VIEWPOINT

Maintenance of Certification (MOC)—Benefit vs Burden

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In 1990, the American Board of Internal Medicine (ABIM) moved from lifetime board certification to time-limited, 10-year certification. Subsequently, in 2014, ABIM announced the maintenance of certification (MOC) examination, which was proposed to allow the physician to stay up to date with the current medical knowledge. The ABIM has recently imposed new MOC requirements to maintain board certification. Physicians seeking continuation of initial ABIM certification must fulfill MOC activity, which can be obtained from specific continuing medical education activities, a limited range of activities developed by ABIM, and quality improvement/practice improvement projects, every 2 years, with a threshold of 100 MOC points required during 5-year intervals.

In addition to these requirements, there is a new annual fee of $220 to maintain additional certification. Physicians now calculate that maintaining MOC credentials in internal medicine and 1 to 2 specialties amounts to an imposed fee of tens of thousands of dollars during the coming decades. The unilateral imposition of escalating demands has created frustration among many physicians because the introduction of new ongoing requirements is expensive, is time consuming, and often includes material of dubious relevance and quality as reliable questions.

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Available data regarding the association of the ABIM MOC program and the quality of care are limited and of low quality.[1-4] In contrast with the quality of the medical data within MOC materials, the ABIM promotes the value of MOC from work that has been sponsored by the American Board of Family Medicine Foundation and conducted by employees of the ABIM and the foundation, with seemingly arbitrary end points. Anecdotal impressions and quotes collected by the test sponsors included comments that participants had spent several months preparing and found that a significant fraction of the questions was irrelevant to their practice.[2] Studies have shown conflicting results while examining the association between time-specific certification and practice performance.[3,4]

Taken together, the evidence cited by ABIM to support the efficacy of the MOC program is not unbiased because ABIM invariably conducts and directly funds the work. The resulting evidence relies on retrospective associations and causation rather than proactively assessing causation and assesses end points that are not prospectively defined as being of greatest value to clinicians.

ABIM-certified physicians have expressed concern that MOC is not a direct test of critical knowledge and may be unnecessarily ambiguous and circuitous. According to ABIM, item-writing task force members are responsible for developing questions, which are subsequently reviewed and approved by the approval committee. There is no external mechanism to verify the validity of these questions to substantiate their intended purpose. Critics submit that the questions are lengthy and ambiguous enough that even the leaders in their respective fields find many of these questions inscrutable and lacking a definitive single best answer despite having full knowledge of the data on which the questions are based.[5,6] On occasion, ABIM MOC questions may not reflect the most recent guidelines and Food and Drug Administration approvals update. The ABIM acknowledges this fact and does not include questions in final scoring when ABIM determines that an update has altered what was designed to be the correct answer, although there is no mechanism for test takers to raise concerns and challenge the validity of questions and answers. Just as with all new interventions in medicine, conducting a randomized clinical trial between MOC testees and non-MOC testees and then evaluating its impact on patient outcomes should be the first step moving forward. The ABIM needs both high-quality evidence supporting their intervention and transparency about their questions and what is defined as an optimal answer to be considered a credible source to support MOC for practicing physicians.

Physicians, a group with a high risk for burnout, are already overburdened with mandatory training and obligations. Each of these tests entails dozens to hundreds of hours of study and test-taking time. Although ABIM may say that additional study time should not be required for practicing physicians, many specialize in a limited and potentially narrow subset of a specialty, which means that the tested content outside of this area requires additional study outside of their daily activities and represents content that is irrelevant to their clinical practice. Additional time needed to maintain these requirements will contribute to physician occupational distress and burnout at a time when the US faces physician shortages that are expected to become increasingly acute. In a recent survey, approximately 38% of physicians reported 1 or more symptoms of burnout in 2020.[7]

In social media, the ABIM recently featured a physician who was on vacation with her family yet carved out time to do longitudinal knowledge assessment questions.[8] Physicians criticized ABIM, perceiving that there is an expectation that physicians take valued personal time away from their family vacation to meet ABIM

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requirements. Although ABIM deleted the post, this issue highlights the fundamental problem with its ill-conceived MOC policy.

The mission of the ABIM is to "enhance the quality of health care by certifying internists and subspeciality." In contrast with the dubious value of MOC testing for physicians and the opacity of the process for clarifying the validity of the questions, there is little doubt that the MOC program has been a highly profitable venture for ABIM. The ABIM generated $71.9 million in revenue for fiscal year 2022, with the MOC program contributing 51% in total.[9] Although few details are offered for where their expenses are directed, ABIM compensates its top leadership very well. For instance, the president and chief executive officer of ABIM made more than $1 million in salary and compensation for fiscal year 2021-2022.[9] The same organization also purchased a luxury condominium for $2.3 million.

MOC involves a substantial amount of time and money but fails to test the skill and experience of a physician. Relying on ABIM-sponsored and -conducted data to support its own value, which offers data far inferior to the quality of clinical data that should shape clinical practice, the ABIM imposed a unilateral, ill-conceived edict to impose MOC requirements on physicians. In a world where physicians are already burdened with mandatory health stream modules, electronic documentation, complex billing necessities, and the increasing obligation of obtaining prior authorization for almost every test, ABIM MOC adds an extra burden.

ARTICLE INFORMATION

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