization, one public member, one general dentist, one specialty organization representative and one specialty certifying board representative. After much heated discussion and opposition from the AAOMS and ABOMS, the new committee structure was approved by the Commission on Dental Accreditation in 2006.

This new committee structure decreased the number of oral and maxillofacial surgeons from five to three, and eliminated one of the two ABOMS positions on the review committee. In response to this action by CODA, the AAOMS opened a dialogue with the American Council on Graduate Medical Education (ACGME) to explore the possibility of transferring accreditation responsibility of OMS training programs from CODA to the ACGME. Communities of interest within our specialty were asked to comment on this potential major accreditation change. After reviewing all the information available, the ABOMS decided not to develop a position on whether the OMS training programs should be accredited by the ACGME. After weighing the advantages and disadvantages, the AAOMS decided not to terminate accreditation responsibility for OMS training programs by CODA.

The following year, a gentleman's agreement was made agreed upon ,whereby the AAOMS and ABOMS would take turns in making the appointment recommendation for the specialty certifying board representative to the review committee. It was further agreed that the ABOMS would make the first appointment recommendation under the new structure, and in 2012, the AAOMS would make the appointment if the review committee structure remained the same.

### **Relationship with Other National Dental Groups** *(Page 130)*

The ABOMS has a long history of collaboration with other medical and dental certifying boards. In the Summer of 2006, the Board received an invitation from the American Board of Pediatric Dentistry (ABP) to send a delegation to observe portions of their oral examination in Dallas at the American Board of Obstetrics and Gynecology (ABOG) testing facility in Dallas, Texas. Three members of the ABOMS Board traveled to Dallas and observed examiner calibrations, candidate briefing/debriefing and the overall examination process. The delegation observed a number of situations that the ABOMS would find useful in planning future OCE's in the ABOG testing facility beginning in February of 2008.

In April of 2009, the ABOMS became an organizational member of the American Association of Dental Examiners. An important benefit of this membership gave the ABOMS access to disciplinary actions taken by each licensing body on a monthly basis. In the first monthly report received by ABOMS, there were three OMS's who had been disciplined by state licensing bodies. This monthly information has allowed the Board to become aware sooner and respond more quickly when Diplomates have become involved in unethical or questionable actions.

Early in 2009, the ABOMS received a request from the President-Elect of the International Association of Oral and Maxillofacial Surgeons to send a Director to an international conference to present information about the ABOMS certification process. Since Dr. G.E. Ghali was slated to attend the meeting and present at the opening session, the Board empowered Dr. Ghali to represent the ABOMS in their discussions. This issue of

international accreditation generated a discussion at the 2009 long range planning meeting and resulted in a stated policy that the ABOMS will provide aid and/or guidance related to the certification of specialists for organizations who are American Dental Association (ADA) recognized dental specialties and to member organizations of the International Association of Oral and Maxillofacial Surgeons (IAOMS). At this same meeting, the Directors also affirmed that English is the official language of the ABOMS and would be reflected in all business and examinations delivered by the Board.

## **Relationships with the Oral and Maxillofacial Surgery Foundation** *(Page 130)*

In recognition of the 50th anniversary of the Oral and Maxillofacial Surgery Foundation in 2008, the Board voted to make a one-time contribution to the foundation's REAP campaign. The donated funds had been generated from verification revenues which ensured that Diplomate monies would not be used for this purpose.

## **Relationships with Foreign Groups** *(Page 143)*

In addition to collaborating with medical and dental certifying boards in the United States, the ABOMS has a history of collaboration with certifying boards from foreign countries. In the fall of 2005, an ABOMS representative traveled to Toronto to observe the Fellowship examination of the Royal College of Dentists. The Canadian examination is administered twice a year to all candidates who successfully complete a written examination. The examination is the licensing examination recognized by all the Canadian provinces. Oral and Maxillofacial Surgeons cannot practice as an Oral and Maxillofacial Surgeon until they have successfully completed this process.

After receiving an invitation in 2006, the Board dispatched a representative to attend the Royal Australasian College of Dental Surgeons final examination in oral and maxillofacial surgery to observe the calibration sessions and all seven components of the examination over a three day period. To reciprocate, the Board invited Dr. Leslie Snape, the Chairman of the OMS Examination for the Royal Australasian College of Dental Surgeons to attend the 2008 OCE in Dallas.

At the OCE the following year, the President of the Mexican Board of Oral and Maxillofacial Surgery, Dr. Rafael Ruiz-Rodriguez, was invited to observe and comment on our oral certifying examination. In 2010 the Board was pleased to welcome the Past President of the International Association of Oral and Maxillofacial Surgeons, Dr. Nabil Samman, from Hong Kong to Dallas to observe the week long activities of the oral certifying examination.