Ready or Not, Here It Comes: Maintenance of Certification

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When Sir William Osler, one of the greatest physicians in medical history, left Philadelphia, he offered his remarks on what became one of the most celebrated of treatises: *Aequanimitas*.[1] It was this that my father handed to me as I graduated from medical school. It is a hard thing to attain, a mastery of equilibrium no matter what the challenges. When Sir William Osler wrote it, he was referring to the calm necessary to manage the vicissitudes of professional experiences as a physician—massive blood loss, extreme sadness over loss of life, deformities and disabilities, and any other experiences that would otherwise warrant a steady hand. Physicians must be able to hold steady the course as an essential ingredient in the delivery of proper care. Forensic psychiatry requires the same, where a rapist's tale and vigorous cross-examination must be met with equanimity, objectivity, and professionalism.

This mantra of equanimity may have been the advice proffered by an esteemed physician directed toward the clinical circumstance, but it holds true as advice under many circumstances. Ironically, one area where physicians can lose their equilibrium, bemoan the days of "grandfathering" and become overwhelmed, frustrated, and even angry relates to maintenance of certification (MOC), which is being promulgated by the American Board of Medical Specialties (ABMS) for all physicians seeking board certification and operationalized for forensic psychiatrists through the American Board of Psychiatry and Neurology (ABPN). Some of the negative responses and controversial debates related to MOC are understandable, and the explanation of the ABPN MOC approach that is delineated in this editorial is not an endorsement of the MOC components. Rather, the explanations offered herein are aimed to provide basic understanding of information regarding the elements of MOC, in order for forensic psychiatrists to be better prepared to move into the next, and unavoidable, era of board certification.

According to the ABPN, MOC is aimed at ensuring that physicians who continue with their board certification through the specialties and subspecialties offer patient care of sound quality as exemplified by the physician's willingness and demonstrable engagement in a self-improvement program (ABPN Frequently Asked Questions).[2] This is not just an idea that stems from the ABPN. All medical specialties have some form of MOC requirements, and the ABMS has been working with each discipline in medicine to set out MOC standards. Some of the justification for these activities lies in research that has linked board certification to improved practice.[3–5] For example, Pham and colleagues[5] showed a demonstrable link between board certification and the likelihood of delivery of preventive services in primary care practice. Holmboe and colleagues[4] demonstrated that physicians scoring higher on certification examinations were more likely to conduct processes of care related to diabetes and mammography.

Given the growing trends in expecting greater physician accountability, and the research demon-

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strating a link between certification and performance, national efforts have coalesced and moved away from lifelong certification standards and toward more active ways of assessing physician performance throughout the course of one's career. Within that framework, beginning October 1, 1994, all certificates attained via the ABPN were considered time limited, 10-year board certifications. All forensic subspecialty certifications in psychiatry are similarly time limited. What is more recent, however, is the development of additional requirements beyond the examination. To maintain certification beyond the expiration of the certificate, diplomates must participate in the MOC activities that are explained here.

There are four components to the MOC program, with each requirement being phased in over time. The four components include professional standing; self assessment (SA) and continuing medical education (CME); cognitive expertise; and performance in practice (PIP). Professional standing and the cognitive expertise components are those with which diplomates are already familiar, as they include proof of medical licensure in good standing as well as passage of a written examination every 10 years. Information relating to the MOC is frequently updated and is specific to each person's diplomate year.

Professional standing is demonstrable and generally is proven by showing that one has maintained active and unrestricted licensure to practice medicine in the United States or Canada. Cognitive expertise is demonstrated by completing and passing an examination at 10-year intervals. These examinations are conducted only on computer and are currently administered nationally through testing centers such that examinees no longer are required to travel long distances to take the examinations. To date, according to the ABPN website[6] pass rates for these examinations have been high (98% pass rate in forensic psychiatry recertification examinations for the years 2008, 2009, and 2010). Nonetheless, these examinations can be stressful, and it is recommended that practitioners participate in current CME programs (such as the AAPL Annual Meeting and Review Course) to maintain a current level of knowledge. MOC activities can assist the clinician in lifelong learning in ways that help the psychiatrist identify areas of weakness. MOC activities can point them in the direction of learning activities that will further assist them to demonstrate cognitive expertise and perform better on the periodic exams. Forensic psychiatry diplomates must be alert to examination schedules and application deadlines (additional fees are charged for late registration fees) to ensure timely completion of the cognitive expertise examination.

The two newer areas of MOC with which psychiatrists may be less familiar are SA and PIP. These will be explained in turn.

Self-assessment encompasses a requirement that diplomates participate in self-assessment activities in the interval between examinations. SA activities require several parts and to date consist of multiple-choice practice tests of a variety of types. To be considered SA activities, they must cover knowledge and practices in a variety of areas. The SA tool must provide feedback to the participant regarding his performance (i.e., must provide correct answers to questions), citations related to the content area covered, and a peer comparison analysis of performance. From these elements, the learner should be able to identify areas of weakness that can direct ongoing learning. For those who are required to recertify in multiple areas, SA activities can be in any area and do not have to be repeated for each area of recertification.

The ABPN website provides several references to SA activities that qualify under ABPN standards, including the SA activity developed by the AAPL Education Committee's Task Force on MOC, which was offered for the first time at the 2010 AAPL annual meeting. This SA test was provided as a means to assist members in meeting the SA requirements. However, because SA will be required to have CME attached to its activity by the time one has to take a cognitive examination in 2014, AAPL will be updating its SA exam to meet ABPN's standards.

Performance in practice (PIP) is the last and perhaps still the most complex of the MOC components. For diplomates who are clinically active, PIP is designed under a quality improvement framework and consists of two parts: feedback by others (Feedback Module) and review of one's own practice via chart review (Clinical Module). One unit consists of each of the two parts. For practitioners whose practices use quality-improvement activities, built-in, hospital-based quality-improvement initiatives may count as PIP activities. The Feedback Module requires written peer and patient feedback. Sample feedback forms are available on the website. The Clinical Modules require the review of five patient activities of a specific type (through chart reviews). Examples might include a review of five charts in-

volving management of patients with depression or reviewing five evaluations of competence to stand trial that took place over the prior three-year period. After comparing one's own performance with some established standards (such as those set out in practice guidelines), the physician develops a practice improvement plan and then within two years, re-evaluates again the five charts looking at the same type of clinical management.

Full details related to these requirements can be found on the ABPN website. A number of problems and unanswered questions regarding the MOC program remain. For example, many states are considering maintenance of licensure, which would require individuals to participate in MOC activities, regardless of their desire to maintain board certification, since this could be tied to active licensure. Health care reform and managed-care corporations seem to be considering providing fiscal incentives for those physicians who participate in MOC activities and fiscal disincentives for those who do not.[7] Cost effectiveness overall for MOC programs is also being examined given that there may be quality improvement processes developed within managed care that could fit into some of the MOC requirements.[7] Concerns regarding the psychiatric complexities of eliciting patient feedback have also been raised; and, for those whose practice involves forensic psychiatry only, other challenges and concerns for that particular requirement may have to be resolved.

On the CME front, there are ongoing discussions between the Accreditation Council for Continuing Medical Education (ACCME) and the ABPN. The ABMS and the ACCME recently published a white paper on MOC CME.[8] In that article, several recommendations were offered for ongoing work related to MOC, continuous professional development, and CME. At times, the goals of each of these initiatives may be at odds or disjointed, and how all the various agencies and stakeholders will evolve in their thinking and come together on the new standards for MOC remains unknown.

Although MOC components can seem daunting and unwanted, there is some reassurance available. First, AAPL leadership set a goal of helping members meet the requirements of MOC. Beginning in 2010, several activities have taken place. For example, through the leadership of the Education Committee, a task force was established related to the MOC needs of our members. From there, AAPL hosted a webinar with the ABPN leadership to help address questions. In addition, Larry Faulkner, MD, President and CEO of the ABPN (and former AAPL President), has contributed to our discussions on planning efforts and presented the results in a workshop at the 2011 meeting. The MOC SA test offered at the 2010 meeting was the first of any specialty to offer a live SA activity for meeting attendees. Since then, other organizations have followed suit with these types of activities. This MOC SA examination received very favorable feedback, and there is a plan to offer another SA examination opportunity at the 2011 Annual meeting in Boston. AAPL will continue to provide updates in the newsletter as well, so that members can be apprised of these activities. It is hoped that with these outreach efforts, there can be a greater likelihood of being prepared and maintaining equanimity in the face of new opportunities, and challenges for lifelong learning.

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