



# Faux Board Certifications?

## Editorial

### Executive Summary:

*Initial licensing does not ensure continuing competency of general practitioners and initial board certification does not ensure continuing competency of specialists.*

*Ensuring continuing competency of general practitioners is the purpose of Maintenance of License (**MOL**) systems imposed by state boards for practitioner license renewals. For medical specialists, the Maintenance of Certification (**MOC**) programs recently imposed by specialty boards for re-certifications of medical specialists are used to ensure their continuing competence.*

- *General practitioners...(degree + license)... are required to take part in **MOL** programs for each license renewal as specified by optometry licensing boards and current optometry **MOL** is more robust than **MOL** for medical license renewals often based upon self-reported CE rather than the documented CE attendance required by optometry **MOL**.*
- *Medical specialists... (degree + license + residency training)... once board certified for life, now take part in **MOC** programs to renew their certifications every 10 years. **MOC** was a response to a government study documenting unacceptable rates of avoidable hospital deaths. Accredited health centers long required specialists be board certified but now require they maintain their board certifications via **MOC**.*

*The **MOL** of medical general practitioner has now come under review by the American Federation of State Medical Boards (AFSMB) to determine if current **MOL** systems for re-licensing of general medical practitioners sufficiently ensure their continuing competence.*

*With this beginning review of **MOL** programs for renewal of medical licenses, and the earlier re-certification of medical specialists introduced by medical specialty boards via **MOC**, optometry may be wise to determine if improvements to its **MOL** are needed. Such a study should be led, or coordinated, by state optometry boards as they, alone, are legally responsible for ensuring the continuing competence of licensed optometrists.*

*However, without any study or gathering of evidence, two groups, the American Board of Optometry [ABO] and the American Board of Clinical Optometry [ABCO] have each created a voluntary "board certification in optometry" they claim will better document continued competency of general practice optometrists than the current **MOL** systems required for re-licensure. While there may indeed be need for improved optometry **MOL**, that has not been documented and ABO and ABCO misuse the term "board certification" in naming their process to document continuing competence in general practice optometry since "board certification" is understood in medical credentialing to denote initial advanced competency in a specialty.*

*Relatively few optometrists are specialists and board certification is understood by other medical professions to require residency training and testing of advanced competence in a specialty which ABO and ABCO do not require. ABO and ABCO also offer no evidence optometry **MOL** is inadequate or why improving **MOL**, if needed, is not the solution. They also ignore the fact responsible professions do not permit voluntary continued competence as all licensees (general practitioners and specialists) should remain competent and board certification is not used by other professions to denote the initial or continued competency of general practitioners.*

*ABO and ABCO "board certifications" also ignore the accepted system of optometry specialization via residency training begun in 1975 and that their "certifications" will not be recognized by credentialing committees at accredited facilities. In fact several state optometry boards have already declined to recognize ABO or ABCO board certifications.*

*If a study were to show current optometry **MOL** is inadequate, the correct response would be to improve optometry **MOL** as medicine is considering doing rather than offering less-than-creditable, voluntary board certifications of general optometry practitioners who are not specialists and not required by credentialing bodies to be board certified as specialists.*

ABO and ABCO forgot optometry, like dentistry, is a defined-license profession credentialed by training, degree and licensure for general practice. No organization has decreed general practice optometry should become a specialty or attempt to appear as one without residency training and passage of a written examination testing advanced competence. It is unlikely voluntary, irregular board certifications like ABO and ABCO will be recognized by credentialing committees at Joint Commission accredited medical facilities or accepted as having merit by other board certified specialists.

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## ABSTRACT

The American Board of Optometry (ABO) and the American Board of Clinical Optometry (ABCO) both offer a voluntary “board certification in optometry” to general practice optometrists. Both misrepresent the purpose of board certification, have no legal standing to require or provide MOL and offer credentials that are not board certification in a specialty nor required for re-licensing by any state optometry board. Instead, several optometry state boards have stated such “board certifications” may not be put before the public as board certification and do not represent attainment of a competency beyond that represented by degree and licensure.

These credentials will not be accepted in the US health care credentialing community and do disservice to current optometry specialization via residency training that has been supported since 1975 by the AOA, ASCO and ACOE. If optometry MOL needs improvement, the solution is to improve it rather than offer fringe “board certifications” of general practitioners who are not specialists nor required to be specialists by any credentialing body to practice general optometry.

No study has determined current optometry MOL systems fail to adequately ensure competence after initial licensure nor has our profession decided general practice should become a specialty requiring residency training and board certification. Board certifications not requiring residency training and not testing advanced competence, like ABO and ABCO, offer no value to those seeking to practice within accredited medical facilities or those in private practice and will not aid access to provider panels. Instead, they are what are termed unrecognized credentials that will fragment general practice and burden practitioners with costly but valueless credentials. Their concept that continuing competence is voluntary and up to each practitioner, is unworthy of our profession and poor public health policy.

All other accepted medical credentialing systems use independent state licensing boards with mandatory MOL to ensure continuing competence of general practitioners and independent specialty boards with mandatory MOC to ensure continuing competence of specialists. MOL and MOC have very different goals. ABO and ABCO have no legal standing to determine whether additional credentialing is required of general practitioners and ABO has conflicts of interests since it is essentially controlled by three organizations all of which sponsor and offer continuing education programs and ABO and ABCO mistake board certification for MOL.

A concise explanation of why board certification is not used by other health professions to insure continuing competence of general practitioners was presented by the National Board of Examiners in Optometry during the Summit on Board Certification and Continued Competency in St. Louis in 2001. [\[Link 1\]](#) Unfortunately, that advice was ignored and continuing competency of optometrists became politicized once its trade associations decided to attempt to supercede the role and primacy of state optometry boards.

Optometry must not misuse the credentialing terms long accepted within the US credentialing community nor redefine their meanings to achieve political or economic goals.

The fact neither ABO or ABCO have public members on their boards should also be noted.

## **Part I: Development of Specialists and Board Certification**

*Until the 1940's, the majority of medical (MD) and osteopathic (DO) physicians entered general practice with degree, license and one-year internships.*

*With time, the increasing complexity of medicine led to residency training of 3-5 years in medical specialties that accelerated with the concentration of advanced procedures at hospitals which began to prefer, and then require, residency-trained specialists. Today, the 24 ABMS (American Board of Medical Specialties) recognized specialty boards all require specialty residency training and written specialty examinations for board certification and osteopaths, dentists and podiatrists have similar specialty boards. About 80% of medical-osteopathic physicians are board certified in a recognized specialty. The Joint Commission (Joint Commission on Accreditation of Healthcare Organizations, JCAHO) that accredits US medical facilities requires specialists (but not general practitioners) to be residency trained and board certified in a specialty.*

*Board certification is therefore synonymous with specialization via residency training and with the clinical privileging of specialists at accredited medical facilities.*

*Defined-license, prescribing practitioners, were slower to specialize as their training, degrees and licenses prepared them for general practice without additional training or certification.*

*Dentistry was the first defined-license profession to establish specialties and now has 8 dental specialties for which residency training and board certification are required. But the great majority of licensed dentists remain in general practice and over 99% of the 377,000 general practice dentists in the U.S. are not board certified.*

*Optometry and podiatry began to move to specialization when the Department of Veterans Affairs established hospital residency training programs for them in 1975. Optometry schools soon designated nine specialties for which residency training was appropriate and the American Council on Optometric Education (ACOE) agreed to accredit optometry residency programs in addition to schools of optometry. The Advanced Competence in Medical Optometry examination (ACMO) was offered by the National Board of Examiners in Optometry (NBEO) in 2005 and the American Board of Certification in Medical Optometry (ABCMO) incorporated in 2009 to offer board certification in the specialty of medical optometry with a MOC requirement for recertification every seven years.*

*There are, however, "fringe" medical boards that grant board certifications not requiring residency training. These "board certifications" are not accepted at accredited medical facilities and are not recognized by the ABMS, the Joint Commission or the medical credentialing community. Those holding "fringe" board certifications are not granted specialist privileges at accredited facilities and state medical boards are beginning to dispute their claims of being "board certified" before the public. [\[Link 2\]](#)*

*Similarly, several state optometry boards have stated they will not recognize board certifications not requiring residency training and examinations testing advanced competence nor allow licensees to claim being board certified. [\[Links 3,4\]](#) Fringe board certifications should have no place in our profession.*

## **Part II: Origin of Faux Optometry Board Certifications**

Over the past 12 years the American Optometric Association twice called for voluntary board certification of general practice optometrists. Its reasoning appears centered about what it sees as a need to provide additional evidence of general practitioners' continuing competence. But it has made three false assumptions.

- First, no evidence shows current MOL requirements for license renewal fail to ensure continuing competence of general practitioners and malpractice insurance rates continue at low levels. If there is

concern about continuing competence, an assessment must first be done which is the approach adopted by the American Federation of State Medical Boards (AFSMB) in 2010.

- Second, the purpose of board certification is not to ensure continuing competence in general practice [\[Link 1\]](#) but to denote initial attainment of advanced competence in a specialty gained from post-graduate, post-degree residency training.
- Third, trade associations must not lead or control credentialing of a profession they represent politically. State boards of optometry, alone, are legally responsible for ensuring continued competence of licensed optometrists which is why the AFSMB (not AMA) is determining if current license renewal requirements of physicians and osteopaths are adequate to ensure continued competence in general practice and why independent specialty boards determine criteria for certification of specialists.

The first AOA-effort, the American Board of Optometric Practice, [\[Link 5\]](#), was withdrawn in 2001 but a coalition, the Joint Project Team on Board Certification (JPTBC), formed more recently, decided voluntary board certification of general practitioners was the way to document continuing competence of general practitioners. That this group did not name themselves the Joint Project Team on Continuing Competence indicates they also misunderstood the purpose of board certification.

This misunderstanding continues with ABO supporters stating “optometry is the only prescribing profession without board certification to ensure continued competence” and then making unproven claims that “if board certification in optometry is not established by us, others will require it”. But no evidence supports these claims and these statements only reveal ABO supporters continue to incorrectly believe other professions use board certification to ensure continuing competence rather than MOL or MOC.

Seven types of evidence show ABO continues to make misrepresentations:

1. Board certification is not used to insure continuing competence of general practitioners (or of specialists), which NBEO explained in 2001. [\[Link 1\]](#)
2. No external credentialing group has suggested it is considering requiring board certification of general optometry practitioners. Recently, [www.odwire.com](http://www.odwire.com) cited conversations with officers of vision panel VSP confirming it was not contemplating additional credentials. The Joint Commission still affirms degree and license are sole requirements for general practice in hospitals and there is no evidence of plans to change “any willing licensed provider” requirements of degree and licensure.
3. The accepted systems to ensure continuing competence are maintenance of license (MOL) for general practitioners and maintenance of certification (MOC) for board certified medical specialists. [\[Link 6\]](#),[\[Link 7\]](#) It is, frankly, absurd to argue general practice optometrists should pursue a board certification followed by maintenance of that certification to ensure continuing competence in general practice.
4. Factual studies led specialty boards to adopt MOC and the AFSMB is beginning its study of MOL for medical license renewals. Before optometry urges additional credentialing of general practitioners it must conduct equivalent studies and understand the accepted means to address deficiencies is improved MOL.
5. Voluntary systems (MOL or MOC) are not used to ensure continuing competency of general practitioners or specialists and their use will discredit the profession using them. No one believes practitioners should voluntarily decide if they maintain their continuing competency.
6. Voluntary credentialing systems also fragment a profession. General practice optometry will consist of 15 “areas of interest” under ABO ([Footnote 3](#)) plus those certified by ABCO and those relying upon the legal standard of degree and license. There will thus be 17 possible credentials testifying to competence in general practice of which only license-renewal MOL has legal standing.

7. In 1986, the AOA Commission on Optometric Specialties concluded that specialization was appropriate only if it required residency training, passage of a specialty examination testing advanced competence and led to certification by an independent specialty board. The Commission's recommended policy was rejected by the AOA House of Delegates as being divisive. [\[Link 11\]](#), [\[Link 12\]](#), [\[Link 13\]](#)

To Summarize:

Initial optometry licensure denotes competence in general optometry at time of license issuance that is maintained via MOL (maintenance of license) at each license renewal.

Initial board certification denotes advanced competency in a specialty at time of certification that, once granted for life, is now maintained by MOC (Maintenance of Certification) for certification renewal in medical specialties every 10 years. Creditable board certification requires residency training and testing at levels of competency above those represented by degree and license. ABO and ABCO do not meet these requirements.

### Part III: Misleading Credentials Led to Divisiveness

The formation of the American Board of Optometry ([www.abo.org](http://www.abo.org)), ABO, was soon followed by the American Board of Clinical Optometry ([www.abco.org](http://www.abco.org)), ABCO, organized to offer an alternative, more "cost-effective", certification.

Neither ABO nor ABCO require residency training but both offer "Board certification in Optometry". The ABO requires passage of a 240 item examination [\[Footnote 3\]](#) testing at the level of general practice and the ABCO does not test at all. ABO requires MOC of its certificate while ABCO does not.

Several state boards have ruled the ABO credential will have no standing, and warned against citing it as "board certification" to the public [\[Link 3\]](#), [\[Link 4\]](#) and the Association of Regulatory State Boards has stated why it could not participate in ABO [\[Link 9\]](#). Optometrists familiar with the credentialing process at accredited health facilities also realize ABO and ABCO will not be accepted as denoting board certification and specialist status. [\[Link 8\]](#)

In reaction to strong AOA support and marketing of ABO, the American Optometric Society (AOS) had formed before ABCO was organized to dispute the need for board certification of general practitioners and it has been highly critical of how ABO was promoted by the AOA and of its close ties with ABO. ([www.aos.org](http://www.aos.org).)

This divisiveness increased after ABCO formed to offer a competing certification and ABCO states it is independent of AOS. Meanwhile, AOS has filed suit in federal court citing alleged ABO misrepresentation. ABO responded with a motion for dismissal which was denied and the AOS vs. ABO law suit remains active. Recently ABO offered to amend its website language to resolve the suit but AOS rejected the offer. (Review of Optometry, January, 2011). During its defense the ABO termed its disputed website language as harmless and just the typical "mere puffery" used by commercial firms to advertise their products. [\[Footnote 1\]](#), [\[Footnote 2\]](#)

In addition, the American Board of Medical Specialists (ABMS), representing 24 recognized medical specialty boards and their MOC programs, sent a "cease and desist" letter to ABO alleging ABO website language implied collaboration between ABO and ABMS and ABO removed that language. (Midyear report, 2010, American Academy of Ophthalmology.)

The approval of ABO by the AOA House of Delegates itself was seen by some as divisive as it passed by a small margin (5%) only after one large state delegation voted "en bloc" (winner take all) rather than in proportion to delegate yea vs. nay sentiments.

As a result, for the past three years, intra-professional debates and formation of opposition groups have taken place with many ABO opponents believing it is directed at raising revenues for its sponsors. All net-based opinion surveys showed a large majority of respondents opposed board certification of general practitioners but their sample sizes were small.

It is clear the misuse of credentialing terms by ABO and ABCO added undesirable confusion to what should have been rational debate about the need for improved MOL and this also demonstrates one reason trade associations must not “capture” credentialing and why the Association of Regulatory Boards of Optometry (ARBO) withdrew its participation in ABO on the advice of counsel [Link 9] as did the National Board of Examiners in Optometry for other reasons.

#### **Part IV: Optometry Specialization Ignored**

Forgotten by ABO, ABCO and their supporting bodies is the nationally accredited system of optometry specialization via residency training that began in 1975 which logically leads to specialization and board certification. Today, 20% of O.D. graduates (circa 300) serve accredited one-year specialty residencies after licensure and the schools of optometry (ASCO) have 9 designated areas suitable for specialization via residency training.

Since 1975 the Association of Schools and Colleges of Optometry has supported specialization via residency training and extols the value of residency training at [www.asco.org](http://www.asco.org).

ASCO member schools and colleges recruit faculty from those completing residency training; often requiring it for appointment as clinical faculty. The support between specialization via residency training and ASCO is further shown by ACOE accreditation of residency programs requiring affiliation with a school of optometry. But ASCO endorses ABO, which places it in the conflicted position of supporting a form of board certification that does not require residency training in a specialty nor passage of an examination testing advanced competence in a specialty.

The American Academy of Optometry also has a conflicted position by supporting ABO. Recognized for excellent continuing education programs, it awards the title of Fellow of the Academy to those meeting entrance requirements and has areas of interest (Sections) such as ocular disease and public health in which Fellows meeting additional requirements are designated Diplomates. The Academy in December, 1984, issued the following policy statement which remains in effect that explains Diplomates are not certified specialists.

“To clarify an issue of concern because of the growing attention to credentialing and certification, the Executive Council expressed the position that neither Academy fellowship nor section Diplomate status constitutes certification of specialization, and that Diplomats are knowledge based, not competency based”. (History of the AAO, James R Gregg, page 155.)

Despite this policy, AAO supports a “board certification in optometry” that awards credits to those who are AAO Fellows or Diplomates. (Also see [Link 14].)

#### **Current Optometry Residency and Specialization System**

The American Council on Optometric Education (ACOE) accredits optometry specialty residency programs and the Optometric Residency Matching System (ORMS) matches programs with applicants. In 2005, after years of development, NBEO began administering a written examination (ACMO) testing Advanced Competence in Medical Optometry and, in 2009, the independent American Board of Certification in Medical Optometry incorporated to award certification in the specialty of medical optometry. This development of the first optometry specialty leading to board certification was widely supported by optometry organizations as a sign of

the maturity of the profession and its widen scope of medical responsibilities. But surprisingly, those same organizations now believe a board certification in general practice not requiring residency or the passing of an advanced exam of competence will be seen by other credentialing bodies as creditable board certification.

The costs of ACOE accreditation services (including site visits) are underwritten by annual fees paid by residency programs to ACOE which is housed in the St. Louis AOA offices with VA hospitals its largest fiscal supporter. Yet AOA never asked the VA about its proposed ABO. But, instead, the AOA Board of Trustees met with the National Association of VA Optometrists in 2009 to “demand” they endorse ABO. The NAVAO executive council, after study, informed the AOA that ABO would not meet VA credentialing standards. [\[Link 8\]](#) Under similar pressure, the Armed Forces Optometric Society polled members and a majority did not support ABO

In reality, ABO and ABCO are voluntary MOL required by no one for which the need has not been established.

ABO and ABCO cannot serve as MOL programs unless state boards require them for license renewal and they cannot quality as board certification without requiring residency training and testing for competence above that required for general practice. ABO and ABCO are neither fish nor fowl.

Perhaps as bothersome, creditable health professions do not use voluntary MOL or voluntary MOC. MOL is required for general practitioners by the state optometry boards for license renewal and MOC is required by specialty boards for recertification which makes both mandatory.

ABO and ABCO therefore risk discrediting general practice as well as the 35 year process to establish optometry specialization by mislabeling what are essentially national MOL programs as “board certification in optometry”.

### **AOA Does not Recognize Specialization**

#### **Yet Calls for Board Certification**

While supporting “board certification in optometry”, the AOA has spent decades debating optometry specialization without reaching a conclusion even though 20% of graduates now complete residency training in a specialty. In 1986, the AOA Commission on Optometric Specialties, after much study and consultation, developed a comprehensive set of policies to be employed to recognize and certify competency in an optometric specialty. [\[Link 11\]](#), [\[Link 12\]](#), [\[Link 13\]](#). (Also see [\[Link 14\]](#)) Those policies emphasized the need for a specialty to require post-graduate training such as residency training and for an independent specialty board to offer certification in that specialty by requiring passage of a written examination testing advanced specialized competence. But when put before it, the AOA House of Delegates voted against accepting the Commission’s recommendations on the grounds they would divide the profession, the very thing ABO is doing to general practice. To date the AOA has neither endorsed nor called for the development of specialties even though it houses the American Council on Optometry Education that accredits residencies and has lobbied Congress over the years to support optometry residency programs.

The optometry profession does not have a consistent policy on what constitutes the general practice of optometry, optometry specialization, board certification in a specialty and the purposes of board certification vs. continuing competence via maintenance of licensure.

While AOA, ASCO and AAO support the ABO board certification in optometry the NBEO and ARBO do not. Part V that follows outlines how other prescribing health care professions credential their licensed practitioners and specialists and how the AOA, ASCO and AAO do not utilize the accepted meanings of their terms. In addition, AOA, ASCO and AAO have vested interests that present conflicts of interest in their support of ABO and avoidance of conflicts of interest, real or apparent, is crucial to creditable certification.



## Part V: US Credentialing Systems

[This section sketches in detail how health professions credential general and specialty practitioners and reviews previous material. Readers familiar with credentialing may choose to proceed to Part VI.]

All credentialing begins with an initial determination of competence necessary to enter general practice [degree + licensure] followed by mandatory MOL for license renewal to ensure continuing competence. Medical specialists proceed after degree and licensure to residency training and examinations to become board certified in their specialty. Their continuing competence has recently been mandated via MOC for re-certification every 10 years instead of the previous “good-for-life” board certifications.

With growing concerns over whether practitioners stay current with their fields, it is important optometry adhere to these recognized systems. Optometrists comprise but 3% of US licensed practitioners and must use credentialing terms the same way others use them and not offer “fringe credentials” and must also understand it is optometry MOL systems that may become questioned and not that general practitioners are not board certified.

### ***The two accepted credentialing systems***

1. General practitioners must possess professional degree and state license. Continuing competence is achieved by mandatory MOL. Optometry has one of the strongest MOL systems due to a national program that approves CE courses and maintains attendance rolls. This system, COPE, is operated by the Association of Regulatory Boards in Optometry to help fulfill their legal responsibility to ensure continued competence of licensed optometrists.
2. Specialists undertake residency training (after degree and licensure) to achieve advanced competency exceeding that represented by degree and license. After completing residency and passing written examinations testing advanced competence in their specialty, they become certified as specialists by independent specialty boards. Until recently, board certifications were issued for life. But, in response to increasing concerns about continuing competence of hospital specialists, ABMS specialty boards moved to limited-term certificates requiring MOC procedures for re-certification every 10 years.

General practitioner: Degree + License + MOL

Specialist: Degree + License +MOL >>>> Residency +BC + MOC

(Many state medical boards accept MOC as counting towards MOL)

In addition, post-residency training of 1-2 years duration, “fellowship training”, may be pursued in subspecialties. An example is “fellowship training in glaucoma.”

While general medical practitioners may perform procedures done by specialists they cannot claim to be board certified just as optometrists limiting their practice to a particular area of emphasis cannot claim to be board certified.

**MOC:** Increasing interest has been directed at how health care providers maintain competence (Pew Charitable Trust, Institute of Medicine). Specialty boards took note by questioning use of life-time board certifications and the American Board of Medical Specialties (ABMS) now places expiration dates on certificates conferring specialist status. MOC programs are required for recertification every 10 years to retain specialist status and remain eligible for clinical privileges at accredited healthcare organizations.

**MOL:** Similar concerns about the 20% of non-specialty (general practice) medical-osteopathic providers led the American Federation of State Medical Boards (includes osteopathy) to begin a study in 2010 of whether MOL is sufficient to ensure continuing competence in general medical practice.

## Part VI: General Practitioner or Specialist?

A practitioner's professional degree and state license define the services they may offer in private offices but not necessarily within accredited medical facilities which are determined by credentialing committees. This is especially true of MD and DO practitioners whose medical licenses are open-ended and of which about 80% are specialists.

Hospitals furthered the movement to board certified specialists as a way to remove "casual operators". A symbiosis arose between hospitals, residency training programs, specialty certification boards and hospital accrediting bodies for the purpose of raising the standards of hospital-based care rendered by medical specialists.

Approximately 20% of DO and MD practitioners, combined, meet the definition of general practitioners, are not board certified, and do not practice as specialists within accredited health facilities as specialists. They are limited to practicing in private offices.

The great majority of dentists and optometrists however, are general practitioners offering care in private offices rather than hospitals. State dental and optometry boards are responsible for their continuing competence after licensure via MOL.

The credentialing tier is:

1. General Practitioner (degree and license, private office) MOL required.
2. Specialist (degree and license, residency training, private office and/or accredited medical facility). MOL + MOC required.
3. Sub-specialist (fellowship training after residency) private office and/or accredited medical facility. MOL + MOC required.

\*Most specialists maintain a private office and admit patients for hospital care. Some specialists (anesthesiologists and hospitalists) are primarily hospital-based. Sub-specialists frequently join societies in their subspecialty and may achieve additional recognition through them in addition to board certification.

Like dentists, optometrists are granted defined-licenses enabling them to offer the patient care specified by their license in private offices. Both are educated, trained, tested and licensed to engage in general practice as defined by state dental and optometry laws.

State medical, optometry and dental state boards have the legal responsibility to ensure those they license continue their competence and require MOL for license renewal. Optometry has been more proactive in MOL compared with the current self-reporting of CE accepted by most medical boards and more proactive than specialists who only recently abandoned life-time board certification.

The great majority of dentists are in general practice and 99.4 % of them have not served residencies and are not board certified. Dentists wishing to limit their practice to a dental specialty serve residencies and take specialty examinations to become board certified in a dental specialty.

It is probable that over 85% of licensed optometrists will remain in general practice as the number pursuing residency training is remaining steady and may decrease, as a percentage, from increasing numbers of schools. While board certification is important for specialists to hold clinical privileges at accredited health facilities, it is not required for private practice and cannot expand the range of services offered by an optometrist in private practice. The Joint Commission, since 1986, has recognized that defined-licensed prescribing practitioners may, without additional credentials, hold medical staff membership and have clinical privileges at accredited health care organizations whereas specialists are required to be board certified.

## Part VII: Optometry Misread Concerns about Continuing Competence

The issue that should be under debate is not whether general practitioners need pursue voluntary board certifications but whether current optometry MOL will meet the increasingly critical examination being given of the continuing competence of all practitioners, whether in general or specialized practice. It is optometry MOL that may come under scrutiny by external bodies and not the fact most optometrists are not specialists and not board certified specialists. If optometry wants to continue to be proactive then it should devote itself to studying whether the current MOL systems used by state boards adequately insure continued competence of general practitioners because it is general practice that is the backbone of our profession.

- These facts were emphasized by NBEO in 2001; [\[Link 1\]](#) and earlier in 1987 [\[Link 14\]](#).
- For a comprehensive MOL overview see the article by the Federation of State Medical Boards in the 2010 Journal of Medical Regulation, [\[Link 6\]](#)
- For definition of MOL see [\[Link 7\]](#)
- For the definition of MOC visit [www.abms.org](http://www.abms.org).
- The 1986 AOA Commission on Optometric Specialties properly understood, at that time, the role of board certification was the credentialing of specialties [\[Link 11\]](#), [\[Link 12\]](#), [\[Link 13\]](#) and in 1987 an editorial in the JAOA listed accepted criteria [\[Link 14\]](#).

Whether general practice optometrists are continuing their competence after initial licensing has not been much of an issue until recently. A study of this question will be complicated by the variation of state optometry acts and their MOL requirements. But malpractice rates have remained low and no external group has been critical of optometry MOL. Current concerns are directed at medical specialists who responded by creating MOC and now an internal study of medical MOL by the Federation of State Medical Boards is underway.

### ***Optometry MOL has had a good track record***

Over the years, state optometry practice statues and optometry boards have evolved to reflect increases in optometry training by including broader areas of responsibility.

Examples include state boards requiring older licensees with B.Sc. degrees to attend additional courses and pass written examinations to place O.D. after their name and the three decade process of documenting competence in diagnostic and therapeutic medications and procedures still ongoing and expanding.

These dynamics were accomplished by state legislations and their boards of optometry since only they have legal standing to issue licenses and to specify MOL to protect the public.

The Joint Commission does not consider optometrists or dentists, on the basis of degree and license, to be specialists nor do other credentialing bodies. Any concerns about the continuing competency of optometrists are therefore about MOL.

### ***Better MOL should have been considered***

The logical position to have taken by those concerned reforms of medical continuing competence might be required or imposed upon optometry would have been to determine if current optometry MOL methods are adequate. Our profession has no shortage of qualified clinicians and academics holding degrees in public health and law able to conduct this study.

Instead, in 2000 the AOA created the now defunct American Board of Optometric Practice to issue “board certifications” open to all optometrists.[\[Link 5\]](#) When that failed to gain traction, a second attempt in 2009 led

to the formation of The Joint Task Force on Board Certification which again recommended voluntary board certification as the means to ensure continuing competence of general practice optometrists.

This was startling since our profession still holds the doctrine that degree and license qualify one for general practice and we, like general practice dentistry, continue to eschew postgraduate residency training for general practice.

The task force unfortunately:

- Decided incorrectly that board certification was used to ensure continuing competence in general practice.
- Confused MOL of general practitioners with MOC of specialists.
- Assumed credentialing bodies would accept its version of board certification.

If the Task Force had inspected staff appointment forms they would have seen the OD degree and license do not make their holder a specialist and only specialists are required to list the dates and locations of residency training plus the number and date of the certificate issued by a recognized specialty board. This typical federal form [Link 10](#), Lines 16, 18, 24) indicates board certification requires residency training.

### Part VIII: Two Types of Faux Optometry Board Certification

The American Board of Optometry (ABO) and the American Board of Clinical Optometry (ABCO) propose optometrists voluntarily seek their credentials which each calls “board certification in optometry”. While they differ in complexity and costs, both fail to meet recognized requirements for board certification

**1: ABO** justifies their credential as protection to unproven or false claims that include:

- General practitioners will be pushed into board certification.
- General practitioners may need board certification to access provider panels.
- Board certification insures continuing competence of general practitioners.
- Only optometry fails to have board certification to ensure continuing competence.
- Board certification allows one to later demonstrate continuing competence by meeting conditions for renewal of certification (MOC)

And, more recently, that “Obama-Care” confirms need for board certification of optometrists

These claims are all false and “puffery”. ([Footnote 1](#))

The most recent incorrect claim is that **Sec. 10327**, of “Obama-Care” [Patient Protection and Affordable Care Act of 2010] supports the need for optometrists to seek board certification. This claim is without any basis in fact as shown by reading the Section.

Section 10327 applies only to licensed MDs board certified in an ABMS specialty, undertaking its MOC program and complying with other reporting requirements of the Physician Quality Reporting Initiative (PQRI) enacted five years ago. These specialists may receive a ½% bonus on Medicare billings. This Section does not apply to dentists, optometrists, podiatrists, MD physicians or osteopaths in general practice or those holding fringe board certifications, nor psychologists, audiologists, etc. And optometry has, since PQRI’s inception, been deemed a “qualified practitioner” and eligible for other programs that provide higher incentives of 4.5%.

**2: ABCO** objected to these false ABO claims but, after arguing board certification will not be needed, offers its voluntary board certification as a “cost-effective” alternate based upon equally misleading claims that:

- Optometrists are now already board certified based upon having passed various NBEO examinations during training before receiving the OD degree, as part of their licensing process or as a result of other NBEO post-degree examinations like TMOD.
- Optometrists are already specialists because they concentrate on the human visual system during their entire professional training unlike MDs.
- Optometrists are already board certified by their respective state licensing boards.

ABCO believes general practitioners are remaining competent, have demonstrated that in various ways and no additional testing or MOL improvements are needed and their board certification documents this fact. It suggests general practice optometrists hedge their bets using their less cumbersome board certification just in case some future credentialing body requires board certification. In fact, ABCO suggests ABO is working to market its credential to “panels” in the hope they will require it so that board certification will become mandatory rather than voluntary and thus produce a self-fulfilling prophecy.

#### ***Incorrect Claims of being “Board Certification” Not New***

“Boards” taken in the course of training for the OD degree, to initially receive the OD degree (“practicals”), or for updating the OD license do not qualify as board certification just as “boards” taken in medicine in the course of gaining the MD degree and state license are not board certifications. Some in private practice claim to be board certified from having passed NBEO “board” examinations and others cite the TMOD exam offered by NBEO as board certification but many just state they are board certified by the NBEO, the state optometry board or attribute no certifying body. One leading ABO supporter and AOA officer listed himself for some time at his website as being board certified without having served a residency.

The NBEO however has stated it does not offer examinations, other than ACMO, that can be used to document advanced competence in a specialty or advanced competence beyond that required for licensure.

Some planning to take the ABO examination, or have registered to do so, now claim to be “board eligible” although that term is not longer recognized in medicine and osteopathy and has no meaning.

The above all indicate an irrational case of “board certification envy” has infected the optometry body since 1998 when the now defunct American Board of Optometric Practice was formed by the AOA to offer a board certification requiring only passage of a multiple choice examination. [\[Link 5\]](#) But there is no rational basis for this case of envy.

#### ***Part IX: Concluding Opinions***

No evidence shows current MOL requirements do not properly ensure continuing competency of general optometry practitioners. If optometry MOL is deficient that first needs to be determined before offering solutions, and solutions do not include the non-creditable ones proposed by ABO and ABCO. Nor has the profession decided general practice should become a specialty requiring residency training and then board certification.

The issue of optometry continuing competency may deserve consideration by a blue-ribbon panel that includes members of the US health credentialing community and public interest groups coordinated by the Association of Regulatory Boards of Optometry which is the approach being taken by the American Federation of State Medical Boards. If optometry MOL is failing that must first be established as a fact.

That such a study has not been done and the Joint Task Force on Board Certification consisted mainly of trade associations without public health or credentialing experts from outside our profession speaks to why it produced the result it did. As does the fact ABO is housed within the AOA main offices, directed by a former AOA staffer and funded by a two-million dollar line of credit secured by the AOA with the Bank of America.

Our profession deserves an analytical and scientific approach to this issue not influenced by special interest groups which was even pointed out by the 1986 AOA Commission on Optometric Specialties.

The following options appear to offer a rational roadmap.

**Option A:**

- A creditable study to determine if improved MOL is needed to ensure continuing competence of general optometry practitioners.
- If improvements are needed, they cannot be named board certification.
- Improvements must be integral to license renewal so all practitioners comply. No profession should promote voluntary maintenance of competence.
- The study of, and improvements to, MOL must be done in concert with state boards of optometry as only they have legal standing to require MOL and protect the public.

**Option B:**

- If general practice is to become a specialty; residency training, written specialty examination and certification by an independent specialty board are required. A specialty board must test advanced competence and be free of conflicts of interest with trade associations and purveyors of education. The 1986 AOA "Commission on Optometric Specialties" [\[Link 11\]](#), [\[Link 12\]](#) that advocated this approach to specialization stressed the need for residency training and advanced testing which is the path chosen by those now specializing in medical optometry. [\[Link 13\]](#)

**Option C:**

- A national or "super MOL" offered by an independent body free of conflicts of interest having the support and recognition of the state boards will lead to improved uniformity in practice acts and reciprocity. The ABO, if renamed and re-structured, could be this "super MOL" and available to state boards with each state deciding whether to require it every 10 years and/or credit its requirements towards annual MOL CE.
- Testing required by this "super MOL" should reflect the highest level of general practice to support expansion of more restrictive state practice statutes and limited to self assessments and demonstrations of clinical competence not part of state MOL systems. This would produce a greatly enhanced MOL process with the "super MOL" required every 10 years in addition to annual MOL.

**At This Time:**

1: ABO and ABCO cannot offer creditable board certification in general practice without requiring residency training and passage of an examination testing advanced competence in general practice. This would redefine general practice as a specialty.

2: ABO and ABCO cannot offer a creditable "super MOL" without the approval and acceptance of the state optometry boards, a renaming of their certifications and removal of conflicts of interest with trade associations.

A “super MOL” required every 10 years for license renewal by state boards could lead to greater uniformity of licensing laws and enhanced reciprocity. CE hours clocked towards it could be credited towards MOL as for medical specialists with only the self assessment and competency demonstrations unique to the national MOL.

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## References

The reader may consult [www.abms.org](http://www.abms.org) for information on meaning of terms and the websites of specialty boards for osteopathy, dentistry and podiatry. The website “Quack Watch” explains in layman terms the meaning of board certification and discusses “fringe” board certifications not requiring residency training ([www.quackwatch.com](http://www.quackwatch.com).)

An excellent overview of current concerns about continuing competence of medical practitioners is found in the 2010 Journal of Medical Regulation (Maintenance of Licensure: Protecting the Public, Promoting Quality Health Care; Humayun J Chaudhry, D.O. et al.).

This article notes that “...more than 30% of actively licensed physicians are not specialty board certified, most physicians with time-unlimited (“grandfathered”) specialty certificates have chosen not to become recertified and a plurality of physicians with time-limited specialty certificates are not seeking renewal of specialty board certifications...” and concludes this will place additional importance on MOL for medical license renewal.

### **Footnote 1:** (“Puffery”)

In a news report, (see below) the ABO defends against the charge it uses misleading statements by rationalizing them as “mere puffery”. That ABO believes it is justified in using “puffery” to urge colleagues to invest sizable amounts of time and money in their credential is not comforting.

### **Footnote 2:** (As reported in the December 15, 2010 issue of Review of Optometry.)

The ABO statement “board certification is the “highest level” of certification available in “eye care” also appears to be “puffery”.

- A. If “eye care” refers to ophthalmology, the highest level is “sub-specialist” or fellowship trained, rather than “board certification”.
- B. If “eye care” refers to optometry one must ask if it refers to general practice.

If so, many assert a higher level is represented by being elected a Fellow of the American Academy of Optometry. (A 1978 FTC study found Fellows performed more competent examinations.)

But if it refers to limited fields of general optometry, many believe the highest level is obtaining Diplomate Status in a Section of the Academy and/or becoming a member of the Optometric Retinal Society or the Optometric Glaucoma Society.

### **Footnote 3:**

The ABO examination does not test advanced competence as it states it tests “core areas” in “general practice”.

The ABO examination for “board certification in optometry” totals 240 questions ([www.abopt.org](http://www.abopt.org)).

ABO describes the examination as having a “core” based upon ten areas of general practice to which are added two areas of “emphasis” selected by each applicant. The “core” of general practice contains 160 questions and each of the two self-selected areas of “emphasis” has 40 additional core-level questions producing a total of 240 questions.

The core ten areas ABO states comprise “general practice” are weighted from a low of 5% [neuro-ophthalmic, vision rehabilitation] to 16% [ametropia/optics]. Applicants are required to choose 2 areas of emphasis from among 6 offered of which the first is general practice as a whole and the next 5 are drawn from specific core areas of general practice.

Four core areas of general practice are not offered for selection---systemic health, pre-post-operative care, ametropia/optics and optic nerve/glaucoma.

By requiring applicants to pick two areas of emphasis produces 15 differently weighted examinations all based upon general practice test items. (An earlier test version offered 346 different versions.)

Nowhere does ABO claim the examination is a specialty examination and it is insufficiently concentrated to be one. For example, the highest emphasis results when an applicant opts to choose both "Ocular Disease Anterior" and "Ocular Disease Posterior" that add 80 questions or 33% of the total 240 questions. When these are added to the 27% of anterior and posterior questions in the core examination, 49% of the total exam questions pertain to anterior and posterior segments while the other 14 forms of the exam produce lower concentrations. A specialty examination is more concentrated and tests at a higher level of competency.

The ABO examination tests competence at the level of general practitioners that comes in 15 varieties rather than a single test of the competency expected of all in general practice.

It is worth noting that the 10 "core" areas designated by ABO as comprising general practice are not congruent with the 9 areas ASCO lists as suitable for specialization via residency training.

The ABO examination is not an examination of continuing competence in general practice (MOL) since, with 15 varieties, it is not standardized to reflect the level of competence expected of all licensed optometrists. Nor can it serve as a specialty examination since it is insufficiently concentrated and tests general practice level competency.

**Footnote 4:**

Bulletin from the Commission on Optometric Specialties, Bulletin #106, May 29, 1986.

AOA Memorandum, Commission's Report, June 23, 1986

House Rejects Plans for Certification, AOA News, July, 15, 1986

Competence Assessment in Optometric Specialty Certification: The Missing Element, Wallis, N; AOA Journal, Dec. 1987; 58(12).

Note: The requirements developed by the Commission are congruent with those of ABCMO: Accredited residency training and passage of a specialty examination testing advanced competence.

***Acronyms Referenced***

**AAO** American Academy of Optometry. Approximately 9% of licensed optometrists are Fellows of the Academy (FAAO) after meeting criteria that include submission of patient case reports and personal interviews. The Academy offers a well attended annual meeting consisting of lectures, workshops and laboratory sessions and has Sections devoted to various aspects of general practice which can lead to Diplomate status. The annual meetings of groups such as the Optometric Retinal and Glaucoma Societies, National Association of VA Optometrists and Armed Forces Optometric Association are held in conjunction with annual AAO meetings. Attendance is open to non-Fellows and non-ODs.

**ABO** American Board of Optometry. Created primarily by AOA (which guaranteed a line of credit) and ASCO, it will offer voluntary "board certification in optometry" based upon a point system to qualify to sit a written examination available in 15 versions of emphasis. Residency training not required. MCO required.

**ABO Exam** An examination of 240 test items having 16 mandatory "core test items" from each of 10 areas of general practice. Applicants must also select 2 of 6 areas of general practice for an additional 80 test items to emphasize their particular mode of general practice. This produces 15 different forms of the examination. The 10 core areas of general practice do not align with the 10 areas ASCO specifies are suitable for specialization via residency training and all test items are at the level of general rather than specialized practice.

**ABOP** An attempt ten years ago by AOA to introduce a voluntary "board certification" for all optometrists that required a set amount of CE and passage of a multiple choice written examination. Its funding was terminated and the program closed.



**ABCO** American Board of Clinical Optometry. Formed in opposition to ABO. It posits that general practice optometrists have been sufficiently tested during their training prior to and for the OD and then by the state licensing boards and required MOL that additional credentialing is not required for general practice. It offers an alternative to the ABO board certification in optometry. MOC not required.

**ABCMO** American Board of Certification in Medical Optometry. The only specialty board in optometry. Incorporated in 2009 as a non-profit it issued certifications in the specialty of medical optometry in 2010. ABCMO criterion are closely aligned to those of recognized medical and dental specialty boards by requiring residency training and passage of the ACMO specialty examination administered annually by NBEO. MOC is required for renewal of certification in medical optometry.

**ABMS** American Board of Medical Specialties. A federation of 26 medical specialty boards recognized by the Joint Commission for credentialing of medical specialists at accredited health care facilities. Recognized medical specialties require mandatory residency training. The ABMS has created MOC programs to replace former life-time specialty board certifications and holds the trademark for MOC.

**ACMO** Advanced Competence in Medical Optometry written examination administered by NBEO. First administered in 2005 and required by ABCMO following residency training. It is the only specialty-level examination in optometry.

**ACOE American** Council on Optometric Education. The body accrediting schools and colleges of optometry and optometry residency programs. Affiliation with a school or college of optometry is one requirement for accreditation of residency programs and the majority of the training during an accredited residency must be in that specialty.

**AFSMB** The American Federation of State Medical Boards includes state osteopathic and medical boards. In 2010 it began to study whether state MOL requirements for renewal of medical and osteopathic licenses were adequate to ensure continued competence in general practice. Most medical MOL utilizes self reported CME.

**AOA** American Optometric Association. The largest membership trade association of licensed optometrists with offices just outside DC in Alexandria, VA and St. Louis, MO. Membership in an affiliated state optometric society is required. While the percentage of licensed ODs who are members is not available, an estimate would be 65%.

**AOS** American Optometric Society. Formed in 2010 as a trade association primarily to oppose efforts by the AOA to create and support ABO. Some ABCO members are also members of AOS. AOS does not give precise membership numbers but they are estimated to be in excess of 2,000. There is no definitive data on the number of active licensed US optometrists in practice but estimates range from 32,000 to 39,000.

**ARBO** Association of Regulatory Board of Optometry. A national federation of state, district and territorial boards of optometry. At its 2010 House of Delegates a poll showed the great majority of member boards believed it was their legal duty to ensure the continuing competence of their licensees. ARBO recently adopted a code of ethics that bars it from establishing conflict of interest relationships that might derive from affiliations with trade associations. The legal regulation of general practice optometry is the responsibility of state optometry boards.

**ASCO** Association of Schools and Colleges of Optometry. An academic trade association. Its web site lists ten recommended areas of specialization suitable for residency training and lists the advantages

gained by serving a residency. ASCO has supported the development of specialty residencies and the ACOE requires accredited residency programs be affiliated with ASCO member schools.

**JCAHO** Joint Commission on the Accreditation of Health Care Organizations or Joint Commission. The national body that accredits health care facilities and establishes the criteria by which their credentialing and privileging committees determine medical staff membership and privileges of practitioners. In 1986 it ruled degree and license were sufficient for general practice dentists, optometrists and other limited-licensed prescribing practitioners.

**MOC** Maintenance of Certification. Used by the author to indicate methods to ensure continuing competence of medical specialists, MOC is a recently established requirement of ABMS that those board certified in a recognized (residency-trained) medical specialty must re-demonstrate their specialized competence for renewal of certification every 10 years. ABMS board certifications were once life-long. ABMS holds the trademark for the term MOC. Osteopaths have a similar program (see OCC).

**MOL** Maintenance of Licensure. The methods used by state boards of medicine, osteopathy, dentistry and optometry to ensure continuation of competence via required CE for license renewal. The majority of state medical boards rely upon self-reporting of CE whereas state optometry boards require documented CE attendance. The AFSMB has begun to study whether the state medical boards should introduce more stringent MOL.

**“Obama Care”** Patient Protection and Affordable Health Care Act of 2010. Commonly cited, incorrectly, as supporting the need for optometrists to become board certified. One prominent ABO supporter referred to it as the “smoking gun” proving optometrists must be board certified.

**OCC** Osteopathic Continuous Certification is the equivalent of MOC for osteopathic specialists and was established by the American Osteopathic Association Bureau of Osteopathic Specialists.

**ORMS** Optometric Residency Matching System. A national system matching applicants with optometry residency training sites. Applicant preferences are computer matched with the rankings of applicants at the sites to which they applied. Many residency programs require interviews as part of their selection process.

**VA** Since 1974, the Department of Veterans Affairs (DVA) has developed the largest optometry patient care and clinical training programs in the nation at its VA hospitals and outpatient clinics with 675 optometrists on the medical staff of whom 61% hold faculty appointments. In 2010, 1.47 million patient visits were made to optometry staff and about 1,100 4<sup>th</sup> year optometry students served a 3-4 month clinical VA rotation. One-year ACOE accredited clinical residency programs begun by the VA in 1975 now total 73 with 164 stipend-receiving residents completing training each year. Stipends range from \$31,965 to \$37,842. The VA was the lead federal health care system to offer autonomy and therapeutic prescribing privileges to optometrists. This was stimulated by Congress at the request of the AOA and supportive VA-affiliated ophthalmology department chairs, Chiefs of Staff, the Office of Academic Affairs in Headquarters and leading optometry academics.

Information about the above organizations is easily attained via Google internet searches with their names as search terms.

### ***Referenced Links***

The links below will open the supporting documents referred to in the text.

- Link 1 [NBEO Explains \(document\)](#)
- Link 2 [Effort to ban use of BC by non-residents \(article taken from external website\)](#)
- Link 3 [NC State Board statement about ABO \(document\)](#)
- Link 4 [Nevada State Board opinion on ABO \(document\)](#)
- Link 5 [Optometric Management article about ABOP \(taken from external website\)](#)
- Link 6 [MOL for state license \(Journal of medical regulation, article\)](#)
- Link 7 [MOL of MDs and Dos \(website article taken from AFSMB\)](#)
- Link 8 [NAVAO Spring 2009 Newsletter \(first 3 pages excerpt\)](#)
- Link 9 [ARBO statement about ABO \(document\)](#)
- Link 10 [VA Application Form \(document\)](#)
- Link 11 [AOA Commission on Optometric Specialties.](#) AOA Status Report Memo, 1986.
- Link 12 [Final Report of AOA Commission on Optometric Specialties.](#) Lists requirements for a “creditable and defensible” certification process of optometric specialists. These requirements were not adopted by ABO and ABCO for their board certifications in general practice optometry, AOA Publication, 1986.

- Link 13 [AOA Delegates Vote Against Certification of Optometry Specialties](#). A key reason for rejection by the House of Delegates was the opinion board certification would be divisive of general practice optometry. AOA News, 1986
- Link 14 [Competence Assessment in Optometric Specialty Certification](#). Opinion article by Norman E Wallis, Ph.D., O.D, (ED of NBEO) explaining the accepted methods used to certify competence in a specialty of a profession. J of AOA, 1987: 58(12).

(In 1986-87, residencies in optometry specialties had existed for 11 years and were supported by AOA and ASCO; ACOE was moving to accredit residencies and schools of optometry were recruiting residency-trained faculty. The rejection of the 1986 Report of the AOA Commission on Optometric Specialties by the AOA House of Delegates was for political-economic reasons which illustrates trade associations must not control credentialing bodies. In 1986 the House of Delegates rejected traditional criteria for certification of specialists but in 2010 reversed its field and supported non-traditional criteria for certification of general practitioners and ignored the divisive nature this action will have upon general practice.)

#### **Disclaimer**

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*These opinions are solely those of the author and may not necessarily reflect those of the ABCMO Board or its other officers and are based upon what the author believes to be factual and relevant information and are not intended to reflect unfavorably upon individuals supporting ABO or ABCO board certifications of general optometry practitioners.*

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Comments by organizations or individuals correcting or challenging statements in this editorial they believe to be factually in error are welcome and should be sent, with supporting documentation, to [info@abcmo.org](mailto:info@abcmo.org) or to [myers.kenj@gmail.com](mailto:myers.kenj@gmail.com). Necessary corrections will be acknowledged and made to this editorial as they are received.

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