Use of Board Certification and Recertification in Hospital Privileging

Policies for General Surgeons, Surgical Specialists, and Nonsurgical Subspecialists

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Objectives: To better understand the relationship between board certification and credentialing policies for surgeons and nonsurgical subspecialists and to examine possible variation in use of board certification among different types of hospitals.

Design, Setting, and Participants: Telephone survey conducted from November 14, 2006, through March 16, 2007, of the privileging personnel among a random sample of 235 nonchildren’s hospitals stratified by teaching status, bed size, metropolitan statistical area, system affiliation, and tax status.

Main Outcome Measures: Proportion of hospitals that require specialty board certification to gain privileges and hospital requirements for recertification.

Results: Of 235 hospitals, 11 were ineligible and 183 completed the telephone interview, resulting in an overall response rate of 82%. Approximately one-third of hospitals did not require surgeons and nonsurgical subspecialists ever to be board certified to receive hospital privileges. Among the 109 hospitals that required certification at some point, only 5 (5%) required surgeons and 3 (3%) required nonsurgical subspecialists to be board certified at the point of initial privileging. More than three-fourths of hospitals had exceptions to their certification policies for surgeons and 84 (77%) had them for nonsurgical subspecialists. Eighty-two percent of all hospitals and two-thirds of hospitals whose policies required recertification allowed surgeons and nonsurgical subspecialists to retain privileges when their board certification expired.

Conclusion: Most hospitals do not consistently use board certification to ensure physician competence at their institutions.

Hospitals have a responsibility to the public to provide safe medical care. The responsibility encompasses many aspects of patient care but at its most basic level includes exercising due diligence when evaluating potential practitioners and awarding clinical privileges (privileging) to physicians to serve on a hospital staff. This process was first formalized in the early 1900s when the American College of Surgeons identified a minimum standard for practicing medicine in hospitals to exclude incompetent or unethical practitioners. 

A complementary process of quality assurance was undertaken by physician-led specialty boards in the early part of the 20th century. In 1933, the American Board of Medical Specialties (ABMS) was formed to validate physician competence through standardized professional training and rigorous evaluation. Initially, board certification was a one-time event and did not require renewal. In the 1970s, specialty boards began a movement toward time-limited certificates that require renewal every 6 to 10 years. At present, all ABMS member boards issue time-limited certificates only.

To provide independent oversight and further enhance quality in hospitals, the Joint Commission on the Accreditation of Hospitals (later renamed The Joint Commission) was created in 1951. In 1953, The Joint Commission published its first accreditation standards manual, which required hospitals to establish credentialing committees to review physician competence. Current credentialing standards include review of practitioner licensure, relevant training or experience, and competence no less frequently than every 24 months. Specialty board certification is not deemed mandatory by The Joint Commission but may be used as an as-
ments mandate board certification, but significant variation cause no current federal or Joint Commission require-
that pediatricians to achieve certification at some point during certified at initial privileging, but 70% report they require on hospital privileging policies for pediatricians revealed research exists as to how, or whether, hospitals are using core competencies: patient care, medical knowledge, practice-based learning, interpersonal skills, professionalism, and systems-based practice.

Although patient safety leaders have applauded the boards’ efforts in assessing physician competence, little research exists as to how, or whether, hospitals are using board certification in credentialing decisions. A 2005 study on hospital privileging policies for pediatricians revealed that 78% of hospitals do not require pediatricians to be board certified at initial privileging, but 70% report they require pediatricians to achieve certification at some point during their tenure. It is unclear whether these results can be generalized to other specialties. Some have posited that hospital board certification requirements for privileging may vary according to the proportion of high-risk procedures performed by various types of practitioners. However, because no current federal or Joint Commission requirements mandate board certification, significant variation among hospitals may exist.

To better understand the relationship between board certification and credentialing policies and to examine possible variation among different types of hospitals, we conducted a national survey of hospital privileging policies and practices regarding requirements for board certification and recertification of general surgeons and surgical and nonsurgical specialists.

METHODS

SURVEY DESIGN

In conjunction with the ABMS, the research team developed a telephone survey for use with hospital privileging personnel, designed to be completed in 20 minutes or less. The survey focused on the following descriptive research questions:

1. Do hospitals require ABMS board certification for surgical specialists, general surgeons, and nonsurgical subspecialists?
2. Is ABMS board certification required at the point of initial privileging with the hospital?
3. Are hospitals tracking board certification for surgeons and nonsurgical subspecialists?
4. Do hospitals require recertification for surgeons and nonsurgical subspecialists?

The survey was pilot tested for clarity with representatives from a convenience sample of hospitals within the state of Michigan and revised to clarify potentially ambiguous questions. Pilot surveys were not included in the analyses. This study was approved by the institutional review board of the University of Michigan Medical School.

STUDY SAMPLE

The sampling frame was limited to nonchildren’s hospitals in the United States as listed in the 2003 American Hospital Association’s Annual Survey of Hospitals. Federal government hospitals, with the exception of Department of Veterans Affairs hospitals, were excluded. Using the remaining 5571 hospitals as a sampling frame, the research team selected a random sample of 235 hospitals weighted to provide nationally representative estimates. The sample was stratified by the Council of Teaching Hospitals and Health Systems (COTH) designation (teaching vs nonteaching), hospital bed size (large, ≥250 beds; small, <250 beds), metropolitan statistical area (urban vs rural), affiliation (member of a hospital system [MOS] vs independent), and tax status (for-profit vs not-for-profit).

Hospitals were sampled with varying probabilities from each stratum. Weights were applied to create a representative sample of the overall hospital population, using the following formula:

\[ TSW = \frac{1}{P} \times \frac{1}{RR}, \]

in which TSW is the total sample weight calculated for each hospital based on the probability of selection into the study (P) and the response rate (RR).

DATA COLLECTION

From November 14, 2006, through March 16, 2007, the project team attempted to contact the selected hospitals. Research staff requested to speak with the department responsible for physician credentialing or privileging at the hospital. When the appropriate person was identified and located, interviewers explained the purpose of the study and obtained verbal consent to participate. Respondents included directors of credentialing, credentialing managers and coordinators, and medical staff coordinators. A small number of hospitals requested to complete the survey via e-mail or fax.

DATA ANALYSIS

First, frequency responses were calculated for each survey item. Next, the research team examined responses by hospital characteristics. We computed weighted \( \chi^2 \) statistics for each survey item, and \( P < .05 \) was considered statistically significant. Percentages are unweighted for the total sample; however, percentages reported by hospital demographic characteristic are weighted.

RESPONSE RATE

Of the 235 selected hospitals, 11 were ineligible because they had closed, did not have specialists, or had fewer than 5 physicians on staff. Of the remaining 224 hospitals, credentialing personnel at 183 completed the telephone interview, representing an overall response rate of 82%.

Response rates differed significantly between for-profit and not-for-profit hospitals (72% vs 85% [\( P = .02 \)]. Because not every hospital answered every question, the total numbers presented for each question may differ slightly owing to missing responses.

HOSPITAL DEMOGRAPHICS

Of the 183 hospitals that completed the interviews, 56 (31%) were COTH hospitals, 89 (49%) had 250 or more
beds, 63 (34%) were located in urban settings, 78 (43%) were MOS, and 128 (70%) had not-for-profit tax status. There is overlap among the hospital characteristics (ie, an urban hospital can also be a teaching hospital), so all percentages do not total 100.

OVERALL RESULTS

Approximately 60% of hospitals require that surgeons, surgical specialists, and nonsurgical subspecialists be board certified at some point during their tenure (unweighted data) (Table 1). Teaching, large, and not-for-profit hospitals were more likely to report board certification requirements.

Table 1. Certification Ever Required for Privileging Among 183 Hospitals

<table>
<thead>
<tr>
<th>Type of Hospitals That Ever Require Board Certification, %</th>
<th>Total Sample, Unweighted No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching, Size, MSA, Affiliation, Tax Status</td>
<td>COTH Non-COTH Small Large Urban Rural MOS Independent For-Profit Not-for-Profit</td>
</tr>
<tr>
<td>Surgical specialists (n=166)</td>
<td>103 (62) 65a 54a 49a 75a 75 52 57 53 37a 59a</td>
</tr>
<tr>
<td>General surgeons (n=170)</td>
<td>102 (60) 60a 52a 46a 74a 56a 51 47a 54 51 38a 55a</td>
</tr>
<tr>
<td>Nonsurgical subspecialists (n=181)</td>
<td>109 (60) 62a 58a 55a 67a 60a 55a 60 56 49a 60a</td>
</tr>
</tbody>
</table>

Abbreviations: COTH, Council of Teaching Hospitals and Health Systems; MOS, member of a hospital system; MSA, metropolitan statistical area. 

a P<.05.

Table 2. Credentialing Requirements at Initial Privileging Among 109 Hospitals Requiring Board Certification at Some Point

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Surgical Specialists</th>
<th>General Surgeons</th>
<th>Nonsurgical Subspecialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board certification at initial privileging</td>
<td>Yes</td>
<td>5 (5)</td>
<td>5 (5)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>72 (70)</td>
<td>71 (70)</td>
</tr>
<tr>
<td>Mix policy, all except recent graduates</td>
<td>26 (25)</td>
<td>26 (25)</td>
<td>25 (23)</td>
</tr>
<tr>
<td>Required to complete ACGME-approved residency training</td>
<td>Yes</td>
<td>86 (90)</td>
<td>86 (91)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>7 (7)</td>
<td>8 (8)</td>
</tr>
<tr>
<td></td>
<td>Some</td>
<td>3 (3)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Established time frame within which certification must be achieved</td>
<td>None</td>
<td>5 (5)</td>
<td>4 (4)</td>
</tr>
<tr>
<td></td>
<td>1-3 y from privileging</td>
<td>17 (18)</td>
<td>18 (19)</td>
</tr>
<tr>
<td></td>
<td>4-6 y from privileging</td>
<td>38 (39)</td>
<td>39 (41)</td>
</tr>
<tr>
<td>Other, based on training date, board cycles, or case by case</td>
<td>37 (38)</td>
<td>35 (36)</td>
<td>39 (38)</td>
</tr>
</tbody>
</table>

Abbreviation: ACGME, Accreditation Council for Graduate Medical Education. 

a Percentages are based on the totals for each question. 

b Certification policy varied for recent graduates.

Among the 109 hospitals that require certification at some point, only 5 (5%) require surgeons to be board certified and 3 (3%) require nonsurgical subspecialists to be board certified at the point of initial privileging. These hospitals reported that they require the board certification to be current (Table 2). Approximately one-quarter of hospitals reported that their certification policy varied for recent graduates. These hospitals, which were classified as having a mixed policy for certification, allow additional time for recent graduates to become board certified while requiring physicians with more experience to be certified at the point of initial privileging. In the case of some surgical specialties such as urology, documented hospital practice is required before board certification.

Approximately 90% of hospitals that do not require board certification at initial privileging require surgeons and nonsurgical subspecialists to have successfully completed residency training approved by the Accreditation Council for Graduate Medical Education (Table 2).

If a hospital requires board certification for physicians at some point, most have established time frames within which certification must be achieved. More than one-third of hospitals reported that they establish time frames for certification according to the training completion date or the board certification cycles or on a case-by-case basis (Table 2). Teaching and large hospitals were more likely than their peers to set time frames for certification of surgeons and nonsurgical subspecialists on a case-by-case basis (P < .001).

More than three-fourths of hospitals reported that they make exceptions to their certification policies. Most of the hospitals with exceptions to their certification policies (71% for surgical specialists, 72% for general surgeons, and 67% for nonsurgical subspecialists) make them for physicians who have a certain number of years of service or have privileges at the hospital from a specific...
point (eg, grandfather clause). Large, urban, and MOS hospitals are more likely to make exceptions to their certification policy for surgeons and nonsurgical subspecialists. For-profit hospitals were more likely than not-for-profit hospitals to make exceptions for surgical specialists and general surgeons, but not-for-profit hospitals were more likely to make exceptions to their certification policy for nonsurgical subspecialists.

**PRIVILEGING POLICIES**

Non–board-certified surgical specialists and nonsurgical subspecialists are infrequently limited with respect to their privileging. Twenty hospitals (12%) reported that they restrict the privileges of non–board-certified surgical specialists, and 18 hospitals (10%) restrict the privileges of nonsurgical subspecialists. Large, COTH, and MOS hospitals were more likely to restrict privileges of surgical specialists and nonsurgical subspecialists on the basis of board certification status. Urban hospitals were more likely than rural hospitals to restrict the privileges of non–board-certified surgical specialists.

Similarly, 82% of hospitals allow surgeons (134 of 164 hospitals) and nonsurgical subspecialists (143 of 175) to retain privileges after board certification has expired. Large, COTH, and urban hospitals were more likely than their peers to allow surgeons and nonsurgical subspecialists to retain privileges.

Eighteen hospitals (11%) reported that surgical specialists are required to be board certified for specific procedures such as robotics surgery. Nineteen hospitals (11%) reported that board certification is required of nonsurgical subspecialists for specific invasive procedures such as endoscopy or heart catheterizations.

Only 7 hospitals (4%) reported that their privileging policies vary according to whether the physician is primarily employed by the hospital or is a community-appointed physician.

**TRACKING BOARD CERTIFICATION**

Ninety-three percent of hospitals reported that they track board certification expiration dates for surgeons (159 of 171) and nonsurgical subspecialists (170 of 182). Large, COTH, urban, and not-for-profit hospitals were slightly more likely to track expiration dates than their peers.

Most of the hospitals (90%) reported that they verify specialists’ certification every 2 years as part of recredentialing as required by The Joint Commission. Seventy hospitals (38%) indicated they verify certification on expiration of the certificate, whereas 51 (28%) reported continuous monitoring.

**RECERTIFICATION REQUIREMENTS**

The surgical specialists and general surgeons were combined for the recertification requirements portion of the survey. More than half of the hospitals surveyed reported that they require surgeons (98 hospitals [58%]) and nonsurgical subspecialists (100 [55%]) with time-limited board certification to recertify. Non–COTH, large, MOS, and not-for-profit hospitals were more likely to require recertification. Urban hospitals were more likely than rural hospitals to require recertification for surgeons (Table 3).

Only 1 hospital required surgeons with permanent certificates to recertify, and just 2 hospitals reported that they require nonsurgical subspecialists with permanent certificates to recertify in their subspecialty.

Most of the hospitals that require surgeons and nonsurgical subspecialists to recertify establish time frames for recertification based on a unique plan with each physician (Table 4). Fewer than one-quarter of hospitals (22% for surgeons and 24% for nonsurgical subspecialists) reported that they do not allow a gap in certification, whereas 5 hospitals do not have a deadline for recertification of surgeons and nonsurgical subspecialists.

Two-thirds of hospitals that require physicians to recertify allow surgeons (68% of hospitals) and nonsurgical subspecialists (66%) to retain their privileges after their certification expires. Large, COTH, urban, and not-for-profit hospitals were more likely than their peers to allow surgeons and surgical subspecialists to retain privileges after certificate expiration.

Eleven percent of hospitals reported that they terminated at least 1 surgeon (n = 18) or nonsurgical subspecialist (n = 19) solely for failure to certify or recertify in their specialty or subspecialty. Large, COTH, and urban hospitals were more likely than their peers to terminate a surgeon or nonsurgical subspecialist for failing to certify or recertify.

**INCENTIVES FOR BOARD CERTIFICATION**

Most hospitals do not offer surgeons (89%) or nonsurgical subspecialists (89%) economic incentives or re-
wards for board certification. Large, COTH, non-MOS, and not-for-profit hospitals were more likely than their peers to offer incentives such as salary differentials and bonus payments for board certification. Urban hospitals were more likely to offer incentives for certification for nonsurgical subspecialists. Eleven hospitals (6%) offer a pay-for-performance program for surgeons and 15 (8%) offer such a program for nonsurgical subspecialists, yet all hospitals reported that board certification is not a part of these programs.

Table 4. Time Frame in Which Recertification of Surgeons and Nonsurgical Subspecialists Must Occur for 96 Hospitals That Require Recertification

<table>
<thead>
<tr>
<th></th>
<th>Total Unweighted</th>
<th>Weighted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sample No. (%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>COTH Non-COTH</td>
<td>Small</td>
</tr>
<tr>
<td></td>
<td>Size</td>
<td>Large</td>
</tr>
<tr>
<td></td>
<td>MSA</td>
<td>Urban</td>
</tr>
<tr>
<td></td>
<td>Affiliation</td>
<td>Rural</td>
</tr>
<tr>
<td></td>
<td>Tax Status</td>
<td>MOS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Independent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For-Profit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not-for-Profit</td>
</tr>
<tr>
<td>Surgeons (n=96)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No gap in certification</td>
<td>21 (22)</td>
<td>20 (19)</td>
</tr>
<tr>
<td>No time frame</td>
<td>5 (5)</td>
<td>0 (5)</td>
</tr>
<tr>
<td>≤1-2 y</td>
<td>3 (3)</td>
<td>4 (0)</td>
</tr>
<tr>
<td>Unique plan with provider/other</td>
<td>67 (70)</td>
<td>76 (76)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonsurgical subspecialists (n=96)</td>
<td>23 (24)</td>
<td>15 (27)</td>
</tr>
<tr>
<td>No gap in certification</td>
<td>23 (24)</td>
<td>15 (27)</td>
</tr>
<tr>
<td>No time frame</td>
<td>5 (5)</td>
<td>0 (4)</td>
</tr>
<tr>
<td>≤1-2 y</td>
<td>4 (4)</td>
<td>4 (4)</td>
</tr>
<tr>
<td>Unique plan with provider/other</td>
<td>64 (67)</td>
<td>81 (68)</td>
</tr>
</tbody>
</table>

Abbreviations: COTH, Council of Teaching Hospitals and Health Systems; MOS, member of a hospital system; MSA, metropolitan statistical area.

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The most important finding from this study is that one-third of hospitals do not require surgeons and nonsurgical subspecialists to be board certified to receive hospital privileges. Furthermore, almost three-quarters of hospitals that require board certification at some point do not require surgeons or nonsurgical subspecialists to be certified at the point of initial privileging. Among hospitals that require board certification, there appear to be fewer repercussions for physicians who fail to meet this requirement. Few hospitals limit the privileges of non–board-certified surgical specialists (12%) and nonsurgical subspecialists (10%), and just 11% of hospitals reported that they had terminated a surgeon or nonsurgical subspecialist for failure to certify or recertify in their specialty.

In an effort to ensure public safety and trust, the specialty boards of the ABMS have enhanced time-limited board certification to create a more rigorous assessment of physician competence. Our findings indicate that most hospitals do not use this resource on a consistent basis. This raises questions regarding the intent of hospital board certification policies.

Some hospitals may see board certification as synonymous with competence and use it as a risk management tool. Others may require board certification for marketing purposes. Credentialing committees may also choose to use other measures of physician competence such as residency completion.

In 2006, The Joint Commission recommended that hospitals use the 6 core competencies established by the ABMS as part of their credentialing and privileging standards. In light of these new standards, hospitals may begin to require certification and MOC in the future.

However, our results indicate that credentialing committees currently allow a great deal of flexibility in interpretation of how board certification policies should be put into operation. Hospitals likely need to allow some flexibility in these policies to accommodate staffing needs or the timing of certification examinations. However, if exceptions to stated policies are the norm, the board certification requirement loses its value.

Most hospitals that make exceptions to their board certification requirements relax their policies for physicians with a certain number of years of service to the institution. However, previous research has shown that years in practice are not synonymous with quality and that the ever-changing scope of medicine requires continuous learning.

Although COTH and large hospitals are more likely to require board certification at some point, these hospitals are also more likely than their peers to not set a time frame for certification and to allow retention of privileges when board certification expires. It is possible that COTH and large hospitals are more flexible with stated certification policies to compete for physicians in larger markets where these hospitals are typically located or that these hospitals consist of more physicians who primarily conduct research rather than patient care.

Hospital credentialing committees may also choose not to require strict adherence to board certification policies because they realize that most physicians in the United States have been certified at some point by an ABMS member board. However, hospitals may not track board certification status, and many certificates may not be current.

Results of a 2003 national Gallup poll among the general public show that board certification is important to patients. The poll assessed public knowledge of certification and attitudes toward MOC; 98% of respondents believed that physicians should go through the process of certification, and 78% stated that recertification is very important.

More than...
half of the respondents said that they would be very likely to find another physician if they discovered that their physician’s certification had expired. However, only 21% reported that they had actually verified a physician’s board certification status.

At an organizational level, credentialing and competence remain important safety issues. Sentinel event-related data, reported to The Joint Commission from accredited organizations, reveal that competency and credentialing were identified as a root cause in one-third of events in 2006 and 20% of the 3548 events reported from 1995 through 2005.19

Studies have indicated a relationship between board certification and positive clinical outcomes, yet this area remains hampered by a paucity of data.20-22 A recent study demonstrated an inverse relationship between intensification of antihypertensive treatment and time since the last board certification.23 Although the local environment presumably has some effect on treatment, the study by Turchin et al showed that recent recertification made a small yet meaningful difference in the quality of care provided. This area of research is especially important in light of the restructured MOC standards.

Although medical errors and cases of negligent credentialing are not limited to physicians who are not board certified, it is surprising that hospitals do not avail themselves of the resource of recertification more frequently in credentialing, especially as the risk of litigation for credentialing negligent providers appears to be on the rise.24 The Department of Veterans Affairs is currently reviewing credentialing and privileging policies across the country in response to an unusual increase in postsurgical patient deaths at the Marion Veterans Affairs Medical Center in Marion, Illinois.25 Negligent credentialing is believed to be one of the factors that contributed to the patient deaths.26

Our results indicate that fewer hospitals require board certification for surgeons than was previously found for general pediatricians (70%), a specialty that is at lower risk for malpractice claims.13,27,28 It is possible that hospitals have a greater need to attract surgeons and nonsurgical subspecialists than pediatricians to their staff, so requirements may be lower for these physicians. Another possibility is that children’s hospitals, the focus of the pediatrician credentialing study, may maintain higher credentialing standards than other hospitals. Further research is needed to determine why hospitals do not require or enforce board certification requirements for physicians and what measures they use to assess competence.

Evaluating physician competence can be cumbersome and time consuming. Although hospitals may lack the resources necessary to develop their own systems and measures of physician competence, they are able to use the continuous assessments conducted by specialty boards as part of their credentialing processes.

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REFERENCES

The results of a telephone survey conducted by the authors are quite alarming, particularly the findings that one-third of the hospitals surveyed do not require surgeons and subspecialists ever to be board certified and that 82% of all hospitals and two-thirds of hospitals whose policies require recertification allow surgeons and nonsurgical specialists to retain privileges when board certification expires. The executive officials of some of the specialty boards question these results, highlighting that the percentage (approximately 33%) of hospitals never requiring surgeons and nonsurgical subspecialists to be board certified to receive or to maintain hospital credentials is likely an overestimation. However, with only approximately 400 hospitals (of >6000 nationwide) having more than 500 beds, it is feasible that smaller community hospitals are unable to attract physicians/surgeons who have successfully completed their board certification requirements. Whether the cohort of hospitals in this survey (with an overall response rate of 82%) is an outlier is irrelevant. The fact that any appreciable number of hospitals have chosen not to use board certification as a method of assessing physician competency is problematic. With specialty board certification currently being the most established and widely accepted metric available to assess physician competence, the paramount question that the authors failed to adequately address is what specific surrogates or equivalent assessment tools the hospitals are using to ensure physician competency if the specialty board certification process is not being used for credentialing. Perhaps, with a more comprehensive study design, key comparisons could have been made with appropriate statistical analyses to determine whether there were disparities in outcome measures between the hospitals that based credentialing on specialty board certification and the ones that chose a different method of credentialing eligibility. The growing emphasis on quality care and patient safety, with an overarching goal to substantially reduce physician errors, is imperative. It is doubtful that the board certification process being conducted under the auspices of the ABMS is “the emperor without clothes” and that there are other, more established assessment tools that are equal or better in their ability to determine competency. However, the authors’ findings dictate that a substantial number of hospitals are not relying on the ABMS certification process for competency assessment.

A plethora of studies have underscored the growing concern regarding how best to ensure physician competency. Although this investigation lacks the elaborate study design and statistical analyses necessary to answer many important questions that stem from this survey, a daunting question, nevertheless, remains: Should specialty board certification be mandated to become credentialed at a hospital?

Also, with an increasing number of specialists and subspecialists being trained in non–Accreditation Council of Graduate Medical Education programs (without an ABMS board certification track), what should be the assessment tools and metrics required to determine physician competency? Unfortunately, Pandora’s box has been opened.

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