At its Winter 2020 meeting, the Commission directed that the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery be distributed to the appropriate communities of interest for review and comment, with comment due **December 1, 2020**, for review at the Winter 2021 Commission meeting.

Written comments can be directed to snowj@ada.org or mailed to:

ATTN: Ms. Jennifer Snow, 19th Floor
Manager, Advanced Dental Education
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Additions are **Underlined**
**Strikethroughs** indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery
STANDARD 4 - CURRICULUM AND PROGRAM DURATION

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 the institutional teaching staff and may include remote access educational opportunities. The residents must also prepare and present departmental conferences under the guidance of the faculty.

Intent: The broad scope of oral and maxillofacial surgery includes, but is not limited to, trauma, orthognathic, reconstructive/cosmetic, and pathology including temporomandibular disorders and facial pain.

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 must be provided in the basic biomedical sciences at an advanced level beyond that of the predoctoral dental curriculum. These sciences must 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.

Intent: This instruction may be met through the completion of the requirements for the M.D./D.O. or any other advanced degrees.

4-5.1 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 A formally structured didactic and practical 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 patients. Resident competency in physical diagnosis must be documented prior to the completion of the program.

Intent: A medical student/resident level course in physical diagnosis, or a faculty led, formally structured and comprehensive physical diagnosis course that includes didactic and practical instruction should be completed prior to commencement of rotations on the anesthesia, medicine and surgical services. This is to ensure that residents have the opportunity to apply this training throughout the program on adult and pediatric patients. The complete history and physical examination includes a psychiatric assessment, when appropriate.

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 oral and maxillofacial surgery service must have a complete history and physical examination. The majority of these examinations must be performed by an oral and maxillofacial surgery resident.

CLINICAL ORAL AND MAXILLOFACIAL SURGERY

4-7 The program must provide a complete, progressively graduated sequence of outpatient, inpatient and emergency room experiences. The residents’ exposure to non-surgical management and major and minor surgical procedures must be integrated throughout the duration of the program.
In addition to providing the teaching and supervision of the resident activities described above, there must be patients of sufficient number and variety to give residents exposure to and competence in the full scope of oral and maxillofacial surgery. The program director must demonstrate that the objectives of the standards have been met and must ensure that all residents receive comparable clinical experience.

**Intent:** The broad scope of oral and maxillofacial surgery includes, but is not limited to, trauma, orthognathic, reconstructive/cosmetic, and pathology including temporomandibular disorders and facial pain.

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.
- Oral and Maxillofacial Surgery Benchmarks

**MINIMUM CLINICAL REQUIREMENTS**

**OUTPATIENT ORAL AND MAXILLOFACIAL SURGERY EXPERIENCE**

4-8 The program must ensure a progressive and continuous outpatient surgical experience in non-surgical and surgical management, including preoperative and postoperative evaluation, as well as adequate training in a broad range of oral and maxillofacial surgery procedures involving adult and pediatric patients. This experience must include the management of dentoalveolar surgery, the placement of implant devices, management of traumatic injuries and pathologic conditions including temporomandibular disorders and facial pain, augmentations and other hard and soft tissue surgery, including surgery of the mucogingival tissues. Faculty cases may contribute to this experience, but they must have resident involvement.

**Intent:** Residents are to participate in outpatient care activities.

Examples of evidence to demonstrate compliance may include:

- Resident rotation schedules
- Outpatient clinic schedules
- Outpatient surgery case log
- Dentoalveolar-related didactic course materials
4-8.1 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 interdisciplinary consultation, diagnosis, treatment planning, biomechanics, biomaterials and biological basis.

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 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

4-8.2 The training program must include didactic and clinical experience in the comprehensive management of temporomandibular disorders and facial pain.

Examples of evidence to demonstrate compliance may include:

- Education in the diagnosis, imaging, surgical and non-surgical management, including instruction in biomaterials.
- Didactic Schedules
- Resident case logs
- Clinic Schedules

MAJOR SURGERY

4-11 For each authorized final year resident position, residents must perform 175 major oral and maxillofacial surgery procedures on adults and children, documented by at least a formal operative note. For the above 175 procedures there must be at least 20 procedures 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. Sufficient variety in each category, as specified below, must be provided. Surgery performed by oral and maxillofacial
surgery residents while rotating on or assisting with other services must not be counted toward this requirement.

**Intent:** The intent is to ensure a balanced exposure to comprehensive patient care for all major surgical categories. In order for a major surgical case to be counted toward meeting this requirement, the resident serves as an operating surgeon or first assistant to an oral and maxillofacial surgery teaching staff member. The program documents that the residents have played a significant role (diagnosis, perioperative care and subsequent follow-up) in the management of the patient.

Examples of evidence to demonstrate compliance may include:

- Department and institution general operating room statistics and logs
- Patient Medical Records
- 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

4-121.1 In the trauma category, in addition to mandibular fractures, the surgical management and treatment of maxillary, nasal and orbito-zygomatico-maxillary complex injuries must be included.

**Intent:** 4-12.1 Trauma management includes, but is not limited to, tracheotomies, 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.

4-131.2 In the pathology category, experience must include management of temporomandibular joint pathology and at least three other types of procedures.

**Intent:** 4-13.1 Pathology of the temporomandibular joint includes, but is not limited to, internal derangement arthritis, post-traumatic dysfunction, and neoplasms. Management of temporomandibular joint pathology may include medical or outpatient procedures. Other pathology management includes, but is not limited to, major maxillary sinus procedures, treatment of temporomandibular joint pathology, salivary gland/duct surgery, management of head and neck infections, (incision and drainage procedures), and surgical management of benign and malignant neoplasms and cysts.

4-141.3 In the orthognathic category, procedures must include correction of deformities in the mandible and the middle third of the facial skeleton.
Orthognathic surgery includes the surgical correction of functional and cosmetic orofacial and craniomaxillofacial 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 craniomaxillofacial 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: Residents participate in the 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

In the reconstructive and cosmetic category, both bone grafting and soft tissue grafting procedures 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 calvarium, 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

Reconstructive surgery includes, but is not limited to, vestibuloplasties, augmentation procedures, temporomandibular joint reconstruction, management of hard and soft tissue maxillofacial defects, insertion of craniofacial implants, facial cleft repair, peripheral nerve reconstruction and other reconstructive surgery.

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

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

4-162 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.

4-16.1 4-12.1 Residents must keep a current log of their operative cases.

4-173 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.

4-173.1 Each resident must be certified in Advanced Trauma Life Support (ATLS) prior to completion of training.

4-184 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

4-195 The program must provide training in interpretation of diagnostic imaging.

Ethics and Professionalism

4-2016 Graduates must receive instruction in the application of the principle of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

Intent: Graduates should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.

4-2117 The program must include participation in practice and risk management
seminars and instruction in coding and nomenclature.

**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
- Familiarity with AAOMS Parameters of Care

**Patient Safety**

4-18 **Residents must receive formal training in programs, policies, and procedures enhancing patient safety.**

**Intent:** An ongoing, comprehensive focus on promoting safety and quality improvement is an essential part of quality patient care. Residents are exposed throughout training to theoretical and practical means to ensure that consideration of patient safety is routine and consistent.

Examples of evidence to demonstrate compliance may include:

- Documentation of an active, ongoing clinical safety training program. This may include participation in institution-wide programs, or documentation of training in Crew Resource Management, Root Cause Analysis, or other safety-focused protocols
- Formative and summative evaluation of residents’ knowledge of and engagement and compliance with safety initiatives (e.g. use of Benchmarks)

4-19 **The program must have a formal program for medical emergency preparedness in its ambulatory surgery clinics.**

**Intent:** Safety training is enhanced by immersing residents at all stages of training in policies, procedures, and practices which minimize the risk of harm to patients. Active participation by residents, faculty, and appropriate clinical staff in regular routines, including mock emergency drills, reinforces theoretical concepts and models the attention to patient safety expected of the contemporary surgical team. Programs meet or exceed applicable minimal institutional or regulatory requirements, and may develop and implement protocols custom to their clinical facilities.

Examples of evidence to demonstrate compliance may include:

- Logs of mock emergency drills demonstrating participation by faculty, residents and clinical staff
• Ongoing training using high fidelity simulation adapted to simulate the community-based, ambulatory surgery environment

• Adherence to established emergency preparation recommendations, e.g. the AAOMS Office Anesthesia Evaluation Manual

4-20 The program must routinely employ patient safety tools and techniques in its clinical facilities.

Examples of evidence to demonstrate compliance may include:

• Documentation of routine procedural time-outs
• Checklists for preanesthetic preparation, patient and procedure readiness verification, or similar
• Readily available cognitive aids (e.g. charts, placards, checklists, guides) for management of anesthetic and or/medical emergencies