Implant dentistry: The 13th recognised ADA dental specialty?

For many years the American Dental Association (ADA) was in sole control of dental specialty recognition. In 2015 the American Board of Dental Specialties (ABDS) was formed as an independent organisation for certification of dental specialists. The ABDS included four emerging dental specialties, the American Boards of Oral Medicine, Orofacial Pain, Anesthesiology, and Oral Implantology/Implant Dentistry (ABOI). Anaesthesiology, oral medicine and most recently orofacial pain have become added to the nine ADA recognised specialties. The question now becomes, will implant dentistry become the next recognised dental specialty?

In 2009, a Florida court overturned a restriction on dentists to allow advertising credentials by groups other than the nine ADA-recognised specialties. The court cited: "unreasonable restriction of free speech and restraint of trade". It determined that the ADA was effectively a trade association that could not force the law on their opinions and the ABOI was a bona fide credentialing organisation. In 2010, a California court also ruled a statute restricting the advertising of ABOI credentials as unconstitutional. In 2014, a federal lawsuit was filed against the Texas board of dentistry alleging it was unconstitutional for a state regulatory agency to defer to the ADA, a trade organisation, the authority to decide who can advertise as a specialist. The court decided that, under the First Amendment, these groups are entitled to call themselves specialists. However, they did not suggest that the dental board could not impose appropriate restrictions and the plaintiffs agreed that advertising as a specialist is potentially misleading. Under the threat of litigation several state dental boards have begun making changes to their rules on advertising to either allow use of ABDS credentials or provide further clarification to limit which specialties are recognised. In 2016, the ADA Principles of Ethics and Code of Professional Conduct was amended to allow educationally qualified dentists to announce as specialists in areas of dentistry recognised as specialties in their jurisdictions but not by the ADA. Although an underlying reason for these court rulings is that consumers are entitled to the necessary information to make informed decisions about their care, many would argue that this causes more public confusion regarding dental credentials.

As a result of these legal developments, a new independent commission was approved in 2017 to protect the specialty recognition process from any influence by the ADA. The National Commission on Recognition of Dental Specialties and Certifying Boards is composed of an equal number of dental specialists and general dental practitioners, as well as one public member. This commission consists of two committees. One committee examines didactic aspects and other areas of the proposed new specialty. The other committee ensures that similar to the existing specialties, the examining board of the proposed specialty meets a set of rigorous requirements when it awards diplomate status.

With the exception of orofacial pain, the other 11 dental specialties require a dentist to complete a residency programme accredited by the Commission on Dental Accreditation (CODA) of the ADA. The purpose of CODA is to serve the public and profession by developing and implementing accreditation standards that promote continuous quality. The advanced training programmes have specific educational requirements with defined levels of knowledge (in-depth, understanding, familiar) as well as clinical practice guidelines with defined levels of skill (proficient, competent, exposed). The advanced education programmes must undergo close monitoring and continued validation by CODA for accreditation. Clinical treatment is performed by residents under faculty guidance and/or supervision and this accelerates the learning curve. A residency programme is a full time commitment where the student is immersed

in learning for 2 to 6 years. There exists no pathway for a dentist to become a specialist in those 11 areas via part-time continuing education (CE) courses.

A standard for an emerging specialty is that it must demonstrate educational and training programmes that offer a pathway to both didactic and clinical proficiency. The ABOI offers five different routes of entry for board certification. The educational path taken by a significant majority of their diplomates has been the CE route. It requires 570 to 670 hours of CE in courses on implant dentistry (300 hours within a continuum course). There are no clinical requirements but dental practitioners have to complete 75 implant cases (eight with specific guidelines). The International Congress of Oral Implantology (ICOI) formed a competing board, the United States Board of Oral Implantology (USBOI). To apply for diplomate status a candidate must have 250 hours of implant CE in the 5 prior years. There are no clinical requirements but dental practitioners have to complete 120 implant cases (20 with specific guidelines). The USBOI sued the ABDS and ABOI for approval to become another specialty certifying board. However, the defendants were granted a motion to dismiss this lawsuit.

The path to board certification in implant dentistry is much different than other specialties as the majority of candidates are general dental practitioners trained through CE courses. Although the ABOI requires at least 300 hours of CE in a continuum course, there is no standardisation and no structured or specific guidelines for the other 270 to 370 course hours (only 'implant related' topics). As opposed to CODA, there is no oversight of the courses other than approval by a CE provider. Unlike the existing specialties, there are few specific clinical requirements and treatment is usually performed in an office without faculty supervision. Although 570 to 670 hours of CE is substantial, it is a fraction of the time spent in a full-time residency like other specialties. Implant dentistry is a unique field that requires advanced training in oral surgery, periodontics and prosthodontics, as well as radiology and anaesthesia. If it requires at least 3 years of education to become a surgical specialist (oral maxillofacial surgeon, periodontist) or a prosthodontic specialist then why should implant dentistry be any less rigorous? At present, there are no CODA accredited programmes for implant dentistry. However, there are institutions in the United States that offer full time postgraduate programmes in implant dentistry from 1 to 3 years.

The future of implant dentistry as an ADA specialty is still up for debate. Although there are other obstacles, two issues muddle the specialty status of implant dentistry – the right to advertise as a specialist versus the professional acknowledgement of board certification and recognition as a verified specialty. The courts have blurred the lines between these issues by equating a right to advertise with fulfilling the professional criteria for specialty status. Many ADA specialty groups have voiced their concerns with allowing dentists with less education and training being able to advertise in the same manner used to describe graduates from CODA accredited programmes. The focus should be on making the requirements in implant dentistry more like other specialties rather than achieving recognition through litigation. Dental specialties are recognised to protect the public, nurture the art and science of dentistry and improve the quality of care – not to attract patients through advertising. The dental profession, rather than the legal system, should forge our path on this issue going forward.

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