AMERICAN ACADEMY™ OF OPHTHALMOLOGY

Board Certification

Going Back to the Future

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The authors present snapshots of board certification in 1916, the year that the American Board of Ophthalmology was founded, 60 years later in 1976 as periodic recertification emerged, and speculation about what certification might look like in 2036. The concept of board certification and continuous certification in the medical specialties took shape at the beginning of the 20th century with the convergence of a new system of assessment, the emergence of certifying boards, and the creation of the American Board of Medical Specialties (ABMS). The importance of self-regulation is emphasized as are the principles underlying board certification and the standards that guide it to support its continued relevance as a valued credential and symbol of the highest standard in the practice of medicine. *Ophthalmology 2016;123:S55-S60 © 2016 by the American Academy of Ophthalmology.*

The American Board of Ophthalmology (ABO) celebrates its 100th anniversary in 2016. The ABO was the first in a group of boards that founded or later joined what is now the American Board of Medical Specialties (ABMS). The 24 member boards of the ABMS certify physicians in 37 specialties and 85 subspecialties; 2 member boards (the American Board of Radiology and the American Board of Medical Genetics and Genomics) also certify non-physician clinicians. Currently, more than 840 000 physicians are certified by at least 1 ABMS board; hence, more than 80% of the United States physician population is ABMS board certified.[1]

As the ABO and the board certification process celebrate their centenary, some groups question whether ABMS board certification (subsequently referred to as board certification) is relevant and have called for the dissolution of 1 or more boards.[2] Others speak to its value as an indicator of quality.[3] As board certification enters its second century, are its principles still relevant? What will remain consistent? How might things change?

To answer these questions, we explore 3 particular years at 60-year intervals: 1916, 1976, and 2036. The year 1916 marks the founding of board certification, 2036 is a future time for comparison, and 1976 serves as the midpoint. Since 1916, there have been remarkable changes in the world, in the practice of medicine, and in board certification. Although change is inevitable, a number of consistencies in the system of board certification have remained the same, transcending time.

Three principles underlie board certification. First, board certification is a form of professional self-regulation—created and overseen by the profession—that exists to serve the needs of the patients, families, communities, organizations, and others who rely on the credential to provide information about physicians and other board-certified clinicians who claim specialty expertise. Second, board certification both requires and supports high-quality medical education. Third, the board certification system establishes standards and uses multiple methods to inform the consequential decision about whether a physician is certified.

We consider how these principles have manifested themselves in the past and how they may affect the future of board certification. Fidelity to these principles will help to ensure that professional self-regulation through board certification remains relevant to the public and guides the professional responsibilities of the profession in the future.

In 1916, most medical care was delivered at the patient's home. Public hospitals cared for the poor and those who did not have homes in which to receive care. Private hospitals, often in physicians' homes, provided care for surgical and medically complicated patients who could afford such stays. Physicians billed patients directly for their services, often with a sliding scale that took the patient's financial resources into account. Charity care was common.[4]

Standards for medical education largely were nonexistent, and some purported medical schools were no more than diploma mills. The American Medical Association (AMA; founded in 1847) and the Association of American Medical Colleges (founded in 1876) advocated for higher standards in medical education. The AMA created the Council on Medical Education to set the standards for hospital internship programs.[5] Concerns about the standards of medical education and the quality of medical schools were made public by the Flexner report of 1910.[6]

Clinical care was of variable quality.[7,8] Although most of the country's physicians practiced general medicine, there was an expanding group of physician "specialists," particularly in urban areas. There were no standards for determining who was or was not a medical specialist, and specialists varied in their training, professionalism, and quality. Patient safety was in jeopardy.

Concerns for the safety of the public and the reputation of the profession led the medical community, as a collective, to turn away from the guild-style mentality of the 19th century

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and to reassert once again its traditional role as a profession.[5,7–10] Meaningful professional self-regulation was a key element of the social compact that defined professions, and this self-regulation manifested itself in a number of ways.

The AMA identified charlatans and unethical physicians and brought them to the attention of state medical boards and legal authorities.[8] The National Board of Medical Examiners, founded in 1915, created examinations that assessed the medical knowledge of physicians.[11] Contemporaneously, state medical boards were strengthened, in large part because of the establishment of the Federation of State Medical Boards in 1912.[12]

By 1916, the dangers posed to the public by rogue specialists had led several state medical boards to consider the development of specialty medical licenses. However, the complexities related to such a proposal contributed to the state medical boards' decisions to focus their efforts on the general medical license, which was the required legal credential for practicing medicine in the United States, and to decline the pursuit of specialty licensing.[5]

In the absence of state regulatory action, the profession took action. Voluntary member organizations formed in many specialties, including ophthalmology, to offer education, community, and advocacy for physicians who focused their clinical work in that discipline. These organizations began discussions about standards for specialty-based training and for physicians who professed specialty expertise, as well as methods of determining whether such standards are met.[5,13] Recognizing that consequential decisions about what was intended to be an important credential are best made by bodies distinct from these member organizations, the specialty societies placed these responsibilities in a separate organization: the specialty board.

The first board, the American Board for Ophthalmic Examinations, was established in 1916 (renamed the American Board of Ophthalmology in 1935).[7,9] It was followed by 3 additional specialty boards: otolaryngology (1924), obstetrics and gynecology (1927), and dermatology and syphilology (1932). In turn, these boards formed the Advisory Board for Medical Specialties (now the American Board of Medical Specialties) in 1933. Hence, board certification evolved as a voluntary system, designed and implemented by the profession, distinct from licensing by the government or the granting of a medical diploma by a college or university.

From the start, there were strong ties between board certification and the process of medical education. As standard setting and assessment organizations, the boards were deeply concerned about the quality of the physician's general medical education and specialty training. Expectations of physician education were among the earliest standards set. These standards also foreshadow the tight link that remains today between board certification and high-quality specialty training.

Board certification was responsible for the development of standards and of the assessment process that measured whether a candidate met the stated standards of the specialty. In 1916, complex essay questions were the norm. Over time, many boards incorporated oral examinations, observed patient encounters, and reviewed experience as the fledgling movement proceeded. To make judgments about a candidate's character and skills, the boards used interviews, peer recommendations, and membership in specialty societies as part of the assessment process.[7]

1976

Health care and the medical profession were in substantial transition. Health care delivery moved from the patient's home to the physician's office, the hospital, and the nursing home. Extraordinary scientific, pharmacologic, and engineering advances since 1916 have expanded the availability of diagnostic and therapeutic interventions. The 1970s saw the introduction of computed tomography, Doppler ultrasonography, and the chicken pox vaccine, as well as the birth of the world's first test-tube baby. The growth of modern medical knowledge and the application of medical technology placed medicine at the forefront of the public domain, leading to an incessant and increasing demand for greater accountability on the part of practitioners.[5,14,15] The payment models for medical care changed dramatically in recent decades with the widespread adoption of employer-based health insurance and Medicare and Medicaid legislation. Concerns about the expanding costs and availability of health care were beginning to be heard.

Medical specialization became the norm. At this time, there were 22 ABMS boards offering certification in 32 specialties and 34 areas of special competencies (the prelude to subspecialties). In 1976 alone, more than 16 000 physicians were newly certified by an ABMS board.[16] Concurrent with increased national interest in primary care was the recognition of family practice as an ABMS specialty board in 1969 (renamed the American Board of Family Medicine in 2005). The American Board of Emergency Medicine was incorporated in 1976 and was recognized as an ABMS board in 1979. In 1991, the American Board of Medical Genetics (now the American Board of Genetics and Genomics) was added as the most recent ABMS board.

Although board certification remained voluntary, many hospitals recognized it as an important quality indicator and incorporated the requirement of board certification into hospital privileging decisions. Other groups also relied on the credential.[16] As a result, ABMS began to discuss the possibility of recertification requirements.

Recertification had been recommended for a surprising length of time. It was an important recommendation in *Graduate Medical Education*, the 1940 report of the Commission on Graduate Medical Education of the ABMS. The report suggested that the certifying boards consider issuing certificates that were valid for a stated period only.[17] By 1973, the 22 existing boards adopted the principle of recertification, and in 1975, guidelines on recertification were published. In 1974, the American Board of Internal Medicine was the first board to examine diplomates for recertification. It took another decade before all member boards followed suit.[18]

Underlying the creation of recertification programs was the idea that they should emphasize performance in preference to knowledge and should focus on improvement rather