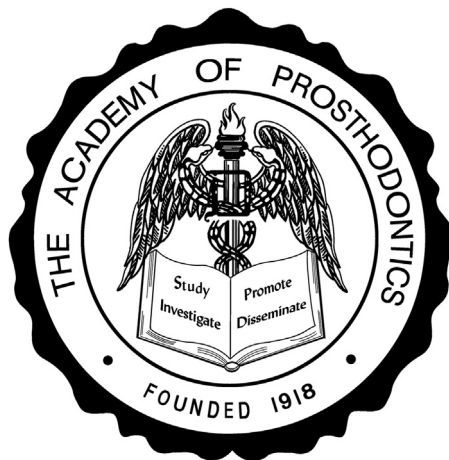


Academy of Prosthodontics centennial: The educational roots of our specialty



The Academy of Prosthodontics was there at the beginning of prosthodontics as a specialty. In 1918, a few distinguished individuals saw the need to develop prosthetic techniques and concepts and formed the National Society of Denture Prosthetists. Renamed the Academy of Denture Prosthetics (ADP) in 1940, the organization recognized the need to study, investigate, and disseminate knowledge related to prosthodontics.¹

As the discipline evolved, the need to establish prosthodontics as a specialty became apparent. In 1947, the first 5 specialties, oral surgery, orthodontics, pedodontia, periodontia, and prosthodontia were recognized by the American Dental Association House of Delegates (ADA HOD). The ADA Council on Dental Education (CDE) formally approved the American Board of Prosthodontics at the 1948 ADA House of Delegates, along with boards for oral surgery, pedodontia, and periodontia. The Academy of Prosthodontics sponsored the American Board of Prosthodontics (ABP) from its beginning in 1947.² The ABP developed and administered the specialty certification examination. In 1965, the ADA HOD adopted the eligibility requirement that all individuals taking the board examination must complete

a 2-year, formal advanced prosthodontic training program. This began the era of formal educational specialty programs and the changes that have led to the current status of the specialty.

In those early years, there was no national Commission for Dental Education, and the individual specialty certifying boards established requirements for specialty education programs. The Academy of Prosthodontics continued to sponsor the ABP until 1972 when the Federation of Prosthodontic Organizations (FPO) assumed responsibility.^{3,4} The FPO was dissolved on December 31, 1994, and responsibility was transferred to the American College of Prosthodontists.^{5,6}

Beginning in 1963, the CDE adopted general educational requirements for advanced specialty education programs.⁷ The CDE was the forerunner of 2 agencies now known as the Commission on Dental Accreditation (CODA) and the ADA-Council of Dental Education and Licensure (CDEL). The formal process was initiated for all specialties in 1966. These early guidelines consisted of general program requirements, approved by the CDE, applicable to all advanced specialty programs as well as a discipline-specific document. These early documents were a series of guidelines, and not standards. The guidelines contained only *should* statements, and no *must* statements. The discipline specific guidelines were developed and maintained by the individual specialty boards. Prosthodontics identified 3 distinct tracks of clinical practice, full-time academics and full-time research were specified. This was the origin of the 60% rule for the required time that students must spend treating patients in specialty prosthodontic programs.

The Commission on Dental Accreditation (CODA) was formed in 1975.⁷ The mission of CODA is to serve the public and the profession by developing and implementing accreditation standards that promote and monitor the continuous quality and improvement of dental education programs. CODA policies and evaluation guidelines provide the framework for all formal

dental education programs. This program and institutional oral health accreditation procedure is a 7-year process that includes a self-study and peer review of the educational programs as specified by the adopted accreditation standards, policies and procedures.

The Commission issued the first standards specific to each specialty in 1975.⁷ These included the general boilerplate guidelines applicable to all specialties and the specific educational guidelines adopted by each of the specialty boards. The prosthodontic specific guidelines were developed jointly by the FPO and the ABP. In 1975, CODA initiated the concept of *proficiency* at the specialty level, the use of *must* statements, the program length specifications of at least 2 years, and the process of measurement and evaluation of student learning.

In 1982, the prosthodontic accreditation guidelines were updated to include the adoption of definitions for levels of knowledge (in-depth, understanding, familiarity) and clinical skills (proficiency, competency, exposure), and the specification of dental laboratory technology skills. Lists of clinical procedures were added, and dental implants were mentioned for the first time. The current CODA Review Committee structure was established, and the ACP was named as the sponsoring organization for the purposes of appointing review committee members. The ABP was also identified as a CODA appointee organization.

Prior to the 1982 updates, the guidelines specified, “the major emphasis of the program should be placed on one of the prosthodontic disciplines” (complete and removable partial prosthodontics, fixed prosthodontics, and maxillofacial prosthetics). As a result, programs had a specific focus, and individuals graduated from fixed or removable programs. This specification limited the scope of prosthodontic education. For the first time, the December 1982 proposed requirements for Advanced Education Programs in Prosthodontics included a combined specialty that mandated students have in-depth knowledge and a broad range of clinical experience in fixed, removable partial, and complete denture prosthodontics, as well as occlusion. These changes were adopted in 1984 when CODA began to implement guidelines specific to each specialty in its own right and independently of the certifying and sponsoring groups. This began the era of iterative accreditation standards development that continually engaged all of the communities of interest.

The next significant update occurred in 1992 when the concept of “standards” as a core accreditation principle was adopted across all dental education. Prosthodontics added more extensive and detailed lists of clinical procedures and outcome standards for both programs and students.

In 1996, the program length was increased from 24 to 33 months to accommodate the expansion of prosthodontic therapies and the areas of temporomandibular

disorders (TMDs), orofacial pain, and geriatrics. The requirement that the program director be board certified was also introduced. Graduating students were now expected to be proficient in a large number of clinical areas, distinguishing them from the 4-year predoctoral (DDS/DMD) curriculum. Changes in 2008 brought the first dental implant placement standard at the participation level.

In 2012, the CODA adopted global changes to the core specialty definitions of didactic knowledge and clinical skills, mandating principles consistent with the predoctoral concept of “competence.”⁷ This modification had a broad effect, as it reduced the levels of didactic knowledge for all 9 recognized specialties from 3 (in-depth, understanding, exposure) to a single level of in-depth. Areas outside in-depth knowledge were to be dropped or raised to that level. Likewise, the definitions for clinical skills were reduced from proficiency, competency, and observation to just competency and observation.

This change in core definitions required all specialties to make their standards consistent with the new boilerplate guidelines. This change led to a comprehensive rewrite of the prosthodontic accreditation standards, which were ultimately implemented on July 1, 2016. These new standards are reflective of the contemporary and forward-looking practice of specialty prosthodontics and include a more diagnostically driven specialty. A broad range of new program standards were introduced, including implant placement at the level of competence.

Although the CODA Review Committee Process was established in 1982, prosthodontics did not have a formal review committee until 1998. The Prosthodontics Review Committee (PRC) is one of the standing committees of the CODA and reports directly to the CODA. As such, they consider all matters related to prosthodontic specialty accreditation, program review, and the process of managing the specialty accreditation standards for the CODA. The chair of the PRC serves as one of the 30 CODA commissioners who oversee all dental education.

There have been 5 prosthodontic commissioners:

Dr Stephen F. Bergen, 1998–2001

Dr Arthur Nimmo, 2001–2005

Dr Ronald D. Woody, 2005–2009

Dr Kent Knoernschild, 2009–2013

Dr Stephen Campbell, 2013–2017

The rich history of the Academy of Prosthodontics demonstrates its role in establishing the specialty of prosthodontics, including the guidelines for specialty education and accreditation as they evolved throughout the 20th century. This vision and involvement resulted in our modern educational processes and specialty. The Academy of Prosthodontics continues to play a critical

role in ensuring that specialty prosthodontics serves the public and future generation of graduates and practitioners.

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