# Maintenance of Certification: Beauty Is in the Eyes of the Beholder

There are no facts, only interpretations.
—Friedrich Nietzsche

In this issue, Baron and Johnson (1) describe the history of and rationale for the creation of the American Board of Internal Medicine (ABIM) and recent changes in maintenance of certification (MOC). They focus on settings standards- and identifying "good doctors" who meet those standards. By implication, those who do not participate or are unsuccessful in achieving recertification are substandard. Although the ABIM is clearly proud of the MOC process that it has developed, many internists find it a source of great distress.

We suggest considering a basic observation in cognitive psychology, the affect heuristic, as a construct to help understand the disconnect between the ABIM's and internists' views of MOC (2, 3). According to this heuristic, when we like a thing or an idea, we overestimate the benefits and underestimate the risks or unintended consequences. If we dislike something, we underestimate the benefits and overestimate the risks.

Those invested in developing the MOC process seem to highlight potential benefits and minimize possible unintended consequences. We have deep concerns that this well-intended policy will, indeed, cause negative consequences for physicians and society.

Over the past several months, we have heard from many internists about the MOC process. These physicians represent a wide variety of training and experience and include well-trained, insightful, and skilled internists who share a commitment to maintaining high standards of professional performance. Yet, their serious concerns over the new demands that the MOC process entails are palpable. Their focus is on the potential unintended consequences, and they are struggling to acknowledge the potential benefits. When these physicians talk with us about MOC, frustration and dismay about the process dominate the conversations.

Internists feel increasing pressure from many directions. Time is an entity that none of us can recoup, and internists appropriately raise concerns about growing time pressures on all fronts (4). They are experiencing increasing administrative burdens that limit their ability to provide the type of patient care that they want to deliver.

These burdens include issues related to usability and interoperability of electronic health records, complex documentation requirements, growing requirements for prior authorization of the tests and treatments that they prescribe, and a payment system that does not recognize the time and effort that they spend on telephone or e-mail communication. The new MOC requirements add to this burden by being time-consuming and costly and having an unclear positive effect on patient care. Added to these concerns is a high-stakes, secure recertification examination whose first-time failure rate has increased from 10% to 22% over the past 5 years.

Although most first-time recertifying examinees who fail will eventually pass the examination, they suffer distress and additional cost to retake it. Internists, like all physicians, want to bring their best, evidence-based practice to every patient every day. They want to test their knowledge and better their practices in a formative way to improve patient care and outcomes.

We worry that the ABIM may focus too much on metrics, administrative processes, and finding the "substandard doctors" who theoretically place the public at risk and too little on the design and implementation of a process that encourages ongoing education and professional development. The implication is that MOC will allow for better policing of "bad" internists rather than helping us all be "better" internists. We believe that the ABIM's stated accountability to the profession, which accompanies its accountability to the public, should lead to better recognition of dissatisfaction among its diplomates and a more collaborative approach with internal medicine specialty and subspecialty societies to address this dissatisfaction.

Unfortunately, the new MOC process has become the straw that broke the camel's back in many internists' minds. They dislike each part of the process but seem most angry about the practice improvement modules and secure examination. They see the first as "busy work" and the second as lacking relevance to their personal practice and to how medicine is currently practiced. The present structure of the summative secure examination of the ABIM does not provide specific feedback to facilitate this process let alone reflect the current state of practice, namely, collaboration in patient care and real-time engagement of evidence-based resources.

Any physician evaluation process should consider the practical wisdom, knowledge, and skill necessary to be a good practicing physician and test how those attributes are actually used in patient care. Fostering the development of *phronesis* (practical wisdom) in physicians through the effective and safe use of knowledge and skill in the clinical moment allows us to fulfill the covenant we have with patients and the contract we have with society.

Our internist colleagues tell us that they embrace the importance of remaining current, but they do not believe that the current MOC process helps them achieve that goal. As currently implemented, MOC involves substantial time, and internists believe that time supersedes more educationally sound activities. Current learning theory supports the use of testing to guide further learning and the provision of educational tools to address knowledge weaknesses.

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Testing for knowledge alone does not determine how skilled and effective an internist is at the bedside, in history-taking, and in performing a targeted physical examination. Would it not be better and more practical to have a testing process that assesses the ability to gather and interpret information and that will encompass the entire clinical encounter? Can the MOC process as it stands truly evaluate our ability to deliver patient-centered care?

Too many internists view "professional self-regulation" as currently conceived by the ABIM to be a nonproductive and often punitive experience. All too often, they see regulatory bodies as depleting money, time, and joy from their professional lives. Further, many do not believe that burdensome processes being forced on them will benefit their patients or their professional lives. Thus, it should be no surprise that internists focus on the direct and indirect costs of MOC rather than on the potential benefits that are the focus of the current commentary of the ABIM leaders.

We recognize the ABIM's good intent and the substantive challenges of developing an effective assessment process that ensures a corps of good internists. Unfortunately, too many internists find some aspects of the current process lacking at a time when concerns about the ramifications of this high-stakes professional endeavor are increasing.

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This article was published online first at www.annals.org on 13 May 2014.

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*Ann Intern Med.*

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