**Robert M. Wachter, MD**

Professor and Associate Chairman, Department of Medicine, University of California, San Francisco, San Francisco, California

# What Will Board Certification Be—and Mean—for Hospitalists?

Soon after they form, most new medical fields begin agitating for a special certification, something that says, "We're here, and we're different." As I've noted previously in the *Journal of Hospital Medicine*, the field of hospital medicine resisted this impulse in its early years, fearing that any special designation or certification would actually harm the field's growth and status.[1] The concern was that managed-care organizations—convinced by the evidence that hospitalists improve efficiency and might improve quality[2]—would react to any new hospitalist sheepskin by mandating that anyone providing hospital care to its covered patients have one. The backlash from primary care physicians locked out of the hospital by such a mandate would have been swift and ultimately damaging to hospitalists. In addition to these political considerations, the early field of hospital medicine lacked the academic credibility and scientific underpinning needed for specialty designation.[3]

Times have changed. There are now more than 15,000 hospitalists in the United States, and nearly half of American hospitals have hospitalists on their medical staffs. In many markets, including my own, hospitalists care for most internal medicine inpatients, as well as significant numbers of pediatric and surgical patients. The field has achieved academic legitimacy, with this journal, several textbooks, large and flourishing groups in every academic medical center, and several residency tracks and fellowship programs.[4,5] The Society of Hospital Medicine (SHM) has grown to more than 6000 members, become a widely respected and dynamic member of the community of professional societies, and published its core competencies.[6]

With this as a background, in 2004 SHM asked the American Board of Internal Medicine (ABIM) to consider a program of certification for hospitalists. As a past SHM president and now a member of the ABIM Board of Directors, I am privileged to have a bird's-eye view of the process. In this article, I reflect on some of the key issues it raises.

## THE NUTS AND BOLTS OF BOARD CERTIFICATION

Since the first board (ophthalmology) was formed in 1917, 24 specialty boards have emerged, all under the umbrella of the American Board of Medical Specialties (ABMS).[7] Because no one type of physician can "do it all," certifying boards have had to struggle not only with how to assess competency in existing disciplines, but with the dynamic and often controversial questions raised when new fields emerge. In the past few decades, certifying boards have grappled with specialties formed around new procedures (such as cardiac electrophysiology), discrete populations




DOI 10.1002/jhm.202
Published online in Wiley InterScience (www.interscience.wiley.com).

(geriatrics, palliative care), complex diseases (HIV medicine), and sites of care (intensive care medicine, emergency medicine). It is this latter category that now includes hospital medicine.

In the past, it was relatively simple for a physician to obtain board certification. Residency or fellowship training was believed to confer on its graduates the presumption of competence and professionalism—the program director's attestation served as the graduate's *Good Housekeeping* seal of approval. Passing the board exam was the final step, ensuring that newly minted graduates had the requisite knowledge and judgment to practice in their fields.

Remarkably, for the first half century of the specialty boards, all certifications lasted for a physician's professional lifetime. Beginning with the 1969 decision of the American Board of Family Practice to limit the validity of its certificates to 7 years, all ABMS member boards now time limit their certifications, usually to 7-10 years.[7] Of course, in an environment of rapidly changing medical knowledge and new procedures, periodic—even continuous—demonstration of competence is increasingly expected by the public.

For ABIM, the mechanism to promote lifelong learning and demonstrate ongoing competence in the face of a rapidly changing environment is known as maintenance of certification (MOC).[8] Through MOC, board-certified internists demonstrate their ongoing clinical expertise and judgment, their involvement in lifelong learning and quality improvement activities, and their professionalism. Because MOC involves no new training requirements and includes an assessment of a physician's actual practice, it provides a potential mechanism, heretofore untapped, of demonstrating a unique professional focus that emerges after the completion of formal training.

## HOSPITALIST CERTIFICATION AND THE MOC PROCESS

As ABIM considered a separate certification pathway for hospital medicine, it faced a conundrum. The vast majority of hospitalists are general internists (most of the rest are generalists in family medicine or pediatrics) who entered hospital medicine at the completion of their internal medicine training or after a period of primary care practice. Job opportunities for hospitalists are plentiful, and—except for additional training in quality improvement, systems leadership, care transitions, palliative care, and communication[9]—there is little clinical rationale to prolong internal medicine training for hospitalists (some individuals may opt for fellowships to enhance their leadership skills or to launch a research career,[5] but few would argue for mandatory additional clinical training in hospital medicine at this time).

**TABLE 1**
**The American Board of Internal Medicine's Criteria for Determining Whether a New Field Merits Focused Recognition through Its Maintenance of Certification Program (from the New and Emerging Disciplines in Internal Medicine II [NEDIM II] Report, American Board of Internal Medicine, 2006)**

- Large numbers of internists must focus their practice only in the discipline, while others in the parent discipline do not focus their practice in the area of focused recognition.
- 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.

So, in the absence of formal training, how could the ABIM (or other boards) recognize the focused practice of hospitalists? This question must be framed within a broader challenge: Is it possible and appropriate for certifying boards to recognize expertise and focus that is accrued not through formal training, but through actual practice experience and accompanying self-directed learning?

In 2006, the ABIM took up this question, producing a report (New and Emerging Disciplines in Internal Medicine II [NEDIM II]) that delineated several criteria to guide whether a new field merited focused recognition through MOC (Table 1). Judging by these criteria, hospital medicine appears to be a suitable first candidate for recognition of focused practice through MOC.

## PRELIMINARY THOUGHTS ON FOCUSED RECOGNITION IN HOSPITAL MEDICINE

The ABIM has endorsed the concept of recognition of focused practice in hospital medicine and charged a subcommittee (that I chair) with working out the details. It would be premature to describe the committee's deliberations in detail (particularly

because the final plan needs to be approved by both the ABIM and the ABMS), but the following are some key issues being discussed.

First, demonstration of focused practice requires some minimum volume of hospitalized patients. In the absence of hard data defining a threshold number of cases for hospitalists, we are likely to endorse a number that has face validity and that reliably separates self-identified hospitalists from nonhospitalist generalists. As with all volume requirements, we will struggle over how to handle academic physicians, physician-administrators, and physician-researchers who limit their overall clinical practice but who spend most of their clinical time in hospital medicine and the bulk of their nonclinical time trying to improve hospital care.

The requirements to demonstrate performance in practice and lifelong learning may be more straightforward. As with all such MOC requirements, the ABIM is increasingly looking to use real practice data, trying to harmonize its data requirements with those of other organizations such as insurers, Medicare, the Joint Commission, or for pay-for-performance initiatives. Despite the operational challenges, this effort is vital: for MOC (including focused recognition) to be highly valued by patients, purchasers, and diplomates, it will increasingly need to measure not only what physicians *know*, but also what they *do*.

Finally, there is the test. It is likely that a secure exam for MOC with Recognition of Focused Practice in Hospital Medicine will involve core content in internal medicine (information that every internist should know), augmented by substantial and challenging content in hospital medicine. Because it will be vital that a competent hospitalist understand key elements of outpatient practice, the exam will not be stripped of ambulatory content but will likely have fewer questions on topics that hospitalists are unlikely to confront (osteoporosis, cancer screening).

## ONGOING ISSUES

As hospital medicine continues its explosive growth, it is important to develop ways to make board certification relevant to hospitalists. The ABIM believes that modifying the MOC process to recognize physicians who have focused their practice and achieved special expertise in hospital medicine is a good way to launch this effort. Ultimately, this process is likely to evolve, particularly if separate training pathways for hospital medicine emerge. For now, the development of Recognition of Focused Practice in Hospital Medicine will further legitimize the new field, provide ABIM with insights into how to recognize physicians who have advanced

through practice-based learning rather than through training, and help to guide other certifying boards (particularly family medicine and pediatrics) considering hospitalist certification. In the end, the process will need to be user-friendly for and satisfying to diplomates, flexible enough to allow for career transitions (both toward and away from hospital medicine), and sufficiently rigorous to be credible to all stakeholders, particularly patients.

Address for correspondence and reprint requests: Robert M. Wachter, MD, Box 0120, UCSF, San Francisco, CA 94143-0120; Fax: (415) 502-5869; E-mail: bobw@medicine.ucsf.edu

Received 30 January 2007; accepted 30 January 2007.

## REFERENCES

1. Wachter RM. Reflections: the hospitalist movement a decade later. *J Hosp Med.* 2006; 1:248-252.
2. Wachter RM, Goldman L. The hospitalist movement 5 years later. JAMA 2002; 287:487-94.
3. Kelley MA. The hospitalist: a new medical specialty? *Ann Intern Med.* 1999;130:373-375.
4. Wachter RM, Goldman L. Implications of the hospitalist movement for academic departments of medicine: lessons from the UCSF experience. *Am J Med.* 1999;106:127-133.
5. Ranji SR, Rosenman DJ, Amin AN, Kripalani S. Hospital medicine fellowships: works in progress. *Am J Med.* 2006; 119:72.e1–e7.
6. Dressler DD, Pistoria MJ, Budnitz TL, McKean SC, Amin AN. Core competencies in hospital medicine: development and methodology. *J Hosp Med.* 2006;1:48-56.
7. Norcini JJ. Recertification in the United States. *BMJ.* 1999; 319:1183-1185.
8. Cassel C, Holmboe ES. Professional standards in the USA: overview and new developments. *Clin Med.* 2006;6:363-367.
9. Plauth WH 3rd, Pantilat SZ, Wachter RM, Fenton CL. Hospitalists' perceptions of their residency training needs: results of a national survey. *Am J Med.* 2001;111:247-254.