Final Report of the Committee on Recognizing New and Emerging Disciplines in Internal Medicine (NEDIM) - 2

Dr. Thomas Blackwell, Chair
Dr. Christine Cassel
Dr. F. Daniel Duffy
Dr. Eric Holmboe
Dr. Holly Humphrey
Dr. David Reuben
Dr. Griffin Rodgers
Dr. Michael Saag
Dr. Robert Wachter
Dr. Donald Wesson
Dr. Laura Wexler
Ms. Lynn Langdon, staff

March, 2006
Philadelphia, PA

Final Report of the Committee on Recognizing New and Emerging Disciplines in Internal Medicine (NEDIM) - 2

As requested by the Executive Committee, this is the final report of the Committee on Recognizing New and Emerging Disciplines in Internal Medicine - 2. The committee was asked to update and revise the first NEDIM Report, adopted in 1993. The committee recommends that the Board of Directors approve this document to replace previous policy.

Introduction and Background

Since 1993 the Board has used the NEDIM Report to guide decisions regarding the creation of certification in new disciplines within internal medicine. Since that time, no new subspecialties have been approved. Certificates of added qualification (CAQs) in the following disciplines have been approved: interventional cardiology, clinical cardiac electrophysiology, transplant hepatology, sleep medicine, and palliative care. Many other disciplines have been slowed down or denied: nutrition, medical management, clinical pharmacology, immunology, and pain management to name a few.

While many of the principles espoused in the original NEDIM Report remain applicable today, the evolution of Maintenance of Certification (MOC) provides potential additional opportunities for recognition of special expertise. Furthermore, the elusive distinction between certificates of added qualification (CAQs) and subspecialty certificates continues to be problematic.

For these reasons the Executive Committee formed a NEDIM-2 committee to update and revise the original NEDIM document. (The Charge to the Committee and first NEDIM Report are attached.)

Committee Recommendations

Competency-Based Certification

Since the NEDIM Report was adopted in 1993, the world of quality measurement, certification, and accreditation in healthcare has evolved rapidly. The IOM report, "Crossing the Quality Chasm" (2001) stimulated a renewed effort to embrace quality standards and measurement techniques to assure patients and the public that medical care in the United States is as safe and effective as it can be.

The Accreditation Council for Graduate Medical Education, for its part, has begun a staged evolution to competency-based training, where the competence required to practice is defined, and trainees are measured against those competency standards. ABMS has embraced

Maintenance of Certification, requiring continued evidence of both knowledge and performance in clinical practice. Distance learning is a reality, and practice-based learning and systems-based practice are becoming a definitive professional responsibility. Quality measures and tools to evaluate systems, practices and individuals are burgeoning.

Maintenance of Certification has become a reality for a rapidly growing majority of Internal Medicine diplomates. MOC is driving the need to fuse effective, efficient continuing medical education programs in general internal medicine and the subspecialties with periodic evaluation of learning and practice performance, and to make both education and evaluation more robust. Internists are beginning to embrace a culture of continuous improvement. Continuing medical education is not only cognitive learning, but also involves measurement of practice performance and re-design of practice systems needed to improve. Competency is not just knowing what to do; it is doing it.

To embrace this broader view of the potential for certification and MOC, *the NEDIM-2 Committee recommends that the ABIM evolve to competency-based certification and MOC in all new and existing certification programs.* This will require continued close collaboration between the Board and the internal medicine educational community, including the continuing medical educational societies.

To issue certification that is based on demonstration of competence instead of months of training requires delineation of specific competencies and development of specific measures of competence in each certification discipline. This delineation of competencies will allow training program directors and the Board to approach each practice discipline or subspecialty as a unit within the broad "parent"[1] discipline. Sub-disciplines will have competencies that are both unique and common to the parent discipline.

Certificates of Added Qualification

The committee agreed quickly that the distinction between CAQs and subspecialty certification is confusing. CAQs were created as an alternative to subspecialty certification in the mid-1980s as a way to reduce fragmentation within the broad discipline of internal medicine. The notion was to recognize emerging disciplines while at the same time keeping a close association with the discipline from which they emerged. The reality is that discipline associations are determined by unique characteristics, not type or classification of certification.

Each of the practice disciplines within internal medicine, including the generalist practices, has a common core training at its base; each addresses an important patient need; and each is a specialty in its own right. Each discipline within internal medicine is essential to providing high quality care, and certification should not imply relative or hierarchical value.

[1] "Parent" discipline may refer to general internal medicine or a subspecialty. It is the broader discipline from which a sub-discipline emerges.

The generalist disciplines of internal medicine (hospital medicine, ambulatory medicine, critical care medicine, and geriatric medicine) require specialized knowledge and experience, much as the traditional subspecialties do. Training pathways, certification requirements, and reimbursement systems should be aligned with this reality. Critical care, geriatric, sports, and adolescent medicine are essentially indistinguishable from the "traditional" subspecialties. Transplant Hepatology, interventional cardiology, and clinical cardiac electrophysiology may be more closely linked to the subspecialty within which they are practiced, yet each is also unique.

Internal medicine is a very broad field with many diverse subspecialties within the overall discipline. Each has its own characteristics and needs. Rather than "classify" the sub-disciplines within internal medicine by type of certificate, the Board should recognize them all as subspecialties with appropriately varying requirements. For example, there is only one training pathway into interventional cardiology, which requires prior certification in cardiovascular disease. In contrast, critical care and sleep medicine have two training pathways: training that is integrated with pulmonary disease training and training directly following internal medicine training.

The NEDIM-2 Committee recommends that the category of Certificate of Added Qualification be eliminated. Existing CAQs should become subspecialties. All large subspecialties should be represented on the Board of Directors. Subspecialties that are closely linked but have multiple training pathways, such as hematology and oncology or critical care medicine and pulmonary disease, should have closely coordinated, complementary policies, standards and requirements. Subspecialties with one training pathway that builds on prior subspecialty training, such as interventional cardiology which follows cardiovascular disease training, should be closely linked to the "parent" subspecialty. In these cases, policy decisions would be brought to the Board of Directors for approval through the "parent" subspecialty discipline.

Maintenance of Certification (MOC) Recognition of Focused Practice

Competency-based certification will identify to the profession and the public that a diplomate has demonstrated the ability to solve problems encountered in the practice of the discipline. Competence, according to Dreyfus[2], means the diplomate can carry out standard actions and can fulfill standard promises to patients without supervision. When faced with a new situation, a competent physician determines appropriate actions by application of rules of practice. In very broad general internal medicine practice, the skill of the internist may remain at this level for uncommon challenges encountered throughout a career.

Over a career, however, many internists narrow or focus their practice, often developing specific areas of proficiency or expertise. A proficient physician, as contrasted with a competent one, deals with complex situations effortlessly. Appropriate actions appear to have come from experience combined with continued learning rather than application of rules. Developing expertise requires considerable experience and practice over years of work. MOC provides an opportunity to identify internists who become proficient in focused areas during their practice.

[2] Dreyfus, SE. The five-stage model of adult skill acquisition. Bulletin of Science, Technology, and Society. 24(3): June 2004: pp 177-181.

The NEDIM-2 Committee recommends creation of an option within MOC for recognition in widely or commonly practiced focused areas within a broad "parent" discipline.[3] *Focused recognition should require demonstration of* ***greater proficiency*** *in the focused area than required for the initial certification and should be identified on the renewed certificate.*

Recognition of changing focus in practice throughout a career values self-directed learning and evaluation, identifies added value of greater proficiency, and provides options for focused expertise over a career. The recognition of focused expertise will be acknowledged within an existing discipline, not a new one. For example, if an internist were to meet standards established for focused recognition in Hospital Medicine, the recertification certificate awarded through MOC would read "Certification in Internal Medicine with Special Expertise in Hospital Medicine." Employers and patients would be assured that such a diplomate had met standards to practice hospital medicine above and beyond those required to be certified in internal medicine. Since certification in internal medicine has been changed only in regards to focus, a diplomate may use the MOC process in subsequent years to continue to meet the standards for Hospital Medicine or, as a career evolves, could maintain the internal medicine certificate without specific focused recognition.

The NEDIM-2 Committee has developed criteria to guide decisions about components of internal medicine or the subspecialties that might be appropriate for focused recognition. It is important that these criteria be considered carefully to make sure they are weighted to allow only recognition of components of internal medicine that are widely practiced by some, but not all, diplomates in the field and that there be evidence that focused recognition in the field would benefit patient care.

Focused recognition should not be used as an MOC merit badge or as a way to inappropriately narrow the scope of practice in general internal medicine. Focused recognition is intended to provide standards of professionalism for those who truly focus their practice in the area in contrast to others who practice in the area very little or not at all. Certification in Internal Medicine should continue to provide the basis for recognized competence needed to practice the broad spectrum of both inpatient and outpatient medicine. Internists will not be required to seek focused recognition, and many certified internists with no additional special recognition will continue to play a vital role in the continuum of care.

Principles for Recognition Through Certification and Maintenance of Certification

Based on the recommendations described above, the NEDIM-2 Committee revised the Principles for Recognition through Certification from the first NEDIM Report. *The committee recommends adoption of the following new principles to guide the Board in considering requests for recognition of new subspecialties or areas of focused recognition within internal medicine or an existing subspecialty.*

[3] "Parent" discipline may refer to general internal medicine or a subspecialty. It is the broader discipline from which a sub-discipline emerges.

The primary reason to recognize a new discipline through certification is to enhance the quality of care by setting and maintaining high standards and publicly recognizing those who meet those standards. Certification in both new and existing disciplines should evolve to become competency-based, **with special attention to the competencies needed to provide coordinated specialized care within a continuum of patient-centered care.**

The integration of internal medicine and its subspecialties is of crucial importance to maintain high standards of practice and to provide continuity of care to patients. The value of each sub-discipline within the broad discipline of internal medicine is derived from patient and healthcare system needs. Each subspecialty is essential to the provision of high-quality care. Wherever possible, the Board prefers incorporation of new knowledge into existing disciplines over the creation of a new subspecialty; however, when a new area meets the criteria for recognition as a subspecialty, it should be designated as such. To be considered for recognition as a new subspecialty, the area of special expertise must meet the criteria specified below.

Maintenance of Certification should provide an option for internists to focus their certification to correspond to widely practiced areas of focus within their parent discipline. MOC recognition in focused practice (informally called "Focused Recognition") should require demonstration of greater proficiency in the focused area and should be identified on the renewed certificate. To be considered for recognition, a focused practice area must meet the criteria specified below.

The decision and responsibility to recognize a new subspecialty or area of focused recognition within internal medicine remains the responsibility of the American Board of Internal Medicine, subject to approval by the American Board of Medical Specialties. Nevertheless the Board should listen to feedback from interested stakeholders throughout the internal medicine and primary care communities before proposing recognition in a new area to ABMS.

Criteria for Recognition as Subspecialty Certification

- The discipline must have a unique body of knowledge that cannot be fully incorporated into the "parent" discipline.

- The discipline must have clinical applicability to be practiced in a form that is distinct from the "parent" discipline.

- The discipline must contribute to the scholarly generation of new information and must advance research in the field.

- There must be an important social need for the discipline and evidence that practice of the discipline improves patient care.

- To become competent in the discipline requires supervision and direct observation provided in formal training settings in order to achieve competence in the scope of practice.

- The minimum training period for demonstration of competence needed for certification is 12 months.

- Commonly, the discipline will involve complex technology or specific site-of-care opportunities for learning that are best provided in the training setting.

- The positive value of certification in the new discipline must outweigh any negative impact on the practice of general internal medicine or an existing subspecialty or on the basic education in the core competencies of internal medicine.

Criteria for Focused Recognition through Maintenance of Certification (MOC)

- Large numbers of internists must focus their practice in the discipline, while others may not practice in the focused area at all.

- There must be an important social need for the discipline and evidence that focusing practice in the discipline improves patient care.

- Proficiency or expertise can be gained through rigorous demonstration of self-directed, continuous learning and self-evaluation of practice over time, and does not require direct observation of technical procedures or skills that can only be achieved through formal residency or fellowship training.

- To become proficient in the discipline requires a volume of experience (focus) that defines the discipline; specific thresholds of experience volume will be established and must be exceeded for recognition in an area of focus.

- The positive value of certification in the focused area must outweigh any negative impact on the practice of, or education in, general internal medicine or an existing subspecialty of internal medicine.

Costs of Certification

The fixed cost of development of secure examinations and performance assessment tools for substantiating competence and proficiency is high so the cost per candidate for certification or focused recognition decreases dramatically as the number of candidates increases. Until now, fees for certification have been based on aggregate costs for all programs, rather than for each individual program.

Using 2005 processes and standards for development of high quality tools and examinations, the "break-even" number of candidates for subspecialty certification is 400 (direct costs) or 600 (including indirect costs.) Because fees can be adjusted and costs can be cut (e.g., half-day exams; biennial administrations) cost should not be a primary determinant of whether to recognize a discipline. *The NEDIM-2 Committee recommends, however, that the Board consider having differential fees within the programs for subspecialty certification and MOC recognition of focused practice.*

Summary Recommendations

The Committee recommends that the Board evolve to competency-based certification and MOC for all new and existing certification programs.

The Committee recommends creation of an option within MOC for Focused Recognition in widely practiced areas within a parent discipline. Focused recognition should require demonstration of greater proficiency in the focused area than required for the initial certification and should be identified on the renewed certificate.

The Committee recommends that the category of Certificate of Added Qualification be eliminated.

The Committee recommends adoption of the new Principles for Recognition through Certification and Maintenance of Certification.

The Committee recommends adoption of the Criteria for Recognition as Subspecialty Certification.

The Committee recommends adoption of the Criteria for MOC Recognition of Focused Practice.

The Committee recommends that the Board consider having differential fees within the programs for subspecialty certification and MOC Recognition of Focused Practice.