Maintenance of Certification: The Role of the American Board of Pediatrics in Improving Children's Health Care

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KEYWORDS

• Quality • Quality improvement • Maintenance of certification
• Professional development

Board certification in American health care began in 1911 and grew out of the *Flexner Report*, which addressed major concerns about the quality of medical education. The American Board of Pediatrics (ABP) was one of the first boards formed. The ABP was created in 1933 by the American Academy of Pediatrics, the American Pediatric Society, and the pediatric section of the American Medical Association to address the issue of who should be called a "pediatrician."[1] At the time, some physicians with little or no training in children's care were calling themselves pediatricians. The ABP was created to answer the question: "What education and training should be required of physicians to provide the best care for children and warrant the title of pediatrician?" The concern about physician quality continued to spread to other clinical areas and eventually led to the establishment of the American Board of Medical Specialties (ABMS), which now has 24 members across all specialties. No other country has a similar voluntary process for defining and assessing physician expertise in specialty care. Pediatric certification initially addressed only general pediatric care. Subspecialty certification began with pediatric cardiology in 1961 and there are now 14 certified pediatric subspecialties, the newest being child abuse pediatrics, which was created in 2007. Over the years, the ABP has certified over 90,000 pediatric generalists and subspecialists. Today, the almost 250 pediatric leaders from around the country who make up the ABP set standards and develop tools to help pediatricians assess their level of knowledge and skills to deliver quality care.

The model for assessing physician quality for the first 7 decades was based on demonstrating medical knowledge: "The more you know, the better the care you

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Pediatr Clin N Am 56 (2009) 987–994
doi:10.1016/j.pcl.2009.05.010 **pediatric.theclinics.com**
0031-3955/09/$ – see front matter

deliver.'' In the beginning, certification involved passing an oral examination. This was eventually augmented with a written examination. Oral examinations at initial certification were given until 1988, but were eliminated when it was determined that performance on the written examination accurately predicted who would pass the oral examination. Initially, pediatric certification was a one-time examination of knowledge at the end of training and certification was a lifetime designation. There are still almost 20,000 ''permanent'' certificate holders who have lifelong certification, but this is no longer considered the gold standard. In 1952, the first randomized clinical trial was conducted and, as both basic and clinical research grew, the knowledge base for pediatrics increased exponentially. It became apparent that the standard of a one-time assessment of medical knowledge at the end of training was not sufficient to assure the public of the ongoing quality of certified pediatricians. As a consequence, in 1988, recertification was introduced and diplomates were required to pass a comprehensive examination of medical knowledge every 7 years to be recertified. Certification has been a continuously evolving process.

American health care is now engaged in a second quality revolution even more profound than the Flexner revolution. The current revolution is focused on the quality and safety of clinical care and is international in scope. As early as the mid-1970s, studies began to appear documenting significant gaps in quality and safety of care at every level of care. In the mid-1970s, John Wennberg[2] published his first study showing significant unexplained variation in health care. This work eventually led to the *Dartmouth Atlas of Healthcare*. Wennberg[3] has shown that even among well-trained, well-intentioned board-certified physicians, variations in quality, cost, and use of care are significant. Using the Medicare national database, Fisher and colleagues[4] showed that increased spending and increased use of specialists do not necessarily translate into better outcomes. In fact, the opposite appears to be true.

By the late 1980s and early 1990s, the tools and methods of quality improvement that had been developed for manufacturing and production in industry were introduced into health care[5] and it became possible to define quality of care. The commonly used definition of ''the gap between the care that could be delivered using evidence-based medicine and best practices and the care that is actually delivered'' became widely accepted. Two seminal Institute of Medicine (IOM) reports were published in 1999 and 2000. *To Err is Human*[6] documented significant gaps in patient safety and *Crossing the Quality Chasm*[7] documented the broader problems with quality in health care and called for the systematic redesign of health care and the use of quality improvement. In the *Chasm* report, the IOM noted that quality care should have six characteristics. It should be (1) safe, (2) timely, (3) effective, (4) efficient, (5) equitable, and (6) patient centered. The IOM reports have focused primarily on system failures as the source of most of the quality problems in American health care. However, there has been increasing interest in the role that physicians play in the delivery of quality care. It became apparent to some health leaders that the model of a medical knowledge as the only physician competency for delivering quality care was not adequate. As a result, Leach, Batalden, and colleagues[8] proposed an expanded set of core physician competencies that they felt were necessary to deliver quality care. The six core competencies of (1) patient care, (2) medical knowledge, (3) communication, (4) professionalism, (5) practice-based learning and improvement, and (6) system-based practice were endorsed by the Accreditation Council for Graduate Medical Education (ACGME) in 1999 and became the standard for resident and fellowship training in medicine.

In 2000, this profound shift in addressing physician quality spread when the ABMS endorsed the same core competencies for board certification and moved from