



The MOC Train is off Course

Scott L Lee*

University of Washington Valley Medical Center, Ear, Nose, & Throat Clinic, USA

*Corresponding author: Scott L Lee, MD, FACS, University of Washington Valley Medical Center, Ear, Nose, & Throat Clinic, 4033 Talbot Road S, Suite 540, Renton, WA 98055, USA, Tel: (206) 575-2602, Fax: 206-575-2607, E-mail: Scott_Lee@valleymed.org

Leaders often use the proverbial departed train to get people on board with unpopular changes, especially ones with little supporting evidence. Most hop on so as to not get left behind, but is the Maintenance of Certification (MOC) train heading in the right direction? In 2000, the American Board of Medical Specialties (ABMS) mandated all specialty affiliates to limit board certification (BC) to 10 years, rather than continue the lifetime certificate. In 2002, the American Board of Otolaryngology (ABOto) complied and was on board the MOC train.

As the ABMS and other financial stakeholders lobbied to entangle MOC with state licensure, payors, and hospital credentialing, MOC participants began to realize that MOC is less “voluntary” and questioned the MOC process [1]. Because BC status is required for staff privileges in many hospital bylaws, the path of the MOC train plays a pivotal role in the otolaryngology occupation. ABOto’s website states the “benefits of MOC...[are] patients experience fewer medical errors, better communication and quality clinical outcomes when they choose a board certified physician... medical specialists who participate in MOC use the most current evidence-based guidelines and standards in their speciality [2].” However, a literature search in PubMed reveals no data to support these claims.

In internal medicine, there was no difference in clinical outcomes among BC vs. BE physicians [3], no difference in care rendered by lifetime vs. 10-year certificate holders [4], and MOC increased health care costs [5]. Perhaps these reasons inspired the physician-led effort in 2014 to create an alternative to the ABMS. These physicians founded the National Board of Physicians and Surgeons (NBPAS), which provides a different pathway to MOC. NBPAS requires initial certification by the ABMS, then continuing medical education (CME) to maintain BC status. NBPAS supports certification in Otolaryngology, Neurology, Pediatric Otolaryngology, Facial Plastics, and Sleep Medicine.

In 2013, the Executive Director of the ABOto attempted to address four concerns about MOC [6]: effectiveness, cost, time and alternatives.

Effectiveness

With no evidence to support MOC effectiveness, readers of the newsletter were directed to the ABMS website for information and advised to wait for future studies to hopefully prove the efficacy of MOC. At the ABMS website, evidence consist of testimonials from physicians, experts, and patients, plus an editorial [7,8]. The ABMS’s

own referenced editorial acknowledges a “major controversy exists regarding the costs and cost-effectiveness of MOC programs.... [because of] the absence of data on either the meaningful effectiveness of MOC programs or costs associated with MOC [8].”

Cost, Time, & Alternatives

Time-limited BC otolaryngologists maintain their certifications by annual payment of \$310, yearly self-assessment modules, then a recertification examination at 10 years. While the ABOto has a financial policy not to profit from MOC, the annual and 10-year exam fees imposed on every time-sensitive certificate holder is not sufficient to cover MOC expenses. The newsletter explained that the solution is to wait, since all future diplomats must pay into MOC annually. For the time-limited certificate holder, uncompensated time and opportunity costs also come in the form of reviewing topics not relevant to his/her practice, study courses & materials, travel to distant testing sites, room & board, and locums coverage [1]. The ABOto does not provide an alternative to MOC and explains “[the] train left the station at least a decade ago,” so MOC must exist to ensure delivery of high quality, evidence-based care [6]. Yet, there is no evidence that MOC ensures delivery of high quality care and the implementation of MOC itself is not evidence-based. Thus, the departed MOC train is not a proverb, but a paradox.

On February 15, 2016, two online petitions opened to otolaryngologists. In one month’s time, 13 otolaryngologists signed the petition in favor of the ABOto’s MOC program and 487 signed the petition against. The ABOto now has an opportunity to support its diplomats. To their credit, ABOto opened a survey in August 2016 to gather opinions from the BC otolaryngologists about MOC. Otolaryngologists should also support the ABOto’s efforts to encourage physicians to maintain relevance in their field. Our respected leaders, who became respected for their adherence to science and integrity, must not be pressured by an ABMS-mandate. If the MOC train is heading in the wrong direction, then otolaryngologists should steer it correctly.

One suggestion is to follow the lead of the NBPAS and use continuing medical education for MOC. This is relevant, current, practical, and supported by State Medical Boards. By comparison, the European Union of Medical Specialists adopted an assessment and certification method in 2008. It is analogous to the US in that there is an initial examination. Then, professional activity monitoring and lifelong learning are used to ensure high quality care. There is no threat of loss of certification (or occupation) without MOC [9].

As the ABOto website states, the common goal is to have fewer medical errors, improve clinical outcomes, and to use current, evidence-based standards. Since these data are lacking, then it is our duty to the specialty, and to the patients whom we care for, to conduct such studies before implementing costly, unproven hurdles.

References

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