Controversy continues to grow over Maintenance of Certification for cardiologists

by L. Samuel Wann, MD, MACC, FESC

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Following closely on the heels of the 1910 Flexner Report, the American Board of Ophthalmic Examinations was established in 1915, examining 11 candidates for board certification in 1916.

This first American certifying board later became the American Board of Ophthalmology, a founding member of the American Board of Medicine and Surgery (ABMS) in 1933. In 1936, the American Board of Internal Medicine (ABIM) was created and joined the ABMS. The ABIM administered the first board examination in the subspecialty of CVDs in 1941. Added qualification examinations for cardiac electrophysiology were initiated in 1992, interventional cardiology in 1999, and advanced HF and cardiac transplantation in 2010.

These certifying boards were established in the best tradition of professionalism, to identify and maintain high standards of education and training and to affirm moral and ethical obligations that society rightly expects when granting considerable autonomy to the profession of medicine. Unlike the Royal Colleges of Canada and the United Kingdom, ABMS and its member boards are independent nonprofit corporations and are not controlled by or accountable to a corresponding professional membership society such as the American College of Cardiology or American College of Physicians.

The ABIM, one of 24 board members of the ABMS, now offers certification in 24 internal medicine-based specialties. The American Board of Surgery offers certification in six areas of subspecialization, but specialties including thoracic surgery, plastic surgery, colon and rectal surgery, and orthopedics are independent board members of ABMS. Independent boards, not related to either the ABIM or ABMS, certify cardiology subspecialties in echocardiography, nuclear cardiology and cardiac CT.

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For many years, individuals voluntarily pursued board certification as a mark of distinction, not as a minimum qualification for entrance into the practice of a specialty. Gradually, the concept of the internist with a special interest in cardiology has given way to the cardiologist with a special interest in arrhythmias or coronary angiography and interventions, for example, to a rigid requirement that all cardiologists attain sub-subspecialty board certification in electrophysiology or interventional cardiology before being granted privileges to practice in these and other highly technical areas of cardiology. Board certification is often required by hospitals and insurance companies and is promoted directly to the public as a mark of individual competence.

Historically, after achieving a passing score on a board examination, boards issued a lifetime certifying credential. Multiple cardiology membership organizations emphasized the principles of lifetime learning and provided extensive opportunities for CME and training in new and expanding fields of CV medicine in a collegial, professional atmosphere.

Board certification changes

Recognizing that medical knowledge is expanding ever more rapidly, ABIM board certifications were changed to time-limited in 1990, requiring diplomates to retake written boards every 10 years. With urging from the Institute of Medicine to the medical profession to ensure that delivery of health care, in this era of an exploding knowledge base, be safe, timely, effective, efficient and patient-centered, the boards introduced the concept of Maintenance of Certification (MOC) in 2002. Now, diplomates are required to participate in a continuous MOC process of board-prescribed self-evaluation, learning and assessment of practice performance, which culminates in passing a rigorous, written examination every 10 years.

Many practicing cardiologists embrace the concepts of CME in the rapidly changing field of cardiology and accept the rationale for periodic written examinations, but have objected strongly to the ABIM practice-improvement modules and other requirements that seem redundant to existing CME requirements and multiple quality improvement initiatives required by hospital staff organizations and payers. The latter will continue to be required by local authorities and, when possible, many who accepted the traditional CME pathway. The added monetary cost and time away from practice, research, teaching and so on that is required to comply with MOC requirements also concerns many cardiologists. This is particularly so for practitioners who face declining reimbursements, time-consuming interactions with insurance benefits managers and increasing demands to make RVU targets those working in academic settings as well as reduced productivity associated with the requisite use of electronic health records.

Limited evidence exists supporting the effectiveness of MOC in improving medical practice and patient outcomes in primary care settings, but most cardiologists fail to see the relevance of current MOC requirements to their highly technical, procedure-oriented specialties. Some believe that the ABIM has intruded into the daily practice of cardiology by prescribing its own brand of MOC. In presenting itself as completely independent from the practitioners it judges, the ABIM has risked losing credibility with those very practitioners. A question remains: Without buy-in from grassroots clinicians, how does the ABIM differentiate itself from commercial organizations such as HealthGrades, Consumer Reports and various payer benefits managers, who are also in the business of independently judging doctors?

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Modified terminology

Due to increasing resistance, the ABIM in January 2014 modified its terminology. It abandoned the term "certified" and instead substituted the phrase "certified, *meeting* or *not meeting* MOC requirements." Thus, those holding lifetime credentials must participate in MOC or be identified to the public as less than fully qualified cardiologists. Although a high percentage of board-certified cardiologists have enrolled in MOC, it will be several years before it is known how many will complete the process. However, nearly 19,000 have signed an online petition on PetitionBuzz.com asking the ABIM to recall its MOC initiative. This represents approximately half of the estimated cardiologists working in the United States.

As a response to growing controversy, the ABIM in February suspended elements of its MOC process and delayed de-certification of current diplomates, promising to work with various medical societies to improve ABIM's MOC initiative.

Paired articles from proponents and opponents of MOC were recently published in *The New England Journal of Medicine*, outlining both the pressing need for board certification to evolve and the serious hazards of proceeding without fully considering the ramifications of MOC on the practicing professionals being certified.

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Tension exists between cardiology membership organizations, which have long been committed to providing their members high-quality CME, promoting the advancement of medical science, providing means for measuring and improving the quality of care such as the National Cardiovascular Data Registry including the PINNACLE Registry, as well as advocating in multiple arenas for excellence in all aspects of patient care and the independent board organizations, which, by design, are not accountable to a physician membership, so that they may assess individual physician competency without bias. The boards claim the public is only their constituency, not the professionals they judge.

As responsible professionals, and members of respected cardiology organizations, cardiologists also claim accountability to patients and the public. There is merit to both arguments.

Medicine and cardiology have undergone vast changes since ophthalmologists began the board certification process in America 100 years ago and since Hippocrates began talking about professionalism on the Greek island of Kos 2.5 millennia ago. The process of board certification continues to evolve.

All of our professional organizations have a vested interest in "getting it right" and continuing the altruistic tradition of putting our patients' best interests before our own. Many cardiologists feel that ABIM overstepped its independent testing mandate and core competency when it exclusively defined and mandated its own MOC process, and believe that ongoing professional development and continuing professional education should remain in the province of membership organizations like the ACC and cardiology subspecialty societies. ■

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