

Commission on Dental Accreditation

Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery

Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery

**Commission on Dental Accreditation
American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611
(312) 440-4653
www.ada.org**

Oral and Maxillofacial Surgery: is the specialty of dentistry which includes the diagnosis, surgical and 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 regions. (Adopted October 1990)

Document Revision History

Date	Item	Action
July 30, 1998	Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery	Approved
January 29, 1999	Accreditation Status Definitions	Revised and Adopted
July 1, 1999	Accreditation Status Definitions	Implemented
July 23, 1999	Standards on Curriculum (Standards 4-2.3, 4-3.5 and 4-16.1)	Revised and Adopted
January 1, 2000	Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery	Implemented
January 1, 2000	Standards on Curriculum (Standards 4-2.3, 4-3.5 and 4-16.1)	Revised and Adopted
January 28, 2000	Standards on Curriculum (Standards 4-8.1, 4-0, 4-11 and 4-12)	Implemented
July 28, 2000	Intent Statements added to Selected Standards	Adopted, Implemented
January 30, 2001	Mission Statement	Revised and Adopted,
January 30, 2001	Policy on Advanced Standing	Revised and Adopted,
July 27, 2001	Standard on Advanced Standing	Revised and Adopted
February 2, 2002	Initial Accreditation Status Definition	Adopted
July 1, 2002	Standard on Advanced Standing	Implemented
January 1, 2003	Initial Accreditation Status Definition	Implemented
August 1, 2003	Intent Statement deleted from Standard 1, Program Administrator	Revised and Adopted
August 1, 2003	Policy on Enrollment Increases in Dental Specialty Programs	Adopted
January 30, 2004	Policy on Enrollment Increases in Dental Specialty Programs	Implemented
January 30, 2004	Intent Statement to Standard 1 on Major Change ("student enrollment" deleted)	Revised and Adopted
January 30, 2004	Intent Statement and Examples of Evidence to Standard 2	Adopted and Implemented
January 28, 2005	Examples of Evidence to Standard 2	Revised, Adopted and Implemented
January 28, 2005	Revisions (Editorial in Nature) for Standards 1-2, and 4-6	Adopted
July 1, 2005	Revisions (Editorial in Nature) for Standards 1-2, and 4-6	Implemented
July 29, 2005	Term and Definition for Student/Resident	Adopted and Implemented
July 29, 2005	Standards to Ensure Program Integrity (Standards 1, 2 and 5)	Adopted

Document Revision History

January 1, 2006	Standards to Ensure Program Integrity (Standards 1, 2 and 5)	Implemented
January 27, 2006	Intent Statement to Standard 2	Adopted and Implemented
January 27, 2006	Revisions (Editorial in Nature) for Standards 4-3.2, 4-3.5, 4-16.1, 4-16.2, 4-16.3, and 6	Adopted
July 1, 2006	Revisions (Editorial in Nature) for Standards 4-3.2, 4-3.5, 4-16.1, 4-16.2, 4-16.3, and 6	Implemented
July 28, 2006	Intent Statements for Standard 5 Examples of Evidence for Standard 1	Adopted and implemented
January 25, 2007	Revisions for Standards 4-9.3 and 4-16.2	Adopted
July 1, 2007	Revisions for Standards 4-9.3 and 4-16.2	Implemented
July 26, 2007	Standards to Ensure Program Integrity Examples of Evidence Modified (Standard 1)	Adopted and Implemented
July 26, 2007	Name Change: The Joint Commission on Accreditation of Healthcare Organizations changed to The Joint Commission	Adopted and Implemented
February 1, 2008	Revised Definition of Terms and usage of Examples of Evidence	Adopted and Implemented
January 30, 2009	Revisions to Language Common to All Specialties (Preface, Definitions of Terms, Standards 1, 4, 5)	Adopted
July 1, 2009	Revisions to Language Common to All Specialties (Preface, Definitions of Terms, Standards 1, 4, 5)	Implemented
July 31, 2009	Revised Policy on Major Change and Accreditation of Off-Campus Sites	Adopted and Implemented
February 5, 2010	Revisions to selected standards in curricular areas (Standards 4-9.3, 4-15.1, and 4-16.3)	Adopted
July 1, 2010	Revisions to selected standards in curricular areas (Standards 4-9.3, 4-15.1, and 4-16.3)	Implemented
August 6, 2010	Term and Definition for Resident	Adopted and Implemented
August 6, 2010	Policy Revisions (Major Change, Off-Campus Sites, Authorized Enrollment Increases)	Adopted
January 1, 2011	Policy Revisions (Major Change, Off-Campus Sites, Authorized Enrollment Increases)	Implemented
August 5, 2011	Revised Policy on Program Changes	Adopted and Implemented

Table Of Contents

	<u>PAGE</u>
Mission Statement of the Commission on Dental Accreditation	1
Accreditation Status Definitions.....	2
Reporting Program Changes in Accredited Programs.....	3
Preface.....	5
Policy On Enrollment Increases In Advanced Dental Specialty Programs.....	7
Definition of Terms Used In Oral and Maxillofacial Surgery Accreditation Standards.....	8
<u>Standards</u>	
1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS.....	11
AFFILIATIONS.....	13
2 - PROGRAM DIRECTOR AND TEACHING STAFF.....	15
3 - FACILITIES AND RESOURCES.....	19
4 - CURRICULUM AND PROGRAM DURATION.....	21
BASIC SCIENCES.....	25
PHYSICAL DIAGNOSIS.....	26
CLINICAL ORAL AND MAXILLOFACIAL SURGERY.....	27
MINIMUM CLINICAL REQUIREMENTS	
Outpatient Oral and Maxillofacial Surgery Experience.....	27
Ambulatory General Anesthesia and Deep Sedation.....	28
Admissions.....	29
Major Surgery.....	30
Variety of Major Surgical Experience.....	30
5 - ADVANCED EDUCATION RESIDENTS	
ELIGIBILITY AND SELECTION.....	34
EVALUATION.....	35
DUE PROCESS.....	36
RIGHTS AND RESPONSIBILITIES.....	36
6 - RESEARCH.....	37

Mission Statement of the Commission on Dental Accreditation

The Commission on Dental Accreditation serves the public by establishing, maintaining and applying standards that ensure the quality and continuous improvement of dental and dental-related education and reflect the evolving practice of dentistry. The scope of the Commission on Dental Accreditation encompasses dental, advanced dental and allied dental education programs

Commission on Dental Accreditation
revised: January 30, 2001

ACCREDITATION STATUS DEFINITIONS

Programs That Are Fully Operational:

Approval (*without reporting requirements*): An accreditation classification granted to an educational program indicating that the program achieves or exceeds the basic requirements for accreditation.

Approval (*with reporting requirements*): An accreditation classification granted to an educational program indicating that specific deficiencies or weaknesses exist in one or more areas of the program. Evidence of compliance with the cited standards must be demonstrated within eighteen (18) months if the program is between one and two years in length or two years if the program is at least two years in length. If the deficiencies are not corrected within the specified time period, accreditation will be withdrawn, unless the Commission extends the period for achieving compliance for good cause.

Programs That Are Not Fully Operational:

A program which has not enrolled and graduated at least one class of residents and does not have residents enrolled in each year of the program is defined by the Commission as not fully operational. The accreditation classification granted by the Commission on Dental Accreditation to programs which are not fully operational is “initial accreditation.” When initial accreditation status is granted to a developing education program, it is in effect through the projected enrollment date. However, if enrollment of the first class is delayed for two consecutive years following the projected enrollment date, the program’s accreditation will be discontinued, and the institution must reapply for initial accreditation and update pertinent information on program development. Following this, the Commission will reconsider granting initial accreditation status.

Initial Accreditation is the accreditation classification granted to any dental, advanced dental or allied dental education program which is not yet fully operational. This accreditation classification provides evidence to educational institutions, licensing bodies, government or other granting agencies that, at the time of initial evaluation(s), the developing education program has the potential for meeting the standards set forth in the requirements for an accredited educational program for the specific occupational area. The classification “initial accreditation” is granted based upon one or more site evaluation visit(s).

REPORTING PROGRAM CHANGES IN ACCREDITED PROGRAMS

The Commission on Dental Accreditation recognizes that education and accreditation are dynamic, not static, processes. Ongoing review and evaluation often lead to changes in an educational program. The Commission views change as part of a healthy educational process and encourages programs to make them as part of their normal operating procedures.

At times, however, more significant changes occur in a program. Changes may have a direct and significant impact on the program's potential ability to comply with the accreditation standards. Program changes tend to occur in the areas of finances, program administration, enrollment, curriculum and clinical/laboratory facilities, but may also occur in other areas. Reporting changes in the Annual Survey does not preclude the requirement to report changes to the Commission. Failure to report in advance any increase in enrollment or other change, using the Guidelines for Reporting Program Change, may result in review by the Commission, a special site visit, and may jeopardize the program's accreditation status. Advanced specialty education programs must adhere to the Policy on Enrollment Increases In Advanced Specialty Programs .

The Commission's Policy on Integrity also applies to the reporting of changes. If the Commission determines that an intentional breach of integrity has occurred, the Commission will immediately notify the chief executive officer of the institution of its intent to withdraw the accreditation of the program(s) at its next scheduled meeting.

When a change is planned, Commission staff should be consulted to determine reporting requirements. This report must document how the program will continue to meet accreditation standards. The Commission's Guidelines for Reporting Program Changes are available on the ADA website and may provide guidance in adequately explaining and documenting changes.

The program must report all programmatic changes to the Commission in writing at least thirty (30) days prior to the anticipated implementation of the change; however, for changes that involve enrollment increases in advanced specialty programs and changes that involve the addition of off-campus sites, different reporting deadline requirements apply. For enrollment increases in advanced specialty programs the program must submit a request to the Commission one (1) month prior a regularly scheduled semiannual Review Committee/Commission meeting. A program must receive Commission approval for an increase in enrollment prior to publishing or announcing the additional positions or accepting additional students/residents. For the addition of off-campus sites, the program must report in writing to the Commission at least six (6) months prior to the anticipated initiation of educational experiences at the off-campus site. See the Policy on Enrollment Increases In Advanced Specialty Programs and the Policy on Accreditation Of Off-campus Sites for specific information on these types of changes.

The following examples illustrate, but are not limited to, changes that would be reviewed by the appropriate Review Committee and the Commission to ensure that the program continues to meet the accreditation standards:

- Transfer of sponsorship from one institution to another;
- Moving a program from one geographic site to another;
- Program director qualifications not being in compliance with the standards;
- Substantial increase in program enrollment beyond the apparent resources of the program. (Specialty programs see Policy on Enrollment Increases In Advanced Specialty Programs);
- Significant change in the nature of the program's financial support;
- Curriculum changes that eliminate content areas required by the standards;
- Modification or reduction in faculty or support staff;
- Increase in the required length of the program; and/or
- Significant reduction of program dental facilities.

The Commission recognizes that unexpected, changes may occur. If an unexpected change occurs, it must be reported no more than 30 days following the occurrence. Unexpected changes may be the result of sudden changes in institutional commitment, affiliated agreements between institutions, faculty support, or facility compromise resulting from natural disaster. Failure to proactively plan for change will not be considered unexpected change. Depending upon the timing and nature of the change, appropriate investigative procedures including a site visit may be warranted.

The following examples illustrate, but are not limited to, additional program changes that are not reviewed by the Review Committee and the Commission but are reviewed at the next site visit:

- Adding content to individual courses;
- Updating or replacing laboratory/clinical equipment;
- Expansion or relocation of dental facilities within the same institution;
- Re-sequencing specific courses within the curriculum; and/or
- Change in program director. A copy of the new or acting program director's curriculum vitae should be provided to Commission staff.

Preface

Maintaining and improving the quality of advanced education in the nationally recognized specialty areas of dentistry is a primary aim of the Commission on Dental Accreditation. The Commission is recognized by the public, the profession and the United States Department of Education as the specialized accrediting agency in dentistry.

Accreditation of advanced specialty education programs is a voluntary effort of all parties involved. The process of accreditation ensures residents, specialty boards and the public that accredited training programs are in compliance with published standards.

Accreditation is extended to institutions offering acceptable programs in the following recognized specialty areas of dental practice: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics. Program accreditation will be withdrawn when the training program no longer conforms to the standards as specified in this document, when all first-year positions remain vacant for a period of two years or when a program fails to respond to requests for program information. Exceptions for non-enrollment may be made by the Commission for programs with “approval without reporting requirements” status upon receipt of a formal request from an institution stating reasons why the status of the program should not be withdrawn.

Advanced education in a recognized specialty area of dentistry may be offered on either a certificate-only or certificate and degree-granting basis.

Accreditation actions by the Commission on Dental Accreditation are based upon information gained through written submissions by program directors and evaluations made on site by assigned consultants. The Commission has established review committees in each of the recognized specialties to review site visit and progress reports and make recommendations to the Commission. Review committees are composed of representatives selected by the specialties and their certifying boards. The Commission has the ultimate responsibility for determining a program’s accreditation status. The Commission is also responsible for adjudication of appeals of adverse decisions and has established policies and procedures for appeal. A copy of policies and procedures may be obtained from the Director, Commission on Dental Accreditation, 211 East Chicago Avenue, Chicago, Illinois 60611.

This document constitutes the standards by which the Commission on Dental Accreditation and its consultants will evaluate advanced programs in each specialty for accreditation purposes. The Commission on Dental Accreditation establishes general standards which are common to all dental specialties, institutions and programs regardless of specialty. Each specialty develops specialty-specific standards for educational programs in its specialty. The general and specialty-specific standards, subsequent to approval by the Commission on Dental Accreditation, set forth the standards for the educational content, instructional activities, patient care responsibilities, supervision and facilities that should be provided by programs in the particular specialty.

General standards are identified by the use of a single numerical listing (e.g., 1). Specialty-specific standards are identified by the use of multiple numerical listings (e.g., 1-1, 1-1.2, 1-2).

POLICY ON ENROLLMENT INCREASES IN ADVANCED DENTAL SPECIALTY PROGRAMS

A program considering or planning an enrollment increase, or any other substantive change, should notify the Commission early in the program's planning. Such notification will provide an opportunity for the program to seek consultation from Commission staff regarding the potential effect of the proposed change on the accreditation status and the procedures to be followed.

A request for an increase in enrollment with all supporting documentation must be submitted in writing to the Commission one (1) month prior to a regularly scheduled semiannual Review Committee meeting. A program must receive Commission approval for an increase in enrollment prior to publishing or announcing the additional positions or accepting additional residents.

The Commission will not retroactively approve enrollment increases without a special focused site visit. Special circumstances may be considered on a case-by-case basis, including, but not limited to, temporary enrollment increases due to:

- Resident extending program length due to illness, incomplete projects/clinical assignments, or concurrent enrollment in another program;
- Unexpected loss of an enrollee and need to maintain balance of manpower needs;
- Urgent manpower needs demanded by U.S. armed forces; and
- Natural disasters.

Failure to comply with this policy will jeopardize the program's accreditation status, up to and including withdrawal of accreditation. If a program has enrolled beyond the approved number of residents without prior approval by the Commission, a special focused site visit will be required at the program's expense.

If the focused visit determines that the program does not have the resources to support the additional resident(s)/resident(s), the program will be placed on "intent to withdraw" status and no additional resident(s)/resident(s) beyond the previously approved number may be admitted to the program until the deficiencies have been rectified and approved by the Commission. Resident(s) who have already been formally accepted or enrolled in the program will be allowed to continue.

Definitions of Terms Used in Oral and Maxillofacial Surgery Accreditation Standards

The terms used in this document (i.e., shall, must, should, can and may) were selected carefully and indicate the relative weight that the Commission attaches to each statement. The definitions of these words as used in the Standards are as follows:

Must or Shall: Indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

Intent: Intent statements are presented to provide clarification to the advanced specialty education programs in oral and maxillofacial surgery in the application of and in connection with compliance with the Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery. The statements of intent set forth some of the reasons and purposes for the particular Standards. As such, these statements are not exclusive or exhaustive. Other purposes may apply.

Examples of evidence to demonstrate compliance include: Desirable condition, practice or documentation indicating the freedom or liberty to follow a suggested alternative.

Should: Indicates a method to achieve the standards.

May or Could: Indicates freedom or liberty to follow a suggested alternative.

Levels of Knowledge:

In-depth: A thorough knowledge of concepts and theories for the purpose of critical analysis and the synthesis of more complete understanding.

Understanding: Adequate knowledge with the ability to apply.

Familiarity: A simplified knowledge for the purposes of orientation and recognition of general principles.

Levels of Skill:

Proficient: The level of skill beyond competency. It is that level of skill acquired through advanced training or the level of skill attained when a particular activity is accomplished with repeated quality and a more efficient utilization of time.

Competent: The level of skill displaying special ability or knowledge derived from training and experience.

Exposed: The level of skill attained by observation of or participation in a particular activity.

Other Terms:

Institution (or organizational unit of an institution): a dental, medical or public health school, patient care facility, or other entity that engages in advanced specialty education.

Sponsoring institution: primary responsibility for advanced specialty education programs.

Affiliated institution: support responsibility for advanced specialty education programs.

Advanced specialty education resident: a resident enrolled in an accredited advanced specialty education program.

A degree-granting program a planned sequence of advanced courses leading to a master's or doctoral degree granted by a recognized and accredited educational institution.

A certificate program is a planned sequence of advanced courses that leads to a certificate of completion in a specialty recognized by the American Dental Association.

Resident: The individual enrolled in an accredited advanced education program.

International Dental School: A dental school located outside the United States and Canada.

Oral and Maxillofacial Surgery Terms:

Oral and maxillofacial surgery teaching service: that service in which the resident plays the primary role in the admission, management and/or discharge of patients.

General anesthesia: is a controlled state of unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to maintain an airway independently and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or combination thereof.

Deep sedation: is a controlled state of depressed consciousness, accompanied by partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or to respond purposefully to verbal command, and is produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

“Board Certified – Completion and maintenance of the certification process of the American Board of Oral and Maxillofacial Surgery (ABOMS). This process requires demonstration of successful completion of training in an accredited oral and maxillofacial surgery advanced specialty education program, post-training experience of defined duration, and successful completion of the ABOMS written and oral examinations. There is no longer specific status (such as “board eligible”) that indicates a candidate’s progress through the ABOMS certification process. An individual that has qualified to participate in the certification process is deemed to be actively engaged in becoming board certified.”

STANDARD 1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS

The program must develop clearly stated goals and objectives appropriate to advanced specialty education, addressing education, patient care, research and service. Planning for, evaluation of and improvement of educational quality for the program must be broad-based, systematic, continuous and designed to promote achievement of program goals related to education, patient care, research and service.

The program must document its effectiveness using a formal and ongoing outcomes assessment process to include measures of advanced education resident achievement.

Intent: The Commission on Dental Accreditation expects each program to define its own goals and objectives for preparing individuals for the practice of oral and maxillofacial surgery and that one of the program goals is to comprehensively prepare competent individuals to initially practice oral and maxillofacial surgery. The outcomes process includes steps to: (a) develop clear, measurable goals and objectives consistent with the program's purpose/mission; (b) develop procedures for evaluating the extent to which the goals and objectives are met; (c) collect and maintain data in an ongoing and systematic manner; (d) analyze the data collected and share the results with appropriate audiences; (e) identify and implement corrective actions to strengthen the program; and (f) review the assessment plan, revise as appropriate, and continue the cyclical process.

The financial resources must be sufficient to support the program's stated goals and objectives.

Intent: The institution should have the financial resources required to develop and sustain the program on a continuing basis. The program should have the ability to employ an adequate number of full-time faculty, purchase and maintain equipment, procure supplies, reference material and teaching aids as reflected in annual budget appropriations. Financial allocations should ensure that the program will be in a competitive position to recruit and retain qualified faculty. Annual appropriations should provide for innovations and changes necessary to reflect current concepts of education in the advanced specialty discipline. The Commission will assess the adequacy of financial support on the basis of current appropriations and the stability of sources of funding for the program.

The sponsoring institution must ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

Examples of evidence to demonstrate compliance may include:

- Written agreement(s)
- Contract(s)/Agreement(s) between the institution/program and sponsor(s) related to facilities, funding, and faculty financial support

Advanced specialty education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity. Hospitals that sponsor advanced specialty education programs must be accredited by The Joint Commission or its equivalent. Educational institutions that sponsor advanced specialty education programs must be accredited by an agency recognized by the United States Department of Education. The bylaws, rules and regulations of hospitals that sponsor or provide a substantial portion of advanced specialty education programs must ensure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.

The authority and final responsibility for curriculum development and approval, resident selection, faculty selection and administrative matters must rest within the sponsoring institution.

The position of the program in the administrative structure must be consistent with that of other parallel programs within the institution and the program director must have the authority, responsibility and privileges necessary to manage the program.

- 1-1 The principal institutions that sponsor accredited oral and maxillofacial surgery programs are dental schools, hospitals and medical schools.**
- 1-2 There must be adequate bed availability to provide for the required number of patient admissions and appropriate independent care by the oral and maxillofacial surgery service.**
- 1-3 Oral and maxillofacial surgeons who are members of the teaching staff participating in an accredited educational program must be eligible to practice the full scope of the specialty in accordance with their training, experience and demonstrated competence.**

Examples of evidence to demonstrate compliance may include:

- Details of bylaws and credentialing process that document that oral and maxillofacial surgeons are allowed to practice those aspects of the specialty for which they have documented evidence of training and experience
- List of procedures performed that show scope, and/or hospital privileges list

- 1-4 One measure of the quality of an education program must be the success of graduates on the American Board of Oral and Maxillofacial Surgery certification examination.**
- 1-5 The educational mission must not be compromised by a reliance on residents to fulfill institutional service, teaching or research obligations. Resources and time must be provided for the proper achievement of educational obligations.**

Intent: All resident activities have redeeming educational value. Some teaching experience is part of a resident's training, but the degree to which it is done should not abuse its educational value to the resident.

Examples of evidence to demonstrate compliance may include:

- Clinic assignment schedule

AFFILIATIONS

The primary sponsor of the educational program must accept full responsibility for the quality of education provided in all affiliated institutions.

Documentary evidence of agreements, approved by the sponsoring and relevant affiliated institutions, must be available. The following items must be covered in such inter-institutional agreements:

- a. Designation of a single program director;**
- b. The teaching staff;**
- c. The educational objectives of the program;**
- d. The period of assignment of residents; and**
- e. Each institution's financial commitment.**

Intent: The items that are covered in inter-institutional agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

- 1-6 Rotations to an affiliated institution which sponsors its own accredited oral and maxillofacial surgery residency program must not exceed 6 months in duration.**
- 1-7 Any program that rotates a resident to an affiliated institution which also sponsors its own separately accredited oral and maxillofacial surgery residency program must submit each year a supplement to its Annual Survey. The supplement must identify the affiliated institution by name and the oral and**

maxillofacial surgery cases on which the rotating resident was surgeon or first assistant to an attending surgeon. This report must be signed by the program director of the sponsoring institution and the chief of oral and maxillofacial surgery at the affiliated institution.

1-8 All standards in this document must apply to training provided in affiliated institutions.

POLICY STATEMENT ON ACCREDITATION OF OFF-CAMPUS SITES

The Commission on Dental Accreditation must be informed when a program accredited by the Commission, plans to initiate an off-campus site (distance site and/or additional training site not located on the main campus). The Commission must be informed in writing six (6) months prior to the anticipated initiation of educational experiences at the off-campus site.

Generally, only programs without reporting requirements will be approved to initiate educational experiences at off-campus sites. The Commission must ensure that the necessary education as defined by the standards is available, and appropriate resources (adequate faculty and staff, availability of patient experiences, and distance learning provisions) are provided to all residents enrolled in an accredited program. When the Commission has received notification that an institution plans to offer its accredited program at an off-campus site, the Commission will conduct a special focused site visit to each off-campus location where a significant portion of each resident's educational experience is provided, based on the specifics of the program, the accreditation standards, and Commission policies and procedures, or if other cause exists for such a visit as determined by the Commission. After the initial visit, each site will continue to be visited during the regularly scheduled site visit to the program.

The Commission recognizes that dental assisting and dental laboratory technology programs utilize numerous extramural dental offices and laboratories to provide residents with clinical/laboratory practice experience. In this instance, the Commission will randomly select and visit several facilities during the site visit to a program. All programs accredited by the Commission pay an annual fee. Additional fees will be based on actual accreditation costs incurred during the visit to on and off-campus locations. The Commission office should be contacted for current information on fees.

STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

The program must be administered by a director who is board certified in the respective specialty of the program. (All program directors appointed after January 1, 1997, who have not previously served as program directors, must be board certified.)

Intent: The director of an advanced specialty education program is to be certified by an ADA-recognized certifying board in the specialty. Board certification is to be active. The board certification requirement of Standard 2 is also applicable to an interim/acting program director. A program with a director who is not board certified but who has previous experience as an interim/acting program director in a Commission-accredited program prior to 1997 is not considered in compliance with Standard 2.

Examples of evidence to demonstrate compliance may include:

For board certified directors: Copy of board certification certificate; letter from board attesting to current/active board certification

(For non-board certified directors who served prior to January 1, 1997: Current CV identifying previous directorship in a Commission on Dental Accreditation- or Commission on Dental Accreditation of Canada-accredited advanced specialty program in the respective discipline; letter from the previous employing institution verifying service)

The program director must be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program's effectiveness in meeting its goals.

2-1 Program Director: The program must be directed by a single responsible individual who is a full time faculty member as defined by the institution.

Intent: Other activities do not dilute a program director's ability to discharge his/her primary obligations to the educational program.

The responsibilities of the program director must include:

2-1.1 Development of the goals and objectives of the program and definition of a systematic method of assessing these goals by appropriate outcomes measures.

2-1.2 Ensuring the provision of adequate physical facilities for the educational process.

- 2-1.3 Participation in selection and supervision of the teaching staff. Perform periodic, at least annual, written evaluations of the teaching staff. (In some situations the evaluation may be performed by the chairman of the department of oral and maxillofacial surgery who is not the program director.)**
- 2-1.4 Responsibility for adequate educational resource materials for education of the residents, including access to an adequate health science library.**
- 2-1.5 Responsibility for selection of residents and ensuring that all appointed residents meet the minimum eligibility requirements, unless the program is sponsored by a federal service utilizing a centralized resident selection process.**
- 2-1.6 Maintenance of appropriate records of the program, including resident and patient statistics, institutional agreements, and resident records.**

Examples of evidence to demonstrate compliance may include:

- Copies of faculty meeting minutes
- Sign-in sheets
- Monthly records of outpatient visits by category

2-2 Teaching Staff: The teaching staff must be of adequate size and must provide for the following:

2-2.1 Provide direct supervision appropriate to a resident's competence, level of training, in all patient care settings.

Intent: Faculty is present and available in clinics, emergency rooms and operating rooms for appropriate level supervision during critical parts of procedures.

Examples of evidence to demonstrate compliance may include:

- Faculty coverage for clinic, operating room and call schedules
- Patient records

2-2.2 In addition to the full time program director, the teaching staff must have at least one full time equivalent oral and maxillofacial surgeon as defined by the institution per each authorized senior resident position. One of the teaching staff who are not program directors must be at least half-time faculty as defined by the institution.

Intent: Senior resident is defined as authorized enrollment in the final year of the program. One resident requires one full-time faculty member and one full-time faculty equivalent (the second faculty equivalent consists of at least one faculty member who is greater than or equal to 0.5 FT; the rest can be comprised of faculty each of which is less than 0.5 FTE).

Two residents equal one full-time faculty member and two full-time faculty equivalents. (These two faculty equivalents includes at least one faculty member who is greater than or equal to 0.5 FTE. The rest can be comprised of faculty less than 0.5 FTE).

Three residents equal one full-time faculty member and three full-time faculty equivalents (as before).

#Resident	#FT	#0.5 FTE	#0.5 FTE	Total FTE
<i>n</i>	1	0.5	$(n-0.5)FTE$	$(n+1)$
1	1	0.5	0.5	2
2	1	0.5	1.5	3
3	1	0.5	2.5	4

For example, the program director counts as 1 F.T.E. Therefore, to be in compliance, one additional F.T.E. is required for each senior resident position. The additional F.T.E. can be a full-time or a half-time position, plus additional fractions thereof.

2-2.3 Eligible oral and maxillofacial surgery members of the teaching staff, with greater than a .5 FTE commitment appointed after January 1, 2000, who have not previously served as teaching staff, must be diplomates of the American Board of Oral and Maxillofacial Surgery or in the process of becoming board certified. Foreign trained faculty must be comparably qualified.

2-3 Scholarly Activity of Faculty: There must be evidence of scholarly activity among the oral and maxillofacial surgery faculty. Such evidence may include:

a. Participation in clinical and/or basic research particularly in projects funded following peer review;

Oral and Maxillofacial Surgery Standards

- b. Publication of the results of innovative thought, data gathering research projects, and thorough reviews of controversial issues in peer-reviewed scientific media; and**
- c. Presentation at scientific meetings and/or continuing education courses at the local, regional, or national level.**

STANDARD 3 – FACILITIES AND RESOURCES

Institutional facilities and resources must be adequate to provide the educational experiences and opportunities required to fulfill the needs of the educational program as specified in these Standards. Equipment and supplies for use in managing medical emergencies must be readily accessible and functional.

Intent: The facilities and resources (e.g.; support/secretarial staff, allied personnel and/or technical staff) should permit the attainment of program goals and objectives. To ensure health and safety for patients, residents, faculty and staff, the physical facilities and equipment should effectively accommodate the clinic and/or laboratory schedule.

The program must document its compliance with the institution’s policy and applicable regulations of local, state and federal agencies, including but not limited to radiation hygiene and protection, ionizing radiation, hazardous materials, and bloodborne and infectious diseases. Policies must be provided to all residents, faculty and appropriate support staff and continuously monitored for compliance. Additionally, policies on bloodborne and infectious diseases must be made available to applicants for admission and patients.

Intent: The program may document compliance by including the applicable program policies. The program demonstrates how the policies are provided to the residents, faculty and appropriate support staff and who is responsible for monitoring compliance. Applicable policy states how it is made available to applicants for admission and patients should a request to review the policy be made.

Residents, faculty and appropriate support staff must be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk to patients and dental personnel.

Intent: The program should have written policy that encourages (e.g., delineates the advantages of) immunization for residents, faculty and appropriate support staff.

All residents, faculty and support staff involved in the direct provision of patient care must be continuously recognized/certified in basic life support procedures, including cardiopulmonary resuscitation.

Intent: Continuously recognized/certified in basic life support procedures means the appropriate individuals are currently recognized/certified.

The use of private office facilities as a means of providing clinical experiences in advanced specialty education is not approved, unless the specialty has included language that defines the use of such facilities in its specialty-specific standards.

- 3-1 Clinical facilities must be properly equipped for performance of all ambulatory oral and maxillofacial surgery procedures, including administration of general anesthesia and sedation for ambulatory patients.**
- 3-2 There must be a space properly equipped for monitoring patients' recovery from ambulatory surgery, general anesthesia and sedation.**

STANDARD 4 - CURRICULUM AND PROGRAM DURATION

The advanced specialty education program must be designed to provide special knowledge and skills beyond the D.D.S. or D.M.D. training and be oriented to the accepted standards of specialty practice as set forth in specific standards contained in this document.

Intent: The intent is to ensure that the didactic rigor and extent of clinical experience exceeds pre-doctoral, entry level dental training or continuing education requirements and the material and experience satisfies standards for the specialty.

The level of specialty area instruction in certificate and degree-granting programs must be comparable.

Intent: The intent is to ensure that the residents of these programs receive the same educational requirements as set forth in these Standards.

Documentation of all program activities must be ensured by the program director and available for review.

If an institution and/or program enrolls part-time residents, the institution must have guidelines regarding enrollment of part-time residents. Part-time residents must start and complete the program within a single institution, except when the program is discontinued. The director of an accredited program who enrolls residents on a part-time basis must ensure that: (1) the educational experiences, including the clinical experiences and responsibilities, are the same as required by full-time residents; and (2) there are an equivalent number of months spent in the program.

4-1 An advanced specialty education program in oral and maxillofacial surgery must encompass a minimum duration of 48 months of full-time study.

4-2 Each resident must devote a minimum of 30 months to clinical oral and maxillofacial surgery.

Intent: While enrolled in an oral and maxillofacial surgery program, full-time rotations on the oral and maxillofacial surgery service while doing a non-oral and maxillofacial surgery residency year or full-time service on oral and maxillofacial surgery during vacation times during medical school may be counted toward this requirement.

Examples of evidence to demonstrate compliance may include:

- Complete schedule of resident activity

4-2.1 Twelve months of the time spent on the oral and maxillofacial surgery service must be at a senior level of responsibility, 6 months of which must be in the final year.

Intent: Senior level responsibility means residents serving as first assistant to attending surgeon on major cases.

4-2.2 Rotations to affiliated institutions outside the United States may be used to supplement the core training experience. Up to two months of the core 30-month requirement for clinical oral and maxillofacial surgery may be used for foreign rotations. Surgical procedures performed during foreign rotations will not count toward fulfillment of the 75 major surgical patients.

Foreign rotations must fulfill the requirements for affiliations outlined in Standard 1.

4-2.3 Training in a private practice facility must be no longer than two (2) months of the core 30 months in duration. In order to ensure the integrity of the educational process, the preoperative, intraoperative and postoperative parts of the procedures undertaken must have active resident participation. The treatment rendered by the resident must be under OMS teaching staff supervision and the resident must keep a logbook of the procedures performed. The cases performed by the resident on this rotation are part of the total oral and maxillofacial surgery case requirement.

Intent: Experience can be gained in segments of less than a month or week at a time. A month is no less than 20 work days. Resident serves as first assistant for the majority of surgical procedures performed during this rotation. They are to be present for most pre- and post-operative patient visits.

Examples of evidence to demonstrate compliance may include:

- Schedules showing that resident was present in pre- and post-operative visits
- Progress notes or resident logs showing resident was present during pre- and post-operative visits
- Resident logbook of all procedures with which resident had active participation

4-3 The residency program in oral and maxillofacial surgery must include education and training in the basic and clinical sciences, which is integrated into the training program. A distinct and specific curriculum must be provided in anesthesia, clinical medicine and surgery.

The integrated clinical science curriculum must include off-service rotations, lectures and seminars given during the oral and maxillofacial surgery training program by oral and maxillofacial surgery residents and attending staff. Course work and training taken as requirements for the medical degree and the general surgery residency year provided within integrated MD/oral and maxillofacial surgery training programs may also qualify to satisfy some of the clinical science curriculum requirements.

When assigned to another service, the oral and maxillofacial surgery resident must devote full-time to the service and participate fully in all the teaching activities of the service, including regular on-call responsibilities.

Examples of evidence to demonstrate compliance may include:

- Lecture schedules
- Curriculum; behavioral objectives
- Attendance sign-in sheets
- Policy of anesthesia department related to on-call participation by residents if residents are not permitted to be on-call
- Rotation schedules

4-3.1 Anesthesia Service:

The assignment must be for a minimum of 4 months. The resident must function as an anesthesia resident with commensurate level of responsibility.

Intent: Any regular outpatient assignment provided by anesthesia is acceptable. Oral and maxillofacial surgery residents rotating on the anesthesia service have levels of

responsibility identical to those of the anesthesia residents, and abide by the anesthesia department's assignments and schedules. Part of this time can be as a medical resident as long as oral and maxillofacial surgery trainee functions at the anesthesia resident level.

Examples of evidence to demonstrate compliance may include:

- Resident on-call rotation schedules
- Anesthesia records

4-3.2 Medical Service:

A minimum of 2 months of clinical medical experience must be provided.

Intent: The intent is to gain the highest educational content possible even if trainee does not have complete management authority over patients. This experience should be at the medical resident clerk level or higher, and may include rotation on medical specialty services.

Examples of evidence to demonstrate compliance may include:

- Resident rotation schedules

4-3.3 Surgical Service:

A minimum of 4 months of clinical surgical experience must be provided. This experience should be achieved by rotation to the general surgery service and the resident must function as a surgery resident with commensurate level of responsibility.

Intent: The intent is to provide residents with adequate training in pre- and post-operative care, as well as experience in intra-operative techniques. This should include management of critically ill patients. Oral and maxillofacial surgery residents operate at a PGY-1 level of responsibilities or higher, and is on the regular night call schedule.

Examples of evidence to demonstrate compliance may include:

- Resident rotation schedules

4-3.4 Other Rotations:

Two additional months of clinical surgical or medical education must be assigned. These must be exclusive of all oral and maxillofacial surgery service assignments.

Examples of evidence to demonstrate compliance may include:

- Resident rotation schedules

- 4-4 Weekly departmental seminars and conferences, directed by participating members of the teaching staff, must be conducted to augment the biomedical science and clinical program. They must be scheduled and structured to provide instruction in the broad scope of oral and maxillofacial surgery and related sciences and must include retrospective audits, clinicopathological conferences, tumor conferences and guest lectures. The majority of teaching sessions must be presented by members of the teaching staff. Residents must also prepare and present departmental conferences.**

Examples of evidence to demonstrate compliance may include:

- Seminar schedules for at least one year
- Resident log of lectures attended
- Course outlines
- Sign-in sheets

BASIC SCIENCES

- 4-5 Instruction in the basic biomedical sciences at an advanced level beyond that of the predoctoral dental curriculum must be provided. These sciences include anatomy (including growth and development), physiology, pharmacology, microbiology and pathology. This instruction may be provided through formal courses, seminars, conferences or rotations to other services of the hospital.**

4-5.1 This instruction may be met through the completion of the requirements for the M.D. or any other advanced degrees. Instruction in anatomy must include surgical approaches used in various oral and maxillofacial surgery procedures.

Examples of evidence to demonstrate compliance may include:

- Resident log of lectures attended
- Course outlines
- Goals and objectives of biomedical sciences curriculum
- Sign-in sheets
- Schedule showing curriculum in the mandated areas for a typical year

PHYSICAL DIAGNOSIS

4-6 Educating residents to take a complete medical history and perform a comprehensive physical evaluation is an essential component of an oral and maxillofacial surgery residency program. A formally structured didactic and clinical course in physical diagnosis must be provided by individuals privileged to perform histories and physical examinations. Resident competency in physical diagnosis must be documented by qualified members of the teaching staff. This instruction must be initiated in the first year of the program to ensure that residents have the opportunity to apply this training throughout the program on adult and pediatric (12 years of age or under) patients.

Intent: A medical resident level course in physical diagnosis, or a faculty led, formally structured and comprehensive physical diagnosis course that includes didactic and practical instruction.

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Course syllabi
- Course schedules
- Credentialing letter from course director that resident has mastered skills

4-6.1 Patients admitted to the OMS service must have a complete history and physical examination performed by an oral and maxillofacial surgery resident.

Intent: It is expected that surgical patients undergo a routine history and physical by the residents.

Examples of evidence to demonstrate compliance may include:

- Patient records demonstrating histories and physicals are performed by residents

CLINICAL ORAL AND MAXILLOFACIAL SURGERY

- 4-7 Each program must provide a complete, progressively graduated sequence of outpatient, inpatient and emergency room experiences. The residents' exposure to major and minor surgical procedures should be integrated throughout the duration of the program.**

In addition to providing the teaching and supervision of the resident activities described above, there must also be provided patients of sufficient number who have a sufficient variety of problems to give residents exposure to and competence in the full scope of oral and maxillofacial surgery. The training of a resident in the full scope of oral and maxillofacial surgery requires, as a minimum, the number of patients and variety of cases enumerated in the following paragraphs. Program directors must demonstrate that the objectives of the standards have been met and must ensure that all residents receive comparable clinical experience.

Examples of evidence to demonstrate compliance may include:

- Records kept by program director that show comparability of surgical experiences in the various aspects of oral and maxillofacial surgery across years and among residents.

MINIMUM CLINICAL REQUIREMENTS

OUTPATIENT ORAL AND MAXILLOFACIAL SURGERY EXPERIENCE

- 4-8 The outpatient surgical experience must ensure adequate training in a broad range of ambulatory oral and maxillofacial surgery procedures involving adult and pediatric patients. This experience must include the management of traumatic injuries and pathologic conditions, dentoalveolar surgery, the placement of implant devices, augmentations and other hard and soft tissue surgery, including surgery of the mucogingival tissues.**

4-8.1 For each authorized final year resident position, an accredited program must demonstrate that the oral and maxillofacial surgery service has 3,000 oral and maxillofacial surgery outpatient visits per year.

Intent: Faculty cases can count within a residency program, but they should have resident involvement.

Examples of evidence to demonstrate compliance may include:

- Tabulation of cases for three consecutive months
- An additional three months data may be requested
- If numbers are low, an entire year's tabulation may be requested

AMBULATORY GENERAL ANESTHESIA AND DEEP SEDATION

4-9 The off-service rotation in anesthesia must be supplemented by longitudinal and progressive experience throughout the training program in all aspects of pain and anxiety control. The clinical practice of ambulatory oral and maxillofacial surgery requires familiarity, experience and capability in ambulatory techniques of general anesthesia. The outpatient surgery experience must ensure adequate training in both general anesthesia and deep sedation for oral and maxillofacial surgery procedures on adult and pediatric patients. This includes competence in managing the airway.

4-9.1 For each authorized final year resident position, residents must administer general anesthesia/deep sedation to a minimum of 100 ambulatory oral and maxillofacial surgery patients per year, a substantial number of which must be general anesthetics.

Intent: A substantial number means at least 10. The pediatric portion of this requirement is that the resident be trained in the unique anatomical/pharmacological/physiological variations of the pediatric anesthesia patient (defined as 12 years of age or under).

Examples of evidence to demonstrate compliance may include:

- 3 consecutive months records of patients with general anesthesia and sedations, including children

4-9.2 In addition to general anesthesia/deep sedation, the residents must also obtain extensive training and experience in all aspects of parenteral and inhalation sedation techniques.

Examples of evidence to demonstrate compliance may include:

- Detailed curriculum plans
- Patient charts

4-9.3 The clinical program must be supported in part by a core comprehensive didactic program on general anesthesia, deep sedation and other methods of pain and anxiety control. This includes Advanced Cardiac Life Support (ACLS) certification (Advanced Cardiac Life Support must be obtained in the first year of residency and must be maintained throughout residency training), lectures and seminars emphasizing patient evaluation, risk assessment, anesthesia and sedation techniques, monitoring, and the diagnosis and management of complications. Residents should be certified in Pediatric Advanced Life Support (PALS) upon completion of training.

Examples of evidence to demonstrate compliance may include:

- Advanced Cardiac Life Support (ACLS) certification records and cards

ADMISSIONS

4-10 Inpatient surgical experience must ensure adequate training in a broad range of inpatient oral and maxillofacial surgery care, including admission and management of patients.

MAJOR SURGERY

- 4-11** For each authorized final year resident position, residents must perform major oral and maxillofacial surgery on 75 patients including adults and children, no more than five (5) of whom require dentoalveolar surgery, documented by at least a formal operative note. In order for a major surgical case to be counted toward meeting this requirement, the resident must be an operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member, the patient must be managed by the oral and maxillofacial surgery service and the resident must be supervised by an oral and maxillofacial surgery attending staff member. A resident will be considered to be the resident surgeon only when the program has documented he or she has played a significant role in determining or confirming the diagnosis, including appropriate consultation, providing preoperative care, selecting and performing the appropriate operative procedure, managing the postoperative course and conducting sufficient follow-up to be acquainted both with the course of the disease and outcome of treatment. Surgery performed by oral and maxillofacial surgery residents while rotating on or assisting with other services cannot be counted toward this requirement.

VARIETY OF MAJOR SURGICAL EXPERIENCE

- 4-12** Of the 75 major surgical patients required for each authorized final year resident position, there must be at least 10 patients in each category of surgery. The categories of major surgery are defined as: 1) trauma 2) pathology 3) orthognathic surgery 4) reconstructive and cosmetic surgery. Patients who have simultaneous surgical procedures in multiple categories must only be counted in one category. Sufficient variety in each category, as specified below, must be provided.

Intent: The intent is to ensure the balanced exposure to all major categories of surgical cases.

Examples of evidence to demonstrate compliance may include:

- Department and institution general operating room statistics and logs

- 4-13** In the trauma category, in addition to mandibular fractures, the surgical management and treatment of the maxilla and zygomatico maxillary complex must be included.

4-13.1 Trauma management includes, but is not limited to, tracheostomies, open and closed reductions of fractures of the mandible, maxilla, zygomatico-maxillary, nose, naso-frontal-orbital-ethmoidal and midface region and repair of facial, oral, soft tissue injuries and injuries to specialized structures.

4-14 In the pathology category, experience must include management of temporomandibular joint pathology and at least three other types of procedures.

4-14.1 Pathology management includes, but is not limited to, major maxillary sinus procedures, treatment of temporomandibular joint pathology, cystectomy of bone and soft tissue, sialolithotomy, sialoadenectomy, management of head and neck infection, including incision and drainage procedures, fifth nerve surgery and surgical management of benign and malignant neoplasms.

4-15 In the orthognathic category, procedures must include correction of deformities in the mandible and the middle third of the facial skeleton.

4-15.1 Orthognathic surgery includes the surgical correction of functional and cosmetic orofacial and craniofacial deformities of the mandible, maxilla, zygoma and other facial bones as well as the treatment of obstructive sleep apnea. Surgical procedures in this category include, but are not limited to, ramus and body procedures, subapical segmental osteotomies, Le Fort I, II and III procedures and craniofacial operations. Comprehensive care must include consultation and treatment by an orthodontic specialist when indicated; and a sleep medicine team should be included when indicated.

Intent: Evidence of resident pre- and post-operative care and intra-operative participation in the treatment of the orthognathic patient and the sleep apnea patient.

Examples of evidence to demonstrate compliance may include:

- Evidence of collaborative care (with orthodontist and/or sleep medicine team)
- Oral and maxillofacial surgery record with orthodontic and/or sleep medicine involvement

4-16 In the reconstructive and cosmetic category, both bone grafting and soft tissue grafting procedures and insertion of implants must be included. Residents must learn the harvesting of bone and soft tissue grafts during the course of training.

Intent: Distant bone graft sites may include but are not limited to calvarian, rib, ilium, fibula and tibia. Harvesting of soft tissue grafts may be from intraoral or distant sites. Distant soft tissue grafts include but are not limited to cartilage, skin, fat, nerve & fascia.

Examples of evidence to demonstrate compliance may include:

- Patient records revealing evidence of hard - and soft-tissue harvesting and grafting to maxillofacial region, including donor sites distant from oral cavity

4-16.1 Reconstructive surgery includes, but is not limited to, vestibuloplasties, augmentation procedures, temporomandibular joint reconstruction, management of continuity defects, insertion of craniofacial implants, facial cleft repair and other reconstructive surgery.

Intent: It is expected that in this category there will be both reconstructive and cosmetic procedures performed by residents.

4-16.2 Dental implant training must include didactic and clinical experience in comprehensive preoperative, intraoperative and post-operative management of the implant patient.

The preoperative aspects of the comprehensive management of the implant patient must include diagnosis, treatment planning, biomechanics, biomaterials, biological basis and interdisciplinary consultation.

The intraoperative aspects of training must include surgical preparation and surgical placement including hard and soft tissue grafts.

The post-operative aspects of training must include the maintenance, evaluation and management of implant tissues and complications associated with the placement of implants.

Examples of evidence to demonstrate compliance may include:

- Implant-related didactic course materials
- Patient records, indicating interaction with restorative dentists

4-16.3 Cosmetic surgery should include but is not limited to three of the following types of procedures: rhinoplasty, blepharoplasty, rhytidectomy, genioplasty, lipectomy, otoplasty, and scar revision.

Examples of evidence to demonstrate compliance may include:

- Patient records revealing resident experience in reconstructive and cosmetic surgery

4-17 Accurate and complete records of the amount and variety of clinical activity of the oral and maxillofacial surgery teaching service must be maintained. These records must include a detailed account of the number and variety of procedures performed by each resident. Records of patients managed by residents must evidence thoroughness of diagnosis, treatment planning and treatment.

4-17.1 Residents must keep a current log of their operative cases.

4-18 Emergency Care Experience: Residents must be provided with emergency care experience, including diagnosing, rendering emergency treatment and assuming major responsibility for the care of oral and maxillofacial injuries. The management of acute illnesses and injuries, including management of oral and maxillofacial lacerations and fractures, must be included in this experience. A resident must be available to the emergency service at all times.

4-18.1 Residents must be verified in Advanced Trauma Life Support (ATLS) prior to completing the program.

4-19 The program must provide instruction in the compilation of accurate and complete patient records.

Examples of evidence to demonstrate compliance may include:

- Seminar or lecture schedule on patient record keeping

4-20 The program must include participation in practice and risk management seminars and instruction in coding and nomenclature. In addition, residents must have familiarity with parameters of care and procedures for obtaining hospital credentials.

Intent: Parameters of care should be taught either in a seminar setting, individually or shown to be utilized throughout the program, i.e. Morbidity & Mortality Conferences.

Examples of evidence to demonstrate compliance may include:

- Seminar or lecture schedules on practice and risk management

STANDARD 5 - ADVANCED EDUCATION RESIDENTS

ELIGIBILITY AND SELECTION

Dentists with the following qualifications are eligible to enter advanced specialty education programs accredited by the Commission on Dental Accreditation:

- a. Graduates from institutions in the U.S. accredited by the Commission on Dental Accreditation;**
- b. Graduates from institutions in Canada accredited by the Commission on Dental Accreditation of Canada; and**
- c. Graduates of international dental schools who possess equivalent educational background and standing as determined by the institution and program.**

Specific written criteria, policies and procedures must be followed when admitting residents.

Intent: Written non-discriminatory policies are to be followed in selecting residents. These policies should make clear the methods and criteria used in recruiting and selecting residents and how applicants are informed of their status throughout the selection process.

Admission of residents with advanced standing must be based on the same standards of achievement required by residents regularly enrolled in the program. Transfer residents with advanced standing must receive an appropriate curriculum that results in the same standards of competence required by residents regularly enrolled in the program.

Examples of evidence to demonstrate compliance include may include:

- policies and procedures on advanced standing
- results of appropriate qualifying examinations
- course equivalency or other measures to demonstrate equal scope and level of knowledge

EVALUATION

A system of ongoing evaluation and advancement must ensure that, through the director and faculty, each program:

- a. Periodically, but at least semiannually, evaluates the knowledge, skills, ethical conduct and professional growth of its residents, using appropriate written criteria and procedures;**
- b. Provides to residents an assessment of their performance, at least semiannually;**
- c. Advances residents to positions of higher responsibility only on the basis of an evaluation of their readiness for advancement; and**
- d. Maintains a personal record of evaluation for each resident which is accessible to the resident and available for review during site visits.**

Intent: (b) Resident evaluations should be recorded and available in written form.

(c) Deficiencies should be identified in order to institute corrective measures.

(d) Resident evaluation is documented in writing and is shared with the resident.

5-1 The program director must provide written evaluations of the residents based upon written comments obtained from the teaching staff. The evaluation should include:

- a. Cognitive skills;**
- b. Clinical skills;**
- c. Interpersonal skills;**
- d. Patient management skills; and**
- e. Ethical standards.**

5-2 The program director must provide counseling, remediation, censuring, or after due process, dismissal of residents who fail to demonstrate an appropriate competence, reliability, or ethical standards.

- 5-3 The program director must provide a final written evaluation of each resident upon completion of the program. The evaluation must include a review of the resident's performance during the training program, and should state that the resident has demonstrated competency to practice independently. This evaluation must be included as part of the resident's permanent record and must be maintained by the institution. A copy of the final written evaluation must be provided to each resident upon completion of the residency.**

DUE PROCESS

There must be specific written due process policies and procedures for adjudication of academic and disciplinary complaints, which parallel those established by the sponsoring institution.

RIGHTS AND RESPONSIBILITIES

At the time of enrollment, the advanced specialty education residents must be apprised in writing of the educational experience to be provided, including the nature of assignments to other departments or institutions and teaching commitments. Additionally, all advanced specialty education residents must be provided with written information which affirms their obligations and responsibilities to the institution, the program and program faculty.

Intent: Adjudication procedures should include institutional policy which provides due process for all individuals who may potentially be involved when actions are contemplated or initiated which could result in disciplinary actions, including dismissal of a resident (for academic or disciplinary reasons). In addition to information on the program, residents should also be provided with written information which affirms their obligations and responsibilities to the institution, the program, and the faculty. The program information provided to the residents should include, but not necessarily be limited to, information about tuition, stipend or other compensation; vacation and sick leave; practice privileges and other activity outside the educational program; professional liability coverage; and due process policy and current accreditation status of the program.

STANDARD 6 – RESEARCH

Advanced specialty education residents must engage in scholarly activity. Such evidence may include:

- a. presentation of papers at educational meetings outside of the sponsoring institution
- b. development and submission of posters for scientific meetings
- c. submission of abstracts for presentation at educational meetings or publication in peer reviewed journals
- d. designated time for active participation in or completion of a research project (basic science or clinical) with mentoring
- e. submission of an article for publication in a peer reviewed journal

Intent: The resident is encouraged to be involved in the creation of new knowledge, evaluation of research, development of critical thinking skills and furthering the profession of oral and maxillofacial surgery.

Advanced Stds

Revised: 7/98; 1/99; 7/99; 1/00; 7/00; 1/01; 7/01; 1/03; 8/03; 1/04; 1/05; 7/05; 1/06; 7/06; 1/07; 7/07; 1/08; 1/09; 7/09; 2/10; 9/10, 1/11