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Board certification in internal medicine and cardiology: Historical success and future challenges

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ABSTRACT

Board certification is at a critical juncture. As physicians face increased regulation and pressures from both inside and outside the profession, board certification and Maintenance of Certification (MOC) are coming under increased scrutiny from the public and the medical community. At this challenging time, it is important to remind ourselves what board certification is (and what it is not) and revisit the origins of this tangible expression of professional self-regulation, even as we contemplate how it needs to improve. Board certification has evolved over time and must continue to evolve; it is our collective responsibility as physicians that peer-developed standards meet the needs of both the profession and the public. In this article, we will reflect on the history of the American Board of Internal Medicine (ABIM), especially which related to Cardiology, and describe some of ABIM's challenges and new directions.

Introduction

Board certification is at a critical juncture. As physicians face increased regulation and pressures from both inside and outside the profession, board certification and Maintenance of Certification (MOC) are coming under increased scrutiny from the public and the medical community. There is much skepticism about the evidence that MOC makes a difference in patient care [1–4]. There is a broad frustration among physicians that autonomy and respect for the profession are eroding [5–7]. At this challenging time, it is important to remind ourselves what board certification is (and what it is not) and revisit the origins of this tangible expression of professional self-regulation, even as we contemplate how it needs to improve. Board certification has evolved over time and must continue to evolve; it is our collective responsibility as physicians that peer-developed standards meet the needs of both the profession and the public. In this article, we will reflect on the history of the American Board of Internal Medicine (ABIM), especially which related to Cardiology, and describe some of ABIM's challenges and new directions.

ABIM's mission is "To enhance the quality of health care by certifying internists and subspecialists who demonstrate the knowledge, skills, and attitudes essential for excellent patient

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care." It is the largest of 24 certifying boards recognized by the American Board of Medical Specialties (ABMS), certifying approximately one out of every four physicians in the United States [8]. As stated in its strategic plan, "ABIM is of the profession but for the public," accountable both to the internal medicine community and to the public who trust in the physician-developed credential of board certification.

The historical legacy

ABIM was created in 1936 by a joint action of the American College of Physicians (ACP) and the American Medical Association (AMA) with the shared goal of distinguishing members practicing in the discipline of internal medicine who met a set of peer-established standards from those who had not. Internists wanted to elevate the discipline by setting standards designed to "raise the bar" for those in practice. The purpose of board certification was then and is now to issue a publicly recognizable credential that indicates an individual has met professionally determined standards in a defined discipline.

Although ABIM certification was initially offered only in general internal medicine, ABIM recognized from its inception the need to develop certification in internal medicine subspecialties. The 1938 ABIM information booklet stated ABIM's intention to "inaugurate, as soon as practicable, similar qualification and procedure for additional certification in certain of the more restricted and specialized branches of internal medicine, as gastroenterology, cardiology," etc., noting that "such special certification will be considered only for candidates who have passed the written examination required for certification in general internal medicine" [9].

ABIM's motivations for developing its initial subspecialty boards were to set high standards for subspecialty training and practice as well as to keep subspecialties within the "house of medicine," rather than fracturing internal medicine into multiple boards. In a 1940 letter, Walter Bierring, MD, the first Chairman of ABIM, expressed concern at the division of the surgical field into separate subspecialties. In contrast to the ABMS boards of Urology, Orthopedic Surgery, Neurosurgery, and Anesthesiology, "all of which might properly be subspecialties of the American Board of Surgery," he noted that "our [ABIM's] way has solved the problem so much better" [2]. As Stevens [10] has observed, "Internal medicine exists because it is organized." The decision by internal medicine to keep all of its subspecialties together in "the House of Medicine" has made internal medicine the largest and most influential of the medical disciplines, and a unified program of certification throughout all of internal medicine has made "certification" interpretable across a variety of disciplines, increasing the power and salience of the credential.

In 1939, in response to a petition from the American Heart Association for ABIM to recognize Cardiology as a subspecialty of Internal Medicine and develop a cardiology certification program, Cardiology became the first subspecialty considered and approved by ABIM–soon followed by Tuberculosis, Gastroenterology and Allergy. The first ABIM subspecialty exams were administered in April 1941 and resulted in the certification of 26 candidates in Cardiovascular Disease, four in Tuberculosis (which was later renamed Pulmonary Disease), three in Gastroenterology, and one in Allergy. It was an entirely oral examination, administered by the members of the subspecialty boards themselves, involving witnessed encounters by candidates with actual patients. No additional internal medicine subspecialties were recognized by ABIM until 1972, when ABIM first administered exams in Endocrinology, Diabetes, and Metabolism; Hematology; Infectious Disease; Nephrology; and Rheumatology.

The approval of new ABIM subspecialties is currently guided by the New and Emerging Disciplines in Internal Medicine (NEDIM)-2 Report approved by the ABIM Board of Directors in 2006 as an update of the first NEDIM Report from 1993 [11]. Proposals for new subspecialties are typically initiated by medical societies. Once approved by ABIM, new subspecialties must then be approved by the American Board of Medical Specialties (ABMS). The number of ABIM subspecialties has risen to a total of 20. Of these, four are tertiary subspecialties of Cardiovascular Disease: Clinical Cardiac Electrophysiology (1992), Interventional Cardiology (1999), Advanced Heart Failure and Transplant Cardiology (2010), and Adult Congenital Heart Disease (2015). Each time a new subspecialty has been approved, it was the result of physician organizations or patient groups coming to ABIM to make the case that this facet of medicine needed to be defined and assessed to ensure patients knew who to go to for their unique care needs and that the field was "mature enough" to support such things as journals, separate training programs, and administrative organizational departments.

Since 1936, ABIM has regularly changed what it does to ensure it continues to achieve its mission "to enhance the quality of health care by certifying internists and subspecialists who demonstrate the knowledge, skills, and attitudes essential for excellent patient care." Standards that define what it means to be an internist cannot—and should not—last forever. The first ABIM exam (Fig.), a written essay test with eight questions, would be unfamiliar and perhaps not passable by most internists practicing today.

The process for earning certification in Cardiovascular Disease has also changed dramatically over time. Until 1972, the subspecialty board exams consisted solely of an oral component, with no written subspecialty board examination. Candidates for subspecialty certification had to pass the written Internal Medicine exam, the oral Internal Medicine exam, and then an oral subspecialty exam. Cardiology was the first subspecialty board to propose a written subspecialty exam. The first question from that first 1972 written examination involved interpreting a single-channel ECG for a patient with intermittent dizziness and syncope 3 weeks status post mitral ball-valve replacement who had been discharged on digoxin and quinidine. ABIM discontinued the oral examinations in 1972 in all disciplines (including Internal Medicine) *except* for Cardiology, which had both a written and oral component to the exam until 1976. After much deliberation, the Cardiology Board discontinued the oral exam after research could not demonstrate its psychometric validity, coupled with the challenge of administering an in-person clinical examination of two patients each to the growing number of cardiologists. The ABIM Cardiology Board