INTRODUCTION

The American Society of Pediatric Otolaryngology (ASPO) has requested the American Board of Otolaryngology (ABOto) create a mechanism for subcertification in Advanced Pediatric Otolaryngology (APO). This white paper is intended to summarize the history of pediatric otolaryngology, the issues surrounding this request, and the results of a meeting of various stakeholders.

HISTORY OF PEDIATRIC OTOLARYNGOLOGY
(Excerpted from Cunningham and Lin, Laryngoscope 121:194-201, 2011)

The history of pediatric otolaryngology parallels the experiences in other surgical specialties. In 1919, Herbert Coe, a general surgeon, began to limit his practice to children becoming the first “pediatric surgeon.” The American College of Surgeons (ACS) rejected his request for recognition of the specialty because of the fear it would further fragment the field of surgery given the prior departures of orthopedics, urology, and plastic surgery. Coe then requested a special section of the American Academy of Pediatrics (AAP) which was established in 1948. In urology, the Society of Pediatric Urologists was established in 1951, but remained separate from the American Urological Association for many years for many of the same reasons pediatric surgery was excluded from the ACS. Pediatric urology was granted an AAP section in 1960.

In 1973, SENTAC was formed as a multidisciplinary group to study the otolaryngology conditions afflicting children. An AAP pediatric otolaryngology section was established with the criteria that its members number no fewer than 20 who devote at least 75% of their practice to children. A 1985 meeting of 56 pediatric otolaryngologists resulted in the creation of ASPO which now has approximately 450 members. Although ASPO initially met separately from the other otolaryngology societies, it joined COSM in 1991.

ACGME ACCREDITATION

In 1995, the Residency review Committee (RRC) for otolaryngology developed and approved the training requirements for pediatric otolaryngology which mandated a two year training paradigm. The length of training was reduced to one year in 2006. Currently, there are 21
accredited pediatric otolaryngology programs. To put this in perspective, there are 18 Accreditation Council for Graduate Medical Education (ACGME) accredited Neurotology programs. The following is a list of ACGME accredited pediatric fellowship programs by specialty:

- Anesthesiology: 46
- Emergency Medicine: 20
- Neurology: 70
- Orthopedic Surgery: 24
- Otolaryngology: 21
- Pathology: 27
- PM&R: 16
- Psychiatry: 124
- Radiology: 46
- Surgery: 44
- Thoracic Surgery: 11
- Urology: 25

**ABMS SUBCERTIFICATION IN PEDIATRIC OTOLARYNGOLOGY**

In the 1990s, the ABOto submitted a proposed CAQ (a term no longer used and replaced with “subcertification”) in pediatric otolaryngology to the ABMS Assembly. The proposal was approved, but never activated by the ABOto.

The following ABMS boards subcertify in pediatric care:

- Anesthesiology
- Dermatology
- Emergency Medicine
- Pathology
- Physical Medicine and Rehabilitation
- Psychiatry and Neurology
- Radiology
- Surgery
- Thoracic Surgery
- Urology
ISSUES

The most complicated issue the ABOto faces in making its determination to subcertify in APO is the balance between the recognition advanced pediatric otolaryngologists seek while ensuring its primary certificate holders can manage appropriately-selected pediatric patients, based on their training and experience.

Many, but not all, pediatric otolaryngologists would pursue a subcertification process. The table below summarizes the results of a 2012 poll of ASPO members.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly agree n(%)</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric subcertification benefits the general public and otolaryngology as a whole by recognizing an advanced level of training</td>
<td>75(36)</td>
<td>83(39)</td>
<td>19(9)</td>
<td>19(9)</td>
<td>15(7)</td>
</tr>
<tr>
<td>Pediatric subcertification should be based on mastery of a specific body of knowledge, measured by written examination</td>
<td>49(23)</td>
<td>73(35)</td>
<td>42(20)</td>
<td>32(15)</td>
<td>14(7)</td>
</tr>
<tr>
<td>Pediatric subcertification should be based on case logs of specific surgical procedures</td>
<td>54(26)</td>
<td>94(44)</td>
<td>25(12)</td>
<td>28(13)</td>
<td>10(5)</td>
</tr>
<tr>
<td>Pediatric subcertification should include an oral examination</td>
<td>21(10)</td>
<td>45(22)</td>
<td>60(29)</td>
<td>55(26)</td>
<td>28(13)</td>
</tr>
<tr>
<td>Pediatric subcertification would encourage fragmentation of otolaryngology</td>
<td>29(14)</td>
<td>52(25)</td>
<td>41(19)</td>
<td>60(28)</td>
<td>29(14)</td>
</tr>
<tr>
<td>Pediatric subcertification would restrict the practice of general otolaryngologists</td>
<td>26(12)</td>
<td>49(23)</td>
<td>39(19)</td>
<td>67(32)</td>
<td>28(13)</td>
</tr>
<tr>
<td>ASPO should move forward now with pediatric subcertification</td>
<td>47(22)</td>
<td>73(35)</td>
<td>37(18)</td>
<td>28(13)</td>
<td>26(12)</td>
</tr>
<tr>
<td>I would be interested in taking a pediatric subcertification examination offered by the American Board of Otolaryngology</td>
<td>42(20)</td>
<td>53(25)</td>
<td>40(19)</td>
<td>38(18)</td>
<td>36(17)</td>
</tr>
</tbody>
</table>

On the other hand, many primary certificate holders believe that APO subcertification would impact their treatment of pediatric patients. One of the concerns is that hospitals could impose a requirement of holding an APO certificate to treat patients under a certain age. The other concern is that APO subcertification would provide a pediatric otolaryngologist a marketing advantage for referrals of uncomplicated pediatric patients that primary certificate holders are very capable of managing. The key to this issue is a clear definition that differentiates the pediatric practice of primary certificate holders from that of an advance pediatric
otolaryngologist. Just having completed a fellowship clearly does not establish this key difference.

As ASPO developed its proposal for subcertification in APO, the ASPO leadership addressed the AAO-HNS Board of Governors (BOG) to describe ASPO’s proposal for APO subcertification. As a result of that discussion, the BOG and ASPO jointly developed a survey instrument (Appendix 1) that was sent to all BOG members/societies. The results of the 2013 BOG poll were 19% in favor of APO subcertification and 81% opposed with fewer than 1% abstaining. The American Neurotology Society (ANS) and the American Otological Society (AOS) and the ARS reported the survey statistics of their membership, and which are summarized in the following table.

<table>
<thead>
<tr>
<th></th>
<th># OF MEMBERS</th>
<th>FOR</th>
<th>AGAINST</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANS/AOS</td>
<td>521</td>
<td>34</td>
<td>127</td>
</tr>
<tr>
<td>ARS</td>
<td>944</td>
<td>34</td>
<td>134</td>
</tr>
</tbody>
</table>

On March 28, 2013, the ASPO leadership wrote a letter to the ABOto formally requesting the development of subcertification in APO. Dr. Joe Kerschner addressed the ABOto Board of Directors (BOD) and answered questions at its annual meeting in April 2013. The BOD decided to analyze the request at its interim meeting in August 2013. The initial analysis consisted of dividing the ABOto BOD into three groups to review the request from three perspectives.

- Needs assessment and mission fit
- Definable body of knowledge and practice parameters
- Feasibility

The results of the BOD discussion of the three groups are:

**NEEDS ASSESSMENT AND MISSION FIT**

- APO would generally be of benefit to the public
- It would separate true tertiary practitioners from those who primarily practice general otolaryngology in the pediatric population
- Having a clear definition of APO would be of value to primary certificate holders and their ability to care for uncomplicated pediatric patients
- It would further enhance the quality of pediatric fellowships and reduce the number of non-ACGME accredited fellowships
DEFINABLE BODY OF KNOWLEDGE AND PRACTICE PARAMETERS

- The complex child who is managed by an advanced pediatric otolaryngologist is defined by the otolaryngic diagnosis and/or co-morbid conditions
- The kinds of tertiary cases need to be defined along with the minimum number and complexity to establish eligibility
- The APO candidate must lead and/or regularly participate in a multi-disciplinary pediatric care delivery team
- The practice setting is both outpatient and inpatient, the latter based in a pediatric hospital or a hospital with an identified pediatric facility
- Mandatory completion of an ACGME approved fellowship

FEASIBILITY

- Given that APO is both a procedural and knowledge based specialty, both a written and an oral exam are required
- Although the written exam (WQE) could be given at the completion of fellowship, the oral exam should be given at least 2 years after completion of fellowship
- To be eligible for the delayed exam(s) the candidate should submit
  - A case log for review demonstrating complexity of cases and patients
  - Evidence of their location of practice and scope of practice, to include letters from such colleagues as the Hospital Chief of Staff, Chief of Pediatrics, Chief of the NICU, etc., to demonstrate participation in multidisciplinary care of complicated patients at an advanced facility.
  - Other possible measures that would indicate an APO practice
- Content for the WQE and oral protocols would need to be developed by a group of senior, "grandfathered" APO clinicians
- The grandfather period for those in practice and not ACGME Fellowship trained, should be 5-6 years
- A business plan will need to be developed to ensure financial feasibility

Based on this discussion, the ABOto BOD concluded that the concept of subcertification in APO has value. Although there are many issues to be addressed, it is worthwhile exploring a common understanding of APO. Critical to this exploration will be the involvement of all interested stakeholders. The ABOto will coordinate this project to include representatives from ASPO, the AAO-HNS, and other interested groups.
JOINT ABOto, ASPO, AND AAO-HNS LEADERSHIP MEETING

On March 15, 2014, the leadership of these three organizations met at the ABOto office in Houston, Texas to discuss possible subcertification in APO. The attendees were:

ABOto
- Ron Cannon, MD
- Paul Lambert, MD
- Randal Weber, MD
- Robert Miller, MD

ASPO
- Joseph Kerschner, MD
- Richard Rosenfeld, MD

AAO-HNS
- Peter Abramson, MD
- Denis Lafreniere, MD
- Richard Waguespack, MD

The group explored APO subcertification in detail, developed a set of general principles, and identified potential components of a subcertification process.

GENERAL PRINCIPLES

- Primary certificate holders have trained and passed an examination in the care of pediatric patients and, based upon appropriate training or experience, may provide care for children with many levels of complexity.

- Some pediatric patients, because of their disease and/or co-morbid conditions, are better cared for by a specialized pediatric care team that includes an otolaryngologist who focuses his/her practice on advanced pediatric otolaryngology, and has additional training and/or experience in APO and has passed an exam in this area.
SUBCERTIFICATION PROCESS

ELIGIBILITY

There would be two pathways for eligibility, Standard and Alternate. The Standard Pathway requires completion of an ACGME-accredited Pediatric Otolaryngology fellowship, whereas the Alternate Pathway would be for individuals who have been in an APO practice, but have not completed an ACGME-accredited fellowship. The Alternate Pathway (also known as grandfathering) would be offered for a limited period of time, most likely five or six years.

Working with the ACGME, some aspects of the current accreditation standards should be reviewed including:

- Length
- Content
- Possible name change to APO which would further differentiate it from non-ACGME fellowships

Applicants for both the Standard and Alternate Pathways should present evidence of an APO practice which could include such things as:

- % or number of:
  - Pediatric cases in practice
  - Surgical patients classified as ASA >2
  - PICU patients
  - Patients under age one year (excluding tympanostomy tubes)
- Some measure of participation in multidisciplinary conferences
- Some measure of participation in pediatric multidisciplinary clinics
- Practice location
  - Children’s Hospital Association (CHA) recognition
- Report from Chief of Service or Medical Director
- Referral sources
  - Particularly from other otolaryngologists

EXAMINATION

Since APO is both a procedure and knowledge-based specialty, the certification process should include both written and oral examinations.
• Written (CBT) Exam
  o Which could be taken upon completion of fellowship
  o If candidate passes, he/she is “Board Eligible”
• Oral exam
  o Must present two years of post-fellowship practice experience or
  o Less than two years if candidate meets threshold in less time

MAINTENANCE OF CERTIFICATION

The ABOto will need to develop an APO MOC program including:
• Part II self-assessment modules (SAM)
• Part III exam
• Part IV performance improvement modules (PIM), surveys, etc.

One question that was raised was the desirability of requesting a case log or some other evidence that the individual continues to practice APO. Currently, the ABOto does not require this step for its other subcertificate holders, and further exploration of this issue needs to be done.

CONCLUSION

The ABOto BOD has concluded that the concept of subcertification in APO has value. Although there are many issues to be addressed, it is worthwhile exploring a common understanding of APO. Critical to this exploration will be the involvement of all interested stakeholders. The ABOto will coordinate this project to include representatives from ASPO, the AAO-HNS with its Board of Governors and other interested groups.

NEXT STEPS

The next step is to develop an online questionnaire that diplomates and other stakeholders can use to express their opinions on the proposed subcertification process. After receiving this input, the ABOto may decide to explore selected issues in more detail, proceed with the development of the subcertification process, or decide not to create a subcertification process at this time.
APPENDIX 1
BOG/ASPO SURVEY INSTRUMENT

AAOHNS Board of Governors Socioeconomic and Grassroots (SEGR) Committee Survey
Regarding Subcertification in Advanced Pediatric Otolaryngology

Dear BOG Otolaryngology-Head and Neck Society:

The Socioeconomic and Grassroots Committee would like to know your opinion regarding the possibility of a new subcertification board in advanced pediatric otolaryngology. We have been discussing this proposal over the last 18 months at the BOG. We would like to know the opinion of your members.

Please poll your members with respect to the following question:

Do you agree or disagree with the proposal to have subcertification in advanced pediatric otolaryngology?

Agree
Disagree

Name of Society ________________________________
State: ________________________________
Number of Members __________
Members voting Agree: ________
Members voting Disagree ________
Contact Person ________________________________
Telephone (____) ______-___________
Email __________@__________________

PLEASE RETURN THIS SURVEY AS SOON AS POSSIBLE BUT NO LATER THAN FEB 15, 2013

Enclosed please find 2 statements which may help you understand the pros and cons for this issue. The following 2 statements were produced in consultation with both representatives of the American Society of Pediatric Otolaryngology (ASPO), which favors subcertification, and others opposed to the new subcertification.

Statement in Favor of Subcertification in Advanced Pediatric Otolaryngology
Subcertification benefits patients and the public by defining and recognizing an advanced level of training. Pediatric subcertification is already in place for anesthesiology, surgery, urology, dermatology, radiology, cardiac surgery, and emergency medicine.

The American Board of Otolaryngology (ABOto) oversees subcertification while preserving the value of the primary certificate. All otolaryngologists holding a primary certificate are pediatric otolaryngologists, fully qualified to evaluate and manage children. Subcertification in “advanced” pediatric otolaryngology will not imply added qualifications for routine surgery such as tonsillectomy or tympanostomy tubes.

Subspecialty certification of individuals is the natural extension of accreditation of fellowship programs by the ACGME. After a possible “grandfather” period, completion of an ACGME-accredited fellowship will be required. An individual who is subcertified will demonstrate advanced knowledge of pediatric basic science (e.g., genetics, child development, communication sciences) and advanced diagnostic expertise and management skills (e.g., open airway surgery, craniofacial surgery, complex congenital anomalies), beyond the primary certificate. Individuals with subcertification will be required to enter Maintenance of Certification, which will ensure that only individuals who maintain their knowledge and skills remain subcertified.

Subcertification will limit the proliferation of non-ACGME accredited fellowship programs, since eventually only graduates of accredited programs will qualify for subcertification. Over the last 15 years the number of pediatric otolaryngology fellowships has grown to 31, but only 18 are currently accredited. Accreditation carries significant financial and resource burdens. Without subcertification, the motivation to pursue accreditation will diminish, allowing additional non-accredited programs to produce more fellowship-trained pediatric otolaryngologists.

Unfortunately, there is the potential for fellowship-trained individuals to misrepresent themselves, whether or not there is subcertification, or for organizations to misinterpret the meaning of subcertification. The American Society of Pediatric Otolaryngology is committed to working with the Board of Governors, ABOto, AAO-HNS, and others to identify, prevent, and correct such abuses.

Statement Opposed to Subcertification in Advanced Pediatric Otolaryngology

There are 3 problems with a CAQ in “advanced pediatric otolaryngology.” It would;

- be too broad in scope and overlap too much with general otolaryngology
- damage the credibility and practice of generalists
- have a negative impact on access to care for children with common ENT problems

Scope of Practice/Overlap: For a new subspecialty certification the American Board of Medical Specialties requires the existence of a body of medical knowledge which is “in large part distinct
from, or more detailed than, that of other areas in which certification is offered.” But the overlap in managing common pediatric ENT problems is dramatic between generalists (35% of their time) and pediatric otolaryngologists (48% of their time). (Preciado, et al. Arch Oto HNS. 2009 Jan;135(1):8-13 and Tunkel, et al. Arch Oto HNS. 2002;128:759-764) As a result, a CAQ entitled “advanced pediatric otolaryngology” would simply be too broad, confusing and misleading to the public and referring physicians.

**Credibility and practice of General Otolaryngologists;** Physicians and parents will feel required to refer children to an “advanced pediatric otolaryngologist”, even for common problems. Insurance companies could deny payment and malpractice attorneys could question the competence of a generalist who performs a simple tonsillectomy. There is already aggressive marketing by pediatric hospitals and otolaryngologists that has shifted cases away from the generalists. Representing a third of the generalist’s practice, this is a major financial loss. ASPO president Richard Rosenfeld, MD recognized this problem when he stated that the CAQ “isn’t meant to erode the general otolaryngologists’ share of pediatric cases” but that has clearly been the trend.

**Access to Care;** Insurers and referring physicians will unnecessarily seek “advanced pediatric subspecialists” who are in short supply. Of the 10,000 otolaryngologists in the United States, 275 classify themselves as “Pediatric Otolaryngologists.” The average wait time for a pediatric otolaryngologist is 6 weeks and then 5 ½ weeks to have a procedure. For a generalist the wait times are considerably shorter. But an “advanced pediatric” CAQ would limit the access for these patients because of the misperception that the generalist isn’t qualified to care for them.

**Solutions;** Just as “neurotology” and “otology” easily explains both groups’ skills, a term that more easily distinguishes the skills of generalists and pediatric subspecialists is necessary; “advanced pediatrics” does not accomplish this. Perhaps a more appropriate term is “Pediatric Head and Neck Specialist.”