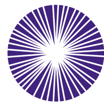
AMERICAN ACADEMY OF OPHTHALMOLOGY®

Editorial

The Vision for the Future Commission on Continuing Board Certification: Initial Perspectives from the American Board of Ophthalmology

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"Passing the boards" has been a highly valued achievement for most physicians since the American Board of Ophthalmology (ABO) instituted the credential in the United States more than a century ago.[1] In contrast, the requirement to revalidate the credential periodically through the American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC) process[2] has resulted in much dissension within the house of medicine, spawning anti-MOC legislation in more than 30 states and, more recently, antitrust lawsuits against the ABMS and several member boards.

In response, in early 2018 the ABMS launched an initiative, entitled *Continuing Board Certification: Vision for the Future*, led by an independent Commission of more than 24 stakeholders, including practicing physicians, members of the public, representatives from healthcare organizations, specialty and state medical societies, and certifying boards. The Commission was charged with reviewing the current state of MOC and making recommendations for improvement to the ABMS Board of Directors. After considering input from more than 36 000 individuals through a national survey, oral and written testimonies from dozens of stakeholders, and an extensive review of published research and opinion about continuing certification, the Commission released a preliminary draft of its findings in December 2018 and a final report on February 12, 2019.[3] The Commission's recommendations are summarized in the Table along with observations from the perspective of the ABO. I have included a few additional comments about the implications of the Commission's report for the ophthalmic community. In brief, I am optimistic that, with collaboration among key stakeholders, our specialty will continue to benefit from the extraordinary privilege of professional self-regulation that society has granted to us for many decades.[4] Here's why.

First, the Commission's report focuses much attention—appropriately—on diplomates who are at risk of losing their certification. Fortunately, in ophthalmology this number is small. To put this in context, since its inception in 1916 the ABO has issued 30 963 certificates. Of these, approximately two-thirds are classified as currently active: 11 804 diplomates who were certified after 1992 and who participate in MOC, and approximately 9300 diplomates who were certified before that time and hold "lifetime" certificates. (The latter number is likely an overestimate, because the ABO often is not notified when a diplomate retires from practice or dies.) As noted in the Table under Recommendations 7 and 8, it is rare for an ophthalmologist to lose certification because of cognitive difficulties. Nevertheless, the ABO wants all diplomates to be professionally successful and is committed to working with "at-risk" colleagues individually, if they are willing, to identify appropriate remediation pathways.

A second advantage for our specialty is the excellence of its membership entities: the American Academy of Ophthalmology and the major subspecialty societies. Through these organizations, ophthalmologists enjoy an abundance of outstanding opportunities for Continuing Medical Education, which is necessary but not sufficient to maintain competence during a decades-long professional career.[5,6] The brisk tempo of technologic change in ophthalmology requires determination and diligence for practitioners to remain current, and unfortunately it has been well established that physicians often are poor judges of their own areas of weakness.[7] Fortunately, the Academy's IRIS registry offers participants the ability to identify where performance can be improved, and such efforts are recognized by the ABO for continuing certification credit.[8] In the future, as public expectations for transparency about clinical outcomes increase, it may be possible for ophthalmologists to volitionally display or provide links to their results through their ABO online profile. Doing so would be consistent with the ABO guiding principle that the certification process, either initially soon after residency training or later in one's career, should be pursued by ophthalmologists voluntarily.[9]

Third, ophthalmologists are deeply committed to the advancement of the profession, as demonstrated by their exceptional volunteerism. The ABO relies on a cadre of approximately 600 diplomates to create examination materials and to administer its Oral Examinations (even traveling to the test site at their own expense). This reflects a culture of service, which we hope to promote through a recently established Committee on Career-Long Competence and Professionalism. The ABO wants to welcome future colleagues into the specialty from the day they match to an ophthalmology residency, emphasizing that all stakeholders in their professional development—their residency program, the Residency Review Committee/Accreditation Council for Graduate Medical Education, the Association of University Professors of Ophthalmology, the Academy, and the ABO—desire for them to succeed. An additional goal of the Committee on Career-Long Competence and Professionalism is to engage lifetime certificate holders, of whom only a small fraction has elected to participate in continuing certification. This is a specific charge of the Commission (Recommendation 9) that may prove difficult to achieve.

The report contains other challenges, as well. For instance, 13 of the Commission's 14 recommendations are presented as "must" mandates, with only the penultimate

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Table.

Commission Recommendations	American Board of Ophthalmology Perspective
Foundational Recommendation	
1. Continuing certification must integrate professionalism, assessment, lifelong learning, and advancing practice to determine the continuing certification status of a diplomate.	The 4 components recommended for continuing certification have been segregated since 2015 into 4 parts per standards set by the ABMS. The ABO has initiated integrative options by which diplomates can satisfy assessment, lifelong learning, and advancing practice through its Quarterly Questions program. All diplomates must maintain an unrestricted medical license (previously the core requirement denoting professionalism) to be certified.
Short-Term and Intermediate Recommendations	
2. Continuing certification must change to incorporate longitudinal and other innovative formative assessment strategies that support learning, identify knowledge and skills gaps, and help diplomates stay current. The ABMS Boards must offer an alternative to burdensome, highly secure, point-in-time examinations of knowledge.	During 2017 and 2018, the ABO transitioned from its decennial, closed-book, high-stakes DOCK examination to Quarterly Questions, a longitudinal assessment program with formative features that allows a summative determination of knowledge, judgment, and skills.
3. The ABMS Board must regularly communicate with their diplomates about the standards for the specialty and encourage feedback about the program.	The ABO's Diplomate Digest, an online "Place for Conversation, Collaboration, and Community," is updated continuously and a link sent to each diplomate monthly. Additionally, since January 2017 the ABO has hosted more than 24 in-person meetings with diplomates, residents, patients, and other stakeholders. Critiques and suggestions are solicited and have been instrumental in identifying and catalyzing opportunities for improvement.
4. The ABMS and ABMS Boards must have consistent processes and requirements for continuing certification that are fair, equitable, transparent, effective, and efficient.	Although this recommendation is more applicable to physicians who are certified in more than 1 specialty or subspecialty, the ABO supports the adoption of consistent definitions and continuing certification cycle length, as well as transparent appeal processes and pathways to regain certification if lost.
5. The ABMS Boards must enable multi-specialty and subspecialty diplomates to remain certified across multiple ABMS Boards without duplication of effort.	Although relevant to few ophthalmologists, the ABO supports this recommendation.
6. The ABMS and ABMS Boards must facilitate and encourage independent research to build on the existing evidence base about the value of continuing certification.	The ABO welcomes research[17,18] examining the efficacy and value of certification, and considers the IRIS registry a potentially valuable resource to promote such investigations.
7. The ABMS Boards must change a diplomate's certification status when continuing certification standards are not met.	The number of ABO diplomates whose certificates were revoked between 2013 and 2018 ranged from 4 and 12 per year, nearly all for loss of medical license related to transgressions of ethics or professionalism. Regaining certification is possible once an unrestricted medical license is restored and requirements for continuing certification are met. Between 2014 and 2018, 139 diplomates failed the DOCK examination (2.5%—4% of candidates/year). Of these, 79 successfully passed the examination on a subsequent attempt and 55 transitioned to the Quarterly Questions program. Only 5 ophthalmologists elected not to pursue certification.
8. The ABMS Boards must have clearly defined remediation pathways to enable diplomates to meet continuing certification standards in advance of and after any loss of certification.	Since the institution of Quarterly Questions in 2017, only 1% of diplomates have been unable to achieve the passing standard. The ABO will work with each willing diplomate individually to determine the cause(s) for substandard performance and recommend options for remediation.
9. The ABMS and ABMS Boards must make publicly available the certification history of all diplomates, including their participation in the certification process. The ABMS Boards must facilitate voluntary re-engagement into the continuing certification process for lifetime certificate holders and others not currently participating in the continuing certification process.	To fulfill its mission to serve the public, the ABO website specifies whether a diplomate holds a non—time-limited or lifetime certificate, is participating in continuing certification, is clinically inactive or retired, or if one's certificate is on probation or has been suspended. The ABO's Career-Long Competence and Professionalism Committee aims, among other goals, to increase the participation of lifetime certificate holders in continuing certification.
10. The ABMS Boards must comply with all ABMS certification and organizational standards, including financial stewardship and ensuring that diverse groups of practicing ophthalmologists and the public voice are represented.	The ABO Board of Directors comprises of ophthalmologists from private practice and academics and is more diverse in regard to gender than the constituency it represents. All Directors are clinically active. Financial transparency is promoted and verified by a GuideStar Platinum rating. The ABO has had at least 1 Public Director on its Board since 2001.
11. The ABMS must demonstrate and communicate that continuing certification has value, meaning, and purpose in the healthcare environment. a. Hospitals, health systems, payers, and other healthcare organizations can independently decide what factors are used in credentialing and privileging decisions.	As ABO Executive Director Robert Shaffer wrote in 1991: "It has never been the purpose of the Board to define requirements for membership to hospital staffs or to gain special recognition or privileges for its Diplomates. Its principal purpose is to provide assurance to the public and to the medical profession that a certified physician has successfully completed an accredited course of education in ophthalmology and an

Table. (Continued.)

Commission Recommendations	American Board of Ophthalmology Perspective
b. The ABMS must inform these organizations that continuing certification should not be the only criterion used in these decisions, and these organizations should use a wide portfolio of criteria in these decisions. c. The ABMS must encourage hospitals, health systems, payers, and other healthcare organizations to not deny credentialing or privileging to a physician solely on the basis of certification status.	evaluation including an examination." That the credential should be pursued voluntarily was expressed concisely in a letter dated February 2, 1916, between ABO founding members Alexander Duane and Walter Lancaster: "I don't see why we should make anyone take our examination or secure our certification who did not apply for it spontaneously."[19] The ABO continues to support these principles.
Aspirational Recommendations	
12. The ABMS and ABMS Boards must seek input from other stakeholder organizations to develop consistent approaches to evaluate professionalism and professional standing while ensuring due process for the diplomate when questions of professionalism arise.	The Commission report amplifies this recommendation by stating that boards should collaborate with specialty societies, professional organizations, and the public, and that "certification represents a higher standard than licensure and expects that unprofessional behavior can lead to the loss of certification regardless of licensure status." The ABO agrees and would, for instance, consider an action against a Fellow or Member of the American Academy of Ophthalmology by its Ethics Committee a reason for investigation.
13. The ABMS and ABMS Boards should collaborate with specialty societies, the CME/Continuing Professional Development community, and other expert stakeholders to develop the infrastructure to support learning activities that produce data-driven advances in clinical practice. The ABMS Boards must ensure that their continuing certification programs recognize and document participation in a wide range of quality assessment activities in which diplomates already engage.	A. The ABO encourages diplomates to use the American Academy of Ophthalmology's IRIS registry to identify gaps in practice performance. Projects to improve clinical practice are recognized for continuing certification credit. B. The ABO has identified leaders from each of the major subspecialty societies to serve as liaisons between their organizations and the ABO, and specifically to identify opportunities to improve the quality of medical care. C. The ABO is working with both academic and private practice groups to promote and recognize team-based quality improvement activities. D. The ABO subscribes to the CME Finder program of the Accreditation Council for CME to assist its diplomates in identifying educational programs that will satisfy their individual needs while meeting continuing certification requirements.
14. The ABMS Boards must collaborate with professional or CME/Continuing Professional Development organizations to share data and information to guide and support diplomate engagement in continuing certification.	The Commission report contains few details about the recommended "data sharing agreements." However, as noted, the ABO meets at least annually with leaders from the American Academy of Ophthalmology and liaisons from the major subspecialty societies to learn how continuing certification programs can be improved to best serve diplomates, including, as resources permit, tailoring continuing certification activities to each diplomate's specific needs.

ABMS = American Board of Medical Specialties; ABO = American Board of Ophthalmology; CME = Continuing Medical Education; DOCK = Demonstration of Ophthalmic Cognitive Knowledge.

recommendation (collaborating with stakeholders, one of the ABO's core principles[9]) using the more lenient "should" in its directive. New programs typically require additional resources. For instance, transitioning from the Demonstration of Ophthalmic Cognitive Knowledge examination to the highly successful Quarterly Questions[10] platform requires greater investment by the ABO in information technology. To keep fees for initial certification examinations and continuing certification activities as low as possible, the ABO is innovating to minimize expense, such as converting from a rented physical office for its Philadelphia-based staff to a "distributed workforce" model in which employees interact in a virtual environment from their homes.

As noted in the Commission report (page 7), the public "expects that 'someone' [is making] sure that physicians are staying current in their fields by assessing their competence on a periodic basis," an expectation that is based on trust.[11] Certifying boards share the responsibility of professional self-regulation with state medical licensing boards as well as hospitals and other healthcare institutions that grant clinical privileges to practitioners. Many physicians and members of the public are unaware that certifying boards oversee disciplinary proceedings, a function to which the ABO devotes considerable resources. Such expenses ultimately are supported by examination fees, because the ABO owns no real estate or other tangible assets and has not accumulated reserves over the past century other than an amount to fulfill its fiduciary responsibility as a not-for-profit organization. Financial considerations are manageable, however, and as mentioned earlier I am optimistic that initiatives already adopted by the ABO and planned for the near future will be successful.

Recent editorialists[12,13] have justifiably questioned the value and future of MOC, as did Arnold Relman, editor of *The New England Journal of Medicine,* in an essay 40 years ago entitled "Recertification: Will We Retreat?"[14] Dr. Relman argued that "total abandonment of the recertification idea would be a mistake. A retreat…would not be well received by a public that has already begun to wonder whether medicine is more interested in defending its privileges than in maintaining its standards." In a

response to a reader who asserted that incompetent physicians inevitably will expose their ineptness, with or without recertification examinations, Dr. Relman opined: "Perhaps so, but that is not a very reassuring prospect to hold out to a public that is becoming increasingly concerned about the reluctance of the medical profession to police itself. We may complain that no other profession is as hard on itself as we already are, but we must also remember that no other profession has been given so much privilege and responsibility."[15]

At approximately the same time, Drs. Bradley Straatsma and David Paton were charged by the ABO with introducing the idea of recertification to the ophthalmic community. In an editorial published in *Ophthalmology* more than 4 decades ago, Dr. Paton opined that "[Ophthalmologists] share the conscientious obligation to keep patient care concurrent with modern advances in medicine. Let us move forward with unity, understanding, and level-headed decisions made by the Diplomates of the ABO and the members of the American Academy of Ophthalmology."[16] A call for collaboration is equally relevant today, and the ABO welcomes the opportunity to work with the Academy, ophthalmic subspecialty societies, and individual diplomates to implement the recommendations of the Vision for the Future Commission on Continuing Board Certification in service to our patients and the profession.

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