ABMS

REPORT OF THE SPECIAL COMMITTEE ON MILITARY PHYSICIANS & CONTINUING CERTIFICATION

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PREFACE

Physician medical specialty certification has changed significantly since its inception in the early 1900s. Originally conceived as a one-time verification of a physician's training and knowledge in a particular medical specialty, by the late 1980s specialty certification had evolved to include initial certification and recertification, the latter requiring physician specialists to undergo re-examination of knowledge every 10 years as a condition of retaining certification. In 2003, responding to public calls for regulatory bodies[1] to ensure the continuing competence of the health professions, the 24 Member Boards of the American Board of Medical Specialties (ABMS) collectively committed to instituting Maintenance of Certification (MOC) – a continuing certification process characterized by ongoing assessment and demonstration of professionalism and professional standing, engagement in learning, assessment of knowledge and judgment, and improvement in practice.

The change from lifetime certification to MOC has significantly impacted both the medical specialty boards and the physicians they certify. ABMS Member Boards are keenly aware of the need to understand how implementation of continuing certification has and will affect physician specialists, and to use this information to meet their needs and expectations. Such assessment is critical to making continuing certification more relevant to and valued by participating physicians.

Presented with the opportunity to assist Member Boards in this reflective process, Dr. Lois Margaret Nora, ABMS President and Chief Executive Officer, commissioned a series of special committees to examine issues facing three cohorts of Board Certified physicians as they engage with certification and continuing certification processes: military physicians, physician scientists, and physician executives.

The first committee to be convened was the Special Committee on Military Physicians and Continuing Certification (SCMPCC), a 16-member committee composed equally of ABMS Member Boards representatives and active and retired military personnel. A full list of Committee participants is included at the end of this report.

Tasked with exploring issues facing military physicians[2] as they engage with ABMS Member Boards' Programs of Certification and MOC, the SCMPCC identified three overarching objectives to guide its work:

1. Educate the ABMS certifying community about the unique environments in which Army, Air Force, and Navy[3] physicians work, and how those environments impact their ability to gain certification or engage in activities required to maintain their certification;

2. Recommend strategies for consideration by the ABMS Member Boards that will facilitate Board Certified military physicians' successful engagement with programs of MOC; and

3. Identify opportunities to support the educational needs of Board Certified military physicians who make tremendous sacrifices on behalf of our country.

The SCMPCC met twice in Chicago, first on June 16, 2014 and again on September 23, 2014. Prior to the first meeting, ABMS staff interviewed individuals with expertise in military medical practice – including representatives from the Army, Navy, and Air Force – to gain insight into the types of issues the Committee might consider

[1] Crossing the Quality Chasm: A New Health System for the 21st Century. Institute of Medicine 2001.

[2] For purposes of this report, the term "military physicians" refers to MDs and DOs on active duty in the Army, Air Force, or Navy. It does not include civilian physicians working for the Department of Defense, nor does it include uniformed or civilian physicians in the US Public Health Service.

[3] Healthcare for the Marines is provided through the Navy.

and to solicit input on potential opportunities for improving military physicians' experience with ABMS Member Boards' MOC programs. The interview results coupled with information about ABMS and Member Boards programs and services that could be of interest to the military were substantive inputs to the Committee's discussions and provided the basis for its recommendations.

This report provides an overview of the medical education pathways leading to military medical practice, highlights key characteristics of military medical practice, and reviews issues military physicians face as they seek to gain and maintain certification by an ABMS Member Board. It summarizes key aspects of the Committee's discussions and closes with recommendations for short- and long-term strategies to improve the Board Certified military physician's experience with MOC and to advance the missions of both ABMS and the United States Military Health System (MHS).

BECOMING A MILITARY PHYSICIAN

In general, there are three pathways to becoming a military physician. Two of the pathways are attending either medical school on scholarship through the Armed Forces Health Professions Scholarship Program (HPSP) or the Uniformed Services University of the Health Sciences (USUHS) F. Edward Hébert School of Medicine. A third pathway is through direct accession, which enables physicians to join a branch of service in a capacity consistent with his/her civilian medical education.

HPSP is a scholarship program authorized under Title 10 of the United States Code that offers individuals a paid medical education in a private or public medical school in exchange for commissioned service in the Army, Navy, or Air Force. While on scholarship, financial expenses for tuition, fees, a monthly stipend, and mandatory books and equipment are paid for by the student's sponsoring service. In exchange, the individual owes three years of active duty service after completion of graduate medical education (GME).

USUHS is a health sciences university run by the federal government that provides medical education to physicians and also educates advanced practice nurses, dentists, and biomedical scientists. The primary mission of the USUHS F. Edward Hebert School of Medicine is to prepare graduates for service in the medical corps of the various Uniformed Services at home or abroad. Individuals enter the School of Medicine as commissioned officers in one of the four Uniformed Services: Army, Navy, Air Force, or Public Health Service. Students are commissioned into their respective Service and are on active duty with full pay and benefits for the four years of medical school in exchange for a seven-year active duty service commitment following residency training. Students complete their clinical training at military and civilian training facilities across the United States. USUHS's medical school graduating classes generally average 165 physicians. Upon graduation, students are promoted to the rank of O-3 (Captain for the Army/Air Force, Lieutenant for the Navy/Public Health Service). The medical school is accredited by the Liaison Committee on Medical Education and all military-sponsored GME sites are accredited by the Accreditation Council for Graduate Medical Education. Approximately 90 percent of USUHS F. Edward Hébert School of Medicine graduates achieve Board Certification from an ABMS Member Board.

Direct accession is the least common way for an individual to become a military physician. This pathway can take two forms: graduating from a civilian medical school and completing a military-funded civilian residency or entering as a fully trained physician. The Financial Assistance Program offers residents a stipend while they are completing their residency in exchange for an active duty service commitment of two years for the first year of participation and six months for each additional six months of training. Individuals also may complete medical school and residency on their own and then join the military; these individuals usually have a three-year service obligation.

MILITARY MEDICAL PRACTICE

At any given time, the MHS employs approximately 12,000[4] active duty physicians to provide health care for service members and their families[5] around the globe, ensuring troops' medical readiness during both times of war and peace. They also are called upon to provide care for victims of disasters at home and abroad.

Medical practice in the military has many different characteristics, including status (active or reserve), location (deployed or stateside), assignment (remote or urban), war state (peacetime or combat), career path (clinical, administrative, research), and branch of service.

[4] 4500 active duty physicians are employed by the Army; 4000 by the Navy; and approximately 3500 by the Air Force.

[5] Approximately 9.2 million beneficiaries receive care through the MHS.

A military physician's ability to successfully gain and maintain certification by an ABMS Member Board can be impacted by one or more of these characteristics.

Status: Military physicians are either active duty or reservists. Active duty physicians (both active and reserve component on active duty) serve in the military full-time and may be deployed at any time. Deployment lengths vary according to the mission, but generally are four to 12 months in duration. Lengths of service range from a minimum of three years to a maximum of 30 years, with the physician being eligible for retirement after reaching 20 years of creditable service.

Physicians in the Reserve Components[6] are civilian doctors who generally practice in non-military settings. There are different Reserve Component categories, each having separate training and service requirements. These categories of physicians may be called to active duty in the Armed Forces when needed (for example, during times of war or in national emergencies). When called to duty, they are considered active service members of the Armed Forces. When not activated, reserve physicians are required to complete a specific number of unit drills in addition to an annual two-week training exercise.

Location/Setting: Military physicians practice in a diverse range of environments — from hospitals and clinics in combat to remote community settings both in the United States and overseas and even quaternary care facilities. Because their practice settings span the globe, military physicians' medical education and training encompass exposure to diseases that are uncommon in the United States but prevalent worldwide in specific geographic locations.

Assignment: Active duty physicians employed by the MHS are "in service" and, as such, must go where they are required and carry out assignments as directed. Depending on the circumstances, deployed physicians may be required to provide patient care that is different than their declared specialty and/or is narrower than the full scope of their specialty. For example, a pediatrician deployed in a combat zone may provide trauma care while a dermatologist caring for families of deployed servicemen may be called upon to provide primary care services.

Career Path: Most physicians leave military service after fulfilling their time commitment and continue medical practice in the civilian community, but a significant number pursue careers within the MHS. Career options for military physicians include clinical practice, teaching, research, and administrative opportunities. While none of the Service Branches of the military mandates medical specialty certification, it is a highly valued credential and a de facto requirement for career advancement and command positions. Achieving and maintaining Board Certification also qualifies eligible military physicians for bonus pay ranging from two to five percent of their salary.

Publications available on the Department of Defense's website reference the MHS' strategic imperative to deliver high-value health care in peacetime as well as in times of conflict. The MHS is engaged in strategic discussions about how to maintain a combat-ready workforce, even as deployed forces are being drawn down from conflicts in Afghanistan and Iraq. How this will impact the military physician community and practice is not yet clear, although it likely will include increased need for specialized education and training to ensure maintenance of battlefield skills.

[6] The Reserve Components of the Armed Forces includes Army and Air National Guards of the United States.

MILITARY PHYSICIANS AND CONTINUING CERTIFICATION

ABMS staff interviewed 16 individuals with military medical practice experience to gather information regarding the types of issues facing military physicians as they engage with ABMS Member Boards' Programs of Continuing Certification. This process of discovery uncovered important insights about Board Certified physicians in military service and their experiences with MOC.

First and foremost, the interviews highlighted the degree to which Board Certification is valued by the MHS and military physicians. Interviewees noted the role medical specialty certification plays in military promotions and professional advancement, emphasizing that Board Certified physicians in military service expect to be held to the same standard as their civilian counterparts. While their concerns about the MOC process generally are similar to those expressed by civilian doctors (e.g., lack of access to practice-relevant activities, cost of participation, and the time/administrative burden), Board Certified military physicians also can face unique challenges in meeting MOC requirements by virtue of their military commitment.

An example of one such challenge is deployment. Military physicians may be deployed within three to six months of completing residency, or may be assigned to a small or remote hospital or clinic in the United States or overseas immediately after completing residency. Deployments generally last four to 12 months and assignments are for 36 months (except to Korea, which is a 12-month assignment).

While the Army, Navy, and Air Force make every effort to accommodate military physicians' efforts to gain and maintain certification, there are times when early deployment or frequent relocation impacts a physician's success in satisfying his or her certifying board's eligibility requirements for initial certification and MOC. Examples of such situations include the plastic surgeon who is deployed to a combat setting within six months of completing residency and unable to collect the requisite case logs needed to meet eligibility requirements for initial certification, and the Board Certified pediatrician deployed to a remote location who has difficulty accessing her certifying board's MOC Part IV activities due to inadequate technological capabilities or security issues.

Likewise, because physicians deployed to combat settings have as their singular priority caring for wounded, ill, or injured service members, they may not have the time and, in some cases, the resources to complete MOC program activities within requisite timeframes. The interviews also identified that:

Military physicians are required to maintain skills that are different from and, in some cases, broader than their declared specialty. For example, skills needed for battlefield medicine (the treatment of combatants or non-combatants in or near a war zone) differ from the skills needed in civilian medicine, necessitating military physicians to undergo trauma training as part of their pre-deployment preparation. Additionally, while the Services Branches make every effort to deploy or assign physicians based on their area of medical specialty, it is not unusual for military physician specialists and subspecialists to serve as primary caregivers to family members of service members or to residents in remote locations.

Technology has changed how military physicians engage in MOC programs. With the availability of online continuing medical education (CME) deployed physicians are generally able to access appropriate activities for MOC Parts II and IV. There are exceptions to this – for example, Navy physicians deployed shipboard may occasionally lack access to the Internet for security reasons. In addition, physicians deployed to remote regions of the globe may have limited access to high-speed Internet required to access and complete some CME or MOC Part IV offerings.

Board Certified military physicians, like other physicians in administrative roles, have difficulty meeting Part IV requirements. Because they spend limited time in clinical settings and typically are not responsible for a full panel of patients, Board Certified military physicians in administrative roles have difficulty finding and participating in the types of clinical quality improvement activities required to meet Part IV requirements. While this is not unique to military medicine, it can be problematic given that the Service Branches will factor in Board Certification status when making career advancement decisions and offer bonus pay based on certification status.

Military physicians can experience a degree of professional isolation due to practice locations and frequent relocation. A Board Certified physician at a small military treatment facility may be the only specialist on site, making certification-required peer review activities difficult to complete.

Returning stateside for recertification events can be impossible for, or a costly administrative burden to, physicians deployed or assigned overseas.

The military is not required to reimburse physicians for costs for CME and other activities needed to maintain certification.

DISCUSSION

The interview findings stimulated robust discussions among Committee members about opportunities for improving Board Certified military physicians' experience with MOC programs and for collaboration between the MHS and ABMS.

Given that Board Certified physicians in military service expect to be held to the same standard as their civilian counterparts, Committee members acknowledged that military physicians' practice context could on occasion compromise their ability to meet certification and MOC requirements. Since Board Certification status is among the qualifications used by the military for promotions and bonus pay, Committee members agreed this issue could be mitigated if Member Boards' policies provided "flex time" to military physicians whose ability to satisfy certification or MOC requirements in a timely fashion is compromised due to a service obligation. Currently, five ABMS Member Boards have official "Special Circumstance" policies that provide military physicians greater flexibility in the timeframe required to meet initial certification or MOC requirements. The provisions and language vary from Board to Board, creating some potential for confusion amongst military physicians and the military branches in which they serve. Four Boards indicated that they consider such requests on a case-by-case basis.

Committee members discussed the finding that military medical specialists are often required to maintain skills that are different than their declared specialty, in part because of the military's need for a "combat ready" workforce. Members felt this could be an opportunity for ABMS Member Boards to work with their partner societies in developing MOC activities for use by military physicians that are common across multiple specialties and address unique health care needs of military service members and their families. Examples of such initiatives are prevalent in the surgical world, where professional surgical societies and associated organizations have partnered with the military to develop programs for use in training and preparing military surgeons for combat operations.[7]

Committee participants also expressed support for working with the Army, Navy, and Air Force Service Branches to develop a mechanism that enables a Board Certified military physician to gain MOC credit for the clinical training received in preparation for deployment.

Committee members were particularly intrigued by the potential for collaboration between the certifying community and the MHS that could help advance both institutions' strategic interests. The ABMS Member Boards could benefit from the Service Branches' experience with, and insights about, use of patient experience of care instruments, systems-based practice evaluations, and simulation for training and assessment. Likewise, the MHS could benefit from ABMS Member Board programs and activities that could be designed to prepare non-military physicians to recognize and address the medical and psychological needs of individuals who have served in the military or the health needs of military families (e.g., children whose parents are deployed).

[7] "One Front and One Battle": Civilian Professional Medical Support of Military Surgeons. Journal of the American College of Surgeons, 2012.

RECOMMENDATIONS

1. Consider developing a model "Special Provisions" policy for use by all Member Boards when considering requests from Board Certified military physicians for extended timeframes to meet initial certification or MOC requirements.

2. Facilitate Member Boards' understanding about the need for flexibility in specialty-specific content requirements for Board Certified military physicians.

3. Encourage Member Boards to recognize practice relevant (but perhaps not specialty-specific) CME for military physicians who, due to their military obligations, are engaging in patient care that is outside the scope of their declared specialty.

4. Foster awareness of military health-related issues impacting medical practice by disseminating research and articles on military medicine to Member Boards, which they in turn could disseminate to their diplomates as part of their MOC programs.

5. Work with Member Boards to foster consistency in how they respond to requests from the military for verification of a physician's certification status.

6. Where appropriate, consider opportunities to extend these recommendations to physicians in the Veterans Health Administration, Coast Guard, Indian Health Service, and Public Health Service.

7. Foster development of programs by Member Boards and/or in collaboration with specialty societies to prepare Board Certified physicians in civilian practice to recognize and address the medical and psychological needs of military service members and their families.

8. Explore with the MHS, opportunities to educate the ABMS Boards Community about innovative approaches it uses to promote team-based care, systems-based practice, and physician use of patient experience to improve care.

9. Engage certifying boards and specialty societies in discussions about developing MOC tools and resources, or repurposing existing MOC tools, that support the training, development, and capabilities of military physicians and surgeons. For example, the Part II educational tools offered by the American Board of Family Medicine could be of use to the military in readying physician specialists and subspecialists for deployment to settings where they will be providing both primary and specialty-specific patient care.

10. Explore the Army, Air Force, and Navy's interest in participating in the ABMS Multi- Specialty Portfolio Program, which would allow Board Certified military physicians to obtain MOC Part IV credit for their participation in the quality improvement activities being pursued within the Service Branches' military facilities.

11. Work with the Service Branches to maintain a list of contacts within the ABMS Member Boards and the Uniformed Services that would be made available to both communities.

CONCLUSION

Understanding the complex and diverse environments in which Board Certified physicians practice is critical to the delivery of a high-quality, relevant, and meaningful continuing certification program. While the SCMPCC report and recommendations pertain to Board Certified physicians in military service, a number of the identified issues are applicable to a broader group of practicing physicians. The SCMPCC appreciates the opportunity to contribute to efforts aimed at improving the Board Certified military physician's experience with ABMS Member Boards MOC programs.

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