Recertification — the debate continues

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Definitions:

Certification is a testimony to the fact that an individual has completed an appropriate form of training. It is of two types:

Certification of attendance: related to the process of training

Certification of competence: certifies the product of training is competent.

Licensure is formal permission from a constituted authority to do something — a certificate of permission.

While certification of competence may sometimes be acceptable for licensure, they are not equivalent; e.g. internship. Certification is granted by the training body (e.g. university), while licensure is granted by the health authority.

Recertification is the process by which a professional body testifies intermittently to the competence of each of its members, either with or without a period of formal retraining.

Relicensure is the means by which an employing body grants permission to the practitioner, whose original licence to practise has lapsed for some reason, to recommence practice.

Logically, one can be recertified only if one has been certified in the first instance. Thus recertification is the responsibility of the body that issued the certificate in the first instance. It is questionable whether a certificate of competence, once issued, could be withdrawn, while it is the prerogative of a licensing body to withdraw the licence of any person who fails to satisfy the requirements for continuing licensure, whether related to incompetence, negligence or malpractice.

The concept of time-limited certification arose to overcome the problem created by a lifetime guarantee of competence when clearly competencies are not static, when new competencies are required to maintain professional competence and when originally acquired competences are sometimes no longer appropriate.

Time-limited certification

Should certification of competence be limited by time?

Arguments have been put forward both for and against time-limited certification:

For:
- induces self-evaluation
- promotes self-improvement
- results in collective improvement of the profession
- profession takes the lead in setting standards for its own practice
- keeps body of knowledge intact; reduces splintering into subspecialties

Against:
- Cannot be done properly; mostly tests of knowledge
- limited research indicating predictive validity of such exams
- thus society may be deprived of a practitioner performing at acceptable level
- practitioners improve throughout their careers
- recertifying is time-consuming and unproductive, as extends beyond scope of practice
- public expectations unrealistic; more concerned with cost-containment than competence

Questions:

1. Should recertification be introduced?

1.1 No: Why not?

The professional is able to look after his/her maintenance of competence
Skills developed are retained for life
Only a small minority of doctors are incompetent
Entry into a specialty is after a stringent training and examination process
The incompetent doctor will automatically be ostracised by the community
The profession has lasted for centuries without recertification
Being judged by a colleague is anathema to a self-respecting professional
There is no uniformity in practice standards

1.2 Yes: For what purpose?

Maintain competence and improve patient care
Set and maintain professional standards with advances in the practice of medicine
Forster learning throughout a lifetime as knowledge continues to grow
Reassure the public who are entitled to the highest standards of medical care
Be accountable to the employer (government) who provides funding
Be legally accountable, as demanded by employers and insurance companies
provide a baseline against which incompetence may be judged.

2. If "Yes" how should recertification be implemented?

Possibilities:

2.1 Through the periodic demonstration of competence by:

2.1.1 performance at examination
2.1.2 audit of practice
2.1.3 outcome measures, e.g survival rates, success rates etc

2.2 Through providing evidence of attempts to maintain competence by:

2.2.1 participation in educator activities, such as:
publication of papers and books
presentation of papers at meetings
teaching students, interns and registrars

2.2.2 attendance at CME activities, such as:
congresses
conferences
workshops

2.2.3 undertaking supervised learning projects, such as:
attendance at a special unit to acquire new skills

2.2.4 involvement in quality assurance activities such as:
attendance at hospital quality assurance meetings

2.2.5 completion of self-assessment tests administered through
the mail
audiotapes
computers

Advantages and disadvantages of each

2.1.1	Examinations:	
	direct evidence of ability	logistic difficulty in setting up
	acceptability high to public	limitation of methods
	quantifiable	unacceptable to professional
		competence not same as performance
2.1.2	Audit	
	performance matters	put on a "show" to impress
	stimulates competent,	threatening
	helps detect incompetent	negativity unacceptable
	self audit acceptable	objectivity questionable
	external audit more objective	costly, acceptability?
	chart audit more acceptable	limited by quality of records
2.1.3	Outcome measures:	
	what ultimately matters	too many intervening variables
	used to validate process measures	follow- up required to find effects
	much outcomes research in hospital	bulk of practice in ambulatory settings
2.2.1	Participation in educator activities:	
	direct evidence of interest	indirect relationship to competence
	helps promote the discipline	does not identify incompetence
		nominal participation possible
2.2.2.	Attendance at CME activities	
	helps update knowledge, skills	little evidence of improved practice
	can be through distance education	takes professional away from practice
	opportunity to share with peers	often more a social event
2.2.3.	Supervised learning projects	
	ideal for new skills	only a few skills at a time
	individual attention given	only a few learners at a time
2.2.4.	Quality assurance activities	
	concern for equlity	paucity of activities available
	aimed at high standards	fails to identify incompetent
	clinical indicators of quality	variable criteria of quality
2.2.5.	Self assessment	
	capitalizes on intrinsic motivation	no guarantee of execution
	immediate feedback	no guidance to address deficiencies
	focus on perceived weaknesses	subjectivity high

Some examples

1. RACS (from 1.1.1994)

It is mandatory for all Fellows to show documented evidence of CME, surgical audit and appointment at an approved institution.

CME: A. attendance at hospital meetings (grand rounds, unit meetings, outcome meetings)
B. self-directed CME (readings, audio, video), self-assessment exams
C. major scientific meetings (congresses, society, state, international)
D. special CME activities (advanced courses, visits, presentations/publications, teaching)

Audit: unit, group or individual with peer review.

Institutional appointment: documented evidence of holding a current surgical appointment to an approved hospital.

2. RACP (from 1.1.1994)

Maintenance of Professional Standards (MOPS) program

Key elements: flexible and diverse, emphasis on CME, recognition of everyday educational activities, greater weight for activities influencing practice and outcome, quality assurance.

Credit distribution (five-year cycle):	
CME (meetings, workshops, learning projects, self assessment)	450 cr
Teaching & research (teaching, presentation, publication)	250 cr
QA (passive, active)	250 cr
Practice quality review	500 cr

3. RACOG (from 1978)

Time-limited certification introduced at time of founding. Fellows granted certificate initially for a period of 10 years. Thereafter, renewal every 5 years. Requirements linked to involvement in professional development activities — accumulation, over a five-year period, of 150 cognate points (based on 1 point per hour of involvement) from:

Educator activities (publication, presentation, teaching)	60 cp
CME attendance (congresses, courses, workshops)	130 CP
Supervised learning projects (special unit/clinic)	50 cp
QA activities (e.g. attendance at hospital QA meetings)	50 cp
Completion of self-assessment tests	120 cp

4. RCPs/UK (Edin, Glasgow & London) (Recommendations, 1994)

"..Not possible to rely solely on what is learnt by experience for the next twenty-five years or more".

A system whereby credit is given for "acquiring and disseminating new knowledge through: reading, writing, teaching, research, audit, clinical meetings, conferences.

"..Research and the giving of papers ..do not ..supplant the requirement of individuals to participate in CME activities".

100 hours/year or more on CME over a 5-year cycle for "approved educational activity".

50% external (courses outside hospital)

50% internal (courses within hospital, clinic units and associated departments)

Both within specialty and across wide spectrum of general internal medicine.

Opposed to complex weighting systems.

Issue certificate of participation in CME.

Conclusion

With the ever-expanding body of medical knowledge it is virtually impossible for the medical practitioner to keep abreast of the developments in the field unless positive steps are taken to achieve that aim. While the medical school has the responsibility of inculcating the skills of self-directed learning in the future members of the profession, it is up to the respective professional bodies to set in place mechanisms which encourage the specialist to maintain his/her competence. One means of achieving this is through recertification procedures, of particular importance in the case of those "at risk", such as the solo practitioner, the ageing practitioner, the overly busy practitioner, the occasional practitioner, the returning practitioner and the practitioner who does not belong to a professional association. However, recertification measures which are punitive in nature focussing on the detection of incompetence rather than on the maintenance of competence, may help identify the few who do not match up to the minimum standards, but do little to improve the competence of the majority. Furthermore, assessment procedures which focus on the testing of knowledge at the expense of practice do not guarantee that the knowledge is applied in actual practice. While the professional resents largely invalid measures of competence, opportunities for self-improvement should be welcomed. Thus recertification processes which enhance competence should be encouraged. It is up to the professional body to regulate itself, rather than await the imposition of mandatory systems of performance assessment by an outside body.