POSITION PAPER

THE AOA’s BOARD CERTIFICATION PROGRAM: A CALL FOR REVIEW

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National Board of Examiners in Optometry ®
4340 East West Highway
Suite 1010
Bethesda, MD 20814
Tel: (301) 652-5192
Fax: (301) 907-0013
E-mail: nbeo@optometry.org
Web: www.optometry.org
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Dear Colleague:

The following position paper is presented to the profession from the Board of Directors of the National Board of Examiners in Optometry (National Board) based on a 7-1 vote. While we have great respect for the work of our “flagship” membership organization, the American Optometric Association (AOA), this paper presents the rationale for the National Board’s concerns about the new AOA “board certification” program in its current form as of this date.

The original need presented by the AOA for “board certification” was based on an unsubstantiated claim that ODs were being denied admission to managed care organizations and hospital staffs. The purported need for this program has changed over the past few months and it has evolved into a program of continuing education (CE) for practicing optometrists based on a national curriculum with post-course testing. While another CE program may be useful, we believe that the AOA’s program is not worthy of the title “board certification” as this term is used and understood by other healthcare professions and the public.

The National Board believes that a better approach would be for the AOA to work with the state boards to enhance the integrity of optometric licensure. Establishing “board certification” as another credential on the same level as optometric licensure is likely to confuse the public and diminish optometry in the eyes of other healthcare professions. Further, the National Board is concerned that, once established, ABOP “board certification” will become a de facto requirement for practice in addition to licensure, unlike the voluntary status with which it is now portrayed.

Consequently, we believe that the AOA’s program of “board certification” is redundant and unnecessary.

I trust that you will take the time to study this paper, as the impact of this issue is an important one for the profession. Please feel free to respond to the National Board’s position at nbeo@optometry.org.

Sincerely,

Donald R. Gordon, O.D.
President
THE AOA’s BOARD CERTIFICATION PROGRAM: 
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Introduction

The writing of this paper was precipitated by the refusal of the American Optometric Association (AOA) to hold a national debate within the profession at large about the merits of its program of “board certification” either before or since taking action at the June 1999 AOA Congress and establishing its American Board of Optometric Practice (ABOP). Although a “call for comments” period was held after the establishment of ABOP, this did not allow a profession-wide debate on the merits of “board certification” before the AOA program had been implemented.

“Board certification” is an important national issue for the whole profession, and the public, not simply a new AOA membership benefit. In fact, as the profession enters the 21st century, this unilateral action of the AOA could have an impact on the future of optometry equivalent to the establishment of state licensure in the first quarter of the 20th century; the consolidation of optometric education around significant pre-optometry education and the 4-year OD degree, and the establishment of “National Boards” in the middle of the 20th century; and the expansion of the scope of practice by the states in the last quarter of the 20th century.

Regrettably, based on the information published in several issues of the AOA News and other optometric publications, as well as a one-hour meeting with three representatives of the AOA Board of Trustees and three representatives of the ABOP Board of Trustees in Seattle, Washington, on December 10, 1999, the Board of Directors of the National Board of Examiners in Optometry (National Board) believes that the AOA program of “board certification,” in its current form (as of February 1, 2000):

• is redundant and unnecessary;
• will introduce another entry-level credential as a requirement for practice in the 21st century;
• will damage the credibility of optometry in the eyes of other healthcare professions;
• will mislead the public.

The National Board submitted a letter to ABOP to this effect on December 17, 1999, in response to the “request for comment from interested persons and entities” announced in the AOA News. This paper more fully addresses, for the profession, the National Board’s understanding of “board certification,” and how this understanding differs from the program being implemented by the AOA through its wholly owned subsidiary -- ABOP.
National Board position on “board certification”

Of historical interest is that the National Board, itself, was first conceived at an AOA conference. One of several resolutions adopted at the First Conference to Establish Optometric Standards, held in St. Louis in 1922, recommended establishing a Central Examining Board, with two main functions: as a basis for membership in an academy of optometry; and, as a basis of certification of eligibility for optometric licensure. The National Board was eventually founded in 1951 by the joint efforts of the International Association of Boards of Examiners in Optometry (IAB), now known as the Association of Regulatory Boards of Optometry (ARBO), and the Association of Schools and Colleges of Optometry (ASCO). This action was taken with the support, but not the participation, of the AOA. The governance of the National Board still represents this original bi-lateral action of the optometry licensing boards and the schools and colleges of optometry, with four directors nominated by ARBO, three nominated by ASCO, and one nominee representing the public.

When the Board of Directors of the National Board became aware in early 1998, through reports in the optometric press, that an AOA Project Team was investigating the need for “board certification” in optometry, the following two motions were adopted unanimously at its meeting in March 1998 to express the National Board’s position on the meaning of “board certification” and to clarify the purpose of the current series of examinations it develops, administers, and scores:

1) the term “board certification” as used in credentials review by managed care organizations refers to earned credentials at a level above licensure;
2) passing any current National Board examination, including the TMOD examination, or any combination of current National Board examinations, is not equivalent to “board certification.”

These positions were submitted by letter to then AOA President John McCall and the AOA Board of Trustees in December 1998, and informally provided to the AOA Project Team in January 1999, along with an offer to help and cooperate. The transmittal letter from the National Board president also stated “the Board is concerned that misinterpreting the meaning of ‘board certification’ as it is usually and customarily used within the ‘medical’ community, of which optometry is a distinct discipline, can have a negative effect in the long term.” No response was received.

Credentialing for entry-level competence

Over the past two decades the profession has expanded the scope of optometric practice through individual state actions, broadened education leading to the Doctor of Optometry (OD) degree, and created credentials that have been accepted as credible measures of entry-level competence. Today, state boards of optometry license new practitioners who have: 1) graduated from an accredited OD program; and 2) passed “National Boards.” Both of these important elements in optometric credentialing (one for educational programs the other for individuals) were primarily established to meet state licensure requirements.
Without state requirements for approving educational programs and testing applicants for initial licensure, it is likely that both the Council on Optometric Education (COE) of the AOA and the National Board would not exist.

New graduates today demonstrate individually their entry-level competence by obtaining the completion certificate of the National Board. This certificate requires passing the National Board’s Part I (Basic Science), Part II (Clinical Science), Part III (Patient Care), and Treatment and Management of Ocular Disease (TMOD®) examinations. Fifty-two optometric licensing boards (all 50 states plus the District of Columbia and Puerto Rico) require or accept passing Parts I and II, 47 require or accept passing Part III, and 47 require or accept passing TMOD. The TMOD examination, which was introduced in 1985, has become the “gold standard” for assuring entry-level competence in this area of expanded scope of practice for both new graduates and already licensed ODs. Both optometric education and the National Board’s sequence of examinations have been subjected to intense challenge during the period of expansion of the scope of optometric practice, and both have withstood scrutiny by state legislatures and opposition from organized medicine.

Thus, it is accurate to report that for demonstrating “fitness to practice,” the current system works well. Over time improvements are made, especially based on new knowledge introduced into education and new testing methods. But the fundamental elements necessary to assure the public that new graduates are ready to be licensed and to assume responsibility for unsupervised practice are in place and the public is protected. At the same time, the legitimacy and quality of this system of public protection reflects well on the profession and all licensed optometrists, as optometry’s entry-level credentials are recognized as being credible by other healthcare professions and the agencies charged with the protection of the public.

**Credentialing for continuing competence**

The mechanisms for assuring continuing competence of licensed ODs for the protection of the public are more diffuse, but have been implemented on a state-by-state basis after years of national debate, much of which was stimulated by the AOA’s leadership through coordinating national conferences and the work of the AOA committees and staff. Also, over the past decade more attention has been given to improving existing programs of continuing competency assurance by all the healthcare professions, including optometry.

The system currently in place assumes that requiring an OD to attend a certain number of hours of optometric continuing education (CE) each year, and in some states some post-course testing of knowledge gained in defined topics, is a reasonable compromise between two extremes: a very rigorous re-licensure program (using knowledge assessment and/or practice accreditation) and the assumption that once licensed an OD is forever competent. Several attempts over the past 20 years to require re-licensure by examination for all the health professions have failed due to opposition by state associations of all professions. In optometry, re-licensure by examination was essentially accomplished during the 1980s and 1990s for ODs preparing to treat and manage ocular disease.
But an ongoing system of re-licensure by examination for optometry has been opposed based on several arguments which have included the observation that malpractice insurance rates have not increased significantly even with expanded scope of practice, that such a system would not necessarily prove anything about individual continuing competence “on the job,” and that it would increase the costs of practice and hence increase patient charges. Although there is face validity to the concept that requiring CE (whether by a state board or by a voluntary membership organization) helps assure continuing competence, especially with post-course testing, there are no research data to support this “assumption.” However, as mandatory CE exists in all but a few states, optometry legitimately can claim that it has taken, and has held, a leadership role within all licensed healthcare professions by at least developing a system of continuing competence credentialing that guarantees the public that every practicing OD is required to “go back to school” periodically to stay in practice. This is a base upon which to build.

At the 1992-94 Georgetown Summit on Optometric Education (Summit) series of conferences, which was co-sponsored by the AOA and ASCO, the invited representatives from the various organizations comprising the profession at-large and the AOA and ASCO leaders present discussed the issues surrounding entry-level competence and continuing competence. The consensus was that while the system in place for developing and determining entry-level competence was quite sound, the then current system for assuring continuing competence based simply on a certain number of hours spent in lectures should be improved within the system of license renewal. Probably the most important statement to emerge from the whole summit series of conferences was adopted on July 12, 1992, at the Conference on Scope of Optometric Practice, held in St. Louis, Missouri. The statement, "Optometry: A Responsible Profession," includes the following sentence: “The maintenance of continuing competencies and professional growth must be ensured by continuing learning and assessment and thereby it sustains the integrity of professional licensure.” It is clear that the intent of this sentence within the larger statement of principle was to recommend that the profession concentrate on, and continue to improve, the system of license renewal for the benefit of the public.

In the late 1990s, the Pew Health Professions Commission released two reports that have refocused national attention on this issue. Recommendation 10 of the 1998 report, Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation, addresses continuing competence as follows: “States should require that their regulated health care practitioners demonstrate their competence in the knowledge, judgment, technical skills and interpersonal skills relevant to their jobs throughout their careers.” While recognizing that state regulatory agencies should be responsible for assuring continuing competence of all the health professions they regulate within each state, the Commission also made a strong case for ongoing efforts of collaboration amongst professional groups to experiment with a variety of options to address this worthy goal. Recognizing that the current state system relies on several forms of CE without assessment at one end of a continuum and disciplinary actions at the other, the Commission has urged all professions to explore more options to assure the public, through the state regulatory agencies, that licensed practitioners are still capable of providing safe and effective care.

One initiative within optometry that followed from this admonition was the National Optometric Continuing Education Conference (NOCEC) held in April 1999, sponsored by ARBO. This invited conference featured eight of the major groups in the profession, in addition to eight state boards. Two Trustees represented the AOA.
A number of well-conceived recommendations which came out of that conference were presented in the widely distributed conference report, including the establishment of accredited learning tracks, the adoption of alternate forms of CE delivery, post-course testing, and outcomes assessment. Roles for all the major groups in the profession, including the AOA, were recognized. The outcomes of this report were discussed at the 1999 ARBO Annual Meeting and action plans concerning the recommendations have already begun. In October 1999, the Council on Optometric Practitioner Education (COPE), a national clearinghouse for state board approval of optometric CE for license renewal implemented by ARBO in 1995 as a service to its member state boards, met with representatives of the National Board to discuss the recommendation for improving the assessment component of Continuing Education with Examination (CEE), formerly called Transcript Quality (TQ) courses. Suggestions from that meeting regarding some reasonable standards for the tests associated with CEE are being incorporated in the COPE course qualification process. A second major recommendation from the NOCEC involved addressing alternative forms of CE delivery. That topic is the focus of an ASCO Critical Issues Seminar scheduled for March 2000, entitled: “Implementing Distance and Distributed Learning: Institutional Implications.” Addressing this exploding area within the CE arena is critical to all of optometry.

Additionally, continued efforts to upgrade the quality of existing continuing education programs presented by the schools and colleges of optometry and national organizations, like the American Academy of Optometry (AAO), and through the work of COPE on behalf of the state boards, have achieved and will continue to achieve improvements in the current system of continuing competence credentialing. Follow-up on the other recommendations from the April 1999 NOCEC and collaborative efforts amongst all optometric organizations, including the AOA, should allow even greater improvements in assuring the public that ODs in practice continue to be safe and effective through license renewal procedures.

In summary, programs are in place to assure entry-level competence, and there is momentum at the state boards level to collaborate with other optometric organizations to bring more standardized and accredited CE to ODs to help assure continuing competence. Consequently, it would be logical to assume that, unless either of these systems was proven to be flawed in some uncorrectable way, any new programs should not undermine the hard-earned credibility of the existing credentials and should be based on greater knowledge and skills than those required for both entry-level competence and continuing competence credentialing. Further, it is also reasonable to assume that any new national credentialing program to be introduced into the profession should be targeted at developing and documenting advanced competence only.

Creating a new national credential with less credibility than existing credentials, or that competes with, or does not exceed, the standards required for obtaining and maintaining an optometric license would be a waste of time and resources, or worse, could reflect badly on all optometric credentials in the eyes of the public and other healthcare professions.

**Credentialing for advanced competence**

The need for, and potential development of, credentials to document knowledge and skills above those required for entering into, and remaining in, the practice of optometry has been debated through three AOA project teams (1968, 1973, 1984), an AOA Commission in the mid-to-late 1980s, and publications by thoughtful optometric leaders in the second half of the 20th century.
The Summit statement, “Optometry: A Responsible Profession,” also recognizes this potential of evolving advanced credentials and specialties in optometry with the following sentence: “Additional education and training provide advanced practice skills and knowledge in specialized areas beyond those requisite at entry.” While the buzzwords “specialties” and “subspecialties” tended to create tensions in the debate during the 1980s and 1990s, the basic premise considered then, which should be the same now, is whether a proven need exists for a system to document optometric knowledge and skills at a level above licensure.

Since 1982 the National Board has been on record as recognizing the potential for a national system of credentialing of advanced competence to be developed, at the appropriate time, by the profession’s organizations with the recognized expertise and experience in post-graduate education and credentialing. This position was also emulated by ARBO and ASCO in the early 1980s. During the 1980s the National Board was a catalyst for discussions and meetings with representatives of ARBO, ASCO, AAO, AOA, and the American Optometric Student Association (AOSA) on the issue of “board certification.” The AOA Commission on Optometric Specialties also reported out a program with some sound recommendations about identifying areas within optometric practice that could be considered worthy of a “specialty” or “subspecialty” designation, and how the credentialing bodies in these areas should be “recognized.” The AOA’s House of Delegates did not adopt this program.

However, despite general agreement in principle, these organizations, individually and collectively, have refrained from developing programs of “board certification” for over 15 years out of respect for the strongly held position of the AOA that developing any program of national credentials other than those needed for gaining and retaining licensure would “splinter” optometry. This AOA position was based on the belief that it was essential to present optometry as a unified scope of services to government officials, legislative committees, and payers of optometric services. The AOA’s argument was that national credentials of advanced competence in areas of special practice (e.g., low vision, binocular vision and perception, contact lenses, advanced disease diagnosis and treatment, etc.) would work against the concept that optometry is the general practice of eye care, and that optometrists, as primary eye care providers, are fully capable of providing full-scope eye care based on state licensure.

Despite all of this collaborative work over many years, the AOA Board of Trustees decided that a need now exists, or can be accurately predicted, to warrant the unilateral implementation of a form of “board certification” at a level “beyond” licensure. Based on the information it has studied, the National Board believes that the program being promoted as “beyond” licensure simply means that it is “after” or “following,” but not “above,” licensure. So what is the need for this new AOA program, and is the program proposed worthy of being called “board certification”?

The “need” for ABOP: check the box?

The original principal reason given by the AOA leadership at the 1999 AOA House of Delegates, and in articles published in the AOA News in late 1999 for the need to immediately develop “board certification” and to establish ABOP was that ODs were (and, presumably, still are) being denied inclusion on provider panels of managed care organizations (MCOs) and hospital staffs because they cannot “check the box” for “board certification.”
So clear was this original mission when described at the 1999 AOA House of Delegates that the editor-in-chief of the Review of Optometry, who was there as an interested observer, published an editorial entitled “Board Certification: Think Outside the Box” in the July 1999 issue of his magazine, and reported that “the outgoing AOA president who championed board certification, makes the case that ABOP would allow ODs to ‘check the box’ on insurance panel and hospital applications that asks ‘Are you board certified?’” The editor goes on, appropriately, to comment: “However, board certification must be about more than a box on an application.” While this denial of inclusion on provider panels may be true in some areas of the country, it has not been documented at a level to prove that this is a major national problem for ODs, as the proponents of ABOP have claimed. The possibility exists that this inability for ODs to “check the box” could be the most convenient excuse du jour available to any MCO or hospital wanting to exclude an, or any, OD, under any circumstance from panel membership.

Further raising the question of the seriousness of intent of this new AOA program is the admitted lack of due diligence or research to determine if ABOP “board certification” will, in fact, solve the so-called “problem.” When questioned at a meeting in late 1999 if AOA has asked MCOs if ODs will be approved (presumably, if they have been denied approval before) with ABOP certification, the ABOP president countered, as reported in the November 1 issue of AOA News: “No. I have a rule about not asking a question that you may not want the answer to. We don’t want to give them another reason to deny us.” Based on this approach to the “problem,” the AOA has decided to change the face of optometric credentialing in the 21st century.

One of the most knowledgeable optometrists in credentialing both ODs and MDs for eye care programs for MCOs is William Hately, O.D., who, for over four years, was the Vice President, Medical Management, of Eye Health Network, a management services organization headquartered in Denver, Colorado. Also a former US Army Lieutenant Colonel and chief of optometry at Walter Reed Army Medical Center, he is now CEO of Wavelength 555, Inc., a credentials verification organization (CVO) for eye care, and optometry’s representative to the National Committee for Quality Assurance (NCQA), the major accrediting agency for MCOs. Dr. Hately’s opinion about the “problem” of not being “board certified,” based on credentialing over 4,000 ODs and 1,000 MDs, is worthy of note: “It was never my experience in four and a half years in states such as Colorado, Texas, Kansas, Nebraska, Iowa, Tennessee, Arkansas, Alabama, North Carolina, New Jersey, New York, and Pennsylvania, where we were required to credential ODs, to have had an MCO refuse to accept our standards because of an inability to designate the ODs as board certified. This included all of our med-surg contracts where ODs were treating pathology. The MCOs never complained or questioned the lack of professional training or experience because of the absence of board certification. They understood this more as a difference in the training between the ophthalmologist and the optometrist. I was able to have my optometrists in the med-surg contracts treat whatever the state allowed them to, per their license. If they had been board certified, as the AOA now is advocating, my feeling is that they would have not been allowed more access to patients than the TPA license already allowed.”

Another optometrist with significant experience in this arena is Scott Edmonds, O.D., founder and lead consultant of the Edmonds Group, a managed care consulting practice in Exton, Pennsylvania. Dr. Edmonds has been involved in developing and consulting with eye care networks and negotiating contracts with MCOs since 1985.
He has assisted ODs in many states, including Connecticut, New Hampshire, New Jersey, Pennsylvania, Ohio, Florida, Indiana, Montana, Idaho, South Carolina, North Carolina, Alabama, Missouri, Michigan, Maryland, Texas, New Mexico, Utah, Mississippi and Kansas. Dr. Edmonds has been an executive with Omega Health Systems and Eye Health Network. In addition to his extensive experience with MCOs, he has had experience in gaining hospital privileges and advising ODs how to gain these privileges. In this 15-year period, he too has never encountered an instance of an OD, or panel of ODs, being denied involvement because they lacked "board certification." Dr. Edmonds commented, "I have been involved in many, many negotiations with MCOs on behalf of eye care providers and there are a number of significant issues that optometry should be addressing, but 'board certification' is certainly not one of them."

Objective data, not anecdotes from small numbers of ODs who were denied inclusion supposedly because they were not “board certified,” need to be shared with all national organizations and state associations to substantiate that this is now, or is fast becoming, a critical national issue and one that prevents the public from obtaining optometric care. Further, even if an OD does “check the box” based on ABOP “board certification” to comply with the traditional credentialing model of the medical establishment, how will the OD answer the next question: “where, and how long, was the residency training before board certification?” Being able to check a box to comply with a medical model of board certification only answers half of the question.

At the present time, there are no NCQA credentialing standards for optometry. Consequently, when an MCO undergoes accreditation review, its credentials verification processes, which are assessed against the NCQA standards for credentialing, cannot require “board certification” for optometrists as this level of credentialing does not exist. But, with ABOP in place, all of this will change. ABOP, which is owned by the AOA, was established, initially, to assure that ODs would be admitted to MCO panels. As AOA is the profession's representative body to NCQA, it will be logical for AOA to advocate ABOP certification as a necessary credential for ODs. NCQA will defer, eventually, to the AOA’s expertise and representation of the profession, and will implement ABOP certification as a required optometric credential when accrediting MCOs. All MCOs wishing to be accredited according to NCQA standards will then require ABOP certification.

Even if NCQA credentialing standards were not a factor, it is logical to reason that MCOs and other eye care provider panels, such as Vision Service Plan (VSP), will eventually require their panel ODs to be ABOP “board certified” so as to give themselves a competitive advantage in marketing their plans. Once this starts, all other third party panels will follow suit to avoid the risk of losing their market share. The ABOP “board certification” program that initially invites OD participation on a voluntary basis will become anything but voluntary. At that point, all AOA members, and all non-AOA members, will be required to be ABOP certified to get on a panel, i.e., to practice. The original "potential problem" of not being able to “check the box” will then be a “real problem”: a self-fulfilling prophecy. It is quite possible that those state associations that voted for the establishment of “board certification” and ABOP at the June 1999 AOA congress will eventually realize that their vote might not have been in the best interest of their members after all.
The “need” for ABOP: another continuing education program?

During the period following release of information about ABOP in the fall of 1999 in the optometric press, and in response to the comments requested, the original program need has become a “moving target” and has “morphed” into one that is supposedly based on recommendations made by agencies in the public policy arena.

At a meeting on December 10, 1999, of six representatives of the National Board with three AOA Trustees and three ABOP Trustees, this more “public friendly” reason was presented to justify the need for “board certification” and ABOP. In a tear-off sheet entitled “ABOP Board Certification Highlights” handed out at that meeting, the stated purpose of ABOP “is to promote ongoing clinical competency through a distinct level of continuing education and assessment.” This new, or expanded, purpose has also been promoted by ABOP in early 2000, at meetings and in articles published in the optometric press.

Taken on its face, the goal of establishing another CE program to promote ongoing clinical competency probably would be greeted with support from most public oriented organizations. And the concept of some form of national curriculum with associated post-course testing could be another useful way for ODs to gain CE credits for license renewal by their state boards. This is consistent with the consensus reached at the Georgetown Summit on Optometric Education and the recommendations from the Pew Health Professions Commission, and parallels work being done in nursing, pharmacy, and medicine. In fact, a collaborative effort between the AOA and ARBO to upgrade the current system of CE for license renewal would be an excellent idea. This was a recommendation that came out of the NOCEC in April 1999, which was attended by two AOA Trustees.

The problem arises when such a program specifically assures the public (or implies) by the term “board certification” that ODs who have fulfilled the requirements of this AOA program of national CE are more competent than those ODs who decided to fulfill only the existing state requirements for license renewal. But how would the results of this program document an improvement in continuing competence over the existing CE programs approved and required by each state board? Does the assessment methodology stand up to scrutiny?

The plan that “each course will be followed by an examination consisting of ten referenced questions per hour of education” means that initial certification for already licensed ODs will be based on five tests (one for each of the five core categories listed) of 20 test items each following a total of five 2-hour courses (i.e., a total of 10 hours of CE.) Basic psychometric principles indicate that such a small number of test items will not provide enough measurement reliability to meet the minimal standards required for determining a valid pass/fail decision. Even if the 5 sets of 20 items were to be combined into one 100-item test, this still would not reach the level of reliability that the National Board uses for its stand-alone examinations, including the Treatment and Management of Ocular Disease (TMOD) examination, which is required or accepted by 47 optometric licensing boards to assure entry-level knowledge for optometric use of therapeutic agents.
While the AOA, through its ABOP, is certainly capable of, and free to, implement another good CE program to add to the programs already available from the schools and colleges, the state and regional associations, and the AAO, the proposed post-course “testing” falls far short of reasonable testing industry standards that one would expect to be associated with a “board certification” examination. No doubt this will be addressed when ABOP engages psychometric experts and begins the detailed work required to develop, administer and score the first full-scale examination in about 3-5 years that will become the requirement for new applicants for “board certification.” At that time, the ABOP “board certification” examination will unnecessarily duplicate the examinations already required for initial licensure, but with a different emphasis and a reduced scope of content.

But another, perhaps less speculative yet fundamental question needs to be asked. Although another CE program based on a national curriculum with some form of post-course assessment seems like a good idea, is passing five 20-item tests, or even a 100-item examination, based on 10 hours of CE worthy of being deemed “board certification” as this term is currently understood by all other independent, licensed healthcare professions? To propose another program of optometric CE with post-course testing and with the goal of assisting ODs to maintain their clinical competence is one thing. To elevate this CE program to one of “board certification” challenges the existing standards of a professional title that is commonly used and understood in the healthcare professions, and which has a specific meaning to patients.

Other healthcare professions

The recent proclamation in the January 2000 issue of Primary Care Optometry News by ABOP that its program of “board certification” will be “the most credible board certification program of any of the 24 medical specialty programs” is suspect. The AOA leadership and the ABOP board members have repeatedly referenced programs of “board certification” in other healthcare professions to justify applying this status to their credentialing program from its inception. But while the proposed program of “re-certification” based on a number of hours of CE with some assessment parallels the re-certification requirements of some medical specialty boards, the ABOP standards for initial certification will be quite different, and considerably lower, than those of any other healthcare profession.

The basic flaw in the ABOP credentialing logic is its belief that any amount of time spent in general practice is all that is required of a new graduate before being eligible for initial certification by taking an examination once the program is fully implemented. At the December 10 meeting the AOA and ABOP representatives were asked at what point a new graduate would be eligible to take the proposed initial certifying examination of 100 test items without the associated CE. The answer given was the January following graduation, i.e., less than 6 months after initial licensure. To require a new graduate who has recently fulfilled the two stringent requirements for initial licensure (i.e., graduation from an accredited school and passing “National Boards”) to take another entry-level examination with some major psychometric flaws, and which is not as rigorous as the assessments conducted only a few months (or even weeks) before by the National Board, raises some concerns about the legitimacy and seriousness of this credentialing program.
When the National Board representatives indicated, at the December 10 meeting, that this form of initial certification was inappropriate for “board certification,” they were challenged to “recommend” to ABOP a more appropriate time delay after graduation for initial certification. The National Board, in its letter of December 17 in response to the “request for comments,” stated: “We are unable to respond to your request for advice on the time delay after graduation that would be appropriate for a new graduate to enroll in your certification program. Our inability to respond results from our disagreement with your basic premise that time in general practice after graduation is equivalent to the advanced clinical training obtained in a residency program or a significant number of years of experience and education in a specified and limited area of practice. These significant experiences are the basic requirements that precede a valid and reliable assessment of advanced knowledge and skills needed for initial ‘board certification’ in all other healthcare professions.”

Since that statement was sent to ABOP during the “request for comments” period, the National Board has learned that ABOP will now require two years of general practice before a new graduate will be able to take the “board certification” examination. The intent, apparently, is that during this 2-year period the new OD will be “board eligible.” The National Board’s position is not negated by this increase of 18 months; the fundamental difference still is that pre-OD clinical training and time in general practice, however long, is no substitute for the requirements of post-doctoral and advanced clinical training required in all other healthcare professions.

In fact, the use of the term “board eligible” for new graduates during that first two years of general practice could be a disservice. Currently, MCOs that credential physicians on the basis of “board certification” do not permit those who are “board eligible” to join their panels. Will not this only add to the problems for new graduates at the time when they are vulnerable and need inclusion in any and all panels? How is this problem, which is likely to be created because of ABOP “board certification” any different from the so-called problem of an inability to “check the box”? Again, the creation of ABOP could lead to the creation of more problems for practicing ODs -- especially new graduates.

The AOA leaders have promoted the American Board of Family Practice (ABFP) as an example of how to get a “board certification” program started. However, they have ignored the educational and credentialing standards that were instituted by that same medical specialty within a few years of its establishment. And the need that stimulated ABFP certification does not exist in optometry. Board certification of family practice in medicine was developed in the late 1960s not only because family doctors were losing ground politically to other physicians and surgeons for such things as hospital privileges, but mostly because allopathic medical school graduates were electing to pursue specialty training instead of entering the general practice of medicine. If family practice had not declared itself a specialty, and then developed rigorous residency programs after the MD degree, it is likely that today there would be no family physicians with allopathic medical education and training. This loss of new graduates from entering general practice to selecting the available specialty training programs is not a problem in optometry. Further, in addition to establishing multi-year residencies, as the newest member board of the American Board of Medical Specialties (ABMS), which passes judgment on the quality of the ABFP certification program and 23 other medical specialty boards, family practice was the first specialty of ABMS to establish rigorous re-certification by a full-day examination every 7 years.
This overall plan for the development of family practice in medicine has not been emulated by ABOP even though ABFP has been promoted as a model and rationale for optometry’s adoption of “board certification.”

Further distancing the AOA’s ABOP model from the true ABFP model is that ABOP is “owned” by the AOA, whereas ABFP is a freestanding non-profit corporation subject only to the requirements for recognition of the ABMS, which is, itself, independent of the American Medical Association (AMA). The AOA is the profession’s major “membership” organization, which, while advocating the need for effective eye care for the American public, is principally concerned with the professional and financial welfare of its OD members. AOA’s expertise is the “politics” of healthcare and the methods by which its members can be successful in practice. Having ABOP accountable to an organization whose main mission is to protect the interests of its OD members will surely raise suspicions from, and open the profession to criticism by, other healthcare professions and third party managers.

The advanced credentials that exist in the other single organ system healthcare professions, dentistry and podiatry, are more worthy of examination if there is to be internal consistency in the development of a model of “board certification” for optometry. Currently, 80% of dentists are in general practice, do not specialize, and are not board certified. Each year, 60% of all graduates of dental schools undertake a 1-year internship after the DDS/DMD is awarded and licensure is obtained, to “gain confidence” for eventual unsupervised practice. However, of these only 50% (i.e., 30% of the total graduating class) go on to complete a residency in one of the nine specialties “recognized” by the ADA Council on Education and Research. Further, not all of those who complete residencies actually apply for “board certification,” as dental ethics (not state laws) require that board certified dentists restrict their practices to the specialty areas and not engage in general practice. There does not appear to be a problem for those dentists who wish to join a managed care panel or to obtain hospital privileges, even if they are not “board certified.”

In podiatry, another single organ system healthcare profession, a completely different model has evolved. Currently, essentially all graduates with the DPM degree undertake a multi-year residency and ultimately seek “board certification” by the two specialty boards recognized by the Council on Podiatric Medical Education: Podiatric Surgery and Podiatric Orthopedics & Primary Podiatric Medicine. This profession apparently has decided that before entering unsupervised practice all future practitioners must undertake additional clinical education after the DPM and licensure, and hold advanced credentials in one of two specialties with the majority selecting podiatric surgery.

It appears that both dentistry and podiatry have recognized the need for more years of clinical education after the doctorate before entering unsupervised practice, either formally through “specialist board certification” in podiatry or even for the “generalist” in dentistry. As dentistry and podiatry are much more similar to optometry in their education and licensing models than medicine, why is it that neither of these models was emulated by the AOA for “board certification” in optometry?
Conclusions

It is clear to the Board of Directors of the National Board that the profession as a whole, which includes those national organizations developed by the profession to safeguard education and credentialing on behalf of the public, especially ASCO and ARBO, should have been consulted, and their advice sought, about this initiative before it was presented to the AOA House of Delegates for action. A profession-wide debate on this issue also would have been consistent with the traditional open dialogue used by the AOA in the last century. This openness to debate and involvement has always helped the profession deal with issues from a position of the public interest, and has rallied the profession-at-large around legitimate initiatives. Unfortunately, the National Board representatives at the December 10 meeting were notified that such a profession-wide debate was not now possible, as the 1999 AOA House of Delegates had mandated that this program be implemented early in 2000.

The National Board, itself a “certification board” established by the profession 50 years ago, has concluded that it cannot support the ABOP certification program, in its current form, as it is simply another credential at the same level as licensure, and therefore it is redundant and unnecessary. Furthermore, as “board certification” has traditionally connoted advanced expertise, a program of “board certification” at the same level as licensure, as proposed by ABOP, is misleading and confusing. The National Board disagrees with the notion that pre-OD clinical training and time spent in general practice after graduation, even if for several years, can be considered equivalent to the advanced clinical training obtained in a residency program or a significant number of years of experience and education in a specified and limited area of practice. These significant clinical experiences are the basic requirements that precede a valid and reliable assessment of advanced knowledge and skills needed for initial “board certification” in all other independent, licensed healthcare professions. It is the National Board’s position that to characterize the ABOP program as equivalent to this traditional understanding of “board certification” is misleading to the public.

The National Board also is disturbed by the misrepresentation of the conclusions and recommendations from both the Summit on Optometric Education and the Pew Health Professions Commission reports. To maintain that the ABOP program is based on the recommendations of both of these milestones is misleading. In both reports the main focus for assuring continuing competence of optometrists (Summit) and all licensed healthcare practitioners (Pew) clearly rests with licensure and the state regulatory boards. To claim that these reports justify the development of a new and separate system of credentialing of competence undermines the credibility of other ABOP pronouncements.

However, all is not negative. The National Board commends the AOA for addressing the concept of a more structured form of continuing education based on a national curriculum of topics that affect patient safety and visual efficiency. Such a program should receive the support of the profession. Collaboration with the schools and colleges and other CE providers like the AAO will further enhance optometry’s reputation for attempting to maintain optometric competence of its practitioners. In fact, based on the Georgetown Summit on Optometric Education statement, “Optometry: A Responsible Profession,” and the Pew Health Professions Commission reports, such an effort in cooperation with ARBO and its member state boards would seem in order.
The model proposed is consistent with efforts over the past twenty years of a number of optometric leaders and state board representatives to develop a “graduate” curriculum for ODs, with the primary purpose being to assure that the licensing function will continue to protect the public. Support for, and involvement in, such an effort from our national membership organization could bring this to fruition. However, a need for improvement in the existing system of assuring continuing competence of licensed ODs does not equate to a need for a program of “board certification.” While the AOA’s program does parallel the re-certification requirements of some specialty boards in medicine, it is neither necessary nor appropriate to identify this as a program of “board certification.”

The National Board acknowledges that the AOA has the resources and power to proceed with its “board certification” program. If this occurs, the National Board predicts that within a few years, even if state laws prevent the use of the title “board certified,” all ODs who wish to practice in managed care environments will be required by MCO credentialing standards to be “board certified” by ABOP. At that point, this additional entry-level credential will have become another “national board” requirement for practice after state licensure. While ABOP is being marketed as a “voluntary” program, registration for “board certification” will become, de facto, mandatory.

Despite its rejection of the National Board’s request that the AOA call the profession together for a national forum on “board certification” before implementing its ABOP program, the National Board believes that the arguments presented in this position paper are important enough for such an event still to be held. An open forum would allow a full debate on the fundamental questions and concerns that many well-intentioned, experienced, and dedicated leaders of the profession from outside AOA have expressed, and it would also help to heal the wounds that this initiative has inflicted on the profession. The National Board stands ready to attend, and to present and defend its positions. In fact the National Board’s original December 1998 offer of help and cooperation with AOA still stands.

The announcement that the “initial availability” of ABOP-approved courses has been delayed until the June 2001 AOA Congress reported in the February 1, 2000, issue of AOA News, is welcome news. While the reasons for the delay are claimed to be administrative (to assure enough courses are available) or contemplative (to review all the “helpful” comments submitted in response to the “call for comments”), this delay now provides an excellent opportunity for the AOA to exercise its leadership again for the good of the profession at large. The National Board hereby calls on the AOA to convene a national meeting in 2000 to discuss the issue of “board certification” in its entirety with all stakeholders in the profession present and represented.

Relative to the goodwill and unity of optometry, the National Board respectfully suggests to our national “flagship” organization, which has led the profession so well in the past, that beginning a new century without profession-wide support for such an important issue is simply wrong.

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Board of Directors, National Board of Examiners in Optometry: Donald R. Gordon, O.D., President; James W. Hartzell, O.D., Vice President; Danny Wedding, Ph.D., Secretary-Treasurer; Lesley L. Walls, O.D., M.D., Immediate Past President; Linda Casser, O.D.; William E. Cochran, O.D.; Mary Freitag, O.D.; Frank Salimeno, O.D.