Time-Limited Certification and Recertification: The Program of the American Board of Internal Medicine

The Task Force on Recertification

Richard J. Glassock, MD; John A. Benson, Jr., MD; Robert B. Copeland, MD; Herman A. Godwin, Jr., MD; W. G. Johanson, Jr., MD; Warren Point, MD; Richard L. Popp, MD; Lawrence Scherr, MD; Jay H. Stein, MD; and O. David Taunton, MD

After more than 20 years of discussion and debate, the American Board of Internal Medicine (ABIM) decided in December 1986 to join 17 other specialty boards by limiting the duration of validity for all certificates it issued. This policy has been in effect since 1987 for Geriatric Medicine and 1988 for Critical Care Medicine and will involve all certificates issued in 1990 and thereafter. It will have a significant effect on current and future trainees in Internal Medicine, its subspecialties and added qualifications, and will also, in all likelihood, have an effect on holders of non-time-limited certificates.

In arriving at this critical decision, the Board was influenced by the rapidly changing scope of medical information, by evidence that the knowledge and skills of practicing specialists decay with time (albeit at variable rates), and by a rising tide of public concern over the need to periodically recredential physicians. The American Board of Family Practice insisted on time-limited certification from its outset in 1969. Time-limited certification and recertification seem to be obligations of an accountable profession.

Previous attempts by the ABIM to mount programs of voluntary recertification for non-time-limited certificate holders had met with only limited and declining interest. Over four examinations, only 8621 certificates were issued since 1974. The last of these efforts, the Advanced Achievement in Internal Medicine examination given in May 1987, attracted only 1403 registrants from an estimated pool of over 40 000 eligible certified internists despite extensive marketing efforts by the Board (1). Thus, the stage was set for the Board to embark on a new era in which its diplomates would be asked, but not required, to renew the validity of their certificates at periodic intervals or face the uncertain consequences of loss of their status as certified internists, subspecialists, or holders of certificates of added qualifications.

Soon after the policy decision was made, a task force was created to develop a strategic plan for recertification for Board review and approval. This Task Force has met on a regular basis since November 1987 and has issued several interim reports. In June 1990 the Board adopted the final elements of the recommended plan, and the recertification program is now entering an implementation phase, which is expected to be completed by July 1995. This communication is intended to summarize and explain the salient features of the ten specific components of the strategic plan.

Goals and Philosophies of Recertification

The goals of recertification are to improve the quality of patient care; to set standards of clinical competence for the practice of internal medicine, its subspecialties, and added qualifications; and to foster the continuing scholarship required for professional excellence over a lifetime of practice.

Early in its deliberations the Task Force recognized that unlike initial certification, the recertification process would need to be flexible enough to meet the needs of a diverse population of physicians whose practices differ in response to individual desires, skills, and local needs. Thus, rather than attempting to prescribe some uniform set of requirements, as had been done with initial certification, the recertification program was designed to assess diplomates in what they actually do and to be adaptable to varied modes of practice. Because of the high value placed on the maintenance of scholarship, the Board adopted elements of the program that seek to identify areas of strengths and weaknesses in knowledge base, synthesis, and clinical judgment, anticipating that such evaluation could provide a useful guide and stimulus to self-initiated, remedial medical education. Finally, the Task Force recognized and anticipated that almost all of its diplomates would be able to successfully revalidate their certificates and thus sought to emphasize continuous improvement of knowledge and skills rather than focusing on borderline performance.

Duration of Validity of the Certificates

The Board adopted the policy that all certificates issued after 1989 would have a 10-year duration of validity. Certificates issued by the ABIM in Critical Care Medicine in 1987 and 1989 and in Geriatric Medicine in 1988 also bear a 10-year limit of validity. The expiration date will be identified on all certificates issued by the Board.

Entry into the Process of Recertification

Entry is intended to be simple and straightforward. Diplomates can apply for entry into the process of recertification at any time after initial certification or recertification. The only requirement will be that the diplomates have been previously certified in the area in which recertification is sought, whether or not their

certificates remain valid. These policies apply to both Internal Medicine and subspecialties; however, recertification in an added qualification will require the diplomate to have been or be recertified in the related underlying competence, either Internal Medicine or a subspecialty, whichever is deemed appropriate by the Board. Diplomates certified in Internal Medicine or the related subspecialty before 1990 will be deemed to have met this requirement. Accordingly, diplomates will seek concurrent recertification in an added qualification (such as Geriatric Medicine, Critical Care Medicine, or Clinical Cardiac Electrophysiology) and the underlying related competence.

For subspecialists, this policy means that one could allow a time-limited certificate in Internal Medicine to expire without jeopardizing entry into the process of recertification in the subspecialty. However, by permitting expiration of one's time-limited certificate in Internal Medicine, the individual would no longer be regarded by the ABIM as a certified internist. For those subspecialists whose practices include significant amounts of general internal medicine, this option may not be desirable. As indicated below, the Board will provide a mechanism whereby individuals can seek dual and concurrent recertification in both Internal Medicine and a subspecialty, two subspecialties (for example, Hematology and Medical Oncology), or a subspecialty or Internal Medicine and an added qualification (for example, Pulmonary Disease and Critical Care Medicine).

Board-Eligibility for Recertification

Once an individual diplomate gains entry into the process, the steps toward gaining board-eligibility for recertification are organized in a sequential fashion. This sequence comprises three steps, each of which must be achieved in order to achieve the time-limited status of board-eligibility for recertification. Each step must be completed before proceeding to the next.

Self-Evaluation Process

The first step involves a self-selected, home-administered, self-paced assessment process called the Self-Evaluation Process, planned as a series of questions arranged in a modular, open-book format. The modules can be spaced over several years. The modules will be selected by a panel of clinicians and will include modified, clinically relevant questions from recent certifying and subspecialty examinations. Each module comprises about 60 questions and will emphasize synthesis and judgment, rather than pure recall of knowledge, as well as recent advances in clinical science. Five modules must be successfully completed. Scoring of the individual modules will be done using a criterion-referenced (absolute standard) method. Internal Medicine candidates will be required to take and pass a minimum of three modules of general undifferentiated internal medicine and can select additional modules from either general internal medicine or subspecialty internal medicine.

For subspecialists, the modules will be developed to encompass the domains of an individual subspecialty (for example, diabetes, thyroid disease, reproductive endocrinology, and adrenal and pituitary disorders for Endocrinology and Metabolism). Subspecialty candidates will be required to take and pass a minimum of one module of undifferentiated general internal medicine and four subspecialty modules. The Self-Evaluation Process for added qualifications will consist of a single expanded module of about 180 questions.

This Self-Evaluation Process will not be linked directly to any prescribed form of education; no continuing medical education credits will be given; and no syllabus will be prepared by the ABIM. However, candidates will receive prompt feedback on performance. It is hoped and anticipated that this step in the recertification process will serve as a significant stimulus to focused continuing medical education such as that offered by the American College of Physicians, subspecialty societies, and medical schools.

Peer Assessment of Clinical Competence

The second step toward achieving eligibility for recertification involves verification of clinical competence. The eight essential components of overall clinical competence will be assessed: clinical judgment, medical knowledge, clinical skills, humanistic qualities, professional attitudes and behavior, medical care, continuing scholarship, and moral and ethical behavior in the clinical setting. Unlike initial certification, the Board will not promulgate a specific list of required procedures for recertification, but rather will insist that candidates provide valid evidence that they have been judged locally as performing in a competent manner the procedures they actually do. The methods and standards which will be applied to this phase of recertification are currently being developed by the Board. Local privileging and credentialing processes within hospitals or other health care organizations, conforming to Joint Commission on Accreditation of Healthcare Organizations, practice guidelines, and outcome standards, may be used to substantiate clinical competence for those candidates with staff appointments. Special programs of evaluation may be required for those individuals who have no direct relationship with a hospital or a health care organization.

Full Licensure

Candidates will be asked to document an unchallenged, unrestricted license to practice medicine in one of the jurisdictions of the United States or Canada. Loss or restriction of license in one of these jurisdictions, despite current valid licensure in a single jurisdiction, may, at the discretion of the Board, limit the candidates's acceptance as eligible for recertification.

Completion of the Self-Evaluation Process, evidence of satisfactory clinical competence, and unrestricted licensure will establish formal Board eligibility for recertification. This eligibility will also be time-limited, lasting for 6 years or three failed examinations, whichever comes first, after completion of the fifth required module of the Self-Evaluation Process.

The Final Examination

The final examination is the third and final step for recertification. At the present time, it is planned that this secured, objective, 1-day examination (for Internal Medicine or a subspecialty) will also be modular—to ensure flexibility and provide multiple content areas related to practice. Some degree of self-selection of examination content will be available. This examination will be scored using a high criterion-referenced (absolute) standard. Nonetheless, given the Self-Evaluation Process and realistic test items, it is the Board's expectation that a very high proportion of diplomates will be successful in their recertification efforts.

A major element in the development of questions for recertification will be a review for their clinical relevance. Each question, before it is accepted for inclusion in an examination, will be reviewed by a panel of practicing certified internists or subspecialists, or both, selected on the basis of their extensive clinical experience and credentials. It is expected that this process will enhance the "face validity" of the examinations and make the content most germane to the actual practice of diplomates. In addition, specialized scoring techniques, new question formats, and other approaches will be developed to assess more critically and reliably the candidate's clinical judgment as opposed to pure knowledge recall.

Concurrent Dual Recertification

Because the Board anticipates that many subspecialists will choose to renew a time-limited Internal Medicine certificate and many may choose to be recertified in more than one domain, the Board will offer special programs for concurrent dual recertification. For example, by completing an expanded version of the Self-Evaluation Process (allowing double credit for certain modules) and by taking both an Internal Medicine and subspecialty final examination, a diplomate can achieve recertification in both Internal Medicine and a subspecialty. Similar programs will be offered for two subspecialties (for example, Hematology and Medical Oncology) or for recertification in Internal Medicine or a subspecialty along with an added qualification. It is important to emphasize that the final examination for such dual recertification will consist of both examinations, allowing credit for certain modules with overlapping content.

Listing in Directories

It should be emphasized that diplomates with non-time-limited certificates who seek recertification will *not* jeopardize their certified status. If successful in recertification, these individuals will be recognized accordingly by the Board, although their recertified status will itself be time-limited.

Diplomates with time-limited certificates must be successful in the recertification process in order to maintain their certification status in Internal Medicine, its subspecialties, or added qualifications after expiration of their time-limited certificates. Those who do not enter or who are unsuccessful in the recertification process will no longer be listed as Board-certified when their time-limited certificates lapse. The Board anticipates that most, if not all, physicians with time-limited certificates will seek entry into the process several years before their certificates are due to expire, in order to allow for more than one attempt at recertification in the event of failure on the first try. Any re-issued certificates will be valid only for 10 years from the time the Final Examination is successfully completed.

Interim Voluntary Recertification

Because the Board anticipates that the entire recertification program will not be fully available until 1995, it will periodically permit both holders of time-limited certificates and non-time-limited certificates to gain access to a program to revalidate their certificates until such time as the full recertification program is implemented. Such interim voluntary recertification will consist primarily of a recent certifying examination in Internal Medicine, its subspecialties, or an added qualification that has been reviewed for relevancy to clinical practice. Eligibility for entry into the interim voluntary recertification process will be similar to the requirements for initial certification. No Self-Evaluation Process will be required. Certificates re-issued under this interim voluntary recertification program will also be dated and valid for only 10 years.

Expectations of the Board

Although rigorous, the recertification process is not viewed as intrusive. Entry is simple and non-restrictive, and the planned self-evaluation component can be accomplished over several years, if desired. Evaluation of clinical competence will rely heavily on peer ratings and will be conducted largely at the local level, using existing methods and structures wherever possible. A uniform, fair, and objective assessment of clinical performance, including procedural skills, will not be easy and will probably evolve over many years, as has the process of evaluation of the clinical competence of residents since 1970. The final examination will be modular with some opportunity for selection of examination content to match patterns of practice.

The Board's philosophy in recertification will be to evaluate diplomates *in what they actually do*. The re-issued certificates will attest that the Board is satisfied that its diplomates are clinically competent to perform in those areas in which they actually practice. However, the certificate will not specify that the diplomate is clinically competent in all procedures encompassed by a discipline. Thus, recertification itself will have limited usefulness in defining areas of procedural competence for the purpose of providing privileges for the individual physician.

It is hoped that the recertification process recognizes the commitment of the ABIM to professional accountability and a high and continuously improving quality of medical care. The achievement recognizes the commitment of its diplomates to the lifelong scholarship required for excellence in clinical practice in the care of

patients. It is expected that most diplomates will be successful in their recertification efforts. The recertification process, when fully implemented and then perfected, should continue to provide the peer recognition of excellence to which the Board has aspired for over 50 years.

Acknowledgments: The Task Force on Recertification thanks the many individuals and organizations who gave assistance and advice during the development of the strategic plan. We also thank the executive officers of the American Boards of Emergency Medicine, Family Practice, Pediatrics, and Surgery; Frank Davidoff, MD, and Linda Johnson White of the American College of Physicians; James S. Roberts, MD, of the Joint Commission on the Accreditation of Healthcare Organizations; Alvin R. Tarlov, MD, of the Henry J. Kaiser Family Foundation; Kathleen Lohr, PhD, of the Institute of Medicine; Edward Rubenstein, MD, of Stanford University; and the staff and committees of the American Board of Internal Medicine.

Requests for Reprints: John A. Benson, Jr., MD, American Board of Internal Medicine, 200 S. W. Market Street #1770, Portland, OR 97201.

Current Author Addresses: Dr. Glassock: Harbor–UCLA Medical Center, 1000 Carson Street, Torrance, CA 90509.

Dr. Benson: American Board of Internal Medicine, 200 S.W. Market Street #1770, Portland, OR 97201.

Dr. Copeland: Southern Cardiovascular Associates, 1550 Doctor's Drive, Suite 301, LaGrange, GA 30240.

Dr. Godwin: Charlotte Medical Clinic, P.A., 1001 Blythe Boulevard, Suite 500, Charlotte, NC 28203.

Dr. Johanson: 123 25th Street, Shearn Moody Plaza, #7135, Galveston, TX 77550.

Dr. Point: West Virginia University Medical Center, 3110 MacCorkle Avenue, S.E., Charleston, WV 25304.

Dr. Popp: Stanford University Medical Center, Cardiology Division, 300 Pasteur Drive, Stanford, CA 94305.

Dr. Scherr: Department of Medicine, North Shore University Hospital, 300 Community Drive, Manhasset, NY 11030.

Dr. Stein: University of Texas Health Sciences, Department of Medicine, 7703 Floyd Curl Drive, San Antonio, TX 78284.

Dr. Taunton: 860 Montclair, Suite 758, Birmingham, AL 35213.

Reference

1. **Langdon LO, Grosso LJ, Glassock RJ, Copeland RB, Kimball HR.** Advanced achievement in internal medicine: the end of the line for voluntary recertification. *J Gen Intern Med.* 1989;4:557-9.