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Continued Demonstration of Qualifications for Board-certified Anesthesiologists

American Board of Anesthesiology

THE AMERICAN BOARD OF ANESTHESIOLOGY (ABA) recently announced a plan for voluntary recertification, designated the "Continued Demonstration of Qualifications," for diplomates of the ABA. The history and rationale of this decision are outlined below to give some perspective to this policy.

When specialty boards were formed in the 1930s, one of the goals was to assure the public that the diplomates had successfully completed an approved training program, had demonstrated an acceptable level of knowledge, and had the experience and skills to provide high-quality medical care in their discipline. The concept of recertification has long been a part of this process. As early as 1932, a commission of the American Association of Medical Colleges urged "continuing medical education for the purpose of maintaining current knowledge," and in 1940, the Advisory Board for Medical Specialties (ABMS)* stated that boards might find it desirable to issue certificates for a finite period of time. In 1970, the Carnegie Commission called for formal recertification, and in 1973, the ABMS urged all Boards to develop and implement a plan for recertification for the "public good."†

The ABA, like other ABMS member boards, has considered issues relating to recertification for some time. In 1977, the ABA adopted a plan for recertification that was to begin in 1984. The arguments for initiating recertification seemed compelling at the time. They included: the motivation for continuing education; the motivation to maintain practice standards; the subtle, but real, pressures to join the "bandwagon" of ABMS policy; and the response to societal pressures and the sense of upholding the public trust through periodic evaluation of certified practitioners. The ABA recognized then, and it continues to acknowledge today, that there are also disadvantages to a recertification process. These include an absence of evidence that qualifications decay over time; an absence of evidence regarding an appropriate interval for recertification if there is a decay in knowledge; uncertainty regarding the ideal methods for revalidating the certificate; and the nature and scope of an examination for individuals who have limited their practice to specific areas for several years, and who may be expert in those areas at the cost of more generalized knowledge in the overall specialty. A fundamental concern involves the balance between cognitive knowledge *per se* and the expertise and judgment that result from increased experience. Quality anesthetic care obviously requires knowledge, judgment, and experience. Knowledge can be tested by a written examination, but judgment is perhaps best tested by an oral examination, and experience is usually evaluated quantitatively, not qualitatively.

The ABA has consistently viewed the process of initial certification as the foundation of the certification process, because initial certification: 1) follows an intense and prolonged period of training in an accredited residency; 2) includes verification of clinical competence by the faculty who trained the applicant; and 3) includes a rigorous written and oral examination process. The ABA remains convinced that the individual who gains diplomate status with the ABA is a high-quality consultant anesthesiologist. The certificate is not awarded for minimum competence (*e.g.*, licensure), but for evidence that the diplomate can perform at a higher level (*e.g.*, certification).

In 1980, only 3 years after announcing the intent to initiate recertification in 1984, the ABA reversed its decision and decided not to implement the process. Since 1980, the ABA has reviewed periodically all of the issues surrounding recertification, including both its advantages and disadvantages, and the ABA has participated in several conferences held by the ABMS to address the issue of recertification. The ABA maintained this position despite considerable "peer pressure" from the ABMS and from the 18 of the 23 ABMS member boards that currently have some form of recertification.‡

Other boards use one of two general types of approach: 1) recertification, which implies that all certificates must be revalidated at intervals determined by a board; or 2) time-limited certification, which implies that the certificate will be valid for a specified time, usually 7–10 years. Time-limited certification is prospective only, and current diplomates are "grandfathered" out of the process, whereas recertification applies to all diplomates.

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* Reorganized in 1970 as the American Board of Medical Specialties.

† Langsley DG: Prior ABMS conferences on recertification, Recertification for Medical Specialists. ABMS, 1987, p 11.

‡ Stevens WC: Why we decided not to recertify, Recertification for Medical Specialists. ABMS, 1987, pp 55–58.

Why does the ABA now believe that some form of revalidation of the primary certificate is appropriate?§ Recent initiatives at federal, state, and local levels, as well as increasing expectations of the public for documentation of continued high-quality medical care, have convinced the ABA that a mechanism should be available to allow its diplomates to demonstrate their continuing qualifications. Federal legislation that would require periodic recredentialing of those reimbursed by Medicare has been proposed for several consecutive sessions of Congress and has been reintroduced for current consideration by a Congressional committee. Although such legislation has not yet passed, the initiative suggests that the issue is of considerable importance to society and to diplomates of all specialty boards. Furthermore, the state of New York is implementing a requirement for some form of recertification before renewing medical licensure, and other states also are considering periodic demonstrations of current knowledge for licensure. These proposals are based on the assumption that current knowledge is a prerequisite for competent practice, and that the demonstration of this attribute is best accomplished through an examination provided by an ABMS member board or, as an alternative, through a more general examination provided by federal or state agencies. Hospitals are experiencing continuing pressure to document qualifications of their practitioners, and some use certification and recertification as an element of the appointment or reappointment process.

Because of societal pressure and the political environment, the ABA joined with the American Society of Anesthesiologists, in the formation of an *ad hoc* committee composed of directors of the ABA and ASA member diplomates who represented a variety of practice styles of anesthesiology, to consider the issues of recertification. The ABA charged this committee with presenting a plan to the ABA, on behalf of practicing diplomates, for revalidation of their certificates. The committee, which included Drs. D. David Glass (Chairman), Robert W. Adams, David E. Longnecker, Jerome H. Modell, Alan D. Sessler, Richard H. Stein, and Betty H. Stephenson, met on several occasions and considered a variety of issues, including the advantages and disadvantages discussed above. In January 1989, the ABA accepted the report of this committee.

The ABA believes these recommendations will provide its diplomates with a mechanism to voluntarily renew their qualifications, as well as provide a mechanism for recredentialing that is consistent with state, local, or federal initiatives. The ABA continues to believe in the validity of the primary certificate as a measure of a high-quality consultant in anesthesiology, and has chosen to refer to the voluntary revalidation of the primary certificate as "Continued Demonstration of Qualifications" (CDQ), rather than to call the process "recertification." In addition, the primary certificate will not be time-limited, and therefore the initial certificate will not expire at a specific time. Further, no one will need to be "grandfathered" in this process, and all diplomates will have the opportunity to voluntarily revalidate their initial certificate at whatever interval is appropriate for their particular circumstance.

The CDQ process will include two main components. The credentialing component is intended to verify current practice and is clearly the most important aspect of a revalidation of ABA certification. This credentialing process will include:

1) Documentation of peer review of current hospital practice by a mechanism such as hospital reappointment criteria or a department chairman's statement, where applicable
2) Verification by the diplomate that he or she is free of active chemical dependency
3) A form submitted by the applicant that describes his or her current practice
4) A similar form to be completed by the chief of staff of the hospital or its equivalent
5) Evidence of a current and unrestricted license to practice medicine
6) A measure of quality assurance review that will undoubtedly change over time as better methods for evaluating quality of practice are demonstrated

The second component of the CDQ process is a secure written examination that is a combination of current, universal anesthesia knowledge and appropriate subspecialty material relevant to the individual diplomate's practice.

There will be no limitation on the number of applications for the CDQ. Upon successful completion of the process, the diplomate will be issued a certificate indicating his or her "Continued Demonstration of Qualifications."

Overall, the intent of the CDQ is to provide a mechanism of credentialing and a cognitive-knowledge examination that will allow ABA diplomates to demonstrate current knowledge and quality of practice through an ABA developed mechanism, rather than through state, federal, or other mechanisms that might not be tailored specifically to the practice of anesthesiology. Announcements about the application process for the CDQ will appear in the ASA Newsletter, in the ABA Newsletter, and in ANESTHESIOLOGY in the near future.

§ ABA: The ABA and Recertification. ABA Newsletter Volume 2, May 1989.