LETTERS TO THE EDITOR

Oral medicine specialty?

I was both interested in and concerned by Dr. Craig Miller's recent editorial regarding specialty recognition for the discipline of oral medicine.[1] It's true that any dental group can form a health profession academy as well as a related certifying board. Yet the Commission on Dental Accreditation (CODA) and the American Dental Association's Council on Dental Education and Licensure (CDEL) continue to serve as the gold standards for the profession by providing independent, consistent, and reliable validation of advanced dental education programs as well as fully vetted recognition of specialty status at the national level under the guidance and approval of the U.S. Department of Education.

Among the six formal requirements for specialty recognition in dentistry adopted as amended by the American Dental Association House of Delegates in November 2013 is the following:

> (3) The scope of the proposed specialty requires advanced knowledge and skills that: (a) are separate and distinct from any recognized dental specialty or combination of recognized dental specialties; and (b) cannot be accommodated through minimal modification of a recognized dental specialty or combination of recognized dental specialties.[2]

As with recent applications to the CDEL for specialty recognition by the American Boards of Anesthesiology, Orofacial Pain, and Oral Implantology/Implant Dentistry, past efforts by the oral medicine organization to gain specialty recognition have failed to satisfy this crucial requirement. While health care providers on both sides of the "recognized specialty" issue have strong opinions, I offer the following facts regarding one advanced education program in oral medicine.

The University of Iowa College of Dentistry has active CODA-approved advanced education programs in all nine recognized dental specialties. Several years ago, the college hired a faculty member "certified" in oral medicine who immediately set out to establish a new advanced education program in oral medicine. The faculty member obtained the university and collegiate curriculum that the college had submitted to CODA before the most recent accreditation site visit and identified the didactic and clinical courses specific to oral and maxillofacial pathology. From this information, an application was prepared for the oral medicine board, which approved the new program.

A review of the 2-year curriculum that had been approved by oral medicine showed that it consisted of no less than 60% of the CODA-approved 3-year oral and maxillofacial pathology program curriculum. No additional clinical or didactic curriculum had been designed for the program.

By approving this application, the oral medicine board had shown de facto that advanced education in oral medicine could consist of nothing more than subtotal completion of an accredited oral and maxillofacial pathology advanced education program. This provided clear evidence that training for the "specialty" of oral medicine could be accommodated via the clinical and didactic educational components of an oral and maxillofacial pathology training program.

The new oral medicine training program was in existence for about 10 years before it was discontinued due to lack of interest and qualified applicants. Not a single resident who completed the program went on to practice or teach oral medicine.

The Texas Dental Board suit represents nothing more than a dental group, unhappy at failing to achieve specialty recognition from informed peers through a legitimate, nationally recognized due process, choosing to take their case to a less knowledgeable group with minimal appreciation of or responsibility for the integrity of the dental profession. The discipline of oral medicine contains no knowledge or skills that are separate and distinct from other recognized dental specialties. Furthermore, it fills no unmet patient care need in the profession of dentistry, a fact that was conveniently omitted in the Texas litigation.

If sustained, the action by the Texas Dental Board could allow any dental practitioner to advertise on a state-by-state basis as a "dental specialist," without independent verification and validation of proper educational credentials or continued competency using nationally recognized standards. This self-serving move threatens to dilute the integrity of the dental health care profession and minimize the well-earned respect afforded current diplomates of American Dental Association—recognized dental specialties, and it could jeopardize the safety of the American public.

At a time when dentists are clamoring for reciprocity and universal recognition of their licensure, it certainly seems like a step back for specialty recognition to be determined on a state-by-state basis by individuals or committees with less knowledge or experience than currently exists.

How could the public be at less risk with such a plan?

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REFERENCES

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2. American Dental Association House of Delegates. Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists. November 2013. Available at: http://www.ada.org/~/media/ADA/Education%20and%20Careers/Files/requirements.pdf?la=en. Accessed July 1, 2016.

http://dx.doi.org/10.1016/j.oooo.2016.07.028

Oral Medicine Specialty? Response to Dr. Vincent

In reply:

We thank Dr. Vincent for his letter to the editor. Diversity of opinion is what makes this country strong and our profession stronger. Having said this, it is important that the discussion directed at specialty recognition be viewed in full context at the historical level as well as its present status.

Dr. Vincent has held the longstanding belief that the American Dental Association (ADA) should serve as the sole designator of specialty recognition. He uses a single case to illustrate his opinion. This example of the closing of an oral medicine program at the University of Iowa unfortunately represents an N of 1; such case reports are considered low-level evidence and have the danger of being overinterpreted.[1,2] The lack of success of Iowa's program expressed by Dr. Vincent may be based on other reasons, including a lack of financial or academic support by the department or college, poor intercollegial cooperation, a lack of adequate teaching faculty, a lack of awareness and understanding of the unique knowledge and skills offered by the specialty of oral medicine, inadequate marketing, or a lack of desire to live in a particular location.

In contrast, there have been many examples of stellar advanced education programs in oral medicine at prestigious institutions over the years (e.g., Carolinas Medical Center, Harvard University, University of Pennsylvania, University of Washington, University of California at San Francisco; see http://www.aaom.com/residency-programs).[3] Furthermore, since 2007, 2-year advanced education programs in new fields of dentistry have been approved by the Commission on Dental Accreditation in oral medicine, orofacial pain, and dental anesthesiology, under the approval of the U.S. Department of Education. Graduate education programs in these new specialties have flourished with academic programs in the United States and Canada in orofacial pain (n = 14), dental anesthesiology (n = 10), and oral medicine (n = 10).[4,5] Hundreds of graduates from each of these programs have gone on to teach, establish clinical practices, improve patient health, and gain research funding from the National Institutes of Health. In fact, we are proud to be among them and have contributed new clinical and scientific knowledge to the profession of dentistry with over 50 combined years of such research funding.

The growth of new fields is a testament to the fact that the profession of dentistry is not stagnant, as Dr. Vincent suggests, but rather evolving to include many new areas of knowledge and clinical expertise that cannot be achieved by expanding existing dental specialties. In fact, the growth of these new specialties has equaled or exceeded that of some existing dental specialties. For example, the numbers of board-certified diplomates in dental anesthesiology (201), orofacial pain (251), implant dentistry (366), and oral medicine (198) are comparable to existing dental specialties including dental public health (146), oral and maxillofacial radiology (131), and oral and maxillofacial pathology (280).[4,5]

Unfortunately, Dr. Vincent fails to recognize the fact that the ADA specialty recognition is a political process, as acknowledged by recent litigation in Texas, Florida, and California. It is also independent of Commission on Dental Accreditation approval and heavily influenced by the self-serving special interests of existing dental specialties. Dr. Vincent notes that the invoking of ADA specialty application requirement number 3 has resulted in the ADA's failing to recognize several specialties, including from the American Boards of Oral Medicine, Orofacial Pain, and Implant Dentistry. Dr. Vincent fails to explain why dental anesthesiology passed all six ADA specialty recognition requirements four separate times; nevertheless, each time, dental anesthesia was rejected by the political process invoked by the ADA House of Delegates. Over the last 30 years, the ADA has rejected 90% of specialty recognition applications. This meager success rate suggests that the ADA specialty recognition process is flawed and the House of Delegates does not embrace the growth and evolution of the dental profession.

Dr. Vincent also fails to appreciate that oral medicine specialists treat tens of thousands of patients who have chronic orofacial pain conditions, salivary gland