

Recertification in Internal Medicine – The American Experience[†]

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Abstract

The American Board of Internal Medicine (ABIM) sets standards and certifies and recertifies physicians to practise internal medicine and its subspecialties in America. The ABIM was established in 1936 as a non-profit corporation, one of many specialty boards, such as the American Board of Family Medicine, the American Board of Pediatrics, the American Board of Surgery, etc. The umbrella organisation for these groups is the American Board of Medical Specialties. Members of the American College of Physicians take certifying and recertifying examinations produced by ABIM. Beginning in 1990, ABIM certificates were valid for 10 years. To maintain certification, physicians were required to participate in ABIM maintenance of certification (MOC) programme. The goals are to improve quality of care, to set standards for clinical competency, to foster continuing scholarship, and lead to medical quality improvement. The MOC programme involves verification of credentials, completion of self-evaluation, and completion of a secure exam. The self-evaluation component is the most complex and has been the most controversial due to the diversity of internal medicine careers and continued learning patterns. ABIM continually introduces new options for evaluation of practice performance. In addition to recertification in General Internal Medicine, ABIM has subspecialty examinations. MOC has been well received by professional organisations, but there are areas of controversy. It has been accepted as an important way for internists to assure quality of practice and currency of medical information.

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Origins of Certification and Recertification

Internal medicine became recognised as a medical specialty in the United States of America (US) with the founding of the American College of Physicians (ACP) in 1915. A group of about 15 self-selected physicians gathered in New York City for this initial meeting. The ACP was modelled after the Royal Colleges of Physicians of London, Edinburgh and Glasgow. The ACP has grown to have now 124,000 members, including Masters, Fellows, Members, Associates, and student members in the US and abroad. There are 6300 international Masters, Fellows and Members. From its modest beginnings, the ACP has always emphasised scholarship, professionalism, and duty to patients and society.

Beginning in the 1930s, leaders of the ACP recognised that the definition of an “internist” would be enhanced by the development of certifying examinations that measured scholarship and the personal qualifications and character of the physician. Rather than incorporate an examining and

certifying process into the College, the ACP sponsored the formation of the American Board of Internal Medicine (ABIM) to serve these functions. Although leadership of the ACP and the ABIM has often overlapped, and both the ACP and the ABIM have always had their offices in Philadelphia, the 2 organisations have grown to be distinct and separate. The mission of the ABIM is “*to enhance the quality of healthcare by certifying internists and subspecialists who demonstrate the knowledge, skills and attitudes essential for excellent patient care.*” In contrast, the mission of the ACP is “*to enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine.*”

For many years, the ABIM certifying examination in internal medicine, usually referred to as the “board exam,” occurred soon after a young internist finished residency training. It was a capstone of the training process. Until the early 1970s, candidates were required both to pass a written examination, and to prove their skills by oral examination

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at the bedside before 2 members of a distinguished panel of nationally recognised scholars in internal medicine. The oral examination was dropped because of the cost and complexity of its administration, difficulty in recruiting patients, and recognised variations between examiners in their approach to the examination. Since the 1970s, evaluation of candidates' personal qualities and professionalism have been the responsibility of residency programme directors and faculty in teaching hospitals and clinics. These qualities are now recorded and reported using standardised methods across the US, throughout the training period. In addition, an "in-service" examination from the ACP helps candidates and programme directors to evaluate the progress for each resident, during the training experience. The written or certifying examination also has been increasingly standardised, with careful metrics to assure the validity and reliability of each question on the test. Over the years, materials have been developed to assure that residents have uniform opportunities for preparing for the certifying examination through the design of curricula and materials such as the ACP's Medical Knowledge and Skills Assessment Program (MKSAP).

Beginning in the 1960s, the ABIM also developed subspecialty examinations in Internal Medicine, and it continues to do so. The first of these examinations was in cardiovascular disease and examinations in other subspecialties followed. The most recent of the ABIM subspecialty examinations and new areas under consideration are hospital medicine, transplant cardiology and sleep medicine.

Board certification is not required to practise internal medicine in the US, but gradually over the years, the proportion of certified internists has increased steadily. Certification is now required for hospital practice in most places, and by most medical practice organisations. Research on the value of certification has determined that the patients of certified internists are more satisfied with their care, and that certification leads to better outcomes, more reliable care, higher rates of preventive services, and lower mortality rates for myocardial infarction. Undoubtedly, however, many factors contribute to these differences, in addition to acceptable performance in the certification process.

Recertification

It is well accepted that physicians need to study and keep their medical knowledge and skills current. Continuing medical education (CME) is an intrinsic and explicit requirement for licensure to practise medicine in the US. Many organisations, including State medical licensing boards, hospitals, insurance companies, government agencies, and practice and peer groups, are continually involved in assessing and reporting a physician's qualifications for practice. In the 1970s, the ABIM began

a voluntary recertification process, supported by the ACP, with follow-up testing by a written examination and questions being recommended at 5- to 10-year intervals. During this same period, other boards, including the American Board of Family Medicine, made recertification a mandatory requirement, but both the ABIM and the ACP accepted voluntary recertification. Enrollment in this process, however, faltered and was never very high. The relatively low rate of voluntary recertification was no match for the rapid advances in understanding the pathophysiology of many diseases, in diagnostic techniques, and in the availability of many new drugs and other treatments in this era. By the early 1980s the ABIM began to advocate a formal recertification process in internal medicine and in its subspecialties. The discussions between the practising community represented by the ACP and the ABIM were often intense, but by 1990 it was accepted that all internists finishing their training after 1990 would have a time-limited certificate, limited to 10 years, with re-examination at least once per decade thereafter.

The drive toward recertification came from the recognition that physicians' skills and knowledge usually decline over time, even though their experience steadily increases. On the other hand, it was recognised that the patient's satisfaction with their physician depends largely upon their physician's interpersonal skills, behaviours and sense of professional responsibility. In 2005, Choudhry et al² published a systematic review of studies on the relation between clinical experience and the quality of healthcare. They reviewed 62 reports of test performance, for knowledge about screening and diagnostic tests, and the use of standard disease treatments. This study showed that physicians who had been in practice for longer tend to perform less well in these evaluations, and may be at risk of providing lower quality care. The study suggested that older physicians may need quality-improvement interventions to maintain their skills.

In an editorial accompanying this article, Drs Christine Cassel and Daniel Duffy of the ABIM, and Dr Steve Weinberger from the ACP,³ commented upon whether "practice makes perfect". They emphasised that professional development is a lifelong process and that CME should be an active, self-directed engagement, relevant to the individual physician's practice activities. They also emphasised that evidence-based practices should be aided by systems of reminders, most effectively presented through electronic medical records that linked the patient's specific problems to the knowledge areas needed for the care of the individual patient. In this editorial, they also stated that all physicians should embrace the principles of maintenance of certification (MOC) to assure the public of the highest quality of care possible.

Maintenance of Certification

Beginning in the year 2000, internists in the US who completed training after 1990 began to recertify. The process of evaluation and certifying competency has been gradual and is still in evolution. Because the process was new and because of the diversity of roles that internists play, ranging from full-time in general internal medicine or subspecialty practice to full-time in research or administration, there is no simple “one-size-fits-all” examination. Also, enormous variation occurs in the severity of illness of the usual patients and the site of practice, e.g., the clinic, hospital, nursing home, the home or the jail.

As MOC was conceptualised, its elements included medical knowledge, professionalism, communication skills and interpersonal skills. It was also expected that patient care and quality could be assessed through surveys of the physician’s patients and peers and chart reviews and audits.

The evaluation of patient care and quality has proven to be the most complicated and controversial part of the MOC process. As developed by the ABIM, it is self-evaluation of practice performance. This concept rests on the principle that it is the physician’s personal performance which really counts, and it is the physician’s responsibility to engage in reviewing what was done and compare one’s own work with norms. It is the individual physician’s responsibility to work actively to improve and to acquire new knowledge and skills to provide high quality care.

To facilitate this process, The ABIM developed the concept of practice improvement modules or “PIMS.” The PIMS are based upon chart reviews and patient surveys to determine quality, a structured evaluation of one’s own performance, and then action to create improvements and report on what has been learned or accomplished. To provide structure to this process, the ABIM developed PIMS in a number of areas, such as asthma, diabetes, hepatitis, HIV-AIDS, and hypertension, and has continued to develop a structured basis for practice evaluation. To the average internist, the PIMS have proven complex to understand, and time consuming to do, but the vast majority of young internists in the US have accepted MOC, including the PIMS, as a necessary and important duty to the profession and to the public.

The ACP has, from its beginnings, developed high quality educational materials, including its MKSAP, which started in the 1970s. As the ABIM defined the expected knowledge for MOC, the ACP has worked with the ABIM to integrate the MKSAP programme into the study process. Its most recent version of MKSAP, MKSAP-14, contains the latest developments in internal medicine and its subspecialties in a programme of 11 study books containing more than 1500 pages of study materials. It also includes 1200 multiple choice questions, similar to those of the ABIM

recertification examination. In addition, the MKSAP-14 materials include answers and critiques on each topic and can be accessed both online and via a CD-ROM version. The materials are translated into Spanish, Japanese and Italian.

The ACP also has a number of other educational materials that are useful for CME, MOC and delivery of high-quality medical care. These include Physician Information Education Resource or *PIER*, a web-based, point-of-care decision support tool, which has modules on more than 400 different medical conditions. *PIER* is a regularly updated and evidence-based information source that is a very useful and succinct summary of much of internal medicine. The College textbook, *ACP Medicine*, also presents similar current material in a frequently updated format, that is also available on-line and in a CD-ROM format, as well as a loose-leaf notebook format. *ACP Medicine* also has a continually produced companion set of CME questions, which aid in preparation for the ABIM certification and MOC. The College produces a number of other materials, such as guidelines, patient education materials and its highly regarded journal, the *Annals of Internal Medicine*, which serve to help physicians keep up-to-date, and to be prepared for the questions of daily practice and the knowledge required for MOC. Each year the College also holds an annual meeting with a variety of formats for CME, and has similar sessions at other places sponsored by its US and international chapters.

Since recertification was first required from year 2000, about 12,000 internists have completed the MOC process, with a pass rate on the first examination of 89%. Follow-up questionnaires show that most internists feel that the process is highly valuable, and that the structure of the process matches their own sense of what internists need to know to stay current in their practice and meet their obligations to their patients and to the profession. Soon, it will be time for the first wave of recertified internists to be re-examined in their second experience with MOC. It is anticipated that recertification over and over again has become an intrinsic feature of the life of the internist in the US.

Continuing Controversies

There are many controversies associated with the certification and recertification process as it has evolved in the US. Many have asked, “Do we need all of this complicated examination and re-examination?” There are questions, also, about the frequency of re-examination. Is the original mandate for recertification every decade sufficient, or should it be more frequent and, if so, just how frequent should it be?

Better information systems at the point of care and the availability of online medical information are rapidly

changing the paradigm for medical care. Handheld and bedside computers have made information available everywhere. It is easier and more reliable to use reference materials than to try to remember all the details of medical diagnosis and treatment. Thus, the specific knowledge requirements to be a good internist are becoming murkier.

At the same time, the scope or sphere of practice for many internists is narrowing, due to specialisation and subspecialisation. The partitioning of internal medicine by the site of practice—hospital practice, nursing home practice or ambulatory practice narrows and defines what an internist needs to know, and know how to do well. As a practice narrows, the scope of practice within subspecialties may narrow also so that examinations could be tailored to exactly what the physician does, not more, not less, since this is the critical area for competency and patient care and safety. Thus, the practise area for MOC might not necessarily correspond to a designated subspecialty area. As mentioned above, the ABIM has acknowledged and approved new areas of subspecialisation, in keeping with this trend.

Undoubtedly, these and other questions will continue to be raised as MOC evolves in the decades ahead. A few fundamental questions remain: “What does it take to be

qualified to be an internist?” “What is required to be a really good internist?”, and “Who would I want to be my internist?”

For more information see also American Board of Internal Medicine, www.abim.org and American College of Physicians, www.acponline.org

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