

REPORT OF THE AMA YOUNG PHYSICIANS SECTION GOVERNING COUNCIL

AMA-YPS Report G - A-08

Subject: Improvements to the Maintenance of Certification Process

Presented by: Gary Katz, MD, Chair

Referred to: Reference Committee

Issue

At the 2007 Interim Assembly meeting of the AMA Young Physicians Section (YPS), the Texas delegation submitted a resolution asking our AMA to:

Exercise its full influence to protect physicians from undue burden and expense in the Maintenance of Certification (MOC) process by endorsing the following specific goals and promoting them in its deliberations with appropriate parties:

1. The MOC process should become more physician-friendly, requiring no more than one missed day of patient care per recertification cycle;
2. Total fees for recertification for the annual board certification option should not exceed \$200 and total fees for the recertification examination should not exceed \$2000;
3. Time spent preparing for MOC should count as AMA PRA Category 1 Credit;
4. Use of ongoing educational processes, such as annual board certification, should be an option for practitioners in all specialties; and
5. There should be greater coordination between American Board of Medical Specialties' member boards to ensure that the demands of the MOC process are similar across specialties.

Testimony from the AMA-YPS Assembly was generally supportive of the resolution's intent, recognizing that MOC requirements can be onerous for physicians – disproportionately impacting young physicians – and that improving the MOC process should be an AMA priority. There was no consensus, however, around specific improvements that would make sense across specialties. There was also a question about the resolution's viability in the AMA House of Delegates (HOD), given the substantial amount of existing AMA policy on this issue and the fact that a very similar resolution had been considered by the HOD at A-07. The AMA-YPS Reference Committee recommended, and the Assembly concurred, that the issue undergo further study before the Section submits any recommendations to the HOD. As a result, the AMA-YPS resolution was referred to the Governing Council. This report is the culmination of your Governing Council's further deliberations on this issue combined with a review of existing AMA policy on certification, recertification and MOC.

Background

The MOC concept was developed by the American Board of Medical Specialties (ABMS) and its 24 member boards – together responsible for certifying physicians in more than 145 specialties and subspecialties – in response to concerns about the safety and quality of medical care. MOC is the latest in a series of modifications to certification and recertification programs that have been made over the years. A premise of the new MOC process is that cognitive knowledge as measured by intermittent examinations does not necessarily equal physician competence, and what is needed for public accountability and transparency – according to the ABMS – is a more rigorous program of lifelong learning and ongoing practice improvement.

Through MOC, the ABMS sought to enhance physician recertification programs by assessing a wider range of physician competencies, namely: 1) patient care; 2) medical knowledge; 3) practice-based

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1 learning; 4) systems-based practice; 5) professionalism; and 6) interpersonal and communications
2 skills. The 24 ABMS member boards have since transitioned to a four-part MOC process comprised
3 of the following assessment components:

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- 5 I. Licensure and professional standing;
- 6 II. Lifelong learning and self-assessment;
- 7 III. Cognitive expertise; and
- 8 IV. Practice performance assessment.
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10 These components represent the overarching parameters for MOC as set forth by the ABMS.
11 Specialty boards have been given significant latitude to define their own specific MOC requirements,
12 standards and fees, subject to approval by the ABMS. While some board discretion is appropriate,
13 what has resulted is a process that is highly inconsistent across specialties. MOC for obstetrics and
14 gynecology, for example, requires that diplomates pass either a written or oral exam every six years
15 or complete annual certification plus 25 CME credits. This process might seem relatively simple when
16 compared to what is required of plastic surgeons – 150 hours of CME during a three-year period, plus
17 a passing grade on a proctored exam, plus submission of a case list covering a six-month period –
18 and many other specialties. Fees also vary widely across specialties, with some specialty boards
19 charging annual fees throughout the MOC cycle on top of exam fees, application fees and the cost of
20 special materials and modules required to complete the new components. Lastly, the time it takes to
21 actually complete the requirements for MOC is likely to differ considerably between, for example, an
22 Ob-Gyn, and a family practice physician, who – in addition to passing an examination – must also
23 complete a series of Internet-based self-assessment modules along with online patient simulations,
24 300 hours of CME, chart reviews and a quality improvement plan.

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26 Overall, we can say with some confidence that the MOC process is having a major bearing on
27 physicians holding time-limited certifications. We should also note that there has been no unanimity of
28 opinion regarding the transition to MOC – among young physicians or otherwise. Some diplomates
29 have gone on record to express satisfaction with the new process, including the manner in which it
30 was developed and introduced by their specialty boards. For many physicians, however, the transition
31 to MOC has brought them face to face with complex, time-consuming and expensive requirements
32 that can be difficult for busy physicians to understand and fulfill. Not surprisingly, there has been no
33 shortage of concerns and frustrations voiced inside and outside the AMA since the boards began
34 rolling out their new requirements. Here are some of the themes we've heard:

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- 36 1. MOC is onerous in terms of costs, time away from practice, inconvenience and hassle;
- 37 2. Some specialty boards have gone above and beyond ABMS mandates to create an overly
38 burdensome MOC process that is of questionable value;
- 39 3. Some diplomates have had to travel long distances to take specialty examinations, further
40 adding to MOC costs and time away from practice;
- 41 4. Some have experienced technical glitches as MOC has transitioned to a mostly computer-
42 based system;
- 43 5. Physician input and feedback on MOC implementation, which could be of value to the
44 boards, has not been sufficiently welcomed;
- 45 6. There is a scarcity of resources available to help physicians cover the costs, time off, and
46 steps such as data collection that are associated with MOC; and
- 47 7. Because recertification is increasingly used by hospitals as a criterion for maintaining staff
48 privileges, the ABMS is becoming an effective monopoly and therefore owes physicians to be
49 accountable for their requirements and fees.
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51 Existing AMA Policy

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53 As physicians have voiced concerns about the MOC process, the AMA has responded by adopting a
54 range of policy statements on the topic, including:

- 1 • A directive to continue monitoring MOC implementation, and to have the AMA exercise its full
2 influence to protect physicians from undue burden and expense in the MOC process (CME
3 Rep. 7, A-07);
- 4 • A pledge to continue working with ABMS to streamline the MOC process to reduce the cost,
5 inconvenience and disruption of practice associated with MOC (Sub. Res. 313, A-06;
6 Reaffirmed: CME Rep. 7, A-07); and
- 7 • A position opposing the use of MOC as a condition of employment, licensure or
8 reimbursement (CME Rep. 7, A-02).

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10 A complete inventory of AMA policy statements on MOC can be found in Appendix A to this report.

11 AMA Involvement

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14 Representatives of the AMA regularly attend meetings of the ABMS and its various committees which
15 are responsible for monitoring, evaluating and providing oversight to the MOC process. The AMA has
16 one delegate vote in the ABMS Assembly.

17 Summary

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20 Because MOC is having a major impact on physician practice, and because it remains a work in
21 progress, we believe it is an appropriate time for the AMA to weigh in. We also ask our AMA to take
22 action because it is in our collective best interest to have a successful MOC process in place for
23 ourselves and those who come after us.

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25 After careful review of existing AMA policy as well as testimony in the HOD regarding two recent
26 resolutions addressing MOC – Resolution 302 (A-06) and Resolution 311 (A-07) – your Governing
27 Council was charged with developing recommendations that: make sense across specialties; do not
28 offend physicians who are satisfied with the MOC process; avoid automatic reaffirmation by the HOD;
29 and recognize that the body ultimately responsible for overseeing MOC, namely the ABMS, has
30 pledged to continue working with the boards to research and refine the MOC process.

31 Recommendations

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34 The AMA-YPS Governing Council recommends:

- 35 1. That the AMA-YPS immediately submit a resolution at A-08.
- 36 2. That this resolution direct the AMA Board of Trustees to send a letter to the ABMS regarding
37 MOC within three months, which will allow sufficient time for a response back prior to I-08.
- 38 3. That this letter ask the ABMS to work with its 24 member boards to:
 - 39 **A.** Coordinate with each other, the ABMS, specialty societies and the AMA to ensure that
40 the demands of MOC are reasonable and consistent across specialties;
 - 41 **B.** Educate physicians and increase their understanding of the MOC process and its
42 requirements;
 - 43 **C.** Solicit physician input and feedback regarding MOC implementation;
 - 44 **D.** Make it a priority to reduce and contain recertification-related costs, and offer an
45 accounting of all associated fees;
 - 46 **E.** Make it a priority to minimize the disruption of physician practice due to MOC
47 requirements;
 - 48 **F.** Ensure that the number of MOC-related testing dates and the locations of testing sites
49 are ample enough to minimize the burden on physician practices and their time away
50 from clinical care; and
 - 51 **G.** Coordinate with the Accreditation Council for Continuing Medical Education (ACCME) to
52 develop continuing medical education (CME) credits for MOC preparation activities.

Appendix A: Existing AMA policy on Certification, Recertification and Maintenance of Certification (MOC)

H-230.986 "JCAHO Recognition of Specialty Boards Recognized by American Board of Medical Specialties and AMA and AOA" (AMA Policy Database) in which the AMA recommends that medical staffs should have flexibility in determining which, if any, specialty board certification will be used as a criterion to delineate clinical privileges. (BOT Rep. XX, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CLRPD Rep. 2, A-06; Reaffirmed: CME Rep. 7, A-07)

H-275.933 "Specialty Board Recertification Requirements for Employment" in which the AMA opposes specialty board recertification as a sole condition of employment. (Res. 303, I-01; Reaffirmed: CME Rep. 7, A-07)

H-275.936 "Mechanisms to Measure Physician Competency" which asks the AMA to: (1) review and propose improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (2) oppose the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency. (Res. 320, I-98; Amended: Res. 817, A-99; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07)

D-275.971 "American Board of Medical Specialties - Standardization of Maintenance of Certification Requirements" in which the AMA pledges to work with the ABMS to streamline MOC to reduce the cost, inconvenience, and the disruption of practice due to MOC requirements for all of its member boards, including subspecialty requirements. (Sub. Res. 313, A-06; Reaffirmed: CME Rep. 7, A-07)

D-275.977 "Update on the American Board of Medical Specialties Program on Maintenance of Certification (MOC)," which states that the AMA will: (1) continue to monitor the progress of MOC and its ultimate impact on the practice community; (2) encourage the Physician Consortium for Performance Improvement, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC; and (3) encourage the ABMS MOC Task Force to develop and adopt recommendations for re-entry into clinical practice and entry into Step IV of MOC for diplomates not involved in direct patient care. (CME Rep. 9, A-05; Reaffirmed: CME Rep. 7, A-07)

D-275.987 "Internal Medicine Board Certification Report—Interim Report," in which the AMA pledges to: (1) support the ACP/ASIM in its efforts to work with the ABIM to improve the MOC program; (2) encourage specialty societies to work with their respective ABMS member board to develop, implement and evaluate MOC; (3) continue to assist physicians in practice performance improvement; (4) continue to monitor progress by the ABIM and other ABMS member boards on implementing the MOC program; (5) encourage the ABMS to include practicing physicians and physicians with time limited board certificates to assist in designing and evaluating the MOC process; and (6) study the ethical implications of the MOC program including the patient assessment component vis-à-vis the doctor-patient relationship and the ethical implications of the peer review component vis-à-vis the practice environment. (CMS Rep. 7, A-02; Reaffirmed: CME Rep. 9, A-05; Reaffirmed: CME Rep. 7, A-07)

H-275.996 "Physician Competence" which (1) urges the American Board of Medical Specialties (ABMS) and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base. (CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07)

H-405.972 “Recertification Alternatives” which asks the AMA to continue to support the development and validation of alternatives to recertification by standardized testing. (Res. 317, I-92; Reaffirmed: Res. 306, I-97; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07)

H-405.973 “Board Certification” which states that it is the policy of the AMA (1) to continue to work with other medical organizations to educate the profession and the public about the board certification process; and (2) that, when the occasion arises that equivalency of board certification must be determined, the Essentials for Approval of Examining Boards in Medical Specialties be utilized for that determination. (CME Rep. D, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 7, A-07)

H-405.974 “Specialty Recertification Examinations” in which the AMA (1) encourages the ABMS and its member boards to continue efforts to improve the validity and reliability of procedures for the evaluation of candidates for certification; and (2) believes that the holder of a certificate without time limits should not be required to seek recertification. (CME Rep. E, A-92; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07)

H-405.975 “Recertification Exam for the American Board of Medical Specialties” in which the AMA actively encourages those specialty boards that issue time limited certificates to include young physicians with such certificates in the decision-making process for any design of plans for recertification. (Res. 303, A-92; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 7, A-07)

H-275.932 “Internal Medicine Board Certification Report – Interim Report” which iterates the AMA’s opposition to the use of recertification or MOC as a condition of employment, licensure or reimbursement. (CME Rep. 7, A-02)

D-275.969 “Specialty Board Certification and Recertification” which directs the AMA to (1) continue to monitor the progress by the ABMS and its member boards on MOC implementation and encourage ABMS to periodically report its research findings; (2) prepare an updated report no later than 2010; (3) encourage dialogue between the ABMS and its specialty societies to work on development, implementation, and monitoring of MOC that meets the needs of practicing physicians and improves patient care; and (4) exercise its full influence to protect physicians from undue burden and expense in the Maintenance of Certification process. (CME Rep. 7, A-07)