Maintenance of Certication (MOC):
Insights and a Golden Opportunity for AAPI to Reshape the Landscape of the Medicine in America

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The American Board of Medical Specialties (ABMS) is the umbrella organization for 24 member boards that certify physicians who are able to pass a specialty specific certification examination after completing residency/fellowship training. Prior to 1994, passing the examination resulted in a lifetime certificate (grandfathered physician), but for diplomats so certified after 1994 have been required to pass a recertification examination every 10 years. Then in 2007, non-grandfathered physicians were required to participate in the Maintenance of Certification (MOC) programs. Grandfathered physicians include a larger percentage of older Caucasian males, so this practice of holding non-grandfathered physicians to a different standard is not only discriminatory based on age, but also gender and race.

The ABMS essentially has a monopoly, as MOC compliance is almost universally required for hospital privileges and insurance credentialing. MOC is expensive, time consuming, and unproven. In terms of expense, when considering lost revenue from time away from practice and costs (the exam, modules, travel, test preparation material, etc.), the cost for a single boarded physician to comply with a 10 year MOC cycle can be over $15,000, and for a multi-boarded physician it can cost over $40,000.1 When considering cost to the physician, one cannot help but think about the revenues generated by the boards. In 2013, ABMS member boards generated $263 million in revenue and $239 million in expenses, yielding a $24 million surplus.2 It is unclear what this surplus is used for, but the American Board of Internal Medicine Foundation's 2015 990 tax form indicates that $6.5 million dollars was deposited into overseas accounts.

Regarding proof that MOC improves patient care, the evidence is scant. Most of the existing literature supports initial certification (not MOC), and the conflicted authors for most of the publications are actually employees/consultants of the ABMS who often generate 6 figure salaries. A detailed analysis was performed, which evaluated 10 of the most highly cited articles by the ABMS, which provided little compelling evidence that MOC compliance improves patient care.3 On the other hand, one study demonstrated no difference between grandfathered and MOC compliant physicians based on 10 primary care performance measures. 4

Another consideration is that, forced MOC compliance reduces patient access to the healthcare system. In addition to clinicians having to take time away from practice to complete MOC activities/testing, physicians who cannot pass the re-certification process are driven out of practice. Imagine if 2% of physicians fail the recertifycation examination. This sounds like a small number, but this is thousands of physicians, and each of them have hundreds of patients under their care, who due to the physician not completing MOC requirements have to wait until the physician can fulfil their MOC requirements or try to find a new physician to receive care.

As the dissatisfaction with MOC has grown, physicians from nearly every specialty have taken action. Publications in both the medical and lay literature have addressed the flaws and negative impacts of MOC. In addition, petitions have been generated, at times reaching over 20,000 signatures. Unfortunately, hospitals and academic institutions have been slow to make changes, as insurance plans often require contracted physicians to be MOC compliant. Specialty and state medical societies have also been slow to take action, either because they stood/stand to profit from the sale of MOC modules or senior leadership find it politically uncomfortable to challenge the status quo. In this case, challenging the status quo can mean publically challenging their peers and colleagues who

make double, triple, or even quadruple what they would in clinical practice as board members of the ABMS. Despite the widespread dissatisfaction among diplomates, the ABMS memberboards in most cases refused to make any changes to the MOC programs. As such, a group of physicians led by an interventional cardiologist, Paul Teirstein, MD, Scripps Clinic, La Jolla, CA, decided to form a new board, the National Board of Physicians and Surgeons (NBPAS.org).

NBPAS is an organization that exclusively re-certifies physicians in any ABMS or AOA specialty based on the following criteria.

1) Initial certification by an ABMS member board
2) Active unrestricted license to practice medicine
3) At least 50 hours of ACCME accredited CME within the past 24 months
4) For selected specialties, active hospital privileges in that specialty
5) Clinical privileges in certified specialty have not been permanently revoked

Since its inception, NBPAS has been promoting legislation to prohibit MOC compliance as a requisite to practice medicine. Fortunately, Texas, Oklahoma, Georgia, and Tennessee have already passed strong legislation to protect physicians from forced MOC compliance. More states have not passed similar laws, in part due to the strong lobby efforts of the ABMS, which has far more resources and well paid personnel to persuade legislators. For the record, NBPAS board members like myself are volunteers, and receive no compensation. Despite this lobbying by the ABMS, NBPAS has worked behind the scenes, and the Department of Justice recently released an opinion letter that states that MOC may have the effect of "harming competition and increasing the cost of healthcare services".5

Given the lukewarm response from many of our physician leaders, specialty societies, and state medical societies, AAPI and its regional chapters have the opportunity to partner with NBPAS to help enact meaningful legislation to protect the practice of medicine from the expensive, time consuming, and unproven MOC programs. MOC serves to reduce patient access to health care, and potentially worsen patient care by limiting the time and resources that a physician can commit to self-guided study tailored to the individual learner's interests and/or deficiencies rather than a one size fits all recipe that often involves subject matter that is irrelevant to the physician's practice. It is administrative burdens like MOC that contribute to the growing epidemic of physician burnout. Indian physicians are known for their clinical acumen, but the time has come for us to unite, and show our colleagues that we have the resources and numbers to emerge as part of a strong legislative solution to end the fiscally conflicted ABMS monopoly that should no longer control the practice of medicine.

1. Sandhu AT, Dudley RA, Kazi DS. A Cost Analysis of the American Board of Internal Medicine's Maintenance-of-Certification Program. Ann Intern Med. 2015 Se p 15;163(6):401-8.
2. Drolet BC, Tandon VJ. Fees for Certification and Finances of Medical Specialty Boards. JAMA. 2017 Aug 1;318(5): 477-479
3. https://nbpas.org/moc-journal-club
4. Hayes J, Jackson JL, McNutt GM, Hertz BJ, Ryan JJ, Pawlikowski SA. Association between physician time-unlimited vs time-limited internal medicine board certification and ambulatory patient care quality. JAMA. 2014 Dec 10;312(22):2358-63.
5. https://nbpas.org/abms-response-to-doj-opinion-letter/

NBPAS provides recertification for all ABMS and AOA Board Specialties

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— *Paul G. Mathew, MD, DNBPAS, FAAN, FAHS*

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