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The Role of Maintenance of Certification Programs in Governance and Professionalism

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Formany physicians, the recent controversy surrounding maintenance of certification (MOC) has been a sentinel event, especially with respect to self-regulation and governance. In recent years, physicians have been saddled with added regulatory burden after burden, compelled by numerous regulatory authorities, such as the Centers for Medicare & Medicaid Services, The Joint Commission, and state authorities. These new requirements have substantially increased the administrative obligations of physicians; however, many of these obligations are unrelated to patient care, teaching, or research.

The 2014 changes in MOC requirements were the tipping point for many physicians. Instead of recertifying every 10 years, many physicians must now enroll in continuous certification, paying annual fees, completing tests every 2 years, and performing practice improvement modules. Some physicians view these tasks and costs as excessive.

The discussion surrounding MOC should begin with an admission that high-quality, level 1 evidence to support any form of recertification is unlikely to be obtained. Specific educational interventions to promote quality are difficult to test in well-designed randomized trials. In clinical research, hard clinical end points like death or softer, yet important, end points like control of diabetes can be readily measured. On the other hand, the quality of care rendered by a physician is largely subjective, influenced by heterogeneous patient characteristics.[1] In recent years, some quality measurements have been expressed by patient satisfaction metrics, which are affected by nonmedical matters (eg, convenience of parking, short wait time). Overall, little of the practice of medicine has a strong basis of evidence, as has been suggested by the reversal of many long-standing guidelines.[2]

In this context, perhaps one of the most overreaching assertions by the American Board of Internal Medicine (ABIM) is that MOC is “evidence based,” even though recent reports

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provide no convincing evidence that MOC has improved quality of care. For instance, a recent literature review promoted as evidence supporting the value of physician certification and MOC[3] concluded: “In general, physicians who are board certified provide better patient care, albeit the results have modest effect sizes and are not unequivocal.” However, that article was written by ABIM employees and published in a special journal supplement that was supported by the American Board of Medical Specialties (ABMS).[4] In an observational study (supported by the ABIM and conducted by ABIM employees) of physicians who provided care for Medicare beneficiaries, imposition of the MOC requirement was not associated with a difference in the increase in ambulatory care–sensitive hospitalizations, but was associated with a small reduction in the increase in differences of cost of care, although the small difference in cost was only discernable after significant statistical adjustment (propensity matching followed by a multivariate analysis).[5] In another observational study among internists who provided primary care at 4 Veterans Affairs medical centers in which an electronic health record was used with embedded reminders, there were no significant differences between physicians with time-limited ABIM certification (and required recertification) and those with time-unlimited ABIM certification on achieving 10 primary care performance measures.[6]

Moreover, the value of written testing for general knowledge in a discipline for continuing certification must be critically evaluated. This is controversial because testing has historically been the metric used to judge medical knowledge. Physicians have become increasingly specialized and virtually every recertification examination contains questions unrelated to an individual physician’s practice. For example, adult anesthesiologists who never treat children must take a test that includes questions about pediatric anesthesiology. General surgeons must review trauma surgery for the recertification examination even though they do not treat patients who sustain trauma. A cardiologist who spends 4 days per week in a basic science laboratory and 1 day caring for patients in a clinic is tested on reading cardiac echocardiograms and exercise stress tests, yet never performs these services.

Written tests have other problems. Clinical decisions are often not black and white, yet test questions must have 1 best answer. Even in a subspecialty, physicians must study to learn the correct answers for the test, although the best answer may not reflect the way medicine is practiced. Moreover, in the era of widely available instantaneous digital access to information and colleagues, secure closed-book examinations are not representative of actual medical practice. Although the secure test has historically been used to measure competence, written tests in the current era have little value for assessment of life-long learning.

The overwhelming majority of physicians care deeply about quality. Of all the attributes that define professionalism, perhaps the most universal among physicians is a desire to provide patients with the best possible care. So how can the medical profession best promote excellence? What requirements will have the best chance of promoting continuous excellence with the least risk of be-coming meaningless work? No approach is perfect. Of established adult learning methods, meaningful continuing medical education (CME) could provide perhaps the best opportunity for efficient, meaningful life-long learning. Organizations providing recognized CME programs are regulated by a rigorous

accreditation body (Accreditation Council for Continuing Medical Education) requiring each CME offering to provide an educational gap analysis, “needs assessment,” speaker conflict of interest, course evaluations, and many other performance standards. Importantly, accredited CME must be independent of commercial interests. MOC focuses on established knowledge, whereas CME can include innovations that keep the physician up to date, such as information on medical therapies not yet approved by the US Food and Drug Administration. Continuing medical education is not perfect. The quality of CME programs varies and it is possible to obtain CME credit for a conference by signing in and then leaving the room. However, most physicians select CME programs that provide meaningful education they can apply in their clinical practices.

Beyond the optimal format and content, the economic aspects of current recertification need to be scrutinized and its efficiency enhanced. Fees and revenues for some medical specialty board organizations have increased substantially during the past decade, despite the major economic downturn. A substantial proportion of these additional revenues have come from physicians paying annual fees for recertification and MOC programs. Some of these funds have been used to lobby government and other organizations to create rules requiring physician participation in MOC,[7] such as the proposed ABMS certification requirement for the new multistate licensure provided by the Federation of State Medical Boards. The result is that physicians are captured in an endless regulatory circle of requirements that ensure they pay for MOC.

Board certification is a critically important accomplishment for most physicians, and is governed by individual ABMS member boards. Although these boards have developed a general agreement surrounding standards for MOC,[8] individual specialty boards have different approaches for fulfilling MOC requirements. It is concerning that some boards have made radical changes to the recertification process apparently with limited engagement of the physician community. Recent discussions regarding MOC, such as the announcement of the reevaluation of the MOC process by the ABIM, underscore the important responsibility board members have to actively govern. It also emphasizes the concept that physician self-governance must involve the larger physician community and not be driven by a limited number of individuals and organizations.

In response to the 2014 MOC requirements, an online petition re-questing a recall of MOC was created and now has more than 22000 signatures.[9] Ten months later, with no response from the ABIM regarding the petition, the National Board of Physicians and Surgeons (NBPAS) was formed.[10] This not-for-profit 501(c)(3) organization is an alternative continuous certification board that currently has more than 1500 applicants and is being examined as an alternative to ABMS certification by many hospitals. The requirements for NBPAS certification include (1) previous certification by an ABMS member board, (2) 50 hours of accredited CME within the preceding 24 months, (3) a valid, unrestricted license to practice medicine, (4) for procedural specialties, active privileges to practice that specialty at an accredited hospital, and (5) no history of hospital privileges in the desired specialty being permanently revoked. Fees for NBPAS certification are $85 per year. Whether this approach to recertification will be successful in ensuring that physicians maintain the skills and are lifelong learners will have to be evaluated in the years to come.

All stakeholders should have an open mind toward innovation in learning. Some argue that CME is too passive with limited evidence. A physician can obtain CME credit for a conference without paying attention to the content. One solution might be to designate a new category of CME that requires completion of simple test questions after the teaching event to ensure the participant was attentive. Moreover, the science of learning rather than the onus of testing should be emphasized as the primary approach for recertification.

The day-to-day life of most physicians is filled with enormous competing demands. The focus is on the primary mission of patient care, education, research, and dealing with daily workplace crises. Even though it may have been easier to leave the concerns about MOC and the related implications for governance and self-regulation to others, many physicians now realize that their preoccupation with the “urgent” must not distract them from addressing the “important.” Physicians must assume the responsibility for self-governance and educate the public as to what is important and relevant for maintaining board certification, ensuring continuous life-long learning, and improving medical care.

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Dr Teirstein reported participating in and directing several annual continuing medical education conferences; being the founder (unpaid) of the National Board of Physicians and Surgeons; being certified by the American Board of Internal Medicine (ABIM) with a time-unlimited certification in internal medicine and cardiology; and being certified and recertified in interventional cardiology. Dr Topol reported being a founding, unpaid advisory board member of the National Board of Physicians and Surgeons; being certified by the ABIM with a time-unlimited certification in internal medicine and cardiology; serving as editor in chief for Medscape; serving as an advisor to AT&T, Google, Walgreens, Illumina, and Genapsys; and serving on the board of directors for Dexcom and Cypher Genomics.

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