Qualifications for Recertification: An Important but Evolving Set of Standards

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Any ethical and conscientious medical practitioner recognizes that education cannot cease when one has successfully completed a training program. All physicians are obliged to their patients to continue lifelong learning throughout their careers. However, until 1994, certification by all American Board of Medical Specialties (ABMS) member boards was a 1-time event that lasted the lifetime of one's practice. Since 1994, all ABMS boards, including the American Board of Psychiatry and Neurology (ABPN), have granted 10-year time-limited certification to successful diplomates. This was a first step in developing policies that require systematic individual plans for lifelong learning. This systematic approach, entitled the "Maintenance of Certification Program" (MOC), has been adopted by all ABMS boards. The MOC of the ABPN is currently being implemented (the phase-in schedule can be reviewed at www.abpn.com). In developing the MOC, the ABPN will provide board-certified psychiatrists with a framework and requirements that ensure a standard of quality for the public through education, recertification examinations, and assessment of "performance in practice."

The MOC has 4 components: (1) Professional Standing, (2) Self-Assessment and Lifelong Learning, (3) Cognitive Expertise—MOC Examination, and (4) Performance in Practice.[1]

Professional Standing is the requirement that diplomates hold an active and unrestricted medical license in the United States or Canada. Self-Assessment and Lifelong Learning is the process by which diplomates perform appropriate continuing medical education (CME) over the 10-year certification period. The current requirements for Lifelong Learning are an average of 30 Category 1 CME credits per year—150 hours in the first 5-year block and 150 hours in the second 5-year block. The self-assessment must be completed once during years 1–3 and again in years 6–8 of the 10-year MOC cycle. Self-Assessment must include at least 100 questions, cover current knowledge and best practices, and provide feedback to the psychiatrist. This feedback is the basis for focused CME, lifelong learning, and career development. An individual must demonstrate that she or he employs the results of this self-assessment to guide the acquisition of new knowledge and best practices in areas of deficiency.

The third component of the MOC, entitled "Cognitive Expertise—MOC Examination," is the process of taking and passing the recertification examination administered by the ABPN. Individuals who meet the first 3 criteria for MOC will be eligible to take this examination.

The fourth component of the MOC requires the diplomate to perform an assessment of his or her practice of psychiatry employing some type of Performance in Practice (PIP) tool (these tools are currently under development by a variety of sources). Three PIP units must be completed over the 10-year period of certification. Each PIP unit has 2 components: the Clinical Module and the Peer/Patient Feedback Module. The Clinical Module is expected to be chart reviews that the psychiatrist performs on at least 5 patient cases in a specific category (diagnosis, type of treatment, or treatment setting) over a 3-year period. The psychiatrist then compares and contrasts the treatment of his or her own patients with published best practices, practice guidelines, or other peer-based standards of care. The information gleaned from these analyses should guide self-study and facilitate growth and development in that individual's practice. Within 24 months of completing the first phase of the Clinical Module, the diplomate must collect the similar data on at least another 5 clinical cases and determine whether there has been an enhancement in the quality of care in his or her practice The second component of PIP is the Peer/Patient Feedback Module. The diplomate will solicit personal performance feedback from at least 5 peers or patients over a 3-year period. Again, this feedback should help improve the effectiveness and efficiency of care. Over the subsequent 24 months, each practitioner will again solicit feedback from 5 peers or patients to determine if the practitioner's quality of practice has been improved by the Feedback Module.

Development of guidelines and formal structures to enable busy clinicians, researchers, and administrators to keep current is an important enhancement that the ABPN is bringing to the field of Psychiatry. These requirements for maintenance of certification parallel similar efforts mandated by the ABMS for all of its 24-member organizations.[2,3] A number of resources are available to help the practitioner who wants to develop a program to maintain certification and for lifelong learning. These include information listed on the ABPN Web site, www.abpn.com; information at the American Psychiatric Association Web site, www.psych.org; and information available from the American College of Psychiatrists Web site, www.acpsych.org.

Although these standards are evolving, and will continue to be refined with time and experience, this rigorous approach to continuing/professional competency and board certification will further enhance the standing of Psychiatry in the eyes of other medical professionals and the public.[3]

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Commentary

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The recognition that physicians have a responsibility for continuing education over the course of their careers and pursuing ongoing improvement in the performance of their practice has been accepted by clinicians, the patients they treat, and the regulatory bodies that oversee medical practice. The review by

Rapaport and Hales is a succinct and cogent review of the steps taken by the ABPN to develop operational guidelines that translate these goals into activities that can be monitored and evaluated. What readers may not perceive, however, is the degree to which controversy exists in the way that requirements for continuing licensure and certification will be articulated and the degree to which conflict exists among the varying agencies that seek to be the designated agent in the mission of serving the public trust. Many questions remain unanswered, the most salient being the degree to which the various requirements proposed can be shown to result in changes in practice pattern and improved patient care. Several studies have shown that the best predictor of physicians' practice is the decade in which they were trained.[1] The absence of sensitive and reliable outcome measures has made it difficult, for example, to show that state licensure requirements for CME credits actually achieve their intended goals.

The ABMS has recently taken an activist position in this regard and has put forward proposed requirements for Maintenance of Certification that differ in many ways from the template adopted by the ABPN as described by Rapaport and Hales (a copy of the ABMS draft document can be requested at http://www.abms.org/ABOUT_ABMS/ABMS_Public_Commenting/default.aspx). The full implications of these alternative standards in definition of MOC, in terms of cost and burden to the practitioner, remain to be fully defined. It is clear, however, that the drive toward standardization in MOC programs across medical specialties will most likely result in required activities that psychiatrists may feel are not specific to their practice or patient population. For example, the ABMS proposal that diplomates' professional and communication skills be assessed using standard peer and patient surveys every 5 years and that the results be available for public review may result in misleading indicators of performance and professional standing for clinicians who are more likely to practice individually, and with patients whose diagnoses and transference experiences affect their evaluations. The ABMS is also proposing a more restrictive series of self-assessment requirements, involving a common value structure that awards varying credit for different types of activities, periodic assessment of patient safety using standardized generic instruments, and mandates for continuous reporting, rather than allowing the physician to determine when in the certification cycle requirements will be completed. In addition, it should be noted that the timeline for implementing these MOC requirements is significantly accelerated over the current ABPN phase-in plan.

How these differing approaches to the definition of MOC will be resolved by the varying member boards of the ABMS and whether state licensing boards will either subscribe to such standards or define their own requirements for maintenance of licensure remain unclear. All parties share a commitment to quality health care and increased transparency in evaluating physician performance, but determining how to do this in a manner that validly improves the clinical care provided to patients and yet does not pose an undue burden to practitioners is still problematic.

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