HOD ACTION: Recommendations in Council on Medical Education Report 4 be adopted and the remainder of the report be filed.

REPORT 4 OF THE COUNCIL ON MEDICAL EDUCATION (Interim 2023)
Recognizing Specialty Certifications for Physicians (Resolution 316-I-22)
(Reference Committee C)

EXECUTIVE SUMMARY

The history of board certification can be traced back to the late 19th century when the need for standardized medical education and training became apparent. In the early years of medical practice, there were no standardized requirements or guidelines for physicians to demonstrate their specialty qualifications. Medical education and training varied widely, and there was a lack of standardized curricula and evaluation methods. Certification boards were established for specialists to be able to distinguish themselves from other physicians. Society relies on and grants physicians the ability to establish and enforce standards for medical practice—that is, grants the profession collectively the privilege and obligation of self-regulation. This privilege depends on trust, and this privilege can and has been lost when the public no longer trusts professional oversight.

In 1933, the American Medical Association (AMA) established the American Board of Medical Specialties (ABMS) to bring order to the proliferation of specialty boards and address conflicts arising between specialty boards. Other entities later emerged as certification boards and have varying standards for obtaining initial board certification and maintaining continuing certification over time. AMA support of these entities is contingent with the certification program meeting accepted standards that include offering an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. Continuing demonstration of physician competency sets the qualifications of physicians above other health professionals. Ongoing assessment and demonstration of competency help identify gaps in knowledge or skills as medicine advances, allowing physicians to address those gaps and provide safe, up-to-date, and effective care to patients. Demonstrating ongoing competency helps build and maintain public trust in the medical profession.

The AMA believes that patients deserve to have increased clarity and transparency in health care. Recognizing that there is confusion among the public as to the education, training, and skills of different health care professionals, which can lead to patients seeking and obtaining inappropriate and potentially unsafe medical care, the AMA created the "Truth in Advertising" campaign to help ensure patients know the education, training, and qualifications of their health care professionals.

The Council on Medical Education stands in support of the current AMA policy. The Council recommends encouraging continued advocacy to federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other interested parties to define physician board certification as the medical profession establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification. The Council recommends reaffirmation of Policy H-275.926, "Medical Specialty Board Certification Standards."

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-I-23

Subject: Recognizing Specialty Certifications for Physicians (Resolution 316-I-22)

Presented by: Cynthia Jumper, MD, Chair

Referred to: Reference Committee C

Resolution 316-I-22, Recognizing Specialty Certifications for Physicians was authored by the Congress of Neurological Surgeons and American Association of Neurological Surgeons and submitted to the 2022 Interim Meeting of the House of Delegates (HOD). The second resolve reads as follows:

> RESOLVED, That our American Medical Association advocate for federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other health care stakeholders and the public to define physician board certification as establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification. (Directive to Take Action).

The second resolve was referred by the HOD for a report back; this report is in response to the referral.

Background

The need for standardized certification

The history of board certification can be traced back to the late 19th century when the need for standardized medical education and training became apparent. In the early years of medical practice, there were no standardized requirements or guidelines for physicians to demonstrate their specialty qualifications. The first board was the American Board of Ophthalmology, which was incorporated on May 3, 1917, to allow ophthalmologists to distinguish themselves from other physicians as eye specialists. Other specialties also formed their own boards leading the AMA to establish the American Board of Medical Specialties (ABMS) in 1933 to bring order to the proliferation of specialty boards and address conflicts arising between specialty boards. Additionally, other entities were established to provide board certification including, but not limited to, the American Osteopathic Association Bureau of Osteopathic Specialists, the National Board of Physicians and Surgeons, the American Board of Physician Specialties, the American Board of Cosmetic Surgery, and the American Board of Facial Plastic and Reconstructive Surgery.

Medical education and training varied widely, and there was a lack of standardized curricula and evaluation methods. Society relies on and grants physicians the ability to establish and enforce standards for medical practice; that is, grants the profession collectively the privilege and

obligation of self-regulation. This privilege depends on trust, and this privilege can and has been lost when the public no longer trusts professional oversight.[1] Thus, certification programs were established to help the public select a physician to meet their needs, as an indicator that a physician has been determined by their peers to be competent in a chosen specialty, and as a testament to the mastery that the physician has shown in their respective field of medicine. Board certification serves as an independent evaluation of a physician's or specialist's knowledge and skills to practice safely and effectively in a specialty.

As part of its efforts, the Council on Medical Education (Council) recognized the importance of assessing physicians' competency after completing their formal education and the need for standardized certification in medical specialties. Several factors were influential in the development of standardized certification in medical specialties, including variation in medical education, calls for professional regulation to ensure competency and accountability of physicians, rapid advancement of medical knowledge, desire for expertise and specialization, and standardization and quality assurance.

The establishment of the American Board of Medical Specialties

These developments led to the AMA establishing the ABMS in 1933 to ensure that physicians met certain standards of knowledge and skill in their respective fields. The founding members of ABMS were the American Board of Dermatology, the American Board of Obstetrics and Gynecology, the American Board of Ophthalmology, and the American Board of Otolaryngology – Head and Neck Surgery.[2] Member boards are established by their respective specialties and are physician-led, non-profit, independent evaluation organizations whose accountability is both to the profession and to the public. Members of the governing bodies include representatives from among the national specialty organizations in related fields. Now an independent organization, ABMS is governed by a Board of Directors, which includes representation from each of the ABMS Member Boards and members of the public. These individuals are working and retired physicians and professionals from across the country who have a broad range of experience in patient care, health policy, business, and community service. The Board of Directors is organized so that a significant portion of its activities are conducted by its committees, each of which operates under a written charter. All committees report to the Board of Directors, and all significant findings of a committee are presented to the Board of Directors for review, discussion, and approval. Additionally, the Board of Directors oversees the activities of the ABMS management team. The governance of ABMS is an essential component of the U.S. medical profession's system of collective self-regulation.

Member boards certify physicians in their primary specialty and subspecialty areas and encourage the professional development of those board-certified physicians throughout their career. This is accomplished through a comprehensive process involving educational requirements, professional peer evaluation, examination, and professional development. Member boards can also revoke certifications when an individual breaches them. There are currently 24 certifying boards or Member Boards of ABMS. In 2022, ABMS published descriptions of all the medical specialties where certification is offered by an ABMS Member Board in the ABMS Guide to Medical Specialties. The ABMS certification process provides an independent evaluation of a physician's or specialist's knowledge and skills to practice safely and effectively in a specialty and serves as a trusted credential patients can rely upon when selecting a physician for their needs.

ABMS/ACGME Core Competencies

To evaluate a physician's knowledge and skills, the ABMS and Accreditation Council for Graduate Medical Education (ACGME) co-developed six core competencies integral to the delivery of high-quality patient care. These competencies are the basis of the milestones physicians and specialists must meet during training and are also the basis for continuing certification assessment. The table below outlines the six core competencies.

Table 1. ABMS/ACGME Core Competencies

PRACTICE-BASED LEARNING & IMPROVEMENT	Show ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve practice.
PATIENT CARE & PROCEDURAL SKILLS	Provide care that is compassionate, appropriate, and effective for the treatment of health problems and to promote health.
SYSTEMS-BASED PRACTICE	Demonstrate awareness of and responsibility to systems of health care. Be able to call on system resources to provide optimal care.
MEDICAL KNOWLEDGE	Demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and their application in patient care.
INTERPERSONAL & COMMUNICATION SKILLS	Demonstrate skills that result in effective information exchange and teaming with patients, their families, and professional associates.
PROFESSIONALISM	Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diverse patient populations.

Each ABMS Member Board's continuing certification program is developed by practicing physicians and specialists according to the standards set through ABMS. Activities and requirements must be met in the following four main components: professionalism, lifelong learning, assessment, and improvement.

Governance of ABMS Member Boards

The governance process used by the Member Boards of the ABMS involves a combination of self-regulation and collaboration within the framework established by the ABMS. While each individual specialty board operates independently, they adhere to certain common principles and guidelines set forth by the ABMS. The ABMS establishes general standards and requirements that Member Boards must meet to ensure consistency and quality across specialties. These standards include criteria for education, training, examinations, and ongoing professional development. The Member Boards are responsible for designing and implementing the certification process for their respective specialties. This process typically involves a combination of educational qualifications, completion of an accredited training program, passing written and/or oral examinations, and meeting specific practice experience criteria. The ABMS promotes the concept of lifelong learning and ongoing professional development through continuing board certification (CBC) programs. Member Boards develop and administer their own CBC programs, which often include requirements such as participation in continuing medical education (CME) activities, self-assessment modules, practice improvement activities, and periodic assessments. While each specialty board operates independently, collaboration and standardization are fostered among the Member Boards. The ABMS provides a forum for sharing best practices, collaborating on research and development, and ensuring consistency in certification standards and processes across specialties. The governance process emphasizes continuous improvement and adaptation to changes in medical knowledge, technology, and health care delivery. Member Boards regularly

review and update their certification and CBC processes to align with evolving standards and practices.

ABMS and Board Eligibility

The ABMS defines board eligibility as the period of time between when a physician completes an ACGME-accredited residency program and when initial certification in a specialty or subspecialty is achieved. The ABMS Board Eligibility Policy for Specialty Certification and the ABMS Eligibility Policy for Subspecialty Certification enable Member Boards to set parameters for how candidates can use the term "board eligible" to signal their preparations for certification while at the same time closing off the potential for abuse through using the term indefinitely. The ability to become board certified by an ABMS Member Board is directly related to when the candidate completed an ACGME-accredited residency or fellowship program. A candidate's eligibility for board certification (board eligible period) expires on a date determined by the ABMS Member Board. For initial certification in a specialty and subspecialty, that date must be no more than seven years following the successful completion of accredited training. In addition, individual Member Board requirements must be met, including time in practice required (if any) for admissibility to the qualifying or certifying examination.[3]

AOA-BOS, Certification Process, and Board Eligibility

The Bureau of Osteopathic Specialists (BOS) is the supervisory body for the approved specialty certifying boards of the American Osteopathic Association (AOA) and is dedicated to establishing and maintaining high standards for certification of osteopathic and non-osteopathic physicians. The BOS ensures that all physicians it certifies demonstrate expertise and competence in their respective areas of specialization. The BOS serves as the certifying body for 29 primary medical specialties and 77 medical subspecialties. The BOS monitors the processes for all certifications, including primary certification, continuous certification, and certificates of added qualification; provides a mechanism to evaluate the validity and reliability of all certification examinations conducted by AOA specialty certifying boards; assesses examination scores and pass rates; and ensures notification of appropriate examination information to the ACGME. The BOS also provides pass rates as well as individual physician examination results (pass/fail) to physicians' training programs.

The BOS defines board eligibility status as "the time frame between a physician's completion of a residency or fellowship training program in a specialty or subspecialty and when the physician achieves initial certification in that specialty or subspecialty or when the physician's board eligibility status expires. The BOS certification examination process includes steps for initial entry, re-entry, and final entry. The re-entry process provides a pathway to certification for candidates who did not achieve board certification through the initial process and the final entry process is for candidates who did not achieve board certification through the re-entry process. To qualify for initial primary certification from the AOA through a specialty certifying board, the applicant must first meet one of five eligibility requirements and then meet additional requirements related to licensure, code of ethics, training, examinations, and clinical practice. Board eligibility status commences upon the physician's completion of a residency or fellowship training program in a specialty or subspecialty. Board eligibility status terminates when the physician achieves initial certification in that specialty or subspecialty or on December 31st of the following sixth (6th) year." Board certification issued by the AOA provides assurance to the public that a physician has demonstrated high levels of clinical competence and is an indication of excellence. Certification is issued upon successful completion of an AOA or ACGME accredited training program and by passing the associated examination(s) administered by an AOA specialty certifying board.

Other board certification entities

In addition to ABMS and AOA-BOS, there are several other entities that provide initial and continuing board certification. These entities have varying standards for obtaining initial board certification and maintaining continuing certification over time. These entities include:

- American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM)
- American Board of Cosmetic Surgery (ABCS)
- American Board of Facial Plastic and Reconstructive Surgery (ABFPRS)
- American Board of Oral & Maxillofacial Surgery (ABOMS)
- American Board of Physician Specialties (ABPS)
- National Board of Physicians and Surgeons (NBPAS)
- United Council for Neurologic Subspecialties (UCNS)

American Association of Neuromuscular & Electrodiagnostic Medicine

In 1987, the AANEM established the American Board of Electrodiagnostic Medicine (ABEM), now an independent credentialing organization in electrodiagnostic medicine. The maintenance of certification program for physicians was added in 1994 to assure that the ABEM followed the requirements of the ABMS. Initial certification for ABEM involves a process where candidates are evaluated in the core competencies. Candidates for the ABEM Initial Examination must meet the following requirements:[4]

- Board certified through American Board of Psychiatry and Neurology, American Board of Physical Medicine and Rehabilitation, American Osteopathic Board of Neurology and Psychiatry, or American Osteopathic Board of Physical Medicine and Rehabilitation (or a Canadian equivalent)
- Six or more months of electrodiagnostic (EDX) training during a residency and/or fellowship program
- Completed 200 EDX studies during training
- One or more years of independent experience
- Completed 200 EDX studies during independent experience
- Complete and pass the annual online CoreComp questions to maintain continuous certification

To maintain one's Continuous Certification with ABEM, one must:

- Attest to possess an active, unrestricted license to practice medicine
- Attest to possess an active primary board certification in either neurology or physical medicine and rehabilitation
- Complete 150 CME credits within one's 10-year cycle
- Pay an annual administrative fee to gain access to the online CoreComp questions.
- Complete and pass the annual online CoreComp questions

American Board of Cosmetic Surgery

The ABCS requires all interested surgeons complete an ACGME or AOA residency program in a related specialty:

- General surgery
- Plastic surgery
- Neurological surgery

- Obstetrics and gynecology
- Orthopedic surgery
- Otolaryngology
- Thoracic surgery
- Urology
- American Board of Oral and Maxillofacial Surgery (ABOMS) with MD degree

Candidate surgeons must also complete an American Academy of Cosmetic Surgery certified fellowship in cometic surgery and pass both written and oral examinations. With all specialties except plastic surgery, the candidate surgeon must also be board certified in one or more of the aforementioned specialties by a board recognized by the ABMS, the AOA, the ABOMS, or the Royal College of Physicians and Surgeons of Canada (RCPSC)

To maintain continuous certification, applicants for ABCS must also pass the ABCS Annual Certifying Examination, which consists of both an oral and written component that is prepared and psychometrically evaluated by the National Board of Osteopathic Medical Examiners (NBOME)[5].

American Board of Facial Plastic and Reconstructive Surgery

The ABFPRS was established in 1986 to improve the quality of medical and surgical treatment available to the public through the establishment of a mechanism for the education, qualification, training, review, and certification of surgeons specializing in facial plastic and reconstructive surgery. Candidates for the ABFPRS initial certification must:[6]

- Have completed a residency program approved by the ACGME or the RCPSC in one of the two medical specialties containing identifiable training in facial plastic and reconstructive surgery: otolaryngology/head-and-neck surgery or plastic surgery
- Have earned prior certification by the American Board of Otolaryngology, the American Board of Plastic Surgery or the RCPSC in otolaryngology/head-and-neck surgery or plastic surgery
- Have been in practice a minimum of two years
- Have 100 operative reports accepted by a peer-review committee
- Successfully pass an 8-hour written and oral examination
- Operate in an accredited facility
- Hold the appropriate licensure and adhere to the ABFPRS Code of Ethics
- Complete the FACEforward® online longitudinal assessments annually to maintain certification

American Board of Oral & Maxillofacial Surgery

Board Certification by the ABOMS requires successful completion of the Qualifying and Oral Certifying Applications and Examinations. Once certified by ABOMS, candidates must participate in the Certification Maintenance process. For initial certification, a candidate must successfully complete both the qualifying examination and the oral certifying examination. The ABOMS also allows internationally trained applicants an opportunity to take the qualifying exam by meeting different requirements that hold the same caliber as the application for individuals taking the examination for the first time. Candidates have three consecutive years following successful completion of the qualifying examination to take and pass the oral certifying examination. Candidates who successfully complete these examinations become diplomates that have time-limited certifications. To maintain one's status as an ABOMS diplomate, one must complete the

components of certification maintenance in four areas: professional standing, lifelong learning, cognitive expertise, and performance in practice. Certification Maintenance is a continuous process of learning, self-assessment, and testing that proceeds over a 10-year period.[7]

American Board of Physician Specialties

ABPS is the official multi-specialty board certifying body of the American Association of Physician Specialists, Inc. ABPS assists the certifying bodies by guiding the planning, development, and psychometric evaluation of assessment procedures designed to measure professional competency. Eligibility requirements and examinations of the boards of certification are developed based on a substantial review and analysis of the current state of clinical knowledge in the field of a particular specialty, as reflected in medical literature and the patient-care setting. Candidates can apply for either certification or recertification and ABPS verifies credentials for both certification and recertification applicants using various sources including, but not limited to, the Federation of State Medical Boards Credentials Verification service and the American Medical Association Physicians Profiling services. ABPS offers two exam processes: one for specialties such as anesthesiology, emergency medicine, and orthopedic surgery that require two steps (written/computer-based and oral exams) and one for specialties such as dermatology, family medicine, and internal medicine that are a single-level (written/computer-based exam).[8]

National Board of Physicians and Surgeons

The NBPAS was established in 2015 and is a non-profit, physician-led organization that provides an alternative pathway for continuous certification from ABMS or AOA in all the broadly recognized areas of specialty medical practice. The NBPAS does not provide initial board certification; it is a pathway for continuous certification after completing the initial board certification from an ABMS or AOA member board. NBPAS performs primary source verification of physician education and training as required by the National Committee for Quality Assurance, Utilization Review Accreditation Commission, The Joint Commission, and Det Norske Veritas, Inc. accreditation standards. The NBPAS requires all physicians to meet the following criteria to be eligible for certification:

- Previous certification through an ABMS/AOA Member Board
- An active, valid, unrestricted license to practice medicine in at least one U.S. state or territory
- Submission of continuing medical education credits
- Active privileges to practice that specialty in at least one U.S. hospital or outpatient facility licensed by a nationally recognized credentialing organization with deeming authority from Centers for Medicare & Medicaid Services
- Medical staff appointment/membership

While the NBPAS indicates it reserves the right to deny certification to any individual believed by the board to lack sufficient qualifications, it also expresses on its website that certification by NBPAS is a measure of training, experience, and life-long learning and does not guarantee competence or any specific medical outcomes.[9]

Existing AMA policy conflicts with support for NBPAS because the board does not offer initial certification. Specifically, AMA Policy H-275.926, “Medical Specialty Board Certification Standards” states Our AMA (1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS)

or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety. (3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet accepted standards for certification that include both a) a process for defining specialty-specific standards for knowledge and skills and b) offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination. (4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.

United Council for Neurologic Subspecialties

UCNS certification has been the recognized certification for emerging neurologic subspecialties since 2003. Requirements for eligibility for UCNS initial certification include[10]:

- Applicants must be certified by an ABMS certifying board or possess equivalent certification by the RCPSC or the AOA.
- Applicants must hold a current, active, valid, unrestricted, and unqualified license to practice medicine in at least one jurisdiction in the United States, its territories, or Canada, and in each jurisdiction in which they practice.
- Applicants must complete one of four eligibility pathways. The pathways are:
    1. UCNS-accredited fellowship
    2. Practice track
    3. Academic appointment at a UCNS-accredited fellowship
    4. Internationally trained faculty at UCNS-accredited training programs
- Applicants must provide documentation of a 36-month* period of time in which the applicant has spent a minimum of 25% of their time in the practice of their specialty.
- Applicants for continuous certification must complete and pass annual online assessments.

Below is a table that provides a comparative overview of these entities based on current AMA policy.

Table 1. Comparison of Credentialing Organizations

Medical Specialty Board Certification Standards H-275.926 (3)	Credentialing Organizations								
	ABMS	AOA-BOS	AANEM	ABCS[i]	ABFPRS[ii]	ABOMS	ABPS[iii]	NBPAS[iv]	UCNS
Certification programs must include a process for defining specialty-specific standards for knowledge and skills	X	X	X	X	X	X	X	X	X
Certification programs must offer an independent, external assessment of knowledge and skills for initial certification in the medical specialty	X	X	X	X	X	X	X		X
Certification programs must offer an independent, external assessment of knowledge and skills for recertification or continuous certification in the medical specialty	X	X	X	X	X	X	X		X

[i]With all specialties except plastic surgery, must also be board certified in one or more of these specialties, by a board recognized by the ABMS, AOA, ABOMS, or the RCPSC.
[ii]Must have earned prior certification by the American Board of Otolaryngology, the American Board of Plastic Surgery, or the RCPSC in otolaryngology/head-and-neck surgery or plastic surgery.
[iii]Must be currently board certified through the ABMS or AOA to be eligible for recertification.
[iv] Must hold a previous certification through an ABMS or AOA member board in the same specialty.

AMA's Truth in Advertising Campaign

The AMA believes that patients deserve to have increased clarity and transparency in health care. There is no place for confusing or misleading health care advertising that has the potential to put patient safety at risk. Recognizing that there is confusion among the public as to the education, training, and skills of different health care professionals, which can lead to patients seeking and obtaining inappropriate and potentially unsafe medical care, the AMA created the "Truth in Advertising" campaign to help ensure patients know the education, training, and qualifications of their health care professionals. The campaign does not increase or limit anyone's scope of practice. Instead, the campaign increases the transparency of health care professionals' qualifications for patients, so that patients can clearly see and make informed decisions about who provides their care.

The campaign includes a model bill created by the AMA that states can use to advocate for health care professional transparency. The model bill features two main components: (1) prohibition of

deceptive or misleading advertisements and requiring all health care practitioners to indicate their license in any advertisements and (2) requirement that all health care practitioners wear a name badge during all patient encounters that includes, among other information, the health care practitioner's license. Presently the "Truth in Advertising" campaign does not acknowledge that there are non-ACGME and non-AOA fellowships that should not be excluded (e.g., ABPS). The model bill also includes an optional drafting note on board certification. This item is optional because it is not AMA policy. The optional drafting note language outlines parameters physicians must meet to be able to claim they are "board certified" in any advertisements and states as follows:

Drafting Note Re: Board Certification—To provide further guidance on an additional type of requirement related to MD or DO board certification, this drafting note provides the following sample.

> A medical doctor or doctor of osteopathic medicine may not hold oneself out to the public in any manner as being certified by a public or private board including but not limited to a multidisciplinary board or "board certified," unless all of the following criteria are satisfied:
> (a) The advertisement states the full name of the certifying board.
> (b) The board either:
> 1. Is a member board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA); or
>
> 2. Is a non-ABMS or non-AOA board that requires as prerequisites for issuing certification:
> (i) successful completion of a postgraduate training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the AOA that provides complete training in the specialty or subspecialty certified by the non-ABMS or non-AOA board;
> (ii) certification by an ABMS or AOA board covering that training field that provides complete ACGME or AOA-accredited training in the specialty or subspecialty certified by the non-ABMS or non-AOA board; and
> (iii) successful passage of examination in the specialty or subspecialty certified by the non-ABMS or non-AOA board.

Discussion

Continuing demonstration of physician competency sets the qualifications of physicians above other health professionals. Ongoing assessment and demonstration of competency help identify gaps in knowledge or skills as medicine advances, allowing physicians to address those gaps and provide safe, up-to-date, and effective care to patients. Demonstrating ongoing competency helps build and maintain public trust in the medical profession. Patients and the broader community have confidence in physicians who actively engage in professional development and demonstrate their commitment to providing high-quality care. Physicians have a professional responsibility to continuously improve and maintain their competence. By engaging in ongoing assessment and self-reflection, physicians demonstrate accountability for their own practice and commitment to meeting the highest standards of patient care. The field of medicine is constantly evolving, with new research, technologies, and treatment options emerging regularly. Continuing education and assessment help physicians stay up to date with the latest evidence-based practices and guidelines, ensuring that patients receive the most current and effective treatments. While there are different ways to achieve continuing board certification, it is debatable whether they produce the same outcomes for patients.

The ABMS has established principles for determining physician competency. These principles guide the certification and continuation of certification processes for medical specialties. The key principles are evidence-based standards, ongoing assessment, lifelong learning, specialty-specific

criteria, transparency and fairness, quality improvement, and collaboration. Other entities also require ongoing assessment of knowledge and skills and should not be discriminated against for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes.

The resolution directly impacts the optional drafting note on board certification in the AMA's Truth in Advertising Campaign. Broadly speaking, the campaign addresses transparency in the level of training, education, and licensing of health care professionals to ensure patients know who is providing their care [and whether they are sufficiently qualified to perform a given procedure or treat a particular disease or condition]. The optional drafting note on board certification specifically addresses whether a physician can advertise as board certified and has been revised multiple times since it was originally added in 2011. More than 25 states have enacted the advertising language and/or name badge language of our Truth in Advertising bill, while three states have enacted language related to board certification and two states have enacted language like the board certification optional drafting note in AMA's model bill. There is not consensus regarding the definition of "board certification" and therefore the future of the optional drafting note in the Truth in Advertising campaign will need to be determined by the House of Delegates.

Summary and Recommendation

The Council on Medical Education therefore recommends that the following resolve be adopted in lieu of Resolution 304-A-22 and the remainder of this report be filed.

That our American Medical Association (AMA):

1. Encourage continued advocacy to federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other interested parties to define physician board certification as the medical profession establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification. (Directive to Take Action)

2. Reaffirm the following policy:

- H-275.926, "Medical Specialty Board Certification Standards"

Fiscal note: $1000

APPENDIX: RELEVANT AMA POLICIES

Medical Specialty Board Certification Standards H-275.926

1. Our AMA:
(1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
(2) Opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
(3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet accepted standards for certification that include both a) a process for defining specialty-specific standards for knowledge and skills and b) offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.
(4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
(5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
(6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.

Continuing Board Certification D-275.954

Our AMA will:
1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a report regarding the CBC process at the request of the House of Delegates or when deemed necessary by the Council on Medical Education.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.

5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies 'leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.
22. Continue to participate in the Coalition for Physician Accountability, formerly known as the National Alliance for Physician Competence forums.

23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's CBC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.
35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.
36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.
38. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development and release of new, integrated standards for continuing certification programs that will address the Commission's recommendations for

flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.
39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.
40. Our AMA will continue to publicly report its work on enforcing AMA Principles on Continuing Board Certification.

Continuing Board Certification H-275.924
Continuing Board Certification

AMA Principles on Continuing Board Certification

1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.

2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.

3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.

4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).

5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.

6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.

7. Careful consideration should be given to the importance of retaining flexibility in pathways for CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.

8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with CBC participation.

9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for CBC Part II. The content of CME and self-assessment programs receiving credit for CBC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit", American Academy of

Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."

10. In relation to CBC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

11. CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

13. The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. CBC should be used as a tool for continuous improvement.

15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

16. Actively practicing physicians should be well-represented on specialty boards developing CBC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. CBC activities and measurement should be relevant to clinical practice.

19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.

20. Any assessment should be used to guide physicians 'self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.

27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians 'time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes.

Mechanisms to Measure Physician Competency H-275.936

Addressing Public Health Disinformation Disseminated by Health Professionals D-440.914

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