

# The Value of Maintaining Primary Board Certification in Physical Medicine and Rehabilitation

## CASE SCENARIO

D. B. is a 49-year-old physiatrist. He is board certified in physical medicine and rehabilitation (PM&R) and also holds a subspecialty certification in spinal cord injury (SCI) medicine. He is an attending physician in the SCI unit at a Veterans Affairs hospital, where he has practiced exclusively since completing his residency 19 years ago. His 10-year Maintenance of Certification (MOC) cycle requires retaking both PM&R and SCI recertification examinations next year to stay board certified. D. B. recently became aware of the new policy from the American Board of Physical Medicine and Rehabilitation (ABPMR) that he no longer has to maintain primary PM&R board certification to keep his SCI subspecialty certification. D. B. believes that it is essential to be board certified; however, because his practice is entirely focused on SCI medicine, he is wondering if he should continue to maintain his primary board certification in PM&R in addition to his SCI certification. James Crew, MD, will argue that maintaining subspecialty certification in SCI is sufficient, and Michelle Gittler, MD, will argue that maintaining primary board certification is essential for D. B. *Please note: These views do not represent the views of the American Academy of Physical Medicine and Rehabilitation or the ABPMR, and this discussion is intended for educational purposes.*

## James Crew, MD, Responds

The case of D. B. is relevant and timely because the American Board of Physical Medicine and Rehabilitation (ABPMR) recently announced the option to allow subspecialists to forego primary PM&R certification maintenance [1]. D. B. is faced with a dilemma that many ABPMR diplomats will have to contemplate: what is the value of primary board certification maintenance for a physician who has already subspecialized? Debate may arise on this issue, depending on the scope of one's clinical practice as well as one's personal and professional value on keeping primary PM&R certification. D. B. is board certified in spinal cord injury (SCI) medicine and has been practicing within this subspecialty exclusively for his 19-year career. As such, it is my opinion that D. B. has no need to maintain his primary PM&R board certification but should focus exclusively on maintaining his expertise in SCI medicine. The following points will aim to illustrate that maintaining subspecialty SCI medicine certification is not only sufficient but most appropriate for D. B. To address one of the fundamental issues on this topic, a brief review of the evolution of our current practice in board certification maintenance is relevant.

The American Board of Medical Specialties (ABMS) changed from traditional periodic recertification testing in

favor of a continuous learning program for physicians to maintain specialty certification within their field. This new dynamic program, known as ABMS MOC (Chicago, IL), developed criteria for demonstrating active lifelong engagement within a given specialty rather than recertifying physicians based solely on passing an examination. MOC was created in 2000 by the ABMS in response to a variety of pressures. These pressures included consumer demand and quality assurance because the lack of standardized physician competency assessments after initial licensure was noted as one of many areas for potential health care improvement by the Institute of Medicine in 1999 [2]. There are 4 ABMS MOC components: professional standing, lifelong learning and self-assessment, cognitive experience, and practice improvement. These MOC components altogether are meant to encompass the 6 core clinical competencies: medical knowledge, patient care, interpersonal skills, professionalism, practice-based learning, and systems-based practice [3]. The ABPMR, as an ABMS member since 1947, is responsible for integrating the ABMS components into MOC for primary PM&R as well as the 6 ABPMR subspecialties (soon to be 7, with brain injury medicine to be added later this year). The

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purpose of MOC is to ensure that physicians who are board certified are keeping current and advancing their knowledge within the specialty and/or subspecialty that reflects their practices. In essence, MOC is meant to be a quality safeguard for health care consumers and a more objective measure to validate certification. Because quality patient care is the primary consideration in MOC, one must ponder whether D. B. or his patients are well served by maintaining primary PM&R certification. More importantly, how does specialization affect patient care?

Specialization does matter, both in terms of patient outcomes and the public perception of expertise. For example, the inpatient mortality rate after acute myocardial infarction has been shown to be significantly lower in patients treated by a board-certified cardiologist instead of a general internist [4]. Board certification in surgery was associated with improved mortality after colon resection [5], and a lack of board certification among anesthesiologists was linked with worse clinical outcomes [6]. Further, in the state of California, disciplinary action has been shown to be more likely to involve physicians who are not board certified [7]. Admittedly, there are studies that looked at this topic that have failed to show a link between physician specialization and quality of care. However, a systematic review of the literature revealed a positive correlation between board certification and patient outcomes in the majority of methodologically sound studies [8]. In addition, patient survey data from the American Board of Internal Medicine collected through the Gallup organization (Gallup Inc, Washington, DC) found that the majority of patients would switch physicians if theirs was not board certified and that a board-certified physician or specialist was more desirable than a noncertified physician recommended by family or friends [3]. Hence, board certification is important because it represents clinical expertise and is valued by the public.

Yet, there is little meaning to this expertise if the physician is not practicing in the specialty or subspecialty in which he or she holds board certification. For example, a board-certified internal medicine specialist would not be considered an expert cardiologist, despite some cardiac training. Similarly, would D. B. be the best physician to prescribe a prosthesis for a below knee amputee, manage a spondylolysis in a competitive adolescent athlete, or treat an adult with a severe traumatic brain injury? My opinion is a resounding, "no." Certainly, a case can be made for a general PM&R physician with a broad scope of practice being able to appropriately manage these 3 clinical scenarios. Yet, it is hard to support D. B. having relevant, updated knowledge and expertise in these other PM&R areas, given his exclusive SCI medicine practice for 19 years. Many physicians have very focused practices, and the case of D. B. is representative of a shift in medicine as it becomes not only specialized but subspecialized. Before 1970, there were a total of 10 ABMS subspecialty certifications. This number grew to 74 by 1996, and today there are 145 ABMS subspecialty certifications [9].

As physicians focus on their subspecialty, the expertise that they had elsewhere in the primary specialty becomes diluted and outdated. More importantly, primary board certification loses relevance if the physician is practicing only in his or her subspecialty area; such is the case for D. B. The ABPMR is not alone in moving away from requiring primary specialty MOC for subspecialists. In fact, the American Board of Internal Medicine does not require internal medicine MOC for the majority of its subspecialties, and the American Board of Surgery does not require general surgery MOC to maintain surgical subspecialty certification [10,11]. It is not clear that D. B. would improve his clinical practice by attempting to maintain his non-SCI medicine PM&R knowledge. Is it a good idea for D. B. to focus time on continuing education or board examination review on areas of PM&R that are not relevant for his current practice?

This would not seem like time well spent for D. B. Rather, he would be better suited clinically and professionally by maintaining and improving his knowledge by attending an SCI conference on the use of functional electrical stimulation after SCI or by creating a practice improvement project aimed at decreasing urinary tract infection rates in his inpatient rehabilitation unit. More importantly, D. B.'s patients would be better served because these endeavors would have a higher yield on the quality of care and education that D. B. will be able to provide. As noted by the ABPMR, "this new policy ensures that physicians stay updated in their areas of expertise without taking time away from patient care to study for and take the primary PM&R exam, which includes 16 topic areas, many of which subspecialists no longer encounter in their practice" [1]. For D. B., his SCI medicine practice represents one-sixteenth of these areas, which accounts only for approximately 6% of the primary PM&R MOC examination. Discussing the PM&R MOC examination is extremely important here, insofar as it is the only MOC component in question for this debate. The ABPMR has reciprocity between primary and subspecialty PM&R MOCs with the other 3 MOC components [12]. (Aside from pediatric rehabilitation medicine for which there is reciprocity across all 4 components.) That is, the professional standing, continuing medical education, self assessments, and practice improvement projects count toward both the primary PM&R and SCI medicine MOCs. In other words, D. B. does not have to do double the work to maintain his 2 board certifications in these areas. Cognitive expertise, as demonstrated by passing a recertification examination, is the lone MOC component that does not have reciprocity, and the ABPMR requires it in both the primary and subspecialty areas to keep certification [12]. The ABPMR has afforded D. B. the power of choice, and it ultimately comes down to whether D. B. should take another test.

To be fair, choosing to take the PM&R primary MOC examination would likely not take much time away from his patients or threaten his SCI medicine expertise. Yet, as mentioned, any time that D. B. would spend away from clinical care to prepare and complete the primary PM&R

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