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The Evolution of Physician Certification and the Canary in the Coal Mine

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In an address before the American Academy of Ophthalmology and Otolaryngology in 1908, Derrick T. Vail introduced the concept of using a peer-review system to evaluate the education, training, and qualifications of medical specialists and advocated for the development of a specialty board that would oversee this process. His foresight served as the springboard for the genesis of the specialty board movement in the United States and led to the establishment of the American Board for Ophthalmic Examinations, now the American Board of Ophthalmology,[1] in 1916.

The subsequent founding of the American Board of Otolaryngology (1924), American Board of Obstetrics and Gynecology (1930), and American Board of Dermatology (1932) led to the establishment of an umbrella organization, the Advisory Board for Medical Specialties, in 1933 to facilitate the common purposes and activities of these fledgling boards; in 1970 it was reorganized as the American Board of Medical Specialties (ABMS).[2] The stated mission of the ABMS, now composed of a total of 24 member boards, is to maintain and improve the quality of medical care in the United States, and it does this by assisting its member boards in their efforts to develop professional and educational standards for the evaluation and certification of physician specialists. These boards issue certificates for more than 150 primary specialties and subspecialties.

The intent of these certificates is to assure the public that a board-certified physician has successfully completed an approved educational program and evaluation process that has assessed the knowledge, skills, and experience required to provide high-quality care in a given specialty or subspecialty. Certificates are initially issued after physicians successfully complete accredited training, pass a secure written examination, and, for some member boards, pass an oral examination. For the first 36 years of existence of the ABMS, these certificates were issued for life. However, when the American Board of Family Medicine was founded in 1969, it did so with the intent of only issuing time-limited certificates that would require renewal every 7 years.[3] Thereafter, growing awareness within the ABMS that one-time certification was not sufficient to guarantee to the public that physicians could continue to deliver high-quality care throughout their careers led to an increasing number of member boards embracing the concept of recertification. However, although the American Board of Surgery and American Board of Thoracic Surgery followed suit with the issuance of time-limited certificates in 1976, it took an additional 30 years before this concept was fully embraced by the ABMS when the final remaining member board began issuing time-limited certificates in 2006.[2]

Spurred by the reluctance of many member boards to fully come to terms with the compelling arguments in favor of recertification, ABMS leadership moved forward with the establishment of the Task Force on Competence in 1998 to ensure that specialists maintained up-to-date knowledge and skills throughout their careers. The work of this task force led to the commitment to evolve existing certification programs into a new paradigm called Maintenance of Certification (MOC). This new process would be built on the definition of a competent physician that encompassed all of the important domains of professional medical practice and

the 6 general competencies jointly developed and agreed upon by the ABMS and the Accreditation Council for Graduate Medical Education—professionalism, medical knowledge, patient care, interpersonal and communications skills, systems-based practice, and practice-based learning and improvement. These competencies would be assessed within the framework of 4 distinct parts of MOC: professional standing, commitment to lifelong learning and periodic self-assessment, cognitive expertise, and performance in practice.[4] This new certification program was approved by the ABMS and its member boards in March 2000, and by 2006 all member boards had received approval for their individual MOC programs.

Although the ABMS was developing the framework for MOC, much was happening within the health care environment. Charged with developing strategies for improving the quality of health care in the United States, the Committee on the Quality of Health Care in America was formed in 1998 by the Institute of Medicine, now the National Academy of Medicine. The Committee published 2 landmark consensus reports. The first, *To Err is Human: Building a Safer Health System* published in 1999,[5] warned that tens of thousands of Americans died each year as a result of errors in their care that a truly high-quality health care system would prevent. The second, *Crossing the Quality Chasm: A New Health System for the 21st Century* published 2 years later,[6] reported that our health care system frequently fell short in its ability to translate knowledge into practice and that a fragmented delivery system resulted in poorly designed care and duplication of services; it concluded that the absence of progress toward addressing quality and cost was distressing. The ongoing work of Fisher and Wennberg[7] with the Dartmouth Atlas of Health Care underscored the issues raised in these reports with convincing evidence of significant variation in health care quality and cost throughout the country.

It would have seemed that the decision by the ABMS member boards to implement their MOC programs at the beginning of the 21st century was propitious. The aims of the program seemed perfectly designed to address these critical issues. Unfortunately, the subsequent implementation of MOC did not match the careful thought and sound rationale that went into conceptualizing it. Controversy swirled around the introduction of this new certification paradigm with considerable resistance from multiple quarters, but most prominently from the Internal Medicine community.[8] Why does so much resistance to MOC exist? An article in this issue of *Mayo Clinic Proceedings* provides some clues to the answer.

Cook et al[9] conducted a national survey by randomly sampling physicians across multiple specialties and querying them about their attitudes toward MOC. The survey instrument included 13 questions about MOC, 2 burnout items, and demographic questions. Overall, 81% of physicians believed that MOC was a burden, only 24% agreed that MOC activities were relevant to their patients, and only 15% felt that MOC was worth the effort. Although attitudes varied significantly across specialties, low perceived value and relevance was seen across almost all the specialties. Although 38% of the respondents met the criteria for being burned out, no association between attitudes toward MOC and burnout was found.

The authors are to be applauded for the rigor of their study design and methodological approach, the meticulous design of their survey instrument, and the robust analysis of their data. Nevertheless, several methodological issues, most acknowledged within the article and not unusual for survey research, may limit our ability to accurately interpret the conclusions. First, the 21.6% response rate raises the potential issue of sampling bias. Second, we do not know how many respondents had actually completed any elements of MOC; given that almost 30% of the respondents held lifetime certificates, the number that may not have participated may have been substantial. Finally, physician responses may have reflected misconceptions about MOC not based in fact.

Even with these limitations, if the ABMS member board community disregards the results of this study, it does so at its own peril. The data suggest that displeasure with MOC is prevalent and that no single member board appears to be immune. Although the reasons for this discontent are multifactorial and beyond the scope of this editorial to enumerate,

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one very important piece of data from this study is illuminating; namely, 88% of respondents felt that MOC activities were not well integrated into their daily routine.

Physicians today are overburdened coping with the vagaries of their electronic health records, endless reporting requirements, and the demands of multiple payors. The amount of time that they are spending with patients continues to dwindle, and the last thing that they want to do is spend additional time, meeting yet another set of requirements that they find burdensome. It is imperative that ABMS member boards take these issues into account and redesign their MOC programs to become more efficient, meaningful, and impactful.

Greater effort needs to be placed on critically assessing whether MOC components are helping physicians deliver better care and are therefore perceived as being valuable. Many member boards have begun the important task of doing so,[10-12] but until this becomes a systematic design feature of MOC programs, member boards will continue to flounder, not knowing whether the assessment tools that they are developing are effective or not. This will only lead to continuing frustration and discontent.

Other than the publication of the Flexner Report in 1910, perhaps no singular event was more important in firmly establishing American medicine as a profession than the establishment of the American Board of Ophthalmology in 1916. Over the past 100 years the continuing evolution of the certification process has provided an important self-regulatory function, helping physicians deal with the increasing complexities of professionalism.[13] However, the work of Cook et al should serve as the proverbial "canary in the coal mine" and spur the ABMS member board community to critically assess and reengineer MOC to preserve this critical aspect of professionalism.

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