

Recertification in Internal Medicine: A Program of Continuous Professional Development

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In 2000, the American Board of Internal Medicine (ABIM) introduced a second-generation recertification process that builds on the current knowledge-centered program by adding assessments of clinical and communication skills, clinical performance, and medical outcomes. The three-part process, called a program of continuous professional development, includes innovative self-evaluation exercises, documentation of essential knowledge, and confirmation of satisfactory qualifications and professional and community good standing. The program introduces the principles of continuous quality improvement; deemphasizes the summary nature of the traditional secure examination; and is designed to be

a more continuous, less saltatory process for maintaining clinical competence. With the continuous professional development program, ABIM believes that it has taken a substantial step toward creating a recertification process that meets its goal of being "valuable, doable, tolerable, and affordable" while maintaining the high standards expected of an accountable profession.

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Thirty years ago, the American Board of Internal Medicine (ABIM) officially endorsed the principle of recertification but decided to implement it on a voluntary rather than a mandatory basis. From 1974 through 1986, four separate recertification programs were designed and offered to diplomates (1, 2). However, progressively fewer diplomates opted to participate in each recertification cycle (3355 in 1974, 2240 in 1977, 1947 in 1980, and 1403 in 1986). This decrease occurred despite strenuous efforts to make the process more relevant and attractive by linking it with the American College of Physician's Medical Knowledge Self-Assessment Program, offering modular formats and choice of content, and charging low fees. Overall, 8945 diplomates, less than 10% of those eligible, elected to undertake voluntary recertification. When asked about their nonparticipation, diplomates cited insufficient time to prepare, perceived lack of relevance to everyday practice, little need to prove their competence to themselves or others, and proximity of retirement. In 1986, ABIM reluctantly concluded that the concept of voluntary recertification, no matter how well-conceived, was unlikely to be successful. The directors voted unanimously to prospectively limit the validity of all certificates to 10 years (3). This policy went into effect in 1987 for critical care medicine, in 1988 for geriatric medicine, and in 1990 for all other certificates (Table).

After almost 50 years of one-time-only certification, this change marked an important turning point for ABIM and for certified internists. In taking this step, ABIM acknowledged that although certification had become an ac-

cepted marker of physician quality, medical knowledge decayed over time and a better mechanism was needed to systematically update certified internists' knowledge base and understanding of scientific advances (4). Citing the need for public accountability and the professional obligations of self-regulation, ABIM embraced mandatory recertification to improve the quality of patient care, set standards for clinical competence, and foster the continuing scholarship required for professional excellence over a lifetime of practice.

Seven years in preparation, the first-generation program debuted in 1995 and was designed around a series of 60-question take-home modules that allowed diplomates to inventory their understanding of new science and recent medical advances (3). After successfully completing these self-evaluation process modules, diplomates documented the possession of essential knowledge by taking a secure written examination. Those who passed received a 10-year certificate after licensure and good standing in the medical community were confirmed.

This knowledge-oriented recertification program was positively received by 1778 recertified internists and subspecialists who responded to surveys given after recertification (return rate, 69%). Seventy-eight percent of those who responded thought that the program had important personal value, and 71% thought that it had important professional value; however, only 18% thought that it had substantial economic value. First-time success rates for the secure examination component of the program exceeded 90%. Through 1999, 2576 diplomates had been success-

fully recertified (343 in internal medicine, 1924 in a subspecialty, and 309 in both), and by January 2000, more than 6000 diplomates had enrolled in the program.

Current Issues

To improve on this promising beginning, ABIM created a task force in 1997 to recommend modifications to the original program. Specifically, the task force addressed several recent developments, including 1) the increasing public concern about the quality and consistency of physician performance; 2) the emergence of evidence-based medicine and new tools for assessing clinical performance, especially in areas of medical professionalism and decision making; 3) the rapid expansion of electronic communication; and 4) the American Medical Association's program to "accredit" physician performance (American Medical Accreditation Program).

In addition, although diplomates were generally satisfied with recertification, they wanted a program that was more relevant to their day-to-day clinical activities and would help to improve the quality of medical care. The architects of the first recertification process fully understood that the program was not initially designed to assess important elements of clinical performance, such as the use of β -blockers for myocardial infarction or angiotensin-converting enzyme inhibitors in congestive heart failure. As a first step, however, ABIM believed that it should concentrate on its core strength of evaluating knowledge and clinical reasoning.

Against this background, the task force sought to restructure recertification to meet the following goals: 1) improving the quality of patient care; 2) affirming the high standards expected of a self-regulating, accountable profession; 3) fostering continuing scholarship and self-improvement; 4) offering diplomates a portfolio of credentials attesting to competence; and 5) adding value to the health care system. This restructuring occurred in the midst of growing public concern about health care quality and demands for increased scrutiny of physicians. Most health care systems regularly use the patient surveys and quality review processes encouraged by the Joint Commission for Accreditation of Healthcare Organizations and the National Committee for Quality Assurance. This convinced the task force that a saltatory 10-year process focusing exclusively on medical knowledge, although important and necessary, was insufficient to document the maintenance of

Table. Chronology of American Board of Internal Medicine Recertification, 1936–2004*

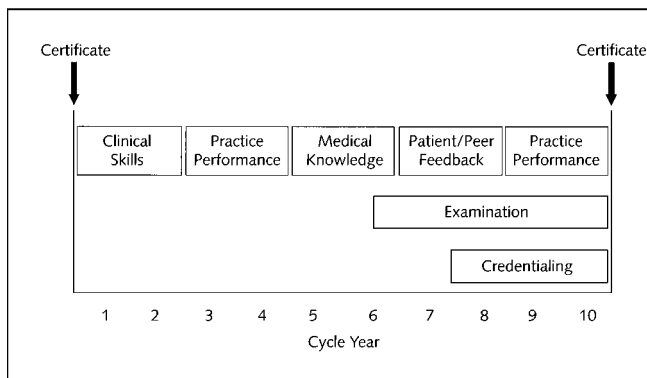
Year	Action
1936	ABIM begins certification
1970	ABIM endorses the concept of recertification (voluntary)
1974	First voluntary recertification program offered
1986	ABIM concludes voluntary recertification is a failure; adopts prospective time-limited certification
1987–1988	Critical care and geriatric medicine certificates time-limited to 10 years
1990	All ABIM certificates time-limited to 10 years
1995	First comprehensive recertification program offered
2000	Recertification evolves to a program of CPD
2004	CPD fully implemented

* ABIM = American Board of Internal Medicine; CPD = continuous professional development.

clinical competence. A more continuous process that assessed a broader range of clinical skills and clinical performance was clearly needed. Another departure from previous recertification programs was the select incorporation of the principles of continuous quality improvement. The continuous quality improvement paradigm was thought to be especially appropriate for self-evaluation of clinical performance, in which there is less uniform agreement among experts about what constitutes "best care" standards. Holding diplomates to strict pass–fail standards in these circumstances was deemed inappropriate.

The task force also reviewed the policy of prospective time-limitation of certificates. This policy, which created a pre-1990 "grandfather" cohort that held "permanent" certificates, is unpopular with younger diplomates, who assert that older internists have a greater need to renew their knowledge base. Younger diplomates argue that it would be fairer to have everyone meet the same standard (that is, to have mandatory recertification for all diplomates regardless of the date that certification was conferred). The ABIM agreed that, as a matter of both professional pride and accountability, all diplomates should hold themselves to current standards of competency. However, because before 1990 certificates were issued without conditions of any sort, post hoc invalidation would have been manifestly unfair and indefensible both in practice and in court. The task force understood that ABIM had little choice but to accept prospective time-limitation as the best possible solution and noted that the problem is self-correcting. Time-limitation was initiated a decade ago, and approximately half (65 000) of all active internal medicine certificates are now time-limited. The ABIM is convinced that as recerti-

Figure. A continuous professional development program for internal medicine.



Self-evaluation modules (clinical skills, practice performance, medical knowledge, and patient/peer feedback) may be completed in any sequence.

fication becomes the norm, older internists will choose to voluntarily recertify, especially with a more comprehensive and relevant program of continuous professional development (CPD) available.

To gain a broader perspective on these knotty issues, the task force met with several health care organizations to review the effectiveness and intrusiveness of various processes of monitoring physician performance. Throughout its deliberations, the task force remained focused on a simple imperative: to develop a continuous and credible assessment process that was “doable, valuable, tolerable, and affordable.”

Four groups of 10 to 12 randomly selected diplomates in Montana, Philadelphia, and Washington, D.C., provided valuable feedback on the various CPD components and the overall direction of the restructured program. Generated during 2 years of deliberation, the task force’s far-reaching recommendations to redesign recertification as a CPD program were unanimously approved by the ABIM board of directors at its June 1999 meeting in Philadelphia (5). In a subsequent action, active participation in CPD was made mandatory for continuing ABIM directors regardless of whether their certificates are “permanent” or time-limited. Directors will receive no special treatment, financial or otherwise.

A Program of Continuous Professional Development

The ABIM adopted a modular recertification process that engages certified physicians throughout their professional lifetime in a process of performance evaluation,

quality improvement, and maintenance of up-to-date medical knowledge. Like its predecessor, the CPD program has three major components: 1) self-evaluation of the components of clinical competence, 2) evaluation of essential knowledge and clinical judgment, and 3) verification of credentials and attestation of institutional and community good standing (Figure).

Self-Evaluation

Throughout 10-year certification periods, diplomates will evaluate themselves in the areas of clinical and communication skills, medical care and professionalism, practice performance, knowledge renewal, clinical reasoning, and critical review of the literature. It is expected that most diplomates with new time-limited certificates will begin the self-evaluation process shortly after their initial certification (or recertification); in any case, they must begin no later than year 4 of the CPD cycle. Diplomates with permanent certificates issued before 1990 may enter the CPD program at any time and do not put their original certificates at risk if they do not complete the program.

A minimum of five modules, covering medical knowledge, clinical and communication skills, medical care and professionalism, and practice performance, will be completed at 1- to 2-year intervals over the 10-year certification span. Because some diplomates with limited or interrupted patient care responsibilities may not be able to complete some of the patient-centered self-assessment modules, alternate modules are being developed for those who are regularly involved in indirect clinical care activities, such as educators, researchers, and most administrators. To be recertified, however, all diplomates must satisfy all credentialing requirements; pass the secure examination of essential knowledge; and participate in the self-evaluation exercises of expert knowledge, clinical and communication skills, and peer ratings.

The first area of self-evaluation involves the maintenance of expert knowledge and clinical judgment. Diplomates must acquire new medical information and learn about newly developed pharmaceuticals and medical technology. To ensure that they are familiar with these advances, diplomates will complete multiple-choice questions specific to the discipline in which they are certified. Questions will focus on cutting-edge knowledge and are likely to require the use of reference sources. This computer- and Internet-based module can be completed at home or in

group settings. The ABIM will provide feedback by identifying incorrectly answered questions and will provide answers to all questions after a module is passed. An absolute standard of performance will be required, but unlimited retakes of each module will be permitted. Except for its electronic delivery, this part of the CPD program is similar to the self-evaluation process in the original recertification program.

A second area of self-evaluation focuses on clinical and communication skills and consists of multimedia questions about standard physical examination and communication techniques. Current technology allows each question to contain video clips or still images that display physical findings. Through this technology, visual inspection, auscultation, and percussion findings can be readily evaluated. Like the medical knowledge module, the clinical and communication skills modules will also have a pass–fail standard; may be repeated as needed; and can be done alone, in groups, at home, or in the office.

The third area of self-assessment is feedback about a diplomate's medical care and professionalism. This module includes confidential patient and physician ratings and is completed through an automated telephone program designed by ABIM. Diplomates will arrange for a minimum of 10 professional colleagues and 25 patients to answer 10 questions about their overall medical care and communication skills. The ABIM will collect the responses, collate them, and provide diplomates with confidential, anonymous ratings of aggregate performance along with comparisons generated from data on other recertifying internists. These feedback instruments have been carefully studied, have been shown to be reproducible and reliable, and are used by an increasing number of institutions (6–8). Although each diplomate will select the peers who will evaluate him or her, it has been shown that this strategy does not significantly bias the results if enough ratings are obtained. Unlike many rating surveys, these evaluations will focus exclusively on physician–patient interactions; they will not ask about matters over which physicians often have little influence (for example, telephone systems and parking). Diplomates will be required to generate a self-improvement plan in response to this feedback. To maintain patient and peer confidentiality, all individual identifiers will be removed from the data that ABIM receives. This feedback module does not have a pass–fail standard, but it must be completed to progress in the CPD program.

The final area of self-evaluation concentrates on clinical

performance. Separate modules will evaluate the care of patients with common “tracer” diseases, such as diabetes, asthma, and congestive heart failure, and others will evaluate specific clinical services or selected procedures, such as preventive services or colonoscopy. Each module will guide diplomates in the completion of chart or practice reviews to determine compliance with accepted standards and guidelines. A self-evaluation module of preventive services is currently available, and feedback from diplomates about this assessment strategy has been encouraging. It is reassuring to find that internists seem to welcome the opportunity to compare their performance with the recommendations of experts. As with patient and peer ratings, ABIM will also provide summary data from all recertifying internists for use by diplomates. These modules will not have a pass–fail standard, but the development of a personal self-improvement plan will be required. Confidentiality will be maintained by removing all patient and physician identifiers after a module is satisfactorily completed.

To maintain the credibility of the feedback and practice improvement evaluations, ABIM plans to randomly audit charts and other primary data of a small number of diplomates. In addition, a small number of randomly selected diplomates will be asked to report the outcomes of the quality improvement plans that they developed in connection with the practice improvement and feedback modules.

Evaluation of Essential Knowledge

The second component of the CPD program is designed to document a diplomate's up-to-date, essential knowledge of internal medicine, the medical subspecialties, or areas of added qualifications. Diplomates will be required to pass a secure, comprehensive, computer-based examination of essential medical knowledge. The ABIM believes that this component is fundamental to providing credibility for the CPD program. By passing this examination, diplomates show that they have mastery of a certified internist's basic knowledge without resorting to reference material. Examinations will use standard ABIM test development and scoring processes; for example, practicing internists will review questions for relevance, and ABIM will prospectively determine a passing standard. Diplomates will receive examination blueprints to assist them in examination preparation. The examination will be available two to three times per year in local computer testing centers or,

after security and other technical issues have been resolved, through the Internet. The examination will have a pass–fail standard, may be taken any time after year 6 of the CPD cycle, and may be repeated as often as necessary.

Although examinations that can be failed provoke anxiety, virtually all health care organizations and health systems with which the task force conferred urged ABIM to retain a secure pass–fail examination. It is believed that such an examination maintains the credibility of a process that attests to the competence of certified internists. For its part, ABIM is committed to ensuring that the examination remains focused on information that is relevant, important, and necessary for practicing internists and subspecialists.

Credentialing

The last component in the CPD program is verification of personal qualifications and professional conduct. The diplomate must provide evidence of a valid, unrestricted medical license and must answer pertinent questions on professional standing. The program will continue to require local attestation that a diplomate is in good standing and possesses satisfactory clinical competence. As is now the case, this component of the CPD program will be carried out primarily by ABIM and will occur shortly before a revalidated certificate is issued.

Implementation

The CPD program will begin with all diplomates who certified in 2000 and thereafter. Because ABIM is convinced that CPD should be continuous and focus primarily on improvement, it is important that diplomates be engaged in the process as early in the 10-year span of certification as possible. Diplomates who fail to enter by year 4 of the CPD cycle could experience a gap in certification status caused by delays in completing the required self-evaluation process.

As is now the case, recertification in a subspecialty, such as cardiology or gastroenterology, will not require the maintenance of an active internal medicine certificate; certificates of added qualifications, such as geriatric medicine or clinical cardiac electrophysiology, will continue to require an active certificate in the underlying discipline. The reason for this differing requirement is the special relation between the parent specialty and the disciplines represented by added qualifications. Subspecialists who hold time-limited certificates in internal medicine and choose

not to recertify will not be recognized by ABIM as being currently certified in internal medicine, although the dates of previous certification will be noted. Mechanisms to allow diplomates with multiple certificates to complete the CPD process in a more synchronous and coordinated manner are being developed.

The ABIM believes that the clinical practice performance components of the CPD program should be developed with the help of professional societies. Such collaboration is crucial to developing sophisticated, high-quality evaluations that will be valuable to busy clinicians. To that end, the first three practice improvement committees in asthma, congestive heart failure, and diabetes are being designed with input from relevant professional societies. For example, the congestive heart failure development group has representatives from the American College of Cardiology, the American Heart Association, the Heart Failure Society of America, and the American College of Physicians–American Society of Internal Medicine. In addition, through arrangements with medical societies, diplomates will receive continuing medical education credit for each completed component of the CPD program, including time spent preparing for the secure examination.

Completion of the CPD program will require an estimated 75 to 100 hours over 10 years, excluding preparation for the secure examination. This is approximately the same amount of time that is required for the current recertification program. To minimize the intrusiveness of CPD, new modules will replace older ones instead of being added.

On the basis of current costs and expected numbers of candidates, it is anticipated that the fees for the CPD program will continue to be similar to those for initial certification. Because many CPD components are not discipline-specific, substantial cost reductions are possible for multiple certificates. Fees will be based on actual costs and can be spread over the 10-year span of the CPD program. When computer technology and Internet security become more advanced, all CPD processes will probably be done in less time without the expense and disruption of travel to distant test centers.

Effects on the Profession and Health Care

Certification is increasingly valuable to patients, managed care organizations, and employers (8). It is one of the few objective indicators of competence and is commonly

used as a marker for the ability of physicians to deliver quality patient care. Information about certification is collected by almost all credentialing organizations and is included in the Health Plan Employer Data and Information Set criteria developed by the National Committee for Quality Assurance. Many studies have documented the relation between certification and medical school experiences (9), graduate training (10, 11), practice volume and experience (12, 13), and clinical outcomes (6, 14).

The CPD program extends the certification process by enabling internists to evaluate a broader range of medical competency. In so doing, it honors the professionalism of internists and advances the goal of ABIM to improve the care that internists and subspecialists provide to patients. Peer and patient evaluations, ongoing practice improvement, and documentation of essential physical examination and communication skills are highly relevant to the clinical activities of most internists. The ABIM believes that the select incorporation of continuous quality improvement principles will decrease the tension and increase the value and usefulness of recertification. In addition, the breadth of the CPD program should decrease the unintended consequences of potentially evaluating only things that can be precisely measured, thereby overlooking important aspects of clinical practice and sending inappropriate messages about what ABIM values. The intent of the CPD program is to allow internists to choose evaluations that are relevant to their everyday clinical practice while permitting them to demonstrate competence and continued improvement. For its part, ABIM will continuously work on improving the CPD program to be sure that it meets these goals.

Conclusion

The ABIM's fundamental purpose embodies medical professionalism and a commitment to promoting excellence in health care. The CPD program is an important step toward enabling internists to demonstrate their competency and professionalism to themselves and others. The availability of new methods has made it feasible to evaluate the cognitive, clinical, and humanistic attributes of certified internists and subspecialists. The CPD program, with its emphasis on continuous improvement and evaluation of clinical skills, patient and peer feedback, and practice performance, offers diplomates the opportunity to reach their potential as competent, caring, and accountable professionals.

Appendix

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But as a sceptic I am dubious about science as about everything else, unless the scientist is himself a sceptic, and few of them are. The stench of formaldehyde may be as potent as the whiff of incense in stimulating a naturally idolatrous understanding.

Robertson Davies
The Rebel Angels
New York: Viking Penguin; 1983:191

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