AMERICAN ACADEMY™ OF OPHTHALMOLOGY

Excellence in Ophthalmology

Continuous Certification

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Over the course of a century, American medical specialty boards including the American Board of Ophthalmology (ABO) have developed significant expertise in assessing physician competence on completion of postgraduate training and, more recently, in defining appropriate criteria for continuous learning and quality improvement in practicing physicians. This article explores why maintaining career-long excellence is an evolving challenge, but one that is at the heart of the ABO's mission to protect the public by improving patient care. *Ophthalmology 2016;123:S25-S29 © 2016 by the American Academy of Ophthalmology.*

No one ever entered medical school or residency training with the goal of becoming a mediocre physician. To the contrary, for millennia, prospective physicians have entered training with the intent not only to be proficient at graduation, but also to become excellent doctors who continuously improve throughout the course of their careers. Fortunately, most physicians achieve these goals and can identify easily their colleagues who have—or have not—been successful in this regard.

Medical specialty boards have developed significant expertise in identifying and assessing criteria for initial certification as a marker for competence on completion of postgraduate training. Developing an appropriate demonstration of staying current in the profession, improving continuously, and maintaining career-long excellence is a much more challenging task, but one that is at the heart of the boards' mission to protect the public.

The Past

Self-regulation of the medical profession originated in the United States with the creation of the American Medical Association in 1847. More than 60 years later, the Flexner report extended standardization efforts to medical education. Concurrently, Edward Jackson and other leading ophthalmologists of the early 20th century began to address standardization in specialty training in ophthalmology, culminating in the formation of what would become the American Board of Ophthalmology (ABO) in 1916, and eventually the American Board of Medical Specialties (ABMS) in 1933, which today oversees 23 other medical specialty boards.

Through the specialty boards, lifetime certification was conferred on diplomates who successfully completed a rigorous examination process. As early as 1940, however, the ABMS Committee on Graduate Medical Education first proposed the possibility of issuing time-limited certificates with periodic renewal. It was not until 1969 that the American Board of Family Medicine became the first board to require its diplomates to recertify by issuing certificates that required renewal every 7 years. In 1974, the ABO began to study the recertification issue under the direction of Bradley Straatsma as committee chair. Minutes from one of his first meetings refer to recertification as "one of the most complex and involved topics in American medicine today."

The ABO's original intent was to make recertification voluntary. A survey completed by more than 1800 ABO diplomates in 1976 indicated that 74% would be willing to participate in a trial recertification program. By 1978, however, diplomate enthusiasm for recertification had cooled, and an ABO forum on recertification at the annual American Academy of Ophthalmology (AAO) meeting became so contentious that participants still remember it vividly today. As a result, the ABO tabled plans to proceed with implementation, but continued to study the issue, working with the AAO to collaborate. With the continued explosion of medical knowledge, the necessity for public accountability, and the realization that, in the words of Marshall M. Parks, noncompulsory recertification would be "doomed to fail," in 1986, the ABO voted to begin issuing 10-year, time-limited certificates in 1992. Thus, the stage was set for the first diplomates to recertify by 2002 through a process developed under the subsequent leadership of Parks, Ronald Burde, Douglas Anderson, George Beauchamp, Richard Abbott, and Lee Duffner. Readers who participated in recertification will recall the open-book Certificate Renewal Examination and the Office Record Review. The questions on the Certificate Renewal Examination covered the entire breadth of ophthalmology, without respect for the diplomate's individual area of practice emphasis. As a result, questions often were difficult for subspecialists to answer and had little relation to the activities the doctors were performing on a daily basis. Data entry for the Office Record Review facilitated reflection on

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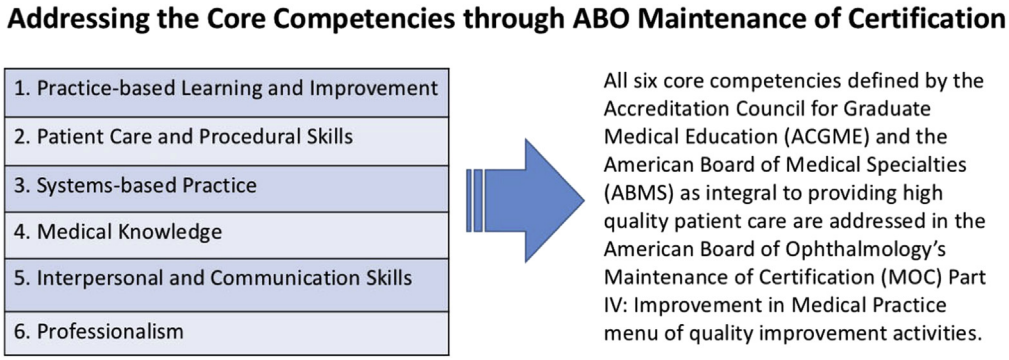

Figure 1. The core competencies addressed by Maintenance of Certification activities.

practice patterns, but fell short of truly measuring quality processes and improving patient outcomes.

In 2000, recognizing that recertification every 10 years could not promote continuous competence and practice improvement, the ABMS moved to replace it with Maintenance of Certification (MOC). The MOC program was founded on the assessment and development of 6 core competencies integral to the practice of high-quality patient care as determined by the Accreditation Council for Graduate Medical Education and ABMS (Fig 1). This process, although individualized by member boards, comprises 4 parts: (I) maintenance of an unrestricted medical license in all jurisdictions where the diplomate practices; (II) participation in lifelong learning and self-assessment activities, specifically, Continuing Medical Education (CME) and the Periodic Ophthalmic Review Tests; (III) documentation of medical knowledge and cognitive expertise relevant to one's practice through a closed-book examination (the Demonstration of Cognitive Knowledge [DOCK] examination); and (IV) participation in ongoing Practice Improvement Modules (PIMs). These changes were implemented at the ABO under the successive leadership of C. P. "Pat" Wilkinson, David Tse, and Janet Davis.

The Present

The Current Environment

The MOC process, particularly in internal medicine, has come under intense scrutiny and criticism in recent years. Criticisms include diplomate cost in both dollars and time, the perception of financial benefits to the board and those who conduct MOC preparatory courses, and constantly changing rules. The challenge for the ABO, as with all ABMS member boards, is to develop a system that minimizes burden and maximizes benefit to diplomates, while also adequately conferring to the public, the profession, and external stakeholders that completion of the process is a reasonable surrogate for competent medical practice. Although currently called maintenance of certification, what the profession and the public both desire is demonstration of maintenance of competence in the things doctors do on a daily basis.

Ophthalmologists understand the difficulty of accurately measuring and ensuring clinical competence, either through initial certification or the MOC process, and the hurdles involved in staying up to date in knowledge and skills. Multiple studies confirm the degradation of both cognitive and technical skills over time without purposeful efforts to combat it.[1,2] Physicians rely more on pattern recognition with age, but this becomes increasingly less effective as new medical knowledge surfaces. For example, a study of internists found that there was a progressive decline in cognitive knowledge between doctors 10 versus 20 or 30 years from residency training, with the most deficient areas being changing or new medical knowledge.[3] Another study of internists revealed that adherence to current hypertension treatment intensification recommendations decreased up to 20% per decade.[4] In ophthalmology, the pass rate on the closed-book DOCK examination decreases from 98% to 99% for doctors 40 to 60 years of age, to 94% in for doctors in their 60s, and only 70% for doctors in their 70s. Unfortunately, we are not our own most reliable assessors; studies show that up to 70% of individuals consider themselves above average in various intellectual domains, with the greatest inflation of perceived performance among those ranking in the lowest quartile.[5]

The public, not surprisingly, remains quite concerned with physician quality and recognizes board certification as a surrogate for such. In a 2010 opinion research survey of more than 1000 patients, 95% stated that board certification was important, and 45% said they would change physicians if they learned that their doctor was not participating in MOC.

The Current Maintenance of Certification Process

In the late 2000s, the ABO began efforts to improve the MOC process. As a result, a number of changes were made to increase the value and decrease the burden to diplomates. Annual CME requirements have been decreased from 30 to 25 category I hours, and attestation has now replaced the need for diplomates to log and report CME to the ABO annually. An ophthalmology-based patient safety module has been added for part II credit. The DOCK examination has become more psychometrically valid, and diplomates choose modules so that the questions on the examination are clinically applicable to their patients. The process has added