# From my perspective

Until recently, most surgeons looked forward with great enthusiasm to the day they received their board certification, largely because they knew it meant they would not have to worry about sitting for another exam until they applied for recertification. And that process didn't seem particularly daunting. After all, a surgeon who passed the boards once and picked up new skills and knowledge during the subsequent years of practice would probably find the recertification experience fairly routine.

Today, however, this laissez-faire approach to sustained board certification is rapidly becoming outmoded as the specialty boards transition from periodic recertification to an ongoing maintenance of certification (MOC) process. Likewise, the state licensing boards are changing their standards for reissuing medical licenses. Our traditional view of license renewal and recertification soon will fade into the hazy past.

As the specialty and licensing boards impose new requirements on surgeons, the College is developing innovative measures to help you comply with these new expectations. Our goal in creating these new programs and initiatives is to decrease the "hassle factor" for surgeons and to provide services that are relevant to their changing needs.

### *Background*

The new requirements for maintenance of certification and licensure are being developed and refined by the American Board of Medical Specialties (ABMS) and the Federation of State Medical Boards (FSMB), respectively. These organizations have crafted the new mandates in response to a number of issues that have been raised repeatedly during the last few years.

First, two reports from the Institute of Medicine that focused on medical errors and quality of care unleashed intense public cries for improved patient safety and more rigorous scrutiny of the profession, particular with respect to the introduction of new procedures and technology. Other studies also showed a gap between intended and actual performance, even among board-certified physicians. At the same time, the media began covering these issues with increasing vigor, and broader use of the Internet made it possible for people to have access to previously unavailable information.

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Additionally, we are seeing new evidence that medical skills and knowledge often decline over time, a reality made only harsher as technology proliferates.

As a result of these findings, surgeons and other professionals are being held more accountable for their actions and the quality of care they provide. The certifying and licensing boards have stepped in and are implementing the types of requirements they believe will help to ensure that patients receive appropriate care from proven professionals.

### *ABMS*

In response to the mounting public and government concerns, and to avert the imposition of federal regulations, the ABMS determined that all physicians should be trained in six competencies: patient care, interpersonal and communication skills, professionalism, medical knowledge, practice-based learning and improvement, and systems-based practice. To ensure that physicians would continue to sharpen these abilities, the ABMS also determined that all

member boards should transition from recertification to MOC programs.

Under the traditional recertification process, surgeons' initial certificates expired six to 10 years after being issued, depending on the issuing specialty board, and successful passage of another exam qualified them for new certification. Under the new MOC process, surgeons will maintain their original certification by periodically meeting board requirements.

The ABMS has organized the MOC process into a four-part framework, which requires that individuals offer evidence of the following: (1) professional standing; (2) lifelong learning and periodic self-assessment; (3) cognitive expertise; and (4) performance in practice.

The ABMS considers verification that a diplomate has maintained basic credentials, such as state licensure, to be evidence of professional standing. Some boards, including the American Board of Surgery (ABS), also ask that diplomates submit reference letters from their chiefs of surgery and the chairs of the credentials committees at the hospitals where they have admitting privileges.

Evidence of commitment to lifelong learning and periodic self-assessment includes verifiable use of an instrument that allows surgeons to test their own knowledge and clinical judgment, such as the College's Surgical Education and Self-Assessment Program (SESAP). Diplomates also must accumulate a specific number of continuing medical education (CME) credits that are relevant to an individual's practice emphasis. The boards typically require 50 Category 1 CME credits per year, varying percentages of which must be specialty-specific.

Passing a board-administered exam, one that's similar to the traditional recertification exam, is considered evidence of cognitive expertise. Diplomates generally will need to take these tests perhaps more frequently than in the past, however.

Finally, surgeons will be expected to participate in programs that will allow them to compare their outcomes to those of other surgeons and to otherwise evaluate their ability to apply the six competencies mentioned previously in their practices. Many of the specialty boards plan to partner with their corresponding specialty societies and umbrella organizations, like the College, to develop feasible assessment methodologies.

This fourth prong of the MOC process poses problems for physicians who cease clinical practice within the scope of the specialty board or who pursue careers in administration, research, education, or public service. Hence, an ABMS task force that has been studying this issue issued a white paper on March 16 recommending that the ABMS member boards develop appropriate methods for evaluating diplomates who do not provide direct or supervised care and for physicians reentering clinical practice after a hiatus.

### *FSMB*

Like the ABMS, the Federation of State Medical Boards has determined that its member boards need to respond to increasing public demands that licensing authorities periodically retest physicians for competence. As the first step in this effort, the FSMB established a special committee on maintenance of licensure in 2003. The following year, the organization issued a policy statement indicating that the 70 state medical boards that are members of the FSMB are responsible for guaranteeing the continuing competence of physicians seeking relicensure. As part of this new relicensure process, some state medical boards are already performing criminal background checks on physicians.

The FSMB is collaborating with the ABMS to determine how the MOC program relates to competence and licensure. The organization also is partnering with the National Board of Medical Examiners, which has a post-licensure assessment system that monitors complaints about level of competence, resumption of practice after a long hiatus, and change in practice emphasis. Additionally, the FSMB is collaborating with the Conjoint Committee on CME to evaluate current CME systems and to dialogue about medical boards' needs to quantify learning and practice outcomes of physicians participating in CME. Later this year, the FSMB intends to gather relevant stakeholders to discuss "core" issues, such as the definition of "competence," methods of assessing physician competence, future collaboration, and remediation of physicians identified as deficient.

### *The College's role*

The College offers a wide range of programs to help surgeons meet the criteria for maintenance of certification and licensure.

With respect to educational programming, the annual Clinical Congress and Spring Meeting offer an ever-expanding array of didactic and hands-on, skills-oriented courses for CME credits. The broadening scope of skills-oriented postgraduate courses are specially designed to address: contemporary topics in surgery; knowledge and skills related to the core competencies, patient safety, and new procedures; and nonclinical topics related to the practice of surgery.

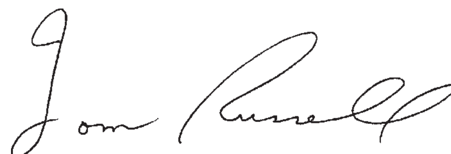
To provide surgeons with more opportunities to participate in CME activities without having to travel away from their practices, we have produced some excellent Internet-based education programs. These Web-based educational vehicles include Web casts of sessions from the 2002, 2003, and 2004 Clinical Congresses, as well as the 2004 and 2005 Spring Meetings. Several of our electronic and other learning programs are aimed at promoting the core competencies that surgeons will need to continually enhance, including professionalism, leadership, and communication skills.

Additionally, we regularly revise SESAP to meet surgeons' changing self-assessment demands. The fact that the ABS has selected this program as the vehicle of choice as evidence of commitment to self-assessment is testimony to its quality and ongoing utility.

We are becoming increasingly active in efforts to measure outcomes and performance in practice. We anticipate that the ACS National Surgical Quality Improvement Program will prove to be an invaluable instrument for analyzing outcomes in a risk-adjusted way and that the data gathered through it will be useful in the surgical decision-making process. Furthermore, we are upgrading the National Cancer Database and the National Trauma Data Bank™ to improve the relevance and application of the data collected through these repositories. Additionally, we are developing programs centered on evidence-based surgery to accumulate, assimilate, and communicate scientifically sound research of effective and safe treatments. Personal digital assistant and Internet-based programs to help surgeons systematically monitor their outcomes and compare these data with national and regional benchmarks are in production.

As I mentioned in my October 2004 *Bulletin* column, we anticipate that the College's Web portal, currently under construction, will eventually support e-learning programs, serve as a repository for surgeons who want to record and track cases, and allow surgeons to share information with the public about their practices and outcomes. We can foresee a time when this device will serve as a central meeting point for surgeons who want to share practice information. We further anticipate that surgeons will be able to enter all the necessary information for MOC in a running personal diary of their activities. For example, case logs, SESAP experiences, and so on, will be entered into this electronic record in "real time" and can then be turned over to the boards when necessary.

Without question, we are entering an era of greater accountability, and the ABMS's and FSMB's efforts to strengthen the recertification and relicensure processes are prime examples of what is occurring in this area. Professional organizations such as the American College of Surgeons owe it to our members and to our patients to ensure that surgeons have the resources they need to comply with the maintenance of certification and licensure requirements emanating from the ABMS and FSMB.



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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.