

COMMENTS AND RESPONSES

The American Board of Internal Medicine

TO THE EDITOR: Although Baron and Johnson (1) may not realize it (or maybe they do), **the boards were never meant to be mandatory.** This incontrovertible fact makes the moral basis for maintenance of certification (MOC) questionable to say the least. It is disappointing that *Annals*, which would never knowingly publish a scientific paper that contained such a **conspicuous factual omission**, saw fit to publish their commentary. It is just as disappointing (and misleading to readers) that this serious omission was not mentioned in Centor and colleagues' accompanying editorial (2).

Edward Volpintesta, MD
Bethel, Connecticut

Disclosures: Authors have disclosed no conflicts of interest. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=L14-0485.

References

1. Baron RJ, Johnson D. The American Board of Internal Medicine: evolving professional self-regulation. *Ann Intern Med.* 2014;161:221-3. [PMID: 24821363] doi:10.7326/M13-2478
2. Centor RM, Fleming DA, Moyer DV. Maintenance of certification: beauty is in the eyes of the beholder [Editorial]. *Ann Intern Med.* 2014;161:226-7. [PMID: 24821483] doi:10.7326/M14-1014

TO THE EDITOR: Baron and Johnson (1) lay out a self-congratulatory defense of the American Board of Internal Medicine (ABIM) and its MOC requirements. It is fitting that Rhon and colleagues' lead article in the same issue (2) reported on the equivalence of corticosteroid injection and manual physical therapy for shoulder impingement. This well-done study offers 2 options for the ABIM board members who **have shoulder pain after repetitively patting themselves and each other on the back.**

In this same issue, Centor and associates (3) make the point that there is a disconnect between the ABIM's view and that of the practicing internist and that the ABIM may be **overestimating the benefits and underestimating the costs and risks of the program.** Centor and associates also note that internists feel time pressure from several professional fronts, with many of these pressures caused by other groups with regulatory power. Things like electronic health records, meaningful use, preauthorizations, and myriad other burdens are frequently mandated by regulatory groups—groups that overestimate the benefits and underestimate the risks and burdens of the regulations that they unleash on the practicing physician.

Baron and Johnson (1) state that the ABIM now requires 2 noninternist public members and a “minimum of one practitioner [I hope they mean a physician] whose primary practice is in a non-university, community setting.” **This is barely a step in the right direction**, and I propose an alternate composition for this and any other governmental or regulatory board with the power to add burdens with unproven or overestimated

benefits. **Namely, that 75% of board members be clinicians who work a minimum of 40 hours weekly in the clinical setting.**

I propose that members of the board who are not full-time physicians be required to engage in a “Clinician Relevant Activity Program.” During this week-long program, which members would be required to participate in every 2 years, persons who are not full-time clinicians could join me or another busy clinician for the week. Knowing that practicing physicians likely earn no money for their time away, I would expect that the salaried ABIM members would donate that week's salary to the charity of the board member's choice. This program would be instructive and offer continuing medical education, and I present the following advanced agenda (which will be changed frequently and without notice):

Monday Through Friday

4:00 a.m.: Wake up, stretch, and read a bit.

4:30 a.m.: Run 5 to 6 miles knowing that physical health is important to you and the significance of being a good example for patients.

6:00–8:00 a.m.: Inpatient rounds (census of 6 to 10 patients, with the hospital conveniently located across the street from the clinic).

8:00 a.m.–Noon: Morning clinic except on days when attending a committee meeting. (As chief of medicine, I currently volunteer on the medical executive, physician wellness, quality, cardiac, and critical care committees.)

Noon–1:00 p.m.: Repeat rounds on sick inpatients or see patients missed on early rounds and inhale food in physician dining room except on Tuesday, which is section journal club.

1:00–3:30 p.m.: Back to the clinic (unless doing nursing home rounds or teaching students and residents).

3:30–4:30 p.m.: Back to the hospital for further inpatient work.

4:30–7:00 p.m.: The real fun (requires caffeine or candy beforehand): Deal with electronic health record inefficiencies, telephone calls, and documentation. This segment lasts 60 to 90 minutes longer than it did 5 years ago.

7:00–10:00 p.m.: Time for children and spouse and community events.

Saturday and Sunday

If on call, expect 28 hours of clinical activity. If not, then only 3 hours are needed to finish last week's activities.

St. Bernard of Clairvaux is credited with saying, “The road to hell is paved with good intentions.” **It is time for the ABIM to stop laying down more pavement on the autobahn.**

Timothy Kleinschmidt, MD
St. Luke's Hospital
Duluth, Minnesota

Disclosures: Authors have disclosed no conflicts of interest. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=L14-0487.

References

1. Baron RJ, Johnson D. The American Board of Internal Medicine: evolving professional self-regulation. *Ann Intern Med.* 2014;161:221-3. [PMID: 24821363] doi:10.7326/M13-2478
2. Rhon DI, Boyles RB, Cleland JA. One-year outcome of subacromial corticosteroid injection compared with manual physical therapy for the management of the unilateral shoulder impingement syndrome: a pragmatic randomized

trial. *Ann Intern Med.* 2014;161:161-9. [PMID: 25089860] doi:10.7326/M13-2199

3. Centor RM, Fleming DA, Moyer DV. Maintenance of certification: beauty is in the eyes of the beholder [Editorial]. *Ann Intern Med.* 2014;161:226-7. [PMID: 24821483] doi:10.7326/M14-1014

TO THE EDITOR: Baron and Johnson (1) state, "Most internists practicing today would be unfamiliar with and perhaps unable to pass the first ABIM examination, a written essay test with 8 questions." That statement is unwarranted—the authors give no documentation that they gave the test or any questions in it to even 1 present-day ABIM board-certified physician. It is unfair because physicians interested in whether they could pass the examination cannot respond. Furthermore, the Figure is so small and faded that it is impossible for a physician, even with a magnifying glass, to see the questions, let alone answer them. What physicians learn from such statements is that, before we can discuss MOC with the ABIM, we need an ABIM that is less righteous and more reasonable.

Joseph J. Weiss, MD
Livonia, Michigan

Disclosures: Authors have disclosed no conflicts of interest. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=L14-0486.

Reference

1. Baron RJ, Johnson D. The American Board of Internal Medicine: evolving professional self-regulation. *Ann Intern Med.* 2014;161:221-3. [PMID: 24821363] doi:10.7326/M13-2478

IN RESPONSE: Given the ongoing debate about the value of MOC, we are not surprised that our commentary generated many comments. We value these constructive remarks as we work to enhance the MOC program. Readers may not be aware that the ABIM recently announced plans to make changes to MOC on the basis of similar valuable feedback received from many specialty societies and diplomates over the past few months. The planned changes, as well as other potential modifications still under discussion, are outlined in a letter to the internal medicine community dated 10 July 2014 and posted on the ABIM Web site at www.abim.org/pdf/press-releases/July28IMLetter.pdf.

Dr. Volpintesta raises the point that board certification was never intended to be mandatory. We agree and regret that our commentary may have implied otherwise. Indeed, board certification and MOC have always been voluntary. In fact, we believe that the voluntary nature of these peer-developed credentials adds to their value. That said, we also recognize that the reality for many physicians is that board certification and MOC may not be experienced as voluntary because many hospitals, health systems, and insurers have adopted them as part of their requirements for credentialing. In seeking an objective sign that physicians are well-trained and keeping up, these institutions have likely gravitated toward certification and MOC because they are peer-developed credentials. In light of this reality, we recognize that the ABIM must always strive to ensure that MOC is meaningful, evidence-based, and fair—a responsibility that we take seriously.



Parenthetically, there is also a common misconception that the ABIM seeks to make MOC a required component of other forms of physician credentialing, such as maintenance of licensure. The ABIM does not support using MOC as a requirement for maintenance of licensure. We do believe that physicians who choose to engage in MOC should be exempt from additional requirements for licensure renewal. To reduce redundancy for these physicians, we want MOC to count as an option—not a requirement—for satisfying other physician credentialing processes.

Dr. Kleinschmidt emphasizes the need to include the perspectives of "practicing physicians" in the ABIM's decision making. We agree. The new governance structure that we described in our commentary is intended to explicitly affirm this commitment. The ABIM's founding documents do require that at least one half of the directors be at the rank of full professor in a medical school accredited in the United States; however, we have over the years reliably included practicing clinicians in our governance and this recent governance change merely codifies those efforts. With the many burdens practicing physicians face in this unprecedented time, we believe that it is vital that those physicians have an active role in shaping the future of MOC.

With respect to Dr. Weiss' comment, we did not intend to reprint the questions from the original 1936 ABIM examination in a way that made them hard to read. Rather, we intended to show how medical knowledge and practice expectations change over time. For example, one of the questions on the 1936 examination was, "Discuss the general principles and sources of error involved in the Wassermann reaction." This antibody test for syphilis was essential knowledge for internists in 1936, and—although internists today may know the answer to the question—this once-common test is no longer relevant to modern practice. The point of sharing the 1936 examination was not to claim that the test was more or less difficult than now or to presume a level of knowledge or lack thereof among our fellow internists; it was merely to show that the definition of what it means to be a good physician has changed and will continue to change over time—and that board certification and MOC will need to change accordingly.

We believe strongly in the principles behind MOC but also agree that the process can improve. Since its inception, the ABIM has been a standard-setting organization committed to ongoing summative and formative assessment of physicians over the course of their careers. To that end, the ABIM remains dedicated to working with specialty societies and others to continuously improve and enhance the MOC program. We welcome constructive feedback from all members of the internal medicine community as we labor to refine board certification and MOC to maximize their relevance and value to physicians and patients.

Richard J. Baron, MD
American Board of Internal Medicine
Philadelphia, Pennsylvania

David Johnson, MD
University of Texas Southwestern Medical Center
Dallas, Texas

Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M13-2478.

Maintenance of Certification

TO THE EDITOR: I read Centor and colleagues' editorial (1) with great interest. I am a medicine-pediatrics guy who quit my private practice of 18 years to work overseas. Largely by accident, I ended up working in a mid-sized emergency department (ED). For that reason, I have spent many hours reviewing ED material. Besides using ultrasonography as part of the patient examination, the other interesting thing that these ED folks have is Free Open Access Medical Education (FOAMed), a grassroots, homegrown phenomenon that provides free ED learning materials. Bright physicians put together podcasts, literature reviews, and practice tips and post them on a Web site. Feedback from ED physicians reading these materials helps promote or debunk the postings. Ratings and feedback help rank articles according to importance and effect on practice. Information that is below average is devalued.

Maintenance of certification (MOC) has none of this. There is little incentive to make learning interesting, valuable, or relevant to practice. There is no user feedback or survival-of-the-fittest competition to boost quality. The American Board of Internal Medicine (ABIM) has a captive audience, and that gives it—like any other monopoly—the freedom to ignore its constituents.

As with most internists, I want to stay up to date. I do not want the quality of my \$1 million education to fade. I would love to have a high-quality source of succinct, relevant learning. Instead, I get boring, irrelevant, and often pointless “modules” that do precious little to keep my skill set tuned.

Michael Kelley, MD
Zayed Military Hospital
Abu Dhabi, United Arab Emirates

Disclosures: Authors have disclosed no conflicts of interest. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=L14-0499.

Reference

1. Centor RM, Fleming DA, Moyer DV. Maintenance of certification: beauty is in the eyes of the beholder [Editorial]. *Ann Intern Med.* 2014;161:226-7. [PMID: 24821483] doi:10.7326/M14-1014

TO THE EDITOR: Centor and colleagues' editorial (1) is thought-provoking from the perspective of a physician nearing retirement. I'm 61 years old and keep up with the literature, attend conferences, and try my best to apply thoughtful care to my patients. I plan to retire at 65. I have “grandfathered” internal medicine and pulmonary certificates, and I let my critical care certification lapse because, mercifully, I don't do critical care anymore. I did want to participate in MOC so that prospective patients who search the Internet see that I meet this criterion. Meeting MOC requirements is also useful for recertification and insurance purposes. Furthermore, I have a basic pride in my work, and to remain (in

my mind, at least) fully credentialed was important to me personally.

Let's look at how this plays out. Reading the requirements carefully, I need to do 1 MOC activity promptly to buy 2 years of sufficient activity to meet MOC requirements. I then have to complete a second module, including one of the self-assessment modules, by the end of another 2 years. This creates an interval of slightly fewer than 4 years during which I will meet MOC requirements for having done 2 activities. Because of where my birthday lands, I'll be practicing without the benefit of meeting these requirements for approximately 6 months. At that point, I'm not going to worry about it.

To reiterate: By completing 2 ABIM MOC modules, I will remain certified by the ABIM for 4 years. (As an aside, I completed the first MOC module as a beta tester, so I was able to provide feedback about the utter irrelevancy of many of the questions.) I've gotten the requirement out of the way and can move on to useful continuing medical education. I pay the MOC upkeep fee on a yearly basis, so I'm spending several hundred dollars each year to look like I'm doing what I'm doing anyway. If I were not diligent, this process would present an easy way for me to slither away from this MOC stuff and do my “continuing medical education” on a cruise ship.

I feel mostly like I am paying for an imprimatur that has little or no incremental value. Worst of all, for those of us close to retirement, it's easy to meet MOC requirements while doing very little, and, arguably, we would be one of the groups that might warrant closer attention. I had hoped for a program that would have made me feel engaged, and this one does not.

Edward Ringel, MD
Maine General Medical Center
Augusta, Maine

Disclosures: Authors have disclosed no conflicts of interest. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=L14-0498.

Reference

1. Centor RM, Fleming DA, Moyer DV. Maintenance of certification: beauty is in the eyes of the beholder [Editorial]. *Ann Intern Med.* 2014;161:226-7. [PMID: 24821483] doi:10.7326/M14-1014

TO THE EDITOR: Centor and colleagues' editorial (1) made me think that, as a generalist medicine-pediatrics physician board certified by the American Board of Pediatrics (ABP) and the ABIM for more than 20 years with time-limited certification for both, I have always found the ABP MOC examinations to be much more primary care-focused than the initial or subsequent MOC ABIM general internal medicine examinations. In fact, it was particularly galling for me as someone who practices primary care to have had a faculty cardiology lecturer at an ACP-sponsored internal medicine MOC preparation course 3 years ago say that we needed to memorize some information being presented based on ABIM core content, even though the lecturer had never seen a case requiring this information in his more than 20 years in cardiology practice. He explained that the ABIM nonetheless likes to ask questions about that disorder on the general internal medicine MOC examination.

LETTERS

On my most recent ABIM examination, the first-time pass rate for internists who were already board-certified was 84%. This contrasts with my recent ABP MOC examination, which had a pass rate of approximately 95% for the board-certified pediatricians taking it. My wife is a board-certified obstetrician-gynecologist with time-limited certification who earlier this year took the American Board of Obstetrics and Gynecology MOC examination, which also had a pass rate well above 90%. Why does the ABIM think that it has to be so hard on practicing board-certified internists? In fact, one could argue that the ABIM and other certifying agencies might be better served by focusing on those physicians practicing internal medicine in the United States who have never been board-certified rather than “punishing” practicing internists who have always been board-certified, are physician leaders of their clinical organizations and delivery systems, have never been sanctioned by their state licensing board or by Medicare or Medicaid, and have been recognized by third-party payors for their clinical quality.

Secure MOC examinations—particularly for the ABIM due to their higher failure rates—have turned themselves into a cottage industry in which MOC preparation courses proliferate. These courses cost thousands of dollars for registration, travel, accommodations, and time away from practice, as well as the costs for the MOC processes and secure examination themselves. When I first became board-certified more than 20 years ago, achieving certification was viewed as “icing on the cake.” However, now board certification is being used as a litmus test for continued participation in health plans and medical staffs without other evidence of inadequate or inappropriate clinical practice, despite the examination having a pass rate of 84%.

More specifically regarding the ABIM's secure MOC examination, the ABP did not require fingerprints or palm prints for entrance or reentrance to the MOC examination during breaks. The actual taking of the ABIM secure examination felt like I was being booked for a minimum-security prison. Lastly, why does it take weeks or even a month or more to tell the ABIM MOC examination testers the outcome of a computerized examination that other clinicians can find out the moment that their examination is over or within days? At the very least, it gives the appearance of a “smoke-filled room,” where scores may be massaged and pass rates determined after the fact or other potentially unsavory activities.

Maintenance of certification as administered by American Board of Medical Specialties boards is intended to ensure clinical knowledge and, allegedly, competency, although I am not aware of any study that clearly shows that the latter is true. Let's please put the pleasure back into lifelong clinical learning. This can be done with measurement and feedback loops to participating board-certified physicians that do not unwittingly put continued board certification in jeopardy by a single periodic secure examination. I do not believe that this should occur without such physicians showing their unwillingness or inability to improve their clinical knowledge or practice. I do believe that this can be done while ensuring the laudatory original purposes of MOC.

Donald Trainor, MD
HealthNet, Inc.
Indianapolis, Indiana

Disclosures: Authors have disclosed no conflicts of interest. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=L14-0500.

Reference

1. Centor RM, Fleming DA, Moyer DV. Maintenance of certification: beauty is in the eyes of the beholder [Editorial]. *Ann Intern Med*. 2014;161:226-7. [PMID: 24821483] doi:10.7326/M14-1014

TO THE EDITOR: Centor and colleagues' editorial (1) and multiple ACP mailings, e-mails, and telephone calls have made me well aware that I am not alone in my concern about the ABIM's position on MOC. The current generic ABIM statement for those internists without time-limited certification is “certified, not meeting maintenance-of-certification requirements.”

The ABIM does not know what those of us who consider professionalism and lifelong scholarship a critical personal obligation may be doing. I consider the statement an insult. Patients, employers, and insurers may well read it as “unfit to practice medicine”!

I have successfully taken 5 ABIM certification and recertification examinations without paying for spoon-feeding or subscribing to any ABIM program. At age 77, I continue to practice, study, teach, run a free clinic, and medically direct a complex regional hospital department. The maintenance of medical knowledge and diagnostic skills is very, very important to me.

I have corresponded with Dr. Baron, the President and Chief Executive Officer of the ABIM. He was respectful but, it seemed to me, terribly out of touch. He did suggest that I visit the ABIM Foundation Web site to read the physician charter on professionalism. I had to inform him that it was my high personal privilege to have been a part of the group that wrote that charter.

Some 25 years ago, Holly Smith chided the leadership of the ABIM about its proclivity to “chew on more than it had bitten off” in a speech given at the 50th Anniversary Celebration of the ABIM on 17 June 1986. Its current opaque position on MOC using its my-way-or-no-way program seems to show that the ABIM is still at it. It also raises the question of whether the ABIM is our principled setter of standards or is becoming a toll collector on the road to changing health care in the United States.

I have proudly served on ABIM's Board of Governors and ACP's Board of Regents. The last thing that I want to do now is promote adversarial positions. However, when the best efforts of well-intended persons prove to be more capricious than constructive, it is time to reconsider.

Robert B. Copeland, MD
West Georgia Physicians
LaGrange, Georgia

Disclosures: Authors have disclosed no conflicts of interest. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=L14-0502.

Reference

1. Centor RM, Fleming DA, Moyer DV. Maintenance of certification: beauty is in the eyes of the beholder [Editorial]. *Ann Intern Med*. 2014;161:226-7. [PMID: 24821483] doi:10.7326/M14-1014

TO THE EDITOR: As Centor and colleagues' editorial (1) suggests, at the end of the day, what the ABIM must answer as it figures out how to respond to the loud chorus of criticism from internists and subspecialists is how the "evolving" process of MOC has helped our patients. As internists, we concern ourselves with the time and costs involved in the process. However, as a society, I believe that we can agree that we could accept our individual burden if all of these changes lead to improved patient outcomes.

Particularly at a time of a shortage of primary care physicians that is projected to worsen, how does increasing the number of physicians who are no longer certified (a consequence of increasing recertification failure rates) help the population in general? Furthermore, as physicians aged 60 years or older try to decide whether to continue practice and now face the additional time and costs associated with MOC, are we encouraging them to stay in practice to serve their patients or **retire?** As a patient who is attempting to contact a physician's office for an appointment and refill, would I rather the office staff busy themselves with reaching out to patients to complete surveys to meet MOC requirements **or take care of my medical needs?** If the physician practice is large, the need to complete great quantities of surveys along with all of the requisite insurance information further reduces the amount of time spent on direct patient care. Have any of our patients ever complained to our certifying organization about their inability to answer surveys, or **do they more frequently complain about wait times as they try to schedule appointments and get refills?** Patients' ultimate approval of our care comes when they decide to see us again. If physicians remain busy throughout their practice, what is the additional benefit of a patient survey through the ABIM to confirm their ability?

If the ABIM cannot answer how the current MOC process (including the test content itself) has improved patient care by using actual peer-reviewed data, I suggest that they commission some of the **\$70 million in the ABIM Foundation's funds for such research showing its actual practical value.** In medicine, we produce treatment guidelines on the basis of the principle of "studies show," not "we believe." It is past time for the **ABIM to start using the rules of evidence to support its current MOC process or refocus this process on how to better serve our patients.** I commend the ACP leadership for pushing this issue further over the past several months and suggest that we continue to remind the ABIM whom they serve.

Leonard Johnson, MD
St. John Hospital and Medical Center
Grosse Pointe Woods, Michigan

Disclosures: Authors have disclosed no conflicts of interest. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=L14-0497.

Reference

1. Centor RM, Fleming DA, Moyer DV. Maintenance of certification: beauty is in the eyes of the beholder [Editorial]. *Ann Intern Med.* 2014;161:226-7. [PMID: 24821483] doi:10.7326/M14-1014

TO THE EDITOR: I have been following the discussions about the changes in the ABIM MOC program that went into effect in January 2014. In contrast to Baron and Johnson's commen-

tary (1) in support of these changes, Centor and colleagues' accompanying editorial (2) suggests that heuristics are at play, resulting in a disconnect between the intentions of the ABIM and the perceptions of the internal medicine community for whom MOC is one of many mounting stressors. Medicine and the external influences on physicians have certainly changed dramatically since the 1990s when I started to practice. Electronic health records, the rigors of documentation, and pay-for-performance measures that we may or may not agree with all eat up our professional as well as personal time.

What strikes me here is that, if we physicians want to take a stand against these infringements on our time, why did we choose MOC to rebel against? Is it because "it," the ABIM, is us? The ABIM is governed by physicians. Can we say that of some other external entities? Have we chosen this fight because the ABIM is an easier target than the Centers for Medicare & Medicaid Services or other agencies?

I think that we should be careful. What MOC seeks to accomplish is education. It provides a mechanism for all of us to keep up with our specialties and remain current. I was recently at the meeting that ABIM held in Philadelphia to hear feedback from the societies. Nearly everyone who spoke up was from a major medical institution. That is not where the bulk of medicine is practiced. **It is practiced in small hospitals around the country where physicians do not have the benefit of training programs and residents to keep current every day.** I have worked in private practice and understand the challenges in keeping current. Sometimes, we all need an impetus to devote time and energy to a solid, focused review of our specialty. Our patients demand it, as does the oath that we all took upon graduation from medical school.

I completely support streamlining the process, participating in activities that are relevant to our practice, and making MOC as easy to work into our days as possible. I must say that reading some of the things written against MOC does not necessarily make us look good as physicians. When nonphysicians ask me why we are complaining about keeping current and paying \$200 per year, I find it a difficult question to answer. We are entrusted with people's lives. I don't enjoy spending time and money and taking the secure examination any more than anyone else, nor do I have a higher salary than others. I do, however, believe that participating in MOC is the right thing to do, and I support it.

Antoinette Spevetz, MD
Cooper University Hospital
Camden, New Jersey

Disclosures: Authors have disclosed no conflicts of interest. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=L14-0501.

References

1. Baron RJ, Johnson D. The American Board of Internal Medicine: evolving professional self-regulation. *Ann Intern Med.* 2014;161:221-3. [PMID: 24821363] doi:10.7326/M13-2478
2. Centor RM, Fleming DA, Moyer DV. Maintenance of certification: beauty is in the eyes of the beholder [Editorial]. *Ann Intern Med.* 2014;161:226-7. [PMID: 24821483] doi:10.7326/M14-1014

IN RESPONSE: These thoughts are important and reinforce the idea that the objections to the current MOC processes are not rejections of ongoing education or professional development. As we read these comments, it is clear that internists want to maintain competency and expand knowledge for the sake of their profession and the welfare of patients. We want processes that help us grow at many levels. Many internists believe that alternate strategies would help them succeed in this effort.

Dr. Kelley challenges the MOC process to be more like FOAMed in ED medicine. He raises an important concern about continuing education. We can imagine changes in MOC that would enhance the enjoyment of learning. We hope that the ABIM Assessment 2020 project (1) will help transform MOC from merely a summative examination to a formative process (that is, a process that focuses on improving knowledge rather than one that only evaluates it).

Dr. Ringel has concerns about the relevance of MOC to physicians with lifetime certificates. He makes explicit what many older physicians are doing in their engagement of MOC. We understand his concern. We who hold lifetime certificates are encouraged but not required to participate in MOC for certification. Dr. Ringel expresses uncertainty about the value of the MOC process as he nears retirement. We believe that a more formative process would help him feel engaged.

Dr. Trainor raises a critical concern: differing initial MOC pass rates across specialty boards. We have cited this issue repeatedly and hope that the ABIM will respond. We agree that the progressively lower initial pass rate for the secure internal medicine board examination continues to be an unavoidable problem that needs to be addressed.

Dr. Copeland speaks with wisdom as a former ACP and ABIM leader. We respect his opinions.

Dr. Johnson asks how MOC is helping our patients. In the current climate that asks physicians to base decisions on the best evidence available, **what evidence exists that the MOC process helps patients? Anecdotal and subjective validity will not suffice in the modern era.**

Dr. Spevetz worries that the internal medicine community is rebelling against the ABIM. This may be true. Internists opine about the problems of electronic health records, prior authorization, the current payment structure, and other ad-

ministrative burdens that distract from patient care and practice enjoyment. The concern about MOC is not about goals but rather processes. We agree with the intent of requiring physicians to maintain competence in their profession but **have questions about the current recertification examination and other aspects of MOC that are logistically burdensome for practicing internists with no evidence showing that patient care will be improved.** The ABIM is now listening to our concerns and making changes that will hopefully encourage acceptance by internists and allow MOC to achieve its patient-centered goals.

We thank all who have commented for reconfirming the importance of lifelong learning and maintaining professional competence while also asking legitimate questions about how best to reach these goals. We believe that the ABIM is now working to improve its MOC processes and applaud the strides that it has made. We look forward to continued joint efforts with the ABIM to foster ongoing improvements in MOC.

Robert M. Centor, MD

University of Alabama at Birmingham Huntsville Regional
Medical Campus
Huntsville, Alabama

David A. Fleming, MD, MA

University of Missouri Center for Health Ethics, University of
Missouri School of Medicine
Columbia, Missouri

Darilyn V. Moyer, MD

Temple University School of Medicine
Philadelphia, Pennsylvania

Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M14-1014.

Reference

1. American Board of Internal Medicine. ABIM announces initiative to seek input on physician knowledge and skill assessment approaches. 28 January 2014. Accessed at www.abim.org/news/abim-initiative-seek-input-on-physician-knowledge-skill-assessment-approaches.aspx on 24 November 2014.