

## Not the Last Word: The Time to Fix ABOS Recertification Has Arrived

Joseph Bernstein MD

Since 1986, The American Board of Orthopedic Surgery (ABOS) has issued only time-limited certificates. I think that's a fine idea. (Trust me, I believed that even before I recertified myself last year). I am less enthusiastic, however, about the ABOS's use of a high-stakes knowledge examination as the final hurdle to

earn recertification every 10 years. A better method is needed.

For one thing, the ABOS recertification exam is costly—and it's not just the fees. (Yes, the exam runs about USD 2100, but when considered as a practice expense amortized over 10 years, this is a paltry sum). The real price of the examination is the time needed to study subjects lacking relevance to one's own practice; even a practice-profiled examination demands studying extraneous material. In preparation for my sports exam, for example, I had to rehearse the dogmas of hip cams and pincers (even though I don't "treat" femoroacetabular impingement [1]) and I memorized the return-to-play standards after tinea skin infections (even though I have not been a wrestling team physician for more than a dozen years). In total, I spent about 100 hours studying material I don't use.

For all that cramming, my ABOS recertification exam was generally dedicated to old material. Most of the questions would have felt at home on my initial exam in 1995. As such, it would be unreasonable to claim that the test determines whether the examinee has "kept up with the field." It does not—and how could it be otherwise? There is just not enough enduring innovation in orthopaedics to

compose a test of 150 questions restricted to concepts and facts discovered in the past 10 years.

The ABOS examination also fails to account for the advent of the smartphone as a clinical resource. I can use my iPhone to look up things outside of my core expertise, in real time. And if I cannot find an adequate answer online, I might text a question (and a photo) to a more-knowledgeable colleague. None of the items on my exam included choices such as "I will look it up" or "I will consult somebody with more experience", yet more than ever, these are reasonable, feasible and, in some cases, preferable options.

Last, the ABOS sets the passing rate too low. Everybody taking the test has passed it at least once in the past. All have completed 240 additional continuing medical education (CME) credits. Everybody taking the test has demonstrated the necessary professional standing and survived a rigorous peer-review process. All examinees have submitted a list of at least 35 surgical cases that reflect appropriate indications and acceptable rates of complications. With that in mind, the 4% failure rate the ABOS reports seem at least 3% too high [5].

Despite these weaknesses, the exam retains great power to inflict damage. Recertification is required to retain admitting privileges in many hospitals [3], and thus failure to recertify may cost surgeons their livelihoods. Whereas board certification may have been a stamp of additional quality back

---

*A note from the Editor-in-Chief: We are pleased to present to readers of Clinical Orthopaedics and Related Research® the next Not the Last Word. The goal of this section is to explore timely and controversial issues that affect how orthopaedic surgery is taught, learned, and practiced. We welcome reader feedback on all of our columns and articles; please send your comments to [eic@clinorthop.org](mailto:eic@clinorthop.org).*

The author certifies that neither he, nor any members of his immediate family, have any commercial associations (such as consultancies, stock ownership, equity interest, patent/licensing arrangements, etc.) that might pose a conflict of interest in connection with the submitted article.

The opinions expressed are those of the writer, and do not reflect the opinion or policy of *Clinical Orthopaedics and Related Research®* or The Association of Bone and Joint Surgeons®.

Joseph Bernstein MD (✉), University of Pennsylvania, 424 Stemmler Hall, Philadelphia, PA 19104, USA, Email: [orthodoc@uphs.upenn.edu](mailto:orthodoc@uphs.upenn.edu)

All ICMJE Conflict of Interest Forms for authors and *Clinical Orthopaedics and Related Research®* editors and board members are on file with the publication and can be viewed on request.

---

J. Bernstein, Department of Orthopaedic Surgery, University of Pennsylvania, Philadelphia, PA, USA

## Not the Last Word

when it first appeared nearly 100 years ago, these days, certification has become a de-facto medical license.

Perhaps some orthopaedic surgery leaders contend that a strict process is needed to convince the public that the profession is serious about monitoring itself. Just as “the tree of liberty must be refreshed from time to time with the blood of patriots and tyrants,” as Thomas Jefferson put it, these people might believe that the credibility of the ABOS requires that both good and bad physicians submit to its painful ordeal.

I don't buy it.

The ABOS exists to serve the best interests of the public and of the medical profession. The ABOS thus has an obligation to help avoid harm across the board—harm of patients by inept doctors, but also harm of its diplomates by harsh procedures. A so-called formative evaluation [2] process, one with frequent feedback linked to remediation of deficiencies, may be the best way to promote the interests of both patients and surgeons, for their mutual benefit.

**Judith Baumhauer MD, MPH**  
**Professor and Associate Chair of Orthopaedic Surgery**  
**University of Rochester Medical Center**

Dr. Bernstein's column begins by focusing on the inadequacy of the Maintenance of Certification Computer Practice Profile Examination in Sports Medicine. Specifically, Dr. Bernstein noted that there were aspects tested that he didn't feel he needed to know for his patient population. What Dr. Bernstein did not convey, however, was that he could have chosen another option for testing—the oral examination pathway. This pathway allows the orthopaedic surgeon taking the exam to list his or her surgical cases for 6 months and be tested on the 12 selected cases with peers in his or her area of expertise. If

the orthopaedic surgeon cannot explain his or her own data collection, consent process, procedure, after care, results, and complications, perhaps the surgeon shouldn't pass the exam, as these are extremely pertinent and important to our patients.

This article is late to the starting line. The ABOS has been investigating other testing options for several years. Beginning in 2019, there will be an additional option for candidates called the ABOS Web-based Longitudinal Assessment program. This program allows the user to choose 15 of 100 different orthopaedic knowledge sources such as journal articles, practice guidelines, and utilization criteria, for example, that are relevant to his or her practice and be tested “open book” style with 30 questions from the self-chosen 15 performed on his/her personal computer during a 5-week period beginning in April. Details can be found at [www.abos.org](http://www.abos.org). The benefit to this testing mode is the user can pick which sources are relevant to his or her specialty and also refer back to this information if needed during questioning. Secondly, there has been pilot testing on a “virtual oral examination” where essentially an oral exam is completed by examiners reviewing the images and documents without the candidate being present. This forward-thinking mechanism will allow case-based testing without travel to Chicago.

Every Diplomate has the opportunity to begin the MOC testing 3 years before his or her certification will lapse. This gives the individual three tries to pass. The ABOS rigorously analyzes the psychometrics of the oral and written MOC examinations. Yes, there are orthopaedists who fail. If their performance falls more than two standard deviations below the mean of their peers on these tests (potentially 3 years in a row), the orthopaedic

surgeon will not be certified. That is a fact.

Lastly, let's clarify the mission of the ABOS. It is “to ensure safe, ethical and effective practice of orthopaedic surgery, the ABOS maintains the highest standards for education, practice, and conduct through examination, certification, and maintenance of certification for the benefit of the public” [4]. The ABOS provides the Diplomate the opportunity for board certification, however, it is earned not purchased and the focus is on protecting the “blood” of the patient.

**David F. Martin MD**  
**Executive Medical Director, ABOS**  
**Peter M. Murray MD**  
**President, ABOS**

Board certification and MOC are external, objective indications to patients, families, hospitals, insurers, and other physicians that ABOS-certified physicians are competent surgeons who have undergone a meaningful evaluation of their professionalism, commitment to lifelong learning, medical knowledge, and dedication to practice improvement. Board certification is a quality marker that our patients need and respect.

Dr. Bernstein voices common concerns about preparing for and taking “high-stakes examinations.” The ABOS, with help from specialty societies and the American Academy of Orthopaedic Surgeons (AAOS), has worked diligently to provide new options, streamlining while maintaining relevance and value.

For those wishing to take a Computer-Based Recertification Examination, there are now nine subspecialty options aimed at meeting surgeons where they practice. ABOS Practice-Profiled Examinations contain no general orthopaedic questions; questions are based exclusively on that subspecialty. Practice-Based Oral Examinations are also available.

## Not the Last Word

Orthopaedic surgeons from across the country assist the ABOS in setting knowledge standards in each field. Careful evaluation has led to updated Examination Blueprints that determine the breadth of examination coverage. A separate group of practicing orthopaedic surgeons independently evaluates each question. With expert psychometric input, the surgeons involved set appropriate passing standards for each examination.

The ABOS recognizes that methods of information dissemination are rapidly changing with technology. While it's true that we depend on our smartphones for many things, the guidance of a knowledgeable physician who is working to keep pace with current research cannot be replaced—or even substantively complemented—by a cursory search on any device. Demonstrating command of a body of knowledge centered on a surgeon's practice remains an indication of quality. The ABOS disagrees with Dr. Bernstein's contention that there is not sufficient innovation in the field to fill examinations every 10 years. With hundreds of peer-reviewed orthopaedic journal articles published monthly, we would argue just the opposite.

We also hear Dr. Bernstein's concerns about the opportunity costs of examinations. The ABOS is working to produce assessments that provide valuable information about a surgeon's knowledge and double as valuable learning opportunities. The ABOS Web-based Longitudinal Assessment is another knowledge-assessment option that will begin next year. Each January, the ABOS posts Knowledge Sources (journal articles, clinical practice guidelines, appropriate use criteria) to its website. Participating Diplomates will choose 15 of the Knowledge Sources to review and study.

During April-May, Diplomates will answer 30 questions based on their 15 chosen Knowledge Sources. The questions will be delivered digitally in an open-book format. This will add a formative assessment to the ABOS MOC program. Diplomates will still submit Case Lists, complete CME and Self-Assessment Examination activities, and undergo peer review—there will always be a summative decision for MOC participation.

With a strong commitment to lifelong learning and assessment, the ABOS is listening and appreciates constructive

feedback. ABOS Diplomates are encouraged to work with us to support self-regulation. If physicians fail to self-regulate, we will likely experience external regulation that will be less relevant and adaptive to patient needs and to our profession. And for the profession to excel, it will always be critical that board certification remain a “for physicians, by physicians” process.

### References

1. Bernstein J. The myths of femoroacetabular impingement. *Clin Orthop Relat Res.* 2014; 472:3623–3628.
2. Dougherty PJ, Andreatta P. *CORR*® Curriculum—Orthopaedic Education: Competency-based medical education—How do we get there? *Clin Orthop Relat Res.* 2017;475:1557–1560.
3. Freed GL, Dunham KM, Singer D. Use of board certification and recertification in hospital privileging: policies for general surgeons, surgical specialists, and non-surgical subspecialists. *Arch Surg.* 2009; 144:746–752.
4. The American Board of Orthopaedic Surgeons. About ABOS. Available at: <https://www.abos.org/about-abos.aspx>. Accessed July 26, 2017.
5. The American Board of Orthopaedic Surgeons. Recertification examination statistics. Available at: <https://www.abos.org/moc/exam-statistics.aspx>. Accessed April 18, 2018.