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Editorial Commentary

Maintenance of certification: Good intentions gone awry

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> "There is nothing more deceptive than an obvious fact."—
>
> Arthur Conan Doyle, The Boscombe Valley Mystery

Physicians currently practice in an environment of ever-increasing scrutiny and review. We are held to performance standards and quality outcomes that meet society's expectations and that are used to gauge the adequacy of our clinical expertise and service. These performance measures have evolved as precise, definitive, quantitative assessments of clinical competency through which we are judged on a regular basis and often compensated accordingly. With the development and ubiquity of the electronic medical record, these metrics can be readily assessed and held as a guide for areas of needed practice improvement.

Moving as we have from an era of purely artful medicine to one of scientifically sound, evidence-based diagnostics and therapeutics, the justification for such objective measures of our performance seems both reasonable and prudent. There remains, of course, room for the art of medicine to be practiced as years of experience coupled with a highly nuanced understanding of patients' clinical presentations leads to rational deviation from accepted guidelines and algorithms: as every seasoned clinician realizes, one size simply does not fit all.

In our efforts to be responsive to a society that demands ever more demonstrable evidence of our continued competence as practitioners, certifying bodies—in the case of internal medicine and cardiovascular medicine, the American Board of Internal Medicine—embarked on two initiatives in the past 25 years. First, time-limited certification was established in 1990. Second, and more recently, a formal program for maintenance of certification (MOC) was developed that went far beyond taking a simple secure examination, as described in the overview by Baron et al. [1] in this issue of the journal. MOC requires continued, lower-level study and evaluation, as well as analysis of patient and peer assessment of performance over the course of several years, punctuated every decade by a secure examination. One can argue from first principles that this approach is rational, deriving as it has from the principles of the initial certifying examination: there are clear cognitive skills and a unique knowledge base required to practice medicine effectively, and continued exposure to updated information coupled with an objective certifying examination is one time-honored way by which to assess a candidate's acquisition of these professional attributes.

The MOC program is, then, well-intentioned, defining its primary purpose as improving and maintaining the skills of practitioners for the benefit of patients. That the information base underlying medicine continues to expand dramatically argues for continued (self-)education in order to ensure that patients receive the most cutting-edge care. A secondary purpose for developing an MOC program is one that is also based on a long-held principle of certifying professional societies: either develop certification, recertification, and MOC programs via the professional society, or suffer the consequences of having these programs developed and regulated by another entity (implicit within this statement is the concern that this other 'entity' may not be as supportive of the practitioner as the professional society to which he/she belongs).

These idealized aspirations for MOC (as a natural outgrowth of certification), while admirable, are complicated by several problems. First, the time required for this continuous process in a busy practitioner's schedule is excessive for some, and, one can argue, really no substitute for the experience of practice itself. Second, the cost of the program is excessive for many practitioners, causing an undue financial burden on them without clear benefit (*vide infra*). Third, the ABIM has placed undue emphasis on the notion of "grandfathers" and "grandmothers," *i.e.*, physicians who have life-long certification according to the terms of their

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successfully passing the examination in the pre-recertification era. Despite the fact that the size of this group of practitioners is decreasing rapidly, currently comprising only a small minority of all internists and cardiologists, the ABIM continues to modify the language of recertification and MOC to honor their legal obligations to the initial certification, yet distinguish those clinicians with life-long certification engaged in MOC ("Meeting MOC Requirements") from those who are not. Obviously, the intention of this evolving policy is to pressure clinicians with life-long certification to participate in MOC or suffer the consequences of discrimination by designation, which has the potential to influence their credentialing within hospitals. Pressured in this way, participation in MOC can be used to demonstrate to those with time-limited certificates that those with life-long certificates have been brought to heel, hardly a principled objective. (In the spirit of full disclosure, I am a "grandfather" currently engaged in the ABIM MOC programs in internal medicine and cardiovascular medicine.) That maintenance of medical licensure in many states is evolving in parallel may render this issue moot, as all practitioners will be required to demonstrate successful participation in MOC-like programs in the near future. Fourth, MOC is currently separate from maintenance of licensure in most states, and incompletely linked to it in others; currently only five states (Idaho, Minnesota, North Carolina, Oregon, and West Virginia) exempt physicians from reporting CME when engaged in ABIM-sponsored MOC programs. This distinction between MOC and maintenance of licensure in the great majority of states leads to unnecessary duplication of effort in an already time-consuming and costly process. Fifth, and perhaps most important, MOC has not yet been proven to yield demonstrable benefits to patients. Put simply, the evidence base for MOC is scant, and, in an era requiring evidence for virtually every aspect of patient care, MOC should not be required on a simple *prima facie* basis. Justification for the benefits of MOC derives largely from a conflation of the evidence for the benefits of certification [2], a distinctly different process imposed at a very different phase of a physician's career. One recent study in the family medicine literature showed that use of self-assessment and practice improvement programs led to only modest improvements in process and intermediate outcome measures over time compared with a control group not engaged in this formal MOC program [3].

Prior work has clearly established that ~10% of physicians do not maintain professional practice standards [4], and that physicians' knowledge base and patient outcomes decline over time after training [5]. The question that remains, of course, is whether or not MOC will provide the needed structure to correct this serious problem. Because such limited objective evidence exists to support MOC in this regard, Centor et al. [6] have argued that the "affect heuristic" offers an explanation for the discordance between the ABIM's view and many physicians' view: proponents of an initiative overestimate the benefits and underestimate the risks, while opponents of an initiative underestimate the benefits and overestimate the risks. The outcome when ultimately assessed objectively as evidence mounts will likely lie between these extremes, but time and proof will tell. In the meantime, practitioners will be subject to yet another set of well-intentioned regulations meant to weed out the "bad apples" among us with the unintended consequences of excessively burdening the majority of clinicians who assiduously maintain their skills. As discussed in a recent editorial, this is, regrettably, a scenario in which we increasingly find ourselves in an age of unbridled oversight and high expectations [7].

Based on these concerns and others raised by cardiovascular leaders [8], I would like to offer some simple solutions for developing MOC into a robust program that will engender participation rather than resentment. First and foremost, develop an evidence base that unequivocally demonstrates the efficacy of MOC in improving patient care rather than simply assuming the efficacy of MOC as an "obvious fact." The ABIM Foundation seems a reasonable entity through which to develop the assessment tools to prove (or disprove) this hypothesis. Short of a definitive study, the ABIM should adapt the MOC program to growing evidence, rather than assume a broad and definitive benefit in all cases. Second, the ABIM should do all that it can to consolidate MOC with maintenance of licensure in every state, educating state boards about the evidence basis for the benefits of MOC and maintenance of licensure as that evidence is acquired. Third, the ABIM should do all that it can to reduce the burden in time and cost on practitioners. It is inconceivable to me that the process cannot be made more efficient and less expensive. If objectively acquired evidence fails to affirm the putative benefits of any element of the current program, those unaffirmed components should be eliminated, which would also reduce time and cost. Lastly, the ABIM should work closely with the practice community to sort out what they truly need to improve practice, and to do so with a variety of approaches that allow for differences in practice structures, from full-time community practitioner to part-time academic practitioner. Rather than applying a rigid structure to the entire practice community, adaptive flexibility should be the dominant principle. Engagement by the practice community is essential in this process, working hand-in-hand with our fellow physicians who comprise the oversight body of MOC. If full, interactive engagement is not part of the process, we might as well be regulated by another "entity" whose purpose would likely be narrower in scope and more straightforward to address. It is encouraging to note that the ABIM has been responsive to the growing concerns of the practice community, having convened a summit on them in July, 2014, with representatives from 26 medical societies. According to Baron et al. [1], changes are in process designed to address some of the concerns raised at this summit. This is a good first step toward advancing a useful, supportive program in which effective practitioner engagement may be achieved to the benefit of the profession and for the ultimate benefit of patients.

REFERENCES

[1] Baron RJ, Krumholz HM, Jessup M, Brosseau JL. Board Certification in internal medicine and cardiology: historical success and future challenges. Trends Cardiovasc Med 2015 [this issue].

[2] Hawkins RE, Lipner RS, Ham HP, Wagner R, Holmboe ES. American Board of Medical Specialties Maintenance of Certification: theory and evidence regarding the current framework. J Contin Educ Health Prof 2013;33:S7–19.

[3] Galliher JM, Manning BK, Petterson SM, Dickinson LM, Brandt EC, Staton EW, et al. Do professional development programs for maintenance of certification (MOC) affect quality of patient care? J Am Board Fam Med 2014;27:19–25.

[4] Leape LL, Fromson JA. Problem doctors: is there a system-level solution? Ann Intern Med 2006;144:107–15.

[5] Choudhry NK, Fletcher RH, Soumerai SB. Systematic review: the relationship between clinical experience and quality of health care. Ann Intern Med 2005;142:260–73.

[6] Centor RM, Fleming DA, Moyer DV. Maintenance of certification: beauty is in the eyes of the beholder. Ann Intern Med 2014;161:226–7.

[7] Loscalzo J. Ever at the mercy of well-intentioned regulations: their adverse consequences and unproven benefits. Circulation 2013;127:1169–72.

[8] O'Gara PT, Oetgen WJ. The American College of Cardiology's response to the American Board of Internal Medicine's maintenance of certification requirements. J Am Coll Cardiol 2014;64:526–7.