AMERICAN BOARD OF MEDICAL SPECIALTIES

STANDARDS FOR INITIAL CERTIFICATION

Approved by the Board of Directors of the American Board of Medical Specialties (ABMS) on February 24, 2016; amended by the Executive Committee of the ABMS Board of Directors on May 11, 2016.

American Board of Medical Specialties

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Preface

Initial Certification by an ABMS Member Board (Initial Certification) serves the patients, families, and communities of the United States (the Public) and improves patient care by establishing high standards for initial assessment of professionalism, training, and knowledge of candidates for specialty certification. ABMS Initial Certification, developed in accordance with the Standards included in this document, is integral to the ABMS' mission to maintain and improve the quality of medical care by assisting the ABMS Member Boards in their development and use of professional and educational standards for the certification of physician specialists.

This document presents the standards and annotations for Initial Certification. Standards are requirements for each ABMS Member Board's program for Initial Certification; it is expected that each Member Board will meet these requirements in a manner consistent with the letter and spirit of the Standards and consistent with the specifics of the relevant specialty. Annotations do not outline additional requirements; however, the annotations provide additional detail, offer potential pathways to meet the requirements, and emphasize important aspects of the Standards.

Initial Certification incorporates the six ABMS/ACGME Core Competencies of Practice-based Learning & Improvement; Patient Care & Procedural Skills; Systems-based Practice; Medical Knowledge; Interpersonal & Communication Skills; and Professionalism, and has an integrated three-part framework that addresses 1) Professional Standing and Professionalism; 2) Training; and 3) Assessment of Knowledge, Skills, and Judgment. The Standards for ABMS Initial Certification are common across the ABMS Member Boards while accommodating differences among the specialties.

In 1933, representatives from the founding specialties (of Dermatology, Obstetrics and Gynecology, Ophthalmology, and Otolaryngology) and the major physician, hospital, medical education, and examination groups of the time met to talk about the education and certification of medical specialists. Together, they were inspired to build a national system of standards for recognizing specialists and providing information to the Public.

Consensus was reached to establish a uniform system for specialty boards to administer examinations developed by experts from within the specialty. The group further concluded that the value of these boards would be maximized by establishing an advisory committee or counsel created by the representatives from the official specialty boards. The result was the formation of the Advisory Board for Medical Specialties (today's ABMS) - which created the framework for standards of excellence in the various specialties that physicians pursue and upon which the Public relies.

In order to assure the Public of their ability to stay current in their knowledge and skills, physicians seek certification and continue to meet standards for continuous learning and assessment throughout their professional careers. The process of certification, once involving occasional continuing medical education courses and periodic assessment, now involves an ongoing cycle of learning and assessment. It places a greater emphasis on professionalism, patient safety, and performance improvement.

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General Standards

Purposes and Anticipated Outcomes

The ABMS General Standards for Initial Certification provide the broad structure for ABMS Member Boards' Standards for Initial Certification. These standards contribute to improved patient care through the development of a rigorous and relevant process for Initial Certification that assesses the knowledge, skills, and professionalism of candidates who care for the patients, families, and communities of the United States. The standards are intended to establish a framework for assessing candidates' fitness for certification through the appraisal of professionalism, training, and expertise by providing a relevant and meaningful process of ongoing professional development and assessment that is aligned with other professional expectations and requirements, and is recognized broadly as a mark of the ability to provide high-quality medical care.

GS-1. Each ABMS Member Board's Standards for Initial Certification will incorporate all six ABMS/ACGME Core Competencies: Practice-Based Learning & Improvement; Patient Care & Procedural Skills; Systems-based Practice; Medical Knowledge; Interpersonal & Communication Skills; and Professionalism.

Annotation
The Six Core Competencies, adopted by ABMS and ACGME in 1999, are recognized as integral to quality patient care. The following are brief descriptions of the competencies.

The competency Practice-based Learning & Improvement refers to the candidate's ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve the candidate's own practice of medicine, the collaborative practice of medicine, or both.

The competency Patient Care & Procedural Skills refers to the candidate's use of clinical skills and ability to provide care and promote health in an appropriate manner that incorporates evidence-based medical practice, demonstrates good clinical judgment, and fosters patient-centered decision-making.

The competency Systems-based Practice refers to the candidate's awareness of, and responsibility to, population health and systems of health care. The candidate should be able to use system resources responsibly in providing patient care (e.g., good resource stewardship, coordination of care).

The competency Medical Knowledge refers to the candidate's demonstration of knowledge about established and evolving biomedical, clinical, and cognate sciences, as well as the application of these sciences in patient care.

The competency Interpersonal & Communication Skills refers to the candidate's demonstration of skills that result in effective information exchange and partnering with patients, their families, and professional associates (e.g., fostering a therapeutic relationship that is ethically sound; using effective listening skills with nonverbal and verbal communication; being mindful of health literacy; and working effectively in a team both as a team member and as a team leader).

The competency Professionalism refers to the candidate's demonstration of a commitment to carrying out professional responsibilities; adhering to ethical principles; applying the skills and values to deliver compassionate, patient-centered care; demonstrating humanism; being sensitive to diverse patient populations and workforce; and practicing wellness and self-care.

ABMS Member Boards should integrate learning and assessment of the six competencies throughout their process for Initial Certification in a manner that best serves the needs of patients cared for by diplomates, and that is relevant to the practice of their respective specialties and to the specific type of practice of a candidate. As appropriate, the component parts of the process for Initial Certification should harmonize with each other.

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GS-2. The Member Board and the training programs in a specialty have a shared responsibility for assessing a candidate's suitability for certification. Multiple methods of assessment, learning, and improvement can be utilized effectively within the process for Initial Certification.

Annotation
To achieve initial certification in a specialty, candidates must be in good standing professionally; they must have satisfactorily completed a rigorous program of education and training with assessment of competencies in the training environment, and they must have passed the Member Board's assessment of knowledge, judgment, and skills. While the program director and faculty should assess all competencies, they have special opportunities to assess those competencies that can be observed in the workplace over time by multiple assessors.

GS-3. Each ABMS Member Board will determine criteria for eligibility, including the expiration date for the Board Eligible period. The expiration date must be no fewer than three and no more than seven years following the successful completion of accredited training, and in accordance with the corresponding Member Board requirements, plus time (if any) in practice required by the Member Board for admission to the certifying examination.

Annotation
The eligibility of a candidate to become Board Certified by an ABMS Member Board is directly related to the recency of completion of an ACGME-accredited residency program (or its equivalent). It is not in the best interests of the medical specialty, the credentialing community, patients or the Public for the status of "Board Eligible" to remain open for an indeterminate period. Allowing an indefinite period of "Board Eligibility" denigrates the achievement of those diplomates who have already achieved Board Certification.

"Board Eligibility" only applies to the period of time between a physician's completion of training and achievement of Initial Certification in a specialty.

In individual instances and for good cause (e.g., military deployment, acute illness), an ABMS Member Board may waive its Board eligibility rules for a candidate.

Additionally, Member Boards should establish well-defined, transparent, and equitable pathways for candidates to re-establish Board eligibility should they not achieve certification during their initial eligibility period.

GS-4. Each ABMS Member Board will work to maintain the value of Initial Certification to the Public and profession through systematic efforts to evaluate and improve the initial certification program to reflect advances in medical practice and assessment methodology. These efforts should seek to increase program quality, relevance, and meaningfulness while remaining sensitive to the time, administrative burden, and costs (monetary and other) to candidates and training programs.

Annotation
The ABMS Member Boards serve the Public through developing and implementing rigorous and relevant Standards for Initial Certification; these Standards also serve the Profession. ABMS Member Boards should be sensitive to advances in residency and fellowship training in their standards design and implementation.

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Professionalism

<u>Purposes and Anticipated Outcomes</u>

Part I of Initial Certification focuses on Professionalism and Professional Standing of candidates for certification by ABMS Member Boards. These Standards contribute to better patient care and improved medical practice by helping to assure the Public that candidates for Initial Certification exhibit professionalism in their medical practice, including acting in the patients' best interests; behaving professionally with patients, families, and colleagues across the health professions; taking appropriate self-care; and representing their qualifications for board certification in a professional manner.

Medical professionalism is at the heart of medicine's social contract with patients and the Public. Core to both the profession's technical expertise and its promise of service, is that members, working together, are committed to maintaining the standards and values that govern their practice to monitoring each other's adherence to these standards and values.

This commitment involves a three-part promise by the profession to acquire, maintain, and advance: an ethical value system grounded in the conviction that the medical profession exists to serve patients' and the Public's interests, and not merely the self-interests of practitioners; the knowledge and technical skills necessary for good medical practice; and the interpersonal skills necessary to work together with patients, eliciting goals and values to direct the proper use of the profession's specialized knowledge and skills, sometimes referred to as the "art" of medicine.

PPS-1. Each ABMS Member Board will identify and convey that Board's professionalism expectations to its candidates for Initial Certification.

Annotation
ABMS Member Boards will identify professionalism expectations for all candidates for Initial Certification. An ABMS Member Board's professionalism expectations may be articulated in documents developed or adopted by the ABMS Member Board.

PPS-2. Each ABMS Member Board will have a process in place to consider the circumstances of an action taken against a candidate's license by a State Medical Board or other determination of unprofessional conduct by an appropriate authority and to respond appropriately.

Annotation
Consistent with the ABMS Minimum Standards for Full and Unrestricted License Policy, at the point of application for Initial Certification, possession of a valid and unrestricted license to practice medicine indicates that the State Medical Board views a candidate's behavior as consistent with the jurisdiction's expectations for professionalism and provision of patient care, and has not identified any issues that justify taking an action against a candidate's license. Hence, this is an appropriate screening mechanism. ABMS Member Boards may, but generally do not, act as the "first investigator" of complaints about a candidate. In some instances, actions taken against a candidate's medical license by a State Medical Board should result in a determination of ineligibility for board certification. In other instances, actions taken against a candidate's medical license by a State Medical Board should not necessarily preclude eligibility for board certification. ABMS Member Boards will appropriately balance their primary obligation to the Public with obligations of fairness and due process to candidates.

ABMS Member Boards with non-physician candidates should establish appropriate mechanisms to address actions taken against the professional licenses of these candidates.

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Education & Training

Purposes and Anticipated Outcomes

These Standards focus on the training of candidates for Initial Certification. Standards for training contribute to better patient care by requiring high quality graduate medical training that is relevant to the candidate's chosen specialty prior to certification. The specialty education of physicians to practice independently is experiential and necessarily occurs within the context of the health care delivery system. Participation in the ABMS Member Board approved residency and fellowship programs prepares candidates for achievement of specialty and subspecialty certification.

ET-1. Each ABMS Member Board will establish requirements for training and document that candidates have met these requirements prior to awarding initial general or subspecialty certification. ABMS Member Boards' training requirements should address duration and quality by specifically requiring that the total training time for general certification must be for a minimum of three years, training for subspecialty certification must be for a minimum of one year, and training programs must be accredited by the Accreditation Council for Graduate Medical Education (ACGME).

Annotation
Each ABMS Member Board will establish training requirements for Initial Certification and determine which programs meet the Board's requirements. Requiring association with the ACGME-accredited residency or fellowship program helps assure ABMS Member Boards that candidates have developed the skills, knowledge, and attitudes for proficiency in all the domains of clinical competency through the assumption of personal responsibility for the care of individual patients under the guidance and supervision of faculty members. Association with an ACGME-accredited residency or fellowship program also ensures that training environments include attention to patient safety and quality improvement.

ET-2. Member Boards may choose to recognize alternate pathways to Initial Certification for candidates who have not completed residency training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

Annotation
Among others, examples of common alternate training pathways to Initial Certification include acceptance of training at international graduate medical education programs deemed to meet the standards of the ABMS Member Board.

Member Board policies and procedures related to approval of candidates from alternate training pathways should not be perceived as arbitrary or capricious; they should be transparent, fair, objective, and equitably available to candidates with comparable credentials.

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Assessment of Knowledge, Judgment, and Skills

Purposes and Anticipated Outcomes

These Standards focus on the secure assessments administered by Member Boards as part of their Initial Certification process. These assessments are intended to provide assurance that a candidate has mastered the core knowledge, judgment, and skills in the specialty necessary for safe and effective performance in provision of patient care. While candidates' preparations for these examinations can drive their learning, the primary purpose of the examinations is to determine whether candidates possess the requisite knowledge, judgement, and skills to assure the Public and the profession that the candidate has met the Standards of the specialty.

The first Standard addresses the overall examination process for Initial Certification. The second and third Standards apply to each examination component for which a pass/fail decision is reported to candidates for Initial Certification.

KJS-1. Initial Certification by an ABMS Member Board is intended to provide patients, health care organizations, and the profession with a dependable mechanism for identifying specialists who have met standards for the specialty. This requires an assessment of candidates' mastery of the core knowledge, judgment, and skills in the specialty.

Annotation
The content covered by the components of the Initial Certification process should be clearly defined and justified in terms of the importance of the content for certification-worthy performance in the specialty, focusing on the knowledge and skills necessary for safe and effective practice.

Member Boards may choose to include more than one examination component (eg, a written and an oral examination; multiple written examinations taken at different stages of training). Design of the examination components should reflect careful consideration of the content and skills to be assessed, whether one or a series of examination components is to be used, when each component may be taken, and how scores on components are to be combined to reach an overall certification decision. To the extent possible, the examination components, taken together, should span the core content, judgment, and skills required for safe and effective practice of the specialty, demonstrating that successful candidates have mastered core knowledge of the specialty and shown they can apply that knowledge in patient care. Professionalism in development, administration, and scoring of all examination components is critical.

To ensure the appropriateness and currency of the certification program, a Member Board should review its examination program on an ongoing basis, revising the overall design for and content covered on individual examination components to reflect the evolution of medical knowledge and clinical practice. When substantial revisions are made to the overall examination or to an examination component, Member Boards should inform candidates about the modifications sufficiently in advance for candidates to prepare for the revised examination.

To aid in monitoring and improving the quality of examinations, Member Boards should track the performance of candidate groups over time (eg, counts and pass rates for first-time and repeat examinees from US/Canadian and international medical schools) and review those reports for trends, anomalous results, and outliers. From a similar perspective, Member Boards should adopt appropriate quality improvement procedures to ensure the appropriateness of content coverage on individual examination components and the relevance, accuracy, fidelity, and currency of test material as medical knowledge and clinical practice evolve.

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KJS-2. Examination procedures should reflect accepted educational standards[1] for test design, development, administration, reliability, validity, fidelity, scoring, and reporting.

Annotation
The purpose and content of each examination component should be defined clearly and justified in terms of importance for current and future practice. To provide an empirical basis for defining the content, Member Boards may wish to perform some type of job analysis, practice analysis, and/or surveys of training program faculty and the broader educational community, practitioners, or other groups; such studies should be coupled with expert judgments about the relative importance of different patient problems and clinical tasks in the practice of the specialty.

Procedures used to score the examination, as well as those used to combine scores on different parts of an examination component to determine overall pass/fail outcomes, should be well-defined and made available to candidates before test administration.

The level of performance required to pass an examination component should be determined by careful analysis and should depend on the knowledge and skills necessary for certification-worthy performance in the specialty. Generally, this will include a periodic review of the pass/fail standard and a structured standard-setting exercise. The pass/fail standard should not be determined to control the number or proportion of persons passing the examination. When alternate forms of an examination are used within or across administrations, the forms should be equivalent from content and psychometric perspectives, and the same level of performance should be required to pass each of the forms.

Each examination component for which a pass/fail decision is reported should be of sufficient length that the same pass/fail decisions would be made for most candidates if they were retested using an equivalent, but not identical examination; appropriate indices of reproducibility (e.g., reliability coefficients, standard errors of measurement, decision consistency) should be estimated for each form and each administration to ensure that this is the case.

Member Boards conducting oral and other subjectively-graded performance-based examinations should provide training to examiners participating in the examination. They should also ensure that each candidate is assessed on a sufficient number of cases by a sufficient number of examiners to obtain reproducible pass/fail decisions and should take steps to ensure that candidates are not disadvantaged based on gender, ethnicity, or other factors unrelated to examination performance.

When possible, to assist candidates in remediating weaknesses identified by an examination component, individual candidates should be provided with feedback on performance that provides meaningful information about areas of strength and weakness without compromising examination security.

Once scores are released, Member Boards should have policies and procedures in place for candidates to request score verifications and for handling appeals.

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[1]These are articulated in the 2014 edition of the *Standards for Educational and Psychological Testing* published by the American Education Research Association, the American Psychological Association, and the National Council on Measurement in Education. Chapter 11 on Workplace Testing and Credentialing is particularly relevant.

KJS-3. Test administrations should be conducted in a manner that ensures that 1) the identified test-taker is, in fact, the person who is taking the test; 2) materials and other assistance used during the examination are limited to those provided or approved by the ABMS Member Board; 3) actual test content is protected and secure; and 4) information about test content is not shared by examinees, examiners, or anyone else associated with the examination unless specifically approved by the Member Board. Policies and procedures consistent with the Americans with Disabilities Act should be in place to evaluate candidates' requests for accommodations in test administration.[2]

Annotation
Test accommodations must be offered to candidates with documented disabilities (e.g., learning and reading disabilities; physical disabilities; visual impairments) to comply with the Americans with Disabilities Act; Member Boards may also offer accommodations in other situations (e.g., extra break time for nursing mothers). Applicants should be provided with information describing the documentation to be submitted with the request for accommodations and the timeframe within which an accommodation decision will be made. Procedures for responding to these requests should be equitable and consistent and should include a mechanism for handling candidate appeals of these decisions.

Member Boards should have well-defined policies in place for dealing with suspected irregularities in test administration. These should include a procedure for handling candidates' appeals of these decisions.

[2] Additional information can be found in the 2014 edition of the *Standards for Educational and Psychological Testing* published by the American Education Research Association, the American Psychological Association, and the National Council on Measurement in Education.

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