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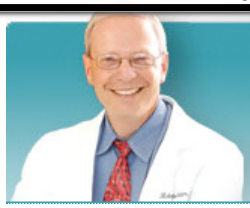

Wachter's World

Lively and iconoclastic ruminations on hospitals, hospitalists, quality, safety and more...

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by BOB WACHTER on AUGUST 14, 2012 in DIAGNOSIS/CLINICAL REASONING, EFFICIENCY, HEALTH POLICY, MEDICAL EDUCATION/ACADEMIA, QUALITY MEASUREMENT, TRANSPARENCY AND REPORTING

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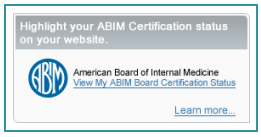
On September 10, 1986, soon after I completed my residency in internal medicine, I "took the Boards" – the certifying examination administered by the American Board of Internal Medicine (ABIM). A few months later, I learned that I passed the exam, and that success, combined with an attestation by my residency program director, rendered me "board certified." I was granted lifetime certification – my framed certificate implied that I was not only a competent internist at that time, but that I could be counted on to remain one (without any further assessment) until the day I retired. I was all of 28 years old.



As the proud owner of ABIM's lifetime seal of approval, I assumed that my thick envelope was the last contact I would ever have with the Board. I was wrong.

Last month, I became chair of the ABIM. The organization has always been well respected in the medical community, but suffered from a reputation for being, shall we say, not particularly nimble. (The former chair of my own department, Holly Smith, once quipped that the Board "chews more than it bites off.")

But that was your father's ABIM. We are now paddling in a very fast current, and the actions that ABIM (and the other certifying boards, such as surgery and pediatrics) takes in the next few years will have a profound influence on how physicians are judged by the public and other key stakeholders. If you believe in professional self-regulation, you should care about what the Boards are doing, and – while nobody loves an accreditor or regulator – you should be rooting for them (er, us) to succeed.

Why, in 1986, did the Board offer me lifetime certification, when patients would undoubtedly value evidence that their doctor is keeping up in his or her field? For the same reason the Joint Commission preannounced its hospital surveys two years in advance, residency programs allowed interns to work 110 hours a week, and hospitals and doctors were paid the same whether their care was stellar or terrible: we simply were not very accountable to the public.

That was then. For the past 15 years, American healthcare has been placed under a microscope. While there are islands of striking success, even miracles, the overall picture is not pretty: there are too many mistakes, quality is often shoddy, variations are the norm, access is spotty, seamless coordination is rare, patient-centeredness is unusual, and costs are unsustainable. Against that backdrop, every regulator, accreditor, payer, and legislator is feeling pressure to do his or her part to make the system better. These pressures have fueled myriad initiatives – transparency, pay for

performance, no pay for errors, more robust accreditation standards, readmission penalties, meaningful use payments – to promote value.

While the early action centered on hospitals, it's now turning to doctors. After all, since doctors' decisions determine most of what is done for patients, viewing quality, safety, and efficiency through a physician lens seems appropriate. Moreover, most healthcare is delivered outside hospitals.

But while measuring the quality of hospital care is hard, measuring individual physicians' quality of care is that much harder. On top of the usual problems of case-mix adjustment (if it's not done – or not done well – it's easy to ding unfairly a great doctor who attracts sick patients), there are other daunting statistical and attribution issues. For example, while it's statistically feasible to determine the better of two hospitals for heart failure if they've each cared for a few hundred patients, it's next-to-impossible to differentiate between two doctors who each cared for 20 patients. Moreover, when a team of doctors manages a patient, which one should be credited, or blamed, for the outcomes? These are tough nuts to crack.

Perhaps an even larger issue is that all of today's quality and safety measures assume that the physician has made the correct diagnosis and that the procedure was actually needed. A world of door-to-balloon times, hemoglobin A1c's, and pneumovax rates inexorably undervalues diagnostic acumen and appropriate use of technology: the ability to take a good history, formulate the right differential diagnosis, order the correct tests and consultations, and interpret all of the data correctly. What is measured matters, and without measures of physicians' knowledge, analytical skills, and judgment, patients won't be able to assess these things when choosing a doctor, and training programs will gradually deemphasize these competencies in their curricula.

Enter the Boards. Over the past 25 years, all the boards have implemented "Maintenance of Certification" (MOC) programs. Under MOC, physicians – no longer deemed competent for life – are required to participate in a lifelong assessment and improvement program. (As often happens, physicians who were certified under the old rules – including me – were "grandfathered." All ABIM board members are required to participate in MOC – to "eat at our own restaurant" – and I recertified three years ago.)

MOC is more than simply passing a test every 10 years. It now includes measuring one's own practice patterns and submitting plans for improvement, reviewing patient and peer satisfaction surveys, and more. While the secure examination is likely to remain a once-a-decade affair, physicians will soon be required to demonstrate that they are measuring and improving some aspect of their practice every two years. If this seems like a lot, just think of commercial airline pilots, who face such requirements every 6-12 months. As a frequent flier, I'm glad about that, and I suspect patients would feel the same way about "continuous MOC."

Tightening MOC requirements is unlikely to make doctors happy, but I believe it is needed to bolster the credibility of board certification, and thus of professional self-regulation. To doctors who say, "I'm working hard, please leave me alone," I can guarantee that they *won't* be left alone – by Medicare and other insurers (which need quality measures for their public reporting and pay for performance programs), by the Joint Commission (which requires hospitals to periodically assess the competency of medical staff members), and by state licensing boards, which are launching "Maintenance of Licensure" (MOL) programs. The Board's goal is for our process to be sufficiently credible to the public and others that it "counts" for all of these programs.

The early returns are positive. Medicare, which has been challenged to find strong and feasible measures for its "Physician Compare" website and its P4P programs, seems attracted to the possibility of using ongoing participation in robust MOC as a quality measure. The Joint Commission is considering a similar idea. And the Federation of State Medical Boards has signaled its intent to accept MOC as meeting requirements for MOL.

We see this as a case of, if we build it (well) they will come. If we don't, each organization can be counted on to do its own thing, and the resulting measures are unlikely to be as robust or as relevant to physicians. On top of that, the lack of harmonization (collecting five different versions of quality reports for five different organizations) is likely to be crazy-making for doctors.

POLL

Regarding the need for Maintenance of Certification,

- I don't believe there should be any MOC requirement
- A process like that of the NBPAS (basically, licensure plus 50 hours of CME) should suffice for MOC
- A more rigorous process, including an exam of some type, is appropriate for MOC

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While our assessment tools must be rigorous enough to be credible, we're highly sensitive to their impact on busy practicing physicians. For this reason, the Boards give doctors credit for participating in many quality assessment programs from hospitals, medical societies, and health systems. We're also striving to make our tools and website more user-friendly and to modernize our "secure exam." For the latter, we aim to write questions that measure what physicians really have to know in practice, to choose high quality AV resources (ECGs, x-rays), and – where appropriate – to allow access to aids such as on-line calculators.

But these are incremental improvements. With medicine changing so rapidly, I suspect we may need to be more ambitious, even audacious. I have charged a new committee, called "Assessment 2020" (chaired by Yale's Harlan Krumholz) to take the long view. What should physician assessment look like in five to seven years? Is there a role for simulation? Should we assess the ability to do a physical examination or interview a patient? Can on-line searches be allowed during the exam without doing violence to the validity of the results? The latter question is particularly important, both because this is how physicians seek information today and because searching the literature is now a core competency. All of these are hard questions, but we are committed to tackling them thoughtfully and with scientific rigor.

Transparency is also on my radar. Today, the Boards deliver a dichotomous verdict: a physician is either certified or not certified. But we know more than that about our diplomates: everything from their test scores to how they performed on practice improvement modules. Just as the Boards would be irrelevant to today's quality dialogue if we hadn't embraced MOC, we may be equally irrelevant in the future if we maintain our traditional "Certified Y/N" stance. When people seek out a good doctor, knowing whether the doctor is board certified is just the beginning. As the popularity of sites like HealthGrades and Angie's List illustrates, patients want far more information. I believe that if the Boards don't provide it, others will.

(To demonstrate this, at a 2010 Board meeting I divided our members into two groups and gave each the task of quickly finding a great cardiologist for Aunt Minnie in Denver. Each had a computer with web access. The groups quickly realized that board certification was only the starting point for their search, but they had to sift through mountains of data, much of it garbage, to try to give poor Minnie a rational – and evidence-based – referral. My favorite moment came when one Board member, a department chair, was gushing over a cardiologist's on-line CV and publication list. Another member of the group stopped him short. "We're looking for a doctor, not applying for an NIH grant!" he said.)

The other big issue we're facing is the cost of care. While the Boards have historically shied away from assessing efficiency, in today's world we must add appropriateness and resource stewardship to our assessment tools. The ABIM Foundation's highly successful "Choosing Wisely" campaign – in which nearly every specialty society has committed to avoiding five costly, low value practices – is a tangible manifestation of our growing commitment to this area.

The public grants to professions the privilege of self-regulation. For physicians, our ability to retain that privilege will be determined by the public's trust that we can deliver on it. If we lose this trust, the Boards will quickly become irrelevant, and physician standards will be set by others: Congress, insurers, dot coms, malpractice attorneys, state licensing boards. I think this would be a major loss – for patients *and* for doctors.

There has never been a more interesting time to be at the center of efforts to measure and improve the quality of care, and thus to be leading the ABIM. Working with our superb Board and staff, I will do what I can to ensure that our work remains true to the ideals of professional self-regulation – and that board certification becomes ever more meaningful to the physicians we represent and the patients we serve.

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235 Responses to "On Becoming Chair of the ABIM: Why the Board Matters More Than Ever"

Betty August 15, 2012 at 6:25 pm #

Bob,
Congratulations on your appointment to the chairmanship. Thank you for acknowledging there's an elephant in the room, I appreciate that honesty.
If, among many things the specialty of IM is based on critical thinking and analysis, then one is rendered speechless with incredulity by the argument that someone who certified during or before 1989 has achieved, and somehow maintained, a level of competency so solid that they never again require reassessment whereas one who certified after 1990 is expected to undergo periodic reconfirmation of their cognitive skills.

I would suggest a program of maintenance where the board would produce study materials periodically (every 2 years?) and an examination would then be administered BASED ON THE STUDY MATERIALS. Or perhaps the exam would be 70% based on the study materials and 30% based on general internal medicine topics. The study materials would be derived from updated subspecialty society guidelines and other resources that would serve to bring the latest evidence-based practices into the active knowledge base of practicing internists.

As care systems seek to distinguish themselves as leaders in quality care, someday we may see an advertisement along the lines: "All of our physicians satisfy the currently recommended Maintenance Of Certification requirements for their particular specialty."

REPLY

Money January 19, 2015 at 12:33 pm #

http://www.kevinmd.com/blog/2015/01/physician-investigates-american-board-internal-medicine.html

It should be noted that in the year of the condominium purchase the president and CEO of the ABIM, Christine Cassel, MD, earned $484,883 from the ABIM and $161,627 from the Foundation. Dr. Cassel continues to serve as president and CEO of the National Quality Forum despite a history of other seemingly conflicted financial dealings. Other executives of ABIM that year included F. Daniel Duffy, MD who served as executive vice president of the ABIM earning $379,915 from the ABIM, and Cary Sennett, MD, PhD who served as senior vice president earning $185,122 from the ABIM and $185,122 from the Foundation and now serves as a vice president of Anthem, Inc., formerly Wellpoint. That year Dr. Richard Baron, the current President and CEO of the ABIM and Foundation, served as the secretary/treasurer of the ABIM Board earning $59,729 until 7/1/2008 when he became an unpaid director of the board. By comparison, according to one reliable source, the median general internal medicine physician salary in the U.S. was $205,441 in 2009.

REPLY

David Mitchell, MD, Ph August 15, 2012 at 8:28 pm #

I'm glad to see a vision for the future of ABIM. We should take pride in the opportunity to prove our competency to our patients, assuming the assessment is fair and reasonable.

All re-certification paths seem to have some degree of an irritating “jumping through hoops” feeling, but having worked in a variety of settings, it is not uncommon to hear from colleagues: “Watch out for Dr. So-and-So, he’s dangerous.” And you have to wonder…what are we doing about that doctor? We do need peer review, self-regulation. Perhaps we even need oral examinations, chart reviews, physical examination observation, remediation, peer mentoring, etc.

Unfortunately, in hospitals, docs seemed to be judged on whether they sign verbal orders within 24 hours or avoid using unapproved abbreviations or document conditions that are present on admission or severity of illness. These are criteria for hospital accreditation and billing, not measures of clinical knowledge, proper decision making, and cost-conscious care. Even the poor understanding of core measures has got our quality of care assessment all screwed up: for example, no, the patient who is in CHF because of progressing renal failure does not need an ACE inhibitor before discharge, but the quality nurse will chase you around asking why…

REPLY

Paul Nadler, MD August 15, 2012 at 11:06 pm #

Congratulations Bob! Thank you for explaining your perspective on this increasingly important and relevant part of modern medical practice. I don’t believe that ABIM has ever made their “case” so informatively and persuasively before.

I agree with you that the “I’m working hard, please leave me alone,” attitude is no longer viable. But I do think that it will continue to be an obstacle in improving the motivation of physicians to work with ABIM in improving their knowledge, and demonstrating their compentency through MOC and tests. To reduce this friction, I believe that looking towards the practice of airline pilots may again be helpful (my father was an airline pilot). I was always impressed by the rigor and the number of competency tests he regularly had to take and pass. But these “check-rides” and tests were well integrated into his employment. His company made it part of his employment experience. Up until now, taking MOC modules and studying for, and taking the recertification test has been on a physician’s “own time”- after the busy work day and often during our limited free time. I think that if we wish to make MOC and board testing as relevent and meaningful and valuable as possible to doctors, patients and review organizations, we should consider how best to integrate it into our usual clinical/teaching/research experience. I realize that this will be difficult to do given the variety of types of medical practices, and the different economic models on which they are based. But I do think that normalizing MOC as part of what it means to practice medicine will improve participation, and lead to higher quality patient care.

REPLY

Menoalittle August 16, 2012 at 2:53 am #

Congratulations Bob,

Speaking of transparency, you and the ABIM ought to disclose its finances, compensation, and why the tests cost as much as they do.

Where does each dollar go, exactly?

You and the ABIM ought to disclose its meeting agendas and minutes and the financial conflicts, real or potential, of those on the Board.

What do you profess to do about the frequent occurrence of the sham peer reviews of doctors who complain and present the truth about the dangers and adversity their patients face when hospitalized, especially, for example, when the CPOE and EMR system crashes, records

disappear, and the doctors can not find their patients (aside from their patients' labs and medications).

Bob, don't forget that doctors need not be as smart as they had to be in the past cause now, there is decision support and medical care guidance for those clicking in orders. There is direct control without over ride as to choice of medications and tests (as simple as urine cultures), so, who needs to think, except on how to do work-arounds.

In conclusion, when you provide for MOC testing and retesting with medicine changing so rapidly, be sure to simulate real nowaday life with user unfriendly EMR devices and pages of jabberwock to test the doctors' ability to overcome the cognitive disruptive influences that such modern advances pose. Be sure to include a CPOE system proficiency test to be sure that the academic attendings do not totally rely on their trainees and paraprofessionals to practice modern click medicine.

Best regards,

Menoalitle

REPLY

Digvijay Singh December 6, 2013 at 11:34 am #

This exactly why people mistrust ABIM. Over the years ABIM has become an efficient machine to extract money to pay high salary to it's employes on the garb of improving physician quality. Unfortunately the greed has crept into every society. It seems like all these societies create multiple ways to charge physicians for MOC and there is no uniformity. It is shame when patient quality is suffering and cost of care is rising when the boards of all societies are more worried about how extract more money from physicians.

REPLY

Sue Thomas, MD August 16, 2012 at 2:53 pm #

I take issue with your statement that medicine is changing rapidly. The tenets of basic, sound medical care have not changed much. Hoever, it is being diluted by vapid computerized clinical decision support geared for paraprofessional physicians' assistants and nurse practioners who parade the hospital halls with long white coats, acting as and deceiving patients as though they are doctors.

If there is any truth to your statement, what is radically altering the provision of medical care is the digitization of ambiguous signs, symptoms, and test results with equipment that is not particularly innovative despite decades of unfettered experimentation using the doctors, nurses, and patients as R and D subjects.

Not only is there a need to assure a plane of competence of the physicians, but the ABIM should take a stand and assure that the practice of medicine by its diplomates is not contaminated by the digitization schemes and computer gear that serve as impediments to the diplomates.

REPLY

Alieta Eck, MD August 18, 2012 at 3:42 am #

I fundamentally disagree with your assertion that MOC is necessary. We physicians worked hard to finish medical school, do a residency and become board certified. We are committed to lifeling learning. The public trusts us, and rightly so. As we care for each patient

and interact with our colleagues, we are tested on our skills. CME in our chosen field is sufficient for us to keep up with new developments.

Most physicians believe that the expense, the time away from our practices, the fact that MOC is not relevant to the niche we have carved in our practices, and the disruption of patient care are too high a price to pay in order to please some bureaucratic entity such as an HMO or hospital executive committee.

Many of us have looked at the compensation awarded those who have stepped away from the practice of medicine to become leaders in the board preparation and testing and re-testing of their fellow physicians. It is hard to justify your salaries, especially in a time when physicians in the trenches are under so much assault.

Your tests do not measure competency, but rather measure things that are quantitatively measurable. They cannot measure bedside manner, compassion or clinical judgment.

There is no evidence that maintenance of certification translates into better patient care. As physicians who are grandfathered work alongside physicians who have re-certified, there is absolutely no difference in the quality of their care for patients. It is time to end this arbitrary burden placed upon our nation's healers. At a time when the government, the malpractice system and insurance companies are making our lives so difficult, it is sad to have our own colleagues heap more pressures on us.

REPLY

Dale Mortimer, M.D. August 24, 2012 at 1:25 pm #

Amen, Dr. Eck!!!!!

REPLY

Mayte August 24, 2012 at 3:19 pm #

Dr. Eck: I completely agree with you and thank you so much for stating it so eloquently. Your right-on-the-target statement has saved me a lot of time and aggravation for writing something myself, which may have not come out so well stated since when offended and angry I do not write well. Government-kiss-up doctors take note of real docs like Dr. Eck. Thanks, again!

REPLY

Mayte Sandrin, M.D. August 24, 2012 at 3:20 pm #

By the way, I'm Mayte Sandrin, M.D., endocrinologist. Thanks.

REPLY

John Bakos August 24, 2012 at 4:02 pm #

Right ON….
And while you are on the topic, grandfathering NEEDS to be abolished. The competent docs in my community take the damn boards every 10 years, and jump through all the inane hoops. The less then competent either don't take the exam, or in many cases, do not have to… pathetic.

REPLY

David A. Doron August 26, 2012 at 2:20 am #

I agree. I feel you make a very strong point on the issue that standarized testing does not meassure neither the knowledge nor the “art” of practicing medicine. How do you meassure compasion towards a terminally ill patient. Your relation with the family on a mentally ill patient. How do you measure your “bedside manners”, your capacity to empathyze. Good points!!

REPLY

Duane Harrison October 17, 2012 at 5:53 pm #

Amen again, Dr. Eck.
The “Boards” have morphed from an assessment of knowledge to an exericise in busy work. I spend 24/7 doing things to make my practice better. My experience with MOC was a total waste of time and exorbitant waste of money.

REPLY

Anonymous MD October 30, 2012 at 9:06 am #

Bravo Dr. Eck! I have spent my career in the “best” teaching hospitals in the world and I am appalled by the “holier than though” attitude displayed by the ABIM, AMA other so-called authorities. What is outrageous is the cost and resources dedicated to endeavors such as MOC (how much does it cost to deliver an ABIM exam? How does the ABIM justify heat it charges?) and the various self-annoited standards of care. We are not cub scouts seeking to earn our “merit badges” by creating some trumped up quality care improvements (an insulting pretense at a minimum). Organizations like the ABIM are lobotomizing thoughtful and individualized clinical care at the expense of cow-towing to healthcare system bureaucrats and their “metrics”. I find the commentary by the newly annoited ABIM chair deeply concerning – that our own profession has been recruited to engage in a “witch-hunt” for rogue mercenary physicians who dare practice medicine as non-board certified physicians. Rather than using teamsters tactics and thuggery, we should be encouraging government reimbursement for CME and time involved in collegial review of medical diagnostics and clinical care. We are not children waiting to be scolded or taught best practice. The evolution of the art of medicine involves careful discussion – no brute force tactics conveniently packaged and branded for the ABIM. The very existence of “grandfather” clauses displays a profound cowardice and hypocrisy in the ABIM. If these organizations expect to gain the respect of physicians, then we deserve to be treated as such. Eliminate yesteryear grandfather clauses and justify costs involved in board certification. For me, the concept of ABIM certification is akin to having a mandatory library card – if that card expires, do we become illiterate? Substance and symbolism are not the same – to the ABIM organization I would submit that board certification is nothing more than compliance with ABIM requirements. It is a symbolic measure of minimally competency without the substance as physicians deserve.

REPLY

Randy Marosok November 25, 2012 at 1:07 pm #

Dr. Eck states with proficiency the feelings of the majority ! I recently re-certified for the second time and the cost is shameful and the Board should be embarrassed. I echo with her ; where does this money go in the era of computerized programming ? The cost of the exam itself is only the beginning as their is the missed patient revenue for the entire day of the exam, the time missed from patient care and family while studying and reviewing for the exam and then the final blow is the cost of the MOC. In my specialty the MOC requirements could not be met by the ” Board ” so I had to got to a separate web site and pay an additional fee for medical knowledge requirements. In addition the exam itself is in no way shape or form a factual representation of what I see on a daily basis. The questions unfortunately are written in a way that obfuscates the true scenario and concentrates on the rarities that most of us will never see in clinical practice in our entire lifetime. The best example is a complicated case presentation of a septic patient and there demand that one gives the diagnosis at the time of presentation and then give therapy based upon that one diagnosis. I am sorry BUT the majority of patients that I get consulted in critical condition are usually not able to provide a history and the family if present are usually not much better. However the real ” art ” and ” competency ” of medicine is determined by the ability to render a differential diagnosis and treatment that is initially broad as answers will be forthcoming by appropriate testing. It would in fact be incompetent and malpractice to treat a patient like the board wants us to in a written fashion. It has been 10 years since my last examination and I would hope (if I chose to stay in practice) that the ” Board ” would finally get it right and design a system that is not financially penal and one that is truly relevant to those in clinical practice and not to those in the glass houses.

REPLY

gary sterba December 19, 2012 at 1:00 am #

As I read your reply , I totally agree on many points. I graduated in 1974 , trained in New York and did a fellowship in Rheumatology , after wich i stayed in the faculty as an assistant professor . For many problems did not pass my boards then . Moved away from the US , and had a successfull carrer in internal medicine and Rheumatology . I became a Fellow of the ACP by internatinal standarts , giving lectures for the acp , and for ilar and panlar . I am back in the US . I was able to come back and get resident allien card because my achievements in medicine , publications etc . I really have a big problem passing exams . I certainly consider myself an excelent physician and so do many of my patients . I have lost much of my time trying to pass the exam . Since I came back to the states , two years ago I have met many board certified physicians , I am impressed on how medicine has changed in the US , and the lack of knowledge, criteria , compassion and care for patients that these “board certified physicians ” have . . I wonder how much of this is known by pleople like BOB , that is assuming this important JOB . And if any thought is given to this BIG problem that many don t want to take in account . What happens with doctors that know how to diagnose, treat and care for patients and don t know how to “”pass exams””.
I do well in the MKSP , I don t in the exam , I have spent several thousands of dolloar in MKASP, courses and exams. My patients and peers recognize me as a good physician . I don t have any problems with that , but some institutions do have problems recognizing me as a good physician , including the ABIM.

REPLY

Mahpara Qureshi April 9, 2013 at 5:09 pm #

I second every word in Dr. Eck’s letter. The ABIM has lost touch with reality. I wouldn’t be surprised if after a few years we will have to do this MOC- who knows- every

month maybe, and pay thousands of dollars for some irrelevant tests.

REPLY

Randy Peters, MD February 26, 2014 at 11:37 pm #

Well said, Dr. Eck. I could not agree more. I am considering my response to this power/money grab by the ABIM, but I am inclined to become "Board Certified – Not participating in MOC" on principle. My patients are more interested in the ability and compassion they see and not some silly, unvalidated, "hoop-jumping" devised by paternalistic medical bureaucrats. Given the current environment in medicine, I foresee people desperate to find a doctor who can take care them at all and with no regard to the ABIM's self importance.

If that makes me a "bad doctor," I guess I am, but my colleagues and patients would disagree.

I say boycott MOC.

REPLY

Jon February 27, 2014 at 1:41 am #

Randy, many feel as you do. Take a look at thui website and get involved. http://www.changeboardrecert.com/index.php

REPLY

k Murray L MD April 30, 2014 at 3:12 am #

Agree with Dr Eck. MOC means make others cash, nothing more. Physicians are involved w lifelong learning and more "meaningful use" CME, engaged in ongoing research and perhaps independent investigations far beyond ABIM 's peculiar and pecuniary MOC activities every day we see patients. MOC has hurt US medicine immeasurably. My reply to Dr Baron this April 2014: Richard J. Baron MD: Thanks for your ABIM response (4/28/2014) to the American College of Cardiology petition against MOC. Physicians must pursue meaningful dialog. I am reminded of Peter Pan's playful song, "Don' t want to go to school. Just to learn to be a parrot… and besides a silly rule." Many of us became parrots to pass MOC and believe that medical competence and professionalism is better measured outside of MOC. I wrote to Dr Cassell about the ABIM's controversial twist of the Angoff test standard, as you might know. I discussed with her staff many examples of how MOC wandered away from clinical relevance in recent years. Basically, Board certified doctors resent and challenge MOC as a false credentialing standard .I can't blame ABIM for seizing new revenue lines and financial opportunities. But taxation without representation is tyranny. Testing and MOC mandates without the expertise of experienced, relevant night-call physicians is almost tyranny. MOC has become an affront to the noble profession and practice of medicine. Why would ABIM attack the competence of their own Board certified physicians so aggressively outside of easy revenue sources for an expanding business? Meanwhile, MOC has hurt US medicine in many ways. MOC promotionals have hurt previous good CME programs like MSKP. MOC has divided physicians and surgeons against themselves. MOC has divided older grandfathers from young and midcareer physicians struggling under MOC. MIC has destroyed collegiality in our hospitals. MOC has cut membership in specialty societies and in organized medicine,. The harm of MOC to US medicine is great while the possibility of improving patient care in any way is highly controversial. Ten thousand

doctors challenging MOC represent just the tip of an iceberg objecting to MOC.
For each signature, thousands more physicians and surgeons support the cardiologists this March against MOC. We are Board certified lifelong scholars loving our careers as we pursue lifelong learning independent of MOC. We bemoan false claims from ABMS and ABIM against any Board-certified physician or sugeon labeling us incompetents after just 10 years unless we pay for your new MOC brand of tests and activities. We understand your large business, your high revenue, tax exempt testing industry and we understand your freedom to grow indefinitely as a recertification monopoly. But as you remove 10% or more of previously Board certified physicians and surgeons who give up MOC each year, have you considered how MOC might wrongfully compromise patient access to the best US physicians and surgeons? Are you not concerned that ever increasing and costly MOC mandates may compromise and hurt patient safety as your remove good doctors arbitrarily? Do you feel that MOC marketing is ethical for improved patient outcomes or for an improved US workforce when good doctors are kept off hospital staffs, out of universities, or otherwise shunned only because they withdrew from MOC? Perhaps CMS supports MOC as a means to shrink the physician workforce and expand the role of noctors and pharmacists as prescribing health care providers.
Meanwhile, perhaps ABIM as a nonprofit might demonstrate its commitment to America's Board certified physicians by dropping MOC mandates; offer truly voluntary lifelong learning and MOC re certification activities as optional choices completely free of charge.
Keep in touch.

REPLY

Stan Jackson, MD August 18, 2012 at 12:39 pm #

I agree with Dr. Eck. The ABIM should not suck up to hospital administrators who control the peer reviewers, credentials committees, and executive committees, and should not suck up to the insurance robber barons, and the politicians who are of the illusion that written tests are a sign of clinical competence.

It behooves the ABIM and surgical counterpart to address more poignant matters such as the depreciation of doctors and medical care by the elevation of poorly trained paraprofessionals who are now considered doctors in what they are permitted to do in the hospitals and their ICUs with sham supervision.

Since when are outcomes better in patients whose care is attended by recertified doctors, compared to older physicians with more wisdom? What does test prep and exam cost? Hello?

REPLY

Paul Kempen August 18, 2012 at 1:00 pm #

Dear Bob: Nice try. I think the ABIM needs MOC more than ever to try to get back into the black. The ABIM's 990 IRS form from 2009 (see @ http://WWW.changeboardrecert.com) shows (part 1, line 22) a net assets of -$40,906,833.00 (yes a DEFICIT amount) while Dr Cassel took home $861,000 and the other board members didn't do bad either.
Tell me please, why is the ABIM the ONLY board with a deficit and how can this COMPANY stay afloat with those degrees of losses? Are you working pro bonum? Were the legal fees for lawsuits against other private attempts to break the MOC monopoly by trying to provide educational materials for people to take the test instrumental in the deficits? (http://blogs.wsj.com/health/2010/06/18/whats-the-next-step-for-doctors-sanctioned-by-abim/)
You mention regulation and self regulation but failed to mention regulatory capture: "Regulatory capture" occurs when special interests co-opt policymakers or political bodies — regulatory agencies, in particular — to further their own ends".

http://techliberation.com/2010/12/19/regulatory-capture-what-the-experts-have-found/
Noone is regulating the ABIM and the FSMB (where MOL originated) and these INCs stand to earn heavily from the program and the products and NEVER has clear evidence supported any need or benefit from a “good housekeeping seal of approval” by the ABMS for doctors. All this push for MOC and MOL is based in overregulation by the government, the waste is incredible. The ACCME’s 2010 report showed that physicians are spending $2.3 BILLION each year on CME registration fees alone.
http://www.accme.org/sites/default/files/null/604_2010_Annual_report_20120702_0.pdf
I feel as many that we need less regulation and more concise education based in reality of patient needs.
The ABIM’s Choosing wisely program http://www.abimfoundation.org/News/ABIM-Foundation-News/2012/Choosing-Wisely.aspx has driven home to me one clear fact: MOC and MOL are NOT enevitable and REcertification is the #1 test that should be immediately dropped in the interests of cost containment and improved care, at this time when midlevel providers with much lesser education are being licensed and their educations funded by the federal government to REPLACE physicians as “providers” (while GME is being gutted!). We need to fight this madness via every medical society and at every state level of legislation!

REPLY

Jane Orient August 18, 2012 at 11:09 pm #

Doing an H&P, using an indirect ophthalmoscope, and passing an endotracheal tube are like riding a bicycle. Once you learn how, you don’t need to spend thousands of dollars every few years to prove you can still do them. A disease that impaired that ability should be obvious to all. On the other hand, evaluating a complex case, making a tough surgical judgment, or dealing with a sudden airway emergency involves unique circumstances. The professional expertise to do these things well cannot be codified in a “secure examination” or improved by bureaucratic “CQI” exercises. All the ABIM can do is waste doctors’ time cramming on ABIM-selected trivia, playing box-check games, or compiling data that are of no use in managing any individual patient. I think it should devote its expertise to assessing whether doctors emerging from recent programs are more or less capable with real patients than older physicians. Has anyone done an outcomes assessment on radical educational “reforms”?

REPLY

Bob Wachter August 19, 2012 at 5:33 am #

Well, this is certainly an interesting set of comments. I’ll respond to a few of the issues raised by them.

Re: Betty’s comment about having an exam derived from study materials distributed by the Board, several of the certifying boards do something like this: they send out a “top ten articles of the year” list and then test diplomates on them. It’s an interesting idea that we’ll consider as part of our thorough review of our assessment tools. None of the boards that do this, however, do so in lieu of a secure, closed-book examination. Personally, I like the idea but don’t think it will replace the need for a more thorough assessment. To be a competent internist or specialist, you need to know far more than just what’s in the key recent studies.

Re: David Mitchell’s comments, the role of the Boards will always be complimentary to that of local peer review. An assessment portfolio created by a national body can never substitute for the deep and intimate knowledge that local colleagues and organizations have regarding a physician’s practice. We need better ways of measuring the quality of individual physicians – both for local review and for national assessment.

Re: Paul Nadler's comments, thanks. Yes, other industries have woven periodic competency assessment into employment. I suspect this will happen over time in medicine as more physicians become employed – some hospitals already cover MOC expenses for their employed physicians and provide time off for participation. At ABIM, we have a pilot project that allows qualified delivery systems (such as hospitals) to sign off on their own physicians' activities for MOC credit. In other words, if you were working on a QI project at an organization that had this designation, that organization's institutional quality officer could certify that your work met criteria for MOC credit. Several organizations already have such an arrangement and we'd like to encourage more to join (UCSF is currently applying for it, FYI). I think this is the way to go – your local, day-to-day QI work should be able to "count" for MOC.

Re: Menoalittle's comments, first of all, all of ABIM's finances are available to the public through the required Form 990 filings. I agree that purely memorized knowledge is less important than in the past because of electronic resources, and that we have to assess how physicians interact with HIT systems. That said, strong foundational knowledge will remain important even in a wired environment – even with ubiquitous Google, UpToDate, and PubMed availability and a good CPOE/decision-support system, the physician still has to know enough to ask the right questions and assess the data correctly. Moreover, there simply isn't enough time in the day to look everything up. I think we make a mistake if we remove cognitive and knowledge-based assessment from our repertoire. Some of this is echoed in Sue Thomas's comments.

I welcome the comments of Drs. Eck, Kempen, and Orient, all leaders in an organization called the Association of American Physicians and Surgeons, which has long opposed MOC, peer review, the ACA, and what it deems government's intrusion into health care. A favorite venue for appearances of many of its leaders these days appears to be "Doctor's Tea Parties," which offers some flavor of the organization's culture and beliefs. There are some glaring factual errors in their notes (a few: MOC *has* been associated with higher quality; there *is* evidence that physicians' skills degrade over time; ABIM is financially sound; ABIM CEO Dr. Chris Cassel's salary is at about the mid-level of comparably qualified senior executives of large non-profits; the fee to diplomates is not "thousands of dollars every few years" but instead approximately $2000 over *ten* years – and ABIM's fee is among the lowest of the certifying boards.)

But these are folks with an agenda, and to them I point out that board certification is voluntary. If they don't believe it adds value to them or their patients, they can opt not to participate. Perhaps their patients – as well as insurers, hospitals, and others – will accept their word that they are keeping up and remaining competent… and that practicing medicine is like "riding a bicycle."

As for me, when I am looking for a good doctor, my first questions are whether he or she is board certified and actively participating in MOC. As I noted in my blog, I'd like to know even more, but these remain the starting point… and if the answers are "no," I look elsewhere. Our work with consumer groups and patient representatives supports this point of view.

REPLY

Paul Kempen, MD, PhD August 19, 2012 at 12:37 pm #

Dear Dr Wachter:
Thank you for indicating that I am a leader, but I hold no office in any agency-I actually provide patient care 100%. Idid check your references and and as expected found only one that was actual research about MOC, whereby this is NOT proof, but an association with even the authors stating in the document:
"Effect of Board Certification on Antihypertensive Treatment:
As in any retrospective study, the nature of the relationship between the predictor (board certification) and outcome (treatment intensification rate) variables is only associative rather than causal. This association could be explained by other factors, including physician comfort

with documentation of the office visit related to physician age or time since the completion of training."
The other papers were "opinion or position papers" written by paid employees of ABMS, ACCME or other MOC companies as indicated below. There is no PROOF that MOC is the answer. Sure, Continuing education is essential-not testing. The CME industry is currently a $2.3 BILLION industry SEE ACCME 2010 annual report) and attests to the AMA's programs accepted for decades and physician committments to ongoing education. The ABIM and the FSMB are practicing "regulatory capture" of this industry to benefit their coffers over that of the current CME industry and absolutely without PROOF that MOC is the answer! The ABIM and all ABMS certification industries work ONLY in the USA, but we continue to lament the greater Longevity and better care found in manyother countries at less COST. The ABIM and ABMS programs only serve to increase the cost and lost man-hours of physicians in the USA at a time when cost containment presses while we let non-physicians do the car without MOC!

Holmboe ES: Chief Medical Officer (CMO) and
Senior Vice President of the American Board of Internal Medicine and the ABIM

Effectiveness of Continuing Medical Education: American College of Chest Physicians Evidence-Based Educational Guidelines

http://journal.publications.chestnet.org/article.aspx?articleid=1089717

Mr. Dellert is the Vice President of Educational Resources for the American College of Chest Physicians. He has served as faculty for Accreditation Council for Continuing Medical Education, holds a committee position with Alliance for Continuing Medical Education, and is immediate past president of the Illinois Alliance for Continuing Medical Education (or IACME).

Paul Miles, MD

American Board of Pediatrics, Chapel Hill, North Carolina

The author has indicated he has no financial relationships relevant to this article to disclose.

http://pediatrics.aappublications.org/content/123/Supplement_2/S108.full.html

Paul V. Miles, MD, Senior Vice President for Quality and Maintenance of Certification, The American Board of Pediatrics, 111 Silver Cedar Ct, Chapel Hill, NC 27514,

Conflicts of interest: Dr Miles is a member of the American Board of Family Medicine Foundation.

REPLY

Arvind Cavale August 19, 2012 at 4:37 pm #

Dr. Wachter:

Your defense of this process is as can be expected – namely demonized and label others that disagree with your view point. Even though you maintain that MOC is voluntary, your organization is certainly using its monopoly to force individual physicians out of hospitals and insurance plans by colluding with such entities. Consumer groups and patient representatives (whoever they may be) currently only get to hear your side of the argument, which they will naturally believe. Once they hear both sides, perhaps they will choose to make their own choices. Why are you afraid to engage in a real discussion with consumer advocates. In fact just last week one of my patients commented "I get it now doc; I don't care what certificate you hang on your wall, I will keep you as my doctor as long as you listen to me and understand how to take care of me" when I showed him how the ABIM MOC actually works.

Also, while you may consider $2000 per 10 years to be insignificant, the doctors who your organization certifies, do not rake in salaries anywhere close to "the mid-level of comparably qualified senior executives of large non-profits" that you receive. Besides, you conveniently discount the cost of all the courses physicians need to take in order to qualify for the 10-yearly

test. So the financial burden is real and time commitment away from family activities/commitments is real. So, please do not try to minimize it. The returns from medical practice do not justify such burdens.

I was just wondering if lawyers have to retake their Bar exams every ten years or Accountants their CPA exams. Aren't they in need of refreshing their skills and knowledge? Do you always look for MOC credentials when you seek legal or accounting services?

Transparency, honesty and acknowledgement of facts (not propaganda) should be your first act, Dr. Wachter. I am sure you will label me as some radical as well. But it behooves you to justify your organization's current methods.

REPLY

Tanna Lim August 27, 2012 at 6:57 pm #

Well put. I was going to comment but glad I read yours since you made some of the same points.

REPLY

Marcus Desio August 29, 2012 at 2:59 pm #

Dr. Cavale makes many significant and valid points on why this MOC program is a farce. It is obvious that physicians have not quit doing post graduate education programs (yep, been reading since 1984 post medical school every day) and attending CME programs and really doubt that I have dummied down through a residency and fellowship and 28 years of practice. But most of us are at the financial limit of staying in practice and do not have the luxury (or bad luck of megacorp employment) of being part of the corporations making such explosive profits in the MOC and CME manufactured markets. I agree that there to be a better explanation and review of the financial standing of MOC and its financial burden and attempts of developing a monopoly and coercion with the state medical boards.

REPLY

Michael Elliott September 8, 2012 at 9:55 pm #

Hear hear.

What a colossal waste of time and money.

Unless you're the ABIM. Or the ABP. Or any other of the ABMS.

REPLY

Greg Hall, MD May 4, 2013 at 4:47 pm #

I'm one of those people that read the posts and never write anything, but even I had to chime in on this one.

Now I'm a "physician tea party" extremist just because I'm opposing a 'voluntary' program that has become mandatory and completely out of hand. The fact that no matter how smart a physician group is, "someone" has to fail their tests points to the adversarial nature of this relationship. As hard as med school was, at least we knew everyone 'could'

pass.

Just like Toto pulling the curtain on the Wizard, this ABIM-thing seems to be disintegrating before our eyes. “Absolute power” is doing what absolute power does: corrupt.

Finally, we’re making progress! When the new head of an organization resorts to name calling, you must have made some good points!

REPLY

dee February 12, 2014 at 2:17 am #

I agree wholeheartedly. How does an organization, who proclaims itself supreme, with no legitimate power except what they proclaim, who makes millions on the backs of busy physicians, and violates every tenet of the constitution- especially the right of a man to earn a living, and the right to be let alone- call itself legitimate and pretends that it matters. The propaganda won’t work in the 21st century where health care is about money, and money only. Try master slave relationship. Probably cause more heart attacks and strokes in doctors than a pork farm. Disgusted with this unconscionable façade. If a nurse practitioner or PA can practice independently, with 1/2 our knowledge, and if doctors do as they are told in practices like Kaiser, regardless of the academic perseverations, in order to make a buck, I see all of this as yet another scam- another scam of the government – and those who lobby them- and have from day one- So, why do I have to know more than God about what they deem important and then pay to be tortured. MOC is wrong, and reflective of the same mentality of those who caused the world wide economic crash- greed.

REPLY

VicMan August 19, 2012 at 6:05 pm #

Bob,

All said and done, I do welcome the candor you have shown. Large organisations will always be disagreement and there can be valid points of view raised by the dissenters.

My concern is really about the trend of Hospital Medicine. You come from leadership position from such Organisation . Will you select an Internist in for “Aunt Minnie in Denver” who does not admit to hospital and farms it out to Hospitalist?

I am an electrophysiologist and believe that more should be done in empowering internists in community. Hope in you new role you will take steps to do that. We need to start flow of graduating internist back to practices and not vie for shift jobs as Hospitalist

Thanks

V

REPLY

Narayanachar Murali August 19, 2012 at 7:23 pm #

Dr. Wachter, let us get to specifics. Dr. kempen has exposed some of the hollow premise on which the MOC was thrust upon us. BTW I am not a tea party member! I am not paid by a hospital, non-profit corporation, not paid for being on boards or committees. I actually work hard to earn money and am sweating to keep my employees away from government

assistance programs.

I have re-certified multiple times, not just in Medicine but also in GI. I have generally done it for my own satisfaction, perhaps ego. I have found NO value in the MOC program. The worst among the modules is the mandatory Practice improvement modules. What a ridiculous idea. Who came up with this? ABIM has neither the expertise nor the experts to guide us in these maters. I guess ABIM was trying to test the limits of patience of practicing docs! What was evident from the MOC for Hepatitis C that I did, was the corruption that is prevalent in the academia. These modules are written by physicians in tertiary centers who know little about the practice in a community setting. There is heavy influence of the drug industry subtly injected into these modules. I also did the patient satisfaction module and wasted a lot of time and money. I had to input data to make myself look inadequate and then try to find fault with my practice and then improve it!

In my field, ACP, ACS, ASGE , AASLD all have decent CME programs, which most of us choose to do.. When ABIM demands a fee to accept the CME from other sources toward MOC, that is nothing short of extortion. Why on the earth do I have to pay for MKASP, do it, earn the CME and then pay you(I mean ABIM) to accept these scores towards MOC? This is where a lawsuit against ABIM may actually hold water. ABIM- ABMS are designated as a non-profit organization and have now created a steady money stream through plain old extortion methods, tested for over a century in New York and Chicago. .

Where was ABIM/ ABMS as an advocacy group for trained, board-certified doctors when hospitals and insurance companies started replacing qualified doctors with mid-levels? Why is ABIM- ABMS not fighting the charlatanism that has become so pervasive? In our Hospital they have changed they bye laws to eliminate board re-certification requirement because the mid-levels will now be treated as equal to physicians. Unless you are under a rock, you probably know you are a “provider” not a physician anymore.

REPLY

Mtbwalt August 19, 2012 at 8:39 pm #

Dear Dr. Watcher,

You were certified by your board as a laurel of excellence at the completion of your residency. You were trusted, as an ethical professional, to keep up your skills and serve you patients well. Why wouldn’t you? That’s why you went into medicine, right? That’s what you had done all throughout your college, medical school, and residency training.

Now you have joined a physician control and regulatory complex that seeks to protect patients from doctors. You have joined the state medical boards, joint commission, government, malpractice lawyers, CMS, payors, hosipitals, ACOs, and others who want to protect patients from their doctors by regulating, measuring, and managing the physicians. This strips meaning and professionalism from the doctor patient relationship. It emboldens politicians to claim that physicians are performing lucrative surgeries by intentionally denying patients prevention. After all, patients must be protected from physicians, and without such regulations the greedy, lazy, ignorant, conniving physicians would terribly abuse out helpless populace.

Guess what. Physicians are the ones responsible for our patient’s health, NOT YOUR BOARD. We are the ones safeguarding that health.

When is my high school going to require me to re-certify my recollection of US history? Perhaps my engineering school should revoke my degree because I do not perform yearly projects for them and send them money. How about medical school, perhaps they should revoke degrees from any graduate who doesn’t send them a $400 check every year. That would be a nice “revenue enhancer” for them.

The mission of protecting patients belongs to their doctor, who the patient selects, not you who they did not select. I understand why you want to use crony relationships with government to

force physicians to pay you money every year, and why you support physicians losing their license to practice if they do not. Your motivations are crystal clear.

Show me validated research that a physician who participates in MOC is a superior doctor to one with similar training and background who performs traditional CME. I know you can't because there is no such research, and frankly both are probably equally studious and committed to the care of their patients.

With no evidence to back up your policies, you will resort to logical fallacies, name-calling, and persecution of any who reveal that your policies are made from organizational self-interest. If you feel that your board must do more to help physicians be better, why don't you put out good CME materials for us, and serve physicians who serve patients rather than distracting us with nonproductive hurdles, hoops, and regulations.

You ask physicians to have many masters, all of the members of the physician control and regulatory complex that you are embracing. But all you masters just serve to take our time and our thoughts away from our real master: the patient.

Sincerely,
Walt

REPLY

Narayanacha S. Murali August 20, 2012 at 5:35 pm #

Are all the board members, including you Dr. Wachter, properly certified and re-certified since graduation like many of us? If not why not?

REPLY

Bob Wachter August 20, 2012 at 5:58 pm #

Thanks, Dr. Murali, for your commitment to staying up to date. As I mentioned in my blog, I am certified and successfully completed MOC 3 years ago. All Board members are required to do the same.

REPLY

Helmi May 14, 2015 at 6:05 am #

Dr. Watcher,
"All Board members required to do the same" Not only is this not the answer to the question by Naranayacha Murali, which was "Are all the board members, including you Dr. Wachter, properly certified and re-certified since graduation like many of us? If not why not?" The -indirect-implication that they are, is simply not true, and this common knowledge. But if the assumption is that we"physicians" are that thick and would fall for that answer, then that would also explain everything that is being done to us.

REPLY

Jim Conway August 21, 2012 at 5:25 pm #

Bob, I clicked on the comments to send my own Congratulations to you for taking on this important position at an essential time.

But as is always the case in things you are associated with, this former hospital exec, and current academic and trustee, has learned a lot from reading the comments and exchange.

I'm reminded of one of my favorite quotes "To do things differently, we must see things differently. When we see things we haven't noticed before, we can ask questions we didn't know to ask before." John Kelsch, Quality Health Care In America Project

I am sure that the communities you build, the transparency of your efforts, and the relentlessness of your focus on improvement efforts will serve us all well not only in the questions but also in the answers.

Congratulations to you and to ABIM. Jim

REPLY

Paul Kempen, MD, PhD August 23, 2012 at 2:09 pm #

Dear Bob: Have you seen the recent reports about Job burnout among us physicians on the front line taking care of patients?
Is your doctor burned out? See:http://www.cnn.com/2012/08/23/health/time-doctor-burnout/index.html?hpt=hp_c2#0_undefined,0_

How do the increased mandates of MOC figure into this aspect of patient care? I mean, it sounds like the imposition of MOC only increases the workload on these important care providers, while also removing them from patient care encounters. Again, there is absolutely no evidence that MOC is better than traditional CME, which is already a $2.3 billion dollar yearly national physician commitment, which very well documents the commitment to lifelong learning since implemented in the late 1960's. Practicing physicians do not have those many "academic hours" for this stuff, so it cuts into sleep, family and ability to meet with patients-especially when you are off to far corners of the world to take these courses in vacation-land environments chosen so the lecturers can enjoy the time away. On line CME has become cheap and efficient-why do we need to pay the ABMS extra to "recognize" these courses for MOC credit, anyway?

REPLY

Marc S Frager MD August 23, 2012 at 4:44 pm #

Dear Bob, While your priority is clearly not "to make doctors happy", you would be a poor chair if you did not recognize and forthrightly address what it is about MOC that makes so many physicians so unhappy. Overburdened physicians appear to not buy into the rationale of the ABIM and ABMS. Some evidence for the benefit of this arduous, expensive procedure would clearly help. Since MOC or recertification has been present in some form for over 35 years, there should have been adequate time for the board to produce some solid evidence of benefit. To merely state that skills decline with age is apparently not enough to convince many physicians that MOC will help them.

REPLY

Dr. Jane August 24, 2012 at 1:49 pm #

Hello Bob,
I read through all of the previous comments. Four people asked you about midlevels. It goes to the heart of certification. You haven't addressed those questions and comments:

Dr, Sue Thomas "…it is being diluted by vapid computerized clinical decision support geared

for paraprofessional physicians' assistants and nurse practioners who parade the hospital halls with long white coats, acting as and deceiving patients as though they are doctors."

Dr. Stan Jackson "…It behooves the ABIM and surgical counterpart to address more poignant matters such as the depreciation of doctors and medical care by the elevation of poorly trained paraprofessionals who are now considered doctors in what they are permitted to do in the hospitals and their ICUs with sham supervision.

Dr. Paul Kempen "…at this time when midlevel providers with much lesser education are being licensed and their educations funded by the federal government to REPLACE physicians as "providers"

Dr. Murali "…Where was ABIM/ ABMS as an advocacy group for trained, board-certified doctors when hospitals and insurance companies started replacing qualified doctors with mid-levels? Why is ABIM- ABMS not fighting the charlatanism that has become so pervasive? In our Hospital they have changed they by-laws to eliminate board re-certification requirement because the mid-levels will now be treated as equal to physicians. Unless you are under a rock, you probably know you are a "provider" not a physician anymore."

Please address these comments – they relate to the heart of the purpose of recertification for physicians- ie. in other words…

Lesser-trained paraprofessional charlatan midlevels parade around hospitals and communities, deceiving the public into thinking they are fully-trained physicians. Some are even INDEPENDENT (NO SUPERVISION). Although they have 50% less training, they command 85% of a physician's salary. Hospital by-laws have changed to allow midlevels to be treated as equal to physicians. Where has the board been in advocating for BOARD-CERTIFIED physicians??!!

REPLY

Otto Kunst, MD August 24, 2012 at 2:02 pm #

Dr. Wachter-

I realize that the medical-political climate may leave you little choice but to climb aboard the MOC-MOL bandwagon, but I wonder if you realize that you are becoming the gravedigger for a significant portion of your specialty's physicians. As such programs become not only required, but also more ongoing rather than episodic, only academic medicine and large group practices will be able to support these requirements by having extra staff, as well as by providing time and resources for those facing the episodic recertification exams to properly prepare for them. Small-group practices and solo practitioners will have to carry this burden themselves. Many will be unwilling or unable, forcing them into mega-practices, but what about the solo rural physician? Without any such support, he/she will be forced to migrate to a larger community, leaving the rural patient with either no nearby medical recource, or have it taken over by a paraprofessional NP/PA with far less training.

Superspecialty internists, such as cardiologists, have their own boards and policies. What MOC/MOL will mean to the less-well-paid general internist, your primary base, will be more out-of-pocket funds for practices that may already be struggling to keep their heads above water. As this becomes general knowledge to the potential medical student population, more and more will either commit to internal medicine subspecialties, other non-IM specialties or, given recent studies showing little overall lifetime income difference between FP/IM physicians and NP\PA's, opt for the latter field, a lower student debt load, a quicker entry into good earnings, and the earlier acess to building families, housing, discretionary spending, etc., that such a route will provide.

As the general IM base erodes, what will you do to support the cost of maintaining the ABIM, its ongoing expenses, staff salaries, etc.? As numbers and earnings of IM's erode, you're going to reach the "blood from a turnip" status, unable to elicit further or higher fees from your

membership. If your main concern is maintaining your own perquisities until retirement, and let the next group deal with the problem, the funds will probably last until the.. But if your focus is truly on the future, as you state, then you may need to factor in these potential problems into your current thinking and your planning for the future.

Full disclosure- I am retired and I was not in the internal medicine field, so my knowledge base may be incomplete, but I also have no personal interest in the outcome of your propsed changes.

REPLY

Karl W Hubbard MD August 24, 2012 at 2:59 pm #

We need to have our Psychiatrist's and Pyschologist's input into this issue, which is really a manifestation of displaced / transferred frustration by the government and unrealistic expectations of a public so pampered and spoiled by the luxurious medical care which has been afforded to them in the past. So many "white elephants" have now stampeded into the room, real solutions can not be addressed.

Politicians made promises for Medicare/Medicaid to get votes. In the past we could pay for all of these promises by borrowing or printing. (Nope, taxes paid by the "hard working people" of this country don't begin to pay for it.) Not any more.

Technology in Medicine is more costly in contrast to other forms of automation. Every MRI gadget, every MIDAS Rex, every Da Vinci robot means more costs: From sales and advertising, to maintenance, to climbing the learning curve of inefficiency at the outset which means huge start up costs, to additional techs to operate it, to a medical arms race which leads to needless duplication.

Decline in quality of core health of Americans due to our sedentary lifestyle and drive-by burger and fries shops.

Extended life span, which expands the discovery/treatment, and therefore cost, of new diseases and treatments beyond the scope of our known universe.

Employment model of physicians which means new costs of Locums firms, recruitment, turnover, gaps in coverage, start up inefficiencies.

The solution is to take it out on the doctors and make it appear that the problem is the need to find the holy grail of free medical care. Quality Care. Low cost care. I have heard that BS smoke screen mantra as the answer to our dilemma so many times I can't stand it. All this endless harassment of doctors with new requirements, coding, justification, verification, quality control, etc being implemented because the politicians, lawyers, and opportunistic businesses benefit.

Example: EMR software companies who know they can sell doctors an expensive POS because of govt. mandates, not because the product they are peddling is a good product that we doctors want to have, or which would truly make our practices and health care delivery system better, but because the government has become like a mobster extortion racket. Now the hospitals and physicians are engaged in "computer tribalism". Every CD or computer program is different. Every data retrieval on every patient at my office and hospital is like an archeological dig: slow, painful and laborious.

All the money for health care is being spent on everything but actual health care.

REPLY

Dr. Hockey August 24, 2012 at 3:29 pm #

States already require a number of hours of Continuing Medical Education for

medical license renewal. Also, we keep our eyes, ears, and minds open as we practice medicine. Some of us even continue to publish in peer-reviewed journals. I suspect many of us think the time and dollars we are required to spend on MOC is a waste of resources.

REPLY

Dan Jones, MD August 24, 2012 at 4:00 pm #

"The public grants to professions the privilege of self-regulation." Used to be. But today? You can't be serious!

REPLY

Philip Sharp, MD August 24, 2012 at 4:01 pm #

Dear Dr. Wachter,

As one who is in position of the trust of our patients, do you not perform them a disservice by promoting interference in the doctor-patient relationship without data to show their safety is increased? As already referenced by many who have posted before me the harms are of significant concern yet this is not addressed. Is more harm being done? Why are there more wrong site surgeries today despite "checklists" and "Golden Moments"? This is an important issue.

I am extremely dissappointed to hear that "consumer groups and patient representatives" are driving decisions rather than data. "Consumer groups and patient representatives" being doublespeak for the insurance industry and government? The reason that you cannot produce that data is because it does not exist. If you feel that it does, please produce such (although if it did I would have expected you to have done so by now). Without that data, distrust only permeates more deeply.

I see this as another reason why 9 out of 10 physicians would not recommend their child enter into medicine (http://www.thedoctors.com/TDC/PressRoom/PressContent/CON_ID_004671). Perhaps physicians should do as you, and regardless of lack of data to support such, entertain that this is the motive behind this change. It is no wonder patients are losing confidence in health care as many doctors are doing the same. Please do not attempt to further weaken your position by denigrating The Doctors Company as you poorly chose to do with Dr. Eck. Such a response exposes a lack of relationship with and understanding of the Delegates and has the unintended consequence of strengthening her position. Or perhaps the plan is to match the successes of the AMA, which proudly represents 16% of all physicians. (And fewer every day.)

I am pleased to hear that the board members are required to complete their MOC. How many patients a week do they care for? How often are they on call? How many personnel from the ABIM assist them to perform MOC related activities. And do they not produce the MOC examination? If so, I should hope they could easily pass their own exam. If not, what is their relationship with those who do produce the exam? Perhaps to avoid conflict of interest and promote trust the board members would agree to take an exam written by the Delegates.

Thank you for your time.

Philip Sharp, MD

REPLY

PJ August 24, 2012 at 4:19 pm #

I agree w/Dr Kempen that MOC is a burden and a waste! As a PCP, I am educating

my patients that BC is a scam that drives up costs and has no proven benefit.

REPLY

Joe August 24, 2012 at 5:13 pm #

Bob, in 1986 becoming an internist still meant something. Would you still become an internist in todays environment? I doubt it. Why do you not practice clinical medicine now? I mean if it's such a great and giving career why not still see patients? You may have to take a little paycut but were talking about the gift of being able to practice mediince here. Especially today with all of the wonderful standards, regulations, performance surveys it's such a great time to be in clinical medicine. It's wonderful to work so hard and put yourself at such risk for all the wonderful rewards that clinical medicine provides for its doctors.

REPLY

cwjonesjrmd August 24, 2012 at 5:15 pm #

Dr. Wachter, I couldn't disagree with you more, Would love to discuss this with you in more depth but I'm busy seeing patients like I've done now for almost 30 yrs. Everytime I read garbage like you espouse I know you most likely have never practiced primary care much at all……..and kudos to Dr. Eck.

REPLY

jack chachkes August 24, 2012 at 7:12 pm #

As pilots are PAID while updating proficiency, who pays the doctors? And are the pilot updates as complex as those of a physician? And in learning a new aircraft, do they continue to earn a living? Funding is an issue that 'Boards' ignore. Is it because of the academicians and administrators that compose the boards? Are the boards, or medical colleges or insurance companies or hospitals going to maintain practitioners income while taking the exams much less while preparing for them, as commercial pilots do?
Insurers, Medicare, hospitals, boards, licensing boards, etc have all significantly increased demands [since you were certified] with NO compensation to pay for implementation. How do you suggest your proposals be met while docs earn a living, without going into millions of debt? Medicare fees are already driving physicians out of practice in this region, and the proposed drop, as of Jan '13 will drive out all those that have med school debt. Or drive them in to bankruptcy.

REPLY

ron benbassat md August 24, 2012 at 11:25 pm #

Dr. Wachter has inherited the Maintenance of Certification (MOC) mantle from Cassel and her predecessor Kimble. Like them and fellow propagandists Holmboe, Levinson and Lipner, he perpetuates the ABIM's mantra of MOC all the way to the bank.

This new Chair's website claims to have "Lively and iconoclastic ruminations on hospitals, hospitalists, quality safety, and more…" but ignores those of us on the front lines—practicing physicians and our patients.

We at Change Board Recertification (www.changeboardrecert.com) find this shameful and

appalling.

If this new Chair wants to be a game-changing advocate for the practicing physician, he should be challenged to dismantle MOC and defuse all attempts to tie it to Maintenance of State Licensure (MOL). Neither has any place in the life of practicing physicians.

We've had an effective system in place for decades, one that is the equivalent of MOC and MOL: keeping up to date through our CME and remaining in good standing to maintain state licensing. There is absolutely no need or justification for MOC/MOL and its imposed burdens.

Let's be clear on what MOC means to the AMBS and its Boards and why they are so insistent on the value of MOC. The twenty-four Boards' 990 IRS documents disclose over $400 million in total reported assets—an amount compounded by the yearly certification and recertification of thousands of diplomates.

Here's just one example: $39,457,253 in revenue reported in the ABIM's 2009 tax return for "examination fees and MOC."

So it's no mystery as to why MOC was developed and continues to be promoted, despite its having evolved into a discriminatory and costly burden to physicians, patients and healthcare. The Boards' MOC program has become a profiteering juggernaut without any reasonable proof of benefit, efficacy or patient protection, and MOC compliance is slowly being tied to the privilege of practicing medicine.

During these changing times of health-care reform, our Boards sit on nearly a half-billion dollars in assets while hard-working physicians get diminishing reimbursements and many Americans remain without health-care coverage. Hmmm….seems like a newsworthy story.

No one is disputing that staying up to date is essential to practicing medicine, but the existing MOC process neither qualifies physicians nor protects patients effectively. MOC requirements have not been shown to be fair, accurate or predictive indicators of a physician's skills or competency nor have they been shown to improve patient care or safety. All licensed professions have continuing education requirements, but imposing MOC on physicians is simply egregious.

The financial agendas of all Board members are transparent; they show no commitment to improving patient care or cultivating better physicians. And the ABIM's plans of changing MOC to an every-2-year cycle of Continuous Maintenance of Certification (CMOC)—thereby aligning their product with state licensure renewal—only reduces "sticker shock" and masks the cumulative costs of MOC. Such a proposition actually increases related costs covertly: Though the resulting fees would be collected in smaller amounts over time, the completion of more frequent MOC requirements would require physicians to spend even more time away from the practice of medicine.

While almost every practicing physician wants MOC abolished, we feel that the system's self-evaluation of medical knowledge modules can be worthwhile. We take issue with the bulk of the MOC process: The Practice Improvement Modules and Patient and Peer Reviews amount to little more than busy work, and the costly, time-consuming Secure Examination—which requires time off from work and an enormous amount of preparation—is clinically irrelevant and has no place in the life of a practicing physician.

Our goals remain clear:

1. MOC should involve only the self-evaluation modules and be a voluntary alternative to obtaining CME.
2. MOC should not require time away from patient care and the office. MOC should represent how physicians actually practice medicine: i.e., open-book and open-colleague, thereby eliminating the secure exam and practice-improvement modules.
3. MOC should not be associated with hospital privileges.
4. MOC should not be associated with insurance reimbursements or network participation.
5. MOC should not be required for Maintenance of Licensure.
6. MOC should not be mandatory.

MOC is deemed "voluntary" by our Boards' Ivory Tower physician/politicians and PhD's, who

generally do not practice medicine or even see patients on a daily basis—yet they create the rules for those on the front lines. Our collective outcry against MOC continues to fall on the deaf ears of the ABMS and its Boards while their bureaucrats are working behind the scenes on a state-by-state basis with the Federation of State Medical Boards (FSMB) to tie their MOC product to Maintenance of Licensure, thereby making it mandatory for maintaining licensure. We absolutely cannot allow this to happen.

As our Boards don't represent the collective interests of its constituency, perhaps mass noncompliance and lawsuits are the only rational and logical means to reclaiming control of our practices.

We appeal to our new Chair to do the right thing.

Respectfully,

Ron Benbassat MD
Founder
Change Board Recertification

REPLY

Bob Wachter August 25, 2012 at 12:46 am #

I note that this particular post has generated a very large number of visits and an unprecedented number of comments. I'd like to welcome all the new visitors to my blog; I hope you'll remain for discussions of other topics, though I expect that few are likely to generate this kind of passion.

I appreciate respectful presentations of alternate views regarding board certification and MOC. The fact that there are some busy physicians who wish MOC or board certification would go away isn't terribly surprising. The Board is committed to making our processes as unburdensome as possible, while also being sufficiently credible and rigorous to assure patients and others that a given doctor is competent and keeping up. Reasonable people may disagree regarding whether we have achieved these objectives, but I can guarantee that a lot of good people are working very hard on meeting them.

As before, there are several comments that are misleading or just plain wrong. To set the record straight:

1) Several commentators (and others on the Sermo dialogue on this topic) appear to believe that I have replaced Dr. Chris Cassel as president and CEO of the ABIM. This is wrong. I am the chair of the board this year – a one-year position that will end in June, 2013. Dr. Cassel has announced that she will step down from her role as CEO/president next year, and we are searching for her replacement.

2) I receive a small stipend from the Board for my role as chair. I continue my day job at the University of California, San Francisco (UCSF), where I am professor, associate chair of the Department of Medicine, and chief of the Division of Hospital Medicine.

3) In my work at UCSF, I remain clinically active, practicing as a hospitalist for about 2 months each year. I had a primary care practice for over a decade earlier in my career. My clinical duties today are in addition to my administrative, teaching, and research/writing roles. I greatly enjoy clinical medicine, and agree that my ongoing clinical work helps me understand the issues facing practicing physicians.

I have tremendous respect for those physicians practicing full time – it is extraordinarily challenging and important work. I'd hope that commentators would be similarly respectful of those of us who have taken other career paths. We're all trying to do what we can on behalf of our patients.

4) The issue of the role of physicians vs. other non-physician providers was raised by several commentators. I believe that our healthcare system needs to embrace interdisciplinary care

models. I also feel that the role of the physician must and will remain of central importance. To me, this is another argument for board certification and MOC – it helps demonstrate to the public that physicians have achieved a certain level of knowledge and skills in a given specialty, which may distinguish them from other providers. On the other hand, when other clinicians, particularly less expensive ones, can provide the same care to patients as physicians do, a rational healthcare system would embrace these models.

Finally, I note that the leaders of the Association of American Physicians and Surgeons, whose leaders include several of the commentators (including the president, Dr. Eck, and the executive director, Dr. Orient), have taken time away from this debate to weigh in on another hot issue. Earlier this week, the AAPS issued a press release in support of Missouri US Senate candidate Todd Akin. Readers of my blog – particularly those trying to interpret all these comments – may want to look this document over.

REPLY

Raymond J Boniface MD September 3, 2012 at 2:44 pm #

Dr Wachter

In what way does the Todd Akin matter have ANYTHING at all to do with this MOC discussion? Other than to paint your adversaries as “unreasonable” based on a completely separate issue?

You resemble a politician, more than a physician, on this one.

I have recertified twice, once with MOC, in my specialty, Orthopaedic Surgery.
I have found it to be more of an expensive, time consuming Dog-and Pony Show than an educational experience.

RJBoniface MD, FACS, AAOS

REPLY

Rada Ivanov MD August 25, 2012 at 1:10 am #

I review test modules for ABIM in my area of practice, Pulmonary and Critical Care medicine, and have done so for the past 15 years, mainly out of curiosity and as a matter of staying current. I have been appalled at the esoteric material included there, I suppose by the academicians who compile the questions (I am in private practice in the community). Example: Why would I be expected to know the complications of a lung transplant if I will never take care of one? All I need to know are the indications for a lung transplant, so I can refer my patient properly. I can only hope that some of these questions were taken out of the actual exam as a result of my input but having certified and recertified in each specialty, that is not the case. I agree that some sort of competence evaluation should be offered for us to practice medicine in the current milieu but if ABIM wants to be credible, they should reduce the fees and requirements, and certify on the basis of what most physicians do in everyday practice.

REPLY

Narayanachar Murali August 25, 2012 at 1:29 am #

Dr. Wachter, you deserve praise for being bold and open minded to include bristling, abrasive yet so plainly visceral and honest appraisal of the performance of the ABIM over the past years. . I hope you will have the foresight, nerve and strength to change ABIM to best represent the needs of qualified physicians who take pains to be board “re-certified”. Let our

voices be heard in your meetings. Open the doors and windows and let some fresh air in. Travel, meet practicing physicians and see what they do to make a difference in their communities. Get rid of this complex nexus with other sundry organizations, just to make money. Do everything to make ABIM -ABMS regain the trust and respect of doctors. Fight the bastardization of our profession. Please stay focused on maintaining the respect for US Board certification. Wish you well.

REPLY

Al Davis, MD August 25, 2012 at 1:34 am #

Dear Dr. Wachter,

In your essay on MOC, you have provided and subsequently ignored the "meta-argument" that places your conclusions, and the goals and concept of MOC, in doubt.

You stated:
"…the overall picture is not pretty: there are too many mistakes, quality is often shoddy, variations are the norm, access is spotty, seamless coordination is rare, patient-centeredness is unusual, and costs are unsustainable. Against that backdrop, every regulator, accreditor, payer, and legislator is feeling pressure to do his or her part to make the system better. These pressures have fueled myriad initiatives – transparency, pay for performance, no pay for errors, more robust accreditation standards, readmission penalties, meaningful use payments – to promote value."

You then said:
"Enter the Boards. Over the past 25 years, all the boards have implemented "Maintenance of Certification" (MOC) programs. Under MOC, physicians – no longer deemed competent for life – are required to participate in a lifelong assessment and improvement program." and "MOC is more than simply passing a test every 10 years. It now includes measuring one's own practice patterns and submitting plans for improvement, reviewing patient and peer satisfaction surveys, and more. While the secure examination is likely to remain a once-a-decade affair, physicians will soon be required to demonstrate that they are measuring and improving some aspect of their practice every two years."

Taken together, those statements can be summed up as:
1) The state of health care is deteriorating, and has been for many years
2)Practically every agency with any peripheral connection to health care has taken it upon themselves to impose more and more regulations, standards, guidelines and initiatives upon hospitals and physicians in order to stem the deterioration
3) 25 years of this ever-increasing regulatory burden has not made progress
4) Finally, (and outlandishly,) since what we've been doing for 25 years hasn't worked, we must do more of it!

Bureaucracy isn't necessarily a bad word. For the right situation – processing a large volume of simple and similar/repetitive transactions in the most efficient manner – bureaucracies are the best method yet conceived by man. But there is absolutely no way that medicine can be accurately described as a large number of simple and similar/repetitive transactions, and for that reason, bureaucracy is seen as a four letter word by physicians who actually practice their craft. Yet the various regulators who would impose their will upon our specialty, including the ABIM, use the mechanisms of bureaucracy – standardization, regimentation and duplication – in their attempts to do so. It comes as no surprise to the thoughtful mind, then, that these regulatory efforts were doomed to fail before they began. And the 25 year history, and results, of those efforts offer clear proof of the premise.

Health care is in dire straits, but our regulatory environment has contributed very much more to health care's deterioration than to its improvement. Given Einstein's definition of insanity, it would seem that the ABIM, by virtue of insisting on more of the same, is certifiable.

Sincerely,

Al Davis, MD

REPLY

susan o'connor, md August 25, 2012 at 2:43 am #

"I also feel that the role of the physician must and will remain of central importance. To me, this is another argument for board certification and MOC – it helps demonstrate to the public that physicians have achieved a certain level of knowledge and skills in a given specialty, which may distinguish them from other providers. On the other hand, when other clinicians, particularly less expensive ones, can provide the same care to patients as physicians do, a rational healthcare system would embrace these models."

Dr. Wachter: if you believe this statement has anything at all to do with what is actually going on in community psychiatry today, where quality of care is being systematically dismantled through combinations of EMR, incompetent (but cheaper) nurse practitioners, and blatant disregard for the time necessary to actually supervise these paraprofessionals so as to catch their errors prior to harm being done to the patient, then it is painfully obvious that you have no idea what is actually happening to clinical medicine. Patients need leaders such as yourself to understand the problems and to stand for solutions, rather than wasting time and money on ideas what will do nothing to improve their safety and well-being.
Please learn from the feedback provided from many of us here, and please help. The situation is truly urgent.

REPLY

william reichert December 9, 2012 at 4:57 pm #

Susan<

This comment struck a nerve with me. Last year I retired after 35 years in medicine.The final straw was the requirement to supervise NP.s. I was working as a hospitalist, initially an interesting and fun field but recently degraded by the requirement to supervise NP's in an attempt to increase PATIENT VOLUME at a low cost.
The charade was enough to make you sick, I had to accept the NP's history and physical as valid before signing off on the orders. Then to add extra revenue I had to make a "face to face" visit which became in actuality (hate to say this but it is true) a stroll into the room of the patient, look at the patient and turn around and leave without so much a a word spoken or even a pulse taken. Off to the next patient.
It is fine to know some things about rare diseases you never see in studying for the boards but really if you dont see these things you forget quickly. Far better to recognize your ignorance and look things up as the need arises.
But what is the point of having knowledge if you are so separated from your patient that you dont really know what the patient's clinical situation is?
This is why there is going to be a disconnect with ABIM test scores and patient outcomes. The physician is being separated from the patient to the point that his knowledge cannot realistically impact the individual patient. Sad.

REPLY

Bhagi August 25, 2012 at 3:26 am #

"On the other hand, when other clinicians, particularly less expensive ones, can provide the same care to patients as physicians do, a rational healthcare system would embrace these models."

You just told us on one hand that a boarded physician who goes through MOC will provide better quality care than one who does not. Yet on the other hand, you tell us “that other clinicians”, that is non physician clinicians can provide the “same” care.

If non physician clinicians can provide the same care, surely a physician who does CME with the MOC can provide the same or better care than that same physician did before.

REPLY

Bhagi August 25, 2012 at 3:29 am #

“Finally, I note that the leaders of the Association of American Physicians and Surgeons, whose leaders include several of the commentators (including the president, Dr. Eck, and the executive director, Dr. Orient), have taken time away from this debate to weigh in on another hot issue. Earlier this week, the AAPS issued a press release in support of Missouri US Senate candidate Todd Akin. Readers of my blog – particularly those trying to interpret all these comments – may want to look this document over.”

You might want to note that the same people trying to tie Todd Aiken to the Republican Presidential candidate and vice-president candidate lionize people like Ted Kennedy who drowned his girlfriend and got a lawyer, and Bill Clinton, who couldn’t keep his hands(and other parts) off of unwilling women around him.

REPLY

Mad As Heck August 25, 2012 at 4:42 am #

Why weren’t all physicians made to take MOC every ten years? Where is your data? Seeing that you are from an academic institution, Department Chair, etc. you should respect data more than most. Where is your proof that MOC makes a better physician? What is your answer to the point raised above that when you go to an attorney, do you ask them if he or she has taken their Bar exams every 10 years? What about mid levels? Why not address some of those questions? Why must you attack Dr. Eck on a personal level? She very eloquently summarized some of the reasons that physicians detest about the MOC and ABIM.

REPLY

C. Canem August 25, 2012 at 5:40 am #

In the interest of full disclosure, I am a FP, not an internist (wasn’t smart enough to get an IM residency, I suppose) and I do come courtesy of Sermo. Nevertheless, the attitude conveyed in this article is so condescending, so laden with medical-establishment groupthink, so disdainful of fellow medical professionals, all medical specialties cannot help but take notice.

The author begins his article regretting his life-long membership in the certification club, and while such sentiment is appreciated, it does not soften the patronizing blows that follow. There are too many mistakes. Quality is often shoddy. Variations are the norm. Access is spotty. Seamless coordination is rare. Patient-centeredness is unusual. Costs are unsustainable. It’s all the physician’s fault, of course, but certainly nothing that can’t be cured by even more overweening oversight from a well-financed medical board. And internists should be rooting for them, their bettors, to succeed.

The author laments that websites like HealthGrades and Angie’s List are providing transparency rather than organizations like the ABIM. So what? Why command the hard-earned compensation of his colleagues when they will provide transparency for free? A plea for relevance, perhaps? Or revenue? Or both?

Medical students are chosen by their medical schools for a reason: by and large, they are hard working, intelligent, compassionate, and extremely conscientious. Medical students prove this throughout medical school, as do residents in residencies, fellows in their fellowships, and attending physicians in their practices. Certainly, some re-certification is a good thing to ensure physicians' knowledge remains current, but practicing physicians cannot sustain the burden of even more oppressive oversight proposed by this author, or his legions of accreditors and regulators. The mentality reflected in this article is making medicine increasingly unpracticable.

P.S. Dr. Watcher, I also took note of your dig on the Association of American Physicians and Surgeons (of which I am not affiliated, so I don't have "an agenda"). What does the AAPS's support for Todd Aiken have to do with the argument at hand and how does it negate Dr. Eck and Dr. Orient's concerns about what you represent? Very unprofessional, undignified, and unbecoming for a man in your position. I've only spent a couple years in an administrative role in my group once, but even a little cheese like me knows one has to thicken one's skin when faced with criticism from one's peers. Rather than trying to stifle dissent with cynicism, you would serve those you supposedly represent–your colleagues, I dare say–by actually listening to them.

REPLY

Marc S Frager August 25, 2012 at 10:17 am #

Dear Bob:

Let's be academic for a moment and stick to the data. The ABIM and ABMS have no real data that MOC accomplishes anything. The detractors have abundant data that MOC is too expensive, too burdensome, and too intrusive: just read the comments. What the ABIM really needs to do is answer how long it can continue to act in a condescending, arrogant, paternalistic manner, require diplomates to pay for this arrogance, and be credible. It seems clear to the majority of commenters that the ABIM is losing the battle. All the heat is being generated by the interference in the lives and livelihood of its diplomates by a supercilious, ponderous organization with no apparent ability to understand or adapt to the real needs of its diplomates.

Since Cassel is leaving ABIM, I would like to apply for the job. She is certified in geriatrics and internal medicine. I am obviously much better qualified since I am certified in internal medicine, endocrinology, and nuclear medicine: 3 boards to her 2. Despite being better qualified, I will work 35 hours/wk with spousal travel for much less than her $800,000. I promise to participate in MOC as soon as I am accepted for the position.

REPLY

I.khan August 25, 2012 at 1:58 pm #

Im a young recent bc internist and it just amazes me that at a time of of an explosion of online (let that sink in) doctorate of nurse practioner programs being created, we have at the exact same time an increasingly burdensome beaucracy on real physicians. This is inexplicable. Basically its as if the health care system as whole is saying, those with the most training and experience need the most oversight, but those with the least training (again online!) dont!! Dr Watcher please comment on this particular trend in todays health care system

REPLY

jack chachkes, m.d. August 25, 2012 at 2:00 pm #

neither you nor Wachter address who pays for the time away from patients that either plan requires.

REPLY

ajay bali Md August 25, 2012 at 8:10 pm #

Dear Bob,
I read with keen interest all the comments and also your essay on recertification .It is generating tremendous amount of debate for and against recertification
It reminds me of a some what similiar article published in New England Journal of medicine few years ago
I have enrolled in this programme for the past 20 years ,some of the recertifications like in internal medicine and cardiology I have done voluntarily.
There are 2 issues which appear of concern to me
I think one issue is of ceritifications before 1990 and after 1990
I think if all the boards think recertifications programmes are the right way to go ,then there should not be any discrimnation between pre 1990 and post 1990 physicians,May be it would cause much less anguish and heartburns among all the physicians since every body have to go thru it and every body is in the same boat as we say some times .One usually gets these answers from the Pre1990 ceritified physicians ,I am glad I do not have to go thru it .In my opinion ,these are the doctors who need this recertification more than the post 1990 physicians
Second is the amount of fee which one has to pay for these recertifications ,I agree that it is for 10 year period,I remember that when this programme was started ,it used to be charged as pay as you go kind of programme .may be the fee could be charged as divided in equal three or four installments over few years may be worth reconsidering
Third is the amount of time which a busy private practioner has to take off while preparing for secure examination ,which in my view is set in at a level for physicians practicing in a university level highly academic center where as majority of physicians are practicing in community hospitals and these physicians usually use internet resources commonly like medical up to date or ACP pier to look at the problems some times they face in their practice ,Is it possible to change the format of this secure exam so that one is allowed to go to medical upto date or ACP peir to look once in a while for those problems they uncommonly face in their practice
In my opinion ,Recertification is there to stay no matter how bad or good one feels about it but certainly it could be made much more physician freindly so that physicians who have life long certifications start participating in it voluntarly more often and not saying we have a life long certification and we do not have to go thru it again
Thanks

REPLY

Paul Kempen August 25, 2012 at 9:17 pm #

The real question is what to do? EVERYONE needs to realize the strength of the ABMS and the MOC and the MOLestation comes from numbers of physicians willing to sit passively or actively support this. The ABMS has FORCED the affiliate franchises known to us as the “specialty boards” to simply accept the ABMS mandate (AND OFTEN AGAINST THEIR WILLS of the individual board) and push the MOC. They are supported by the specialty societies and the “academic machine” who are providing the courses, PIPS and other BS programs and EARNING on the backs of working physicians who are and have been maintaining lifelong learning to actually practice medicine. There is no issue of in competency at the level of licensing physicians or specialists OR any need for Recertification. (SEE: http://www.youtube.com/watch?v=WRS15Dmsk7E). Certify once for life! Recertify, Shame on Me!

Any board not wishing to follow suit with the ABMS MOCTM should vote to succeed from or otherwise leave the ABMS and continue as it's own independent board. All the materials are basically taken from the volunteers of the specialty and that society anyway. Why bother working for the ABMS to indenture us for life or paying the $x00,000 each year to the ABMS for Specialty francises-do it right yourself. Any professional Society which actually has thousands of members could also decide to form the "American Society of XXYY specialist certification" and Certify "Specialists" as an "equivalent" or even superior measure, and should this Board succeed from the ABMS, That would make a unique hole in the program and provide unique strength-it would also provide a precedent for every other board to follow. The ABMS draws the whole strength from the fact that PRACTICING PHYSICIANS in that specialty form the basis of the definition of the knowledge which defines each specialty. If that specialty society in the annual meeting decides to renounce the ABMS and MOCTM, that would strike a vital threat to the ABMS machine! We should work at THIS at every meeting until the problem is resolved!
I wonder if Bob has gotten the message that MOC is not wanted, is causing a great deal of uproar and that HE has a unique opportunity to put medicine back on the right track as indicated above! What will YOU do Bob?

REPLY

Mary Thomas, CMIO August 25, 2012 at 9:25 pm #

The frequency of the mistakes to which you refer is rapidly increasing due to the overly complex and user unfriendly EMRs that have begun to control all care.

Yet, you think that testing is going to solve these problems. Get real.

I know how dangerous these new devices are, and you, at UCSF, do not know cause you have not suffered with CPOE.

Stop trying to generate a reason for the ABIM to also, with the feds, stick its hands in the pockets of the doctors to generate outrageous salaries to be on the bully pulpit.

REPLY

Dr. Jane August 25, 2012 at 10:22 pm #

Ikhan asked:
" …those with the most training and experience need the most oversight (ie physicians), but those with the least training (midlevels) dont!!

Dr Watcher please comment on this particular trend in todays health care system"
Why is this so? Why are physicians so highly tested, trained and regulated whereas those with HALF our training and education are allowed to run wild?

Also, please clarify your sentence that states, "On the other hand, when other clinicians, particularly less expensive ones, can provide the same care to patients as physicians do, a rational healthcare system would embrace these models."

I am hoping you meant to say,"they appear to provide the same care"??!! You of all people should know that midlevels might be less expensive on the front end (salary-wise), but their lack of knowledge/training causes them to order more tests and consult more specialists, thus driving UP HEALTHCARE costs on the back end.

Or are you conceding that the 11 years of training to become a physician and then becoming board-certified is meaningless as a midlevel with only 6 years of training (some online) can do the same job?

PLEASE CLARIFY. I am interested in hearing your thoughts. Thank you very much.

REPLY

Karl W Hubbard August 26, 2012 at 1:05 am #

Dr Jane,

Of course there is hypocrisy, which you have squarely addressed. I would hazard a guess Dr Watcher, in his relatively protected position, and apparently not having had to suffer too many "direct hits" during his career, can afford to be righteous and take the high road.

He doesn't face the prospect of young MDs starting out, many burdened with debt, having to set sail against vicious headwinds while he enjoyed full financial sail during his career.

To be preaching on the virtues of the Medical Boards, MOC, the cross fire of insurance payers, government bounty hunters, Hospital CEOs, lawyers and politicians trying to pander to a public that wants medical care delivered on a silver platter but not willing to pay a dime for it, is the ultimate stab in the back to fellow physicians.

REPLY

Dominic Salvetti, mD August 26, 2012 at 1:23 pm #

I am an older physician with years of wisdom for planning strategies to maximize the quality and quantity of life of my patients. I barely passed the ABIM boards way back when, and there is not any way I will take the time to study to pass them now.

The peer comparison data I get from hospitals and other groups pushing "market forces" indicate that my patients are older and sicker than those of my peers, and the costs of the care I provide to them is equal to that of my peers.

I have about 10 years left to help patients with their illnesses. I will quit if the ABIM screws with my ability to care for patients.

Oh yes, were the "cardiac procedures" and CABG on the late Neil Armstrong medically necessary, actually? Or, would he still be living had he had another medical care strategist?

Additionally, was his care being run by CPOE and EHR systems that have been known to cause errors and neglect?

REPLY

Steven Reznick MD August 26, 2012 at 9:22 pm #

This is a truly wonderful and diverse discussion and it is a shame if it does not lead to a future new way to evaluate physicians who are busily engaged in practice at a price that is affordable and a time requirement that allows all types of physicians to engage in their area of expertise without having to take time off from work or family responsibilities to prep for the test.

While training I had 3 supervised and graded annual examinations with an attending physician. I was sent to a patient room and given a finite amount of time to take a witnessed history, perform a physical exam, create a differential diagnosis and discuss the case. This evaluation of three patients along with my monthly evaluations by my attending physicians provided the evidence that I was qualified to sit for the ABIM Certification exam. I passed that exam in 1979 . No recertification was required. In 1992 I took my time and money and sat for the added qualifications exam in Geriatrics. I took two days off, travelled five hours, incurred hotel expenses and passed that test. While the syllabus was quite good, certification in geriatrics simply guaranteed that individuals under 65 left my practice and went elsewhere and my

waiting room looked like the physical therapy unit at skilled nursing facility. I did not ask to be grandfathered in to my diplomate status in internal medicine. I believe the decision was made by individuals catering to their own needs and caving in to political pressure and expediency just like today's physician members of regulatory boards cater to theirs. I considered re certifying in internal medicine when the option was offered but frankly the practice modules were impossible and the path to re certification conflicted time wise with seeing 35 patients or more a day, caring for my patients in the hospital, nursing home and office, running a practice that was being compensated each year at a lower reimbursement rate and meeting rising cost of business costs or overhead generated by bureaucratic regulation. Each year due to decisions made by regulatory boards and expenses incurred to satisfy regulatory boards I had to see three more patients to stay in the same place and keep the doors open. The time commitment required at that time conflicted with seeing my three children grow up and being a " certified" father and husband. I am not opposed to sane affordable regulation but frankly the 7-9 million dollars the Joint Commission charges for an inspection which results in hospital adminstrative employees chasing me around forcing me to sign my name at the bottom of each progress note page documenting my doctor number plus the date and time and write " Turn to the Next Page" is a bit much for the $8 million dollar price tag. The Joint Commission certainly has not reduced the errors that Dr Wachter refers to in his blog. Could it be that the cost of hiring non health care personnel running around in white coats with clip boards to monitor JCAHO rules is taking funds away from supplying nurses and reducing the nurse to patient ratio which really does improve health results?

The ACP has been uncaring . It is dominated and has been by specialists and academic interests for years. They ignored their original white paper on the future of internal medicine and recognized hospitalists as a unique specialty for economic reasons long before their was any clear evidence in community settings that there was a clear advantage to eliminating longitudinal care by the patients own doctor. This came about because insurance companies wanted their contracted physicians to care for their patient panels and no one else. They wanted control. When independent physicians refused to play their game ,hospitals had no one to answer the call to see patients in the ER when the doctor on call was not on the insurance company panel. At the same time, employers changed health insurance plans annually for the least expensive plan forcing patients to change doctors annually. This created a whole generation of citizens who never knew the benefits of actually having a long term doctor patient relationship. This was encouraged by the ACP, the ABIM, the Joint Commission, the AMA , employers and insurance companies and their cumulative clout coupled with practitioners grueling schedule prevented any meaningful backlash or opposition. From this we got the hospitalist movement of which Dr Wachter is the originator and chief advocate. I do not know if any insurance company money or hospital association lobbying money went into the treasure chest of the ACP and ABIM to create a hospitalist specialty with board certification but if money did flow in that direction it wouldnt surprise anyone. We additionally saw the growth of the nurse practitioner , physician assistant movement designed specifically to put a lower paid health care worker out in the field.

I watched with dismay as recommendations by the Joint Commission led to the dismantling of monthly Department of Medicine meetings at my hospital that were mandatory. Those meetings, while inconvenient in timing , created a forum for discussion of policy and were accompanied by case presentations for continual learning. It gave practitioners a chance to learn what new services and techniques were being offered in the hospital and it forced staff members to be involved. Fast forward to 2012 where committee membership is no longer required and members are either hospital employed physicians or community docs who are felt to be malleable by hospital administration. Who is the advocate for the community and patient then? We also had monthly CPC meetings sponsored (oh my god!) by pharmaceutical company money. Cases were selected by a committee. The attending physician presented the case and the hospital course. The radiologist, pathologist and selected consultants discussed the pathology, differential diagnosis , treatment and outcome.. An invited expert from the university discussed the case and the literature and with the pathologist told us what really happened. These practical community based experiences were eliminated under the Joint Commissions eyes and blessings and supported by those who felt drug company money for any purpose was immoral and a conflict of interest.

There is no reason for us not to be able to test the competency of practitioners in a sane , educational, inexpensive and convenient manner. We should use the same method we used in certifying house officers. Community physicians should review community physicians performing a history and physical and creating a differential diagnosis and care program at their place of work. Physicians participating in hospital care can have their cases and charts reviewed. Continuing education credits can be mandated as they already are. If a doctor doesnt go to the hospital his office charts can be reviewed. The fee for this exam should be minimal and should incorporate time and travel expenses of the examiner and not much more. It is clear to me that experienced physicians treat patients differently as they mature then in their initial post training days. They ask for help in areas they feel less comfortable in. They no longer perform procedures that they once performed frequently and in much greater volume. As long as they know their limitations and know how to say , " I dont know but I need to look it up or ask for some help" they should be capable of seeing patients and maintaining licensure and certification.
There is a movement in Dr Wachter's organization heralded by Z Emanuel MD (brother of Rahm Emmanuel one of the advocates of the new health care law) to shorten training in medical school and residency. With medical technology and knowledge being much more voluminous now than in the past and with communication between doctors and patients and other health care team members being worse than ever, is this really the time for the ABIM to be advocating shorter training for physicians? A doctor in training gets exposure to areas outside his chosen specialty primarily during his third year of medical school when students rotate from service to service. Is it any wonder errors occur and communication is so poor when new physicians do not understand what their colleagues in the other specialties are actually facing day to day in their decision making choices. Medical school and residency training need to be longer not shorter especially with the mandatory reduction in work hours to reduce errors. Those errors occurred as much because of poor supervision and observation by their academic attendings as it did to sleep deprived decision making ! Residents should have to do a one year rotating internship to learn how the other half lives BEFORE they specialize. Of course longer training would cost more and who is going to foot the ball. The ABIM, the ACP, JCAHO, the insurance companies and employers seem to feel we are better off with less well rounded and trained doctors who we charge a large fee regularly to take a test that pays for the regulatory agency to pay its employees and create new rules and regs.

REPLY

Venkat August 26, 2012 at 9:43 pm #

Dr. Wachter,

I am a general pediatrician, who is required by ABP to go through MOC like ABIM requires its physicians. Please do not assume that my following comment is irrelevant to what you stated above in your original post, as ABP is very likely to follow what other boards do.

Based on your responses to the commenters so far, I am starting to believe that you are simply going to ignore what they have recommended, but just do what you have set out to. So, I thought of offering some solutions to make fellow physicians feel at least a little better.

1. Make NPs and PAs undergo exactly the same kind of MOC requirements as we physicians are required to do. Do not make it easy for them because they aren't as highly trained as we are. And do not leave it nursing boards.

2. Because we are paying from our pockets and spending our personal time to meet the MOC requirements, its only fair that ABIM or ABP pays for our efforts and time spent, rather than us paying you, when we did not request MOC.

3. Now, this is a question to you. Arent we cheating the public when we have them see a paraprofessional when they wanted a physician to take care of their health? You are proposing one standard for physicians, while you allow NPs and PAs to practice with very narrow / poor clinical skills. If you think, they are necessary in our current healthcare system, explain how

they arent a risk to the public, but physicians who are not maintaining their certification are.

Thank you for taking time to read through all the comments and responding back.

REPLY

Whatever August 27, 2012 at 12:30 am #

Was Hippocrates certified by American Board of Internal Medicine?

REPLY

OrthoDoc August 27, 2012 at 5:47 am #

In this age of promoting evidence based medicine, it is appalling that a “leadership” organization is pushing / promoting / pandering an intervention with no viable evidence to document the benefit. This is especially disturbing in that the process takes away time, resources and income from those of us treating patients , while generating profits for the governing bodies demanding the MOC. At the very least, a genuine first step would be to do away with all “grandfathering” if indeed the purpose of this process is patient protection.

So Dr Wachter, please back off on individual attacks of hardworking physicians commenting here and provide us with peer-reviewed, level I evidence of the efficacy of MOC in maintaining / increasing patient care and outcomes. That is our collective goal correct?
The rest of your responses are simply distraction and diversion from the point at hand.

At least then we could have a competent debate. We all are waiting for your leadership here …

REPLY

Marc S Frager August 27, 2012 at 11:38 am #

Dear Bob,

Since I applied for the CEO position in previous messages, I would like to tell the board what I would do if appointed. I would make them read all the comments both at this website and at Sermo so they could truly understand the feelings of their diplomates. I would tell the board not to underestimate the negative sentiment of their colleagues, as your page and Sermo are the only places there has been any interaction since the New England Journal article of 2010 in which exactly the same message was sent.

It truly would be a mistake of heroic proportions for the board to ignore or minimize these comments.This is definitely not the time for a “there, there little boys and girls but we know better” demonstration.

Mandatory MOC may capture a few poor individuals who have to do this to maintain their livelihood, but the current and building antagonism toward the ABIM is hardly portending a prosperous future.

The depth and intensity of feelings expressed here and at Sermo clearly document how out of touch the ABIM and ABMS is, no matter how good their intentions are.

A true leader and a true physician would not ignore these findings. I am certain William Osler would not ignore these findings. What are you planning to do?

REPLY

Kenneth Christman, M.D. August 28, 2012 at 3:04 am #

Dr. Wachter:
I believe you would enhance your credibility if you would adhere to the facts, rather than to disparage the Association of American Physicians and Surgeons (AAPS). Please realize that U.S. physicians are becoming sick and tired with the useless regulations that come from any of the ABMS subsidiaries (including ABIM), the Joing Commission, and virtually all the rest of the regulatory bodies, whose existence is to wreak financial havoc on both patients and physicians.

May I suggest that ABIM be the first to withdraw from ABMS? What does ABMS do for ABIM or this nation's internists? How much does ABIM pay to ABMS yearly?

Board certification is a good thing, but there is no need to recertify. It is NOT a productive use of resources. CME is a good thing. Doctors will participate in CME whether it is mandated or not. We are being over-regulated, and the regulators are being overpaid.

REPLY

Wagamama August 28, 2012 at 1:30 pm #

Recertification is a racket, pure and simple. At least the racket used to be more subtle. Now, with a hospitalist in charge, the farce is in plain view. Here's a specialty whose training path is characterized by:

a) Absence of any specialized body of knowledge. Sorry Bob, "hospital medicine" does not qualify just because you can say it in a catchy phrase. Expertise in discharge paperwork is NOT a medical specialty. The IQ and knowledge requirements are dramatically lower than for any internal medicine subspecialty.

b) A pitifully solipsistic focus on self-justificatory research. And even that, more often than not, shows that hospitalists improve neither care nor cost.

Come on Bob – show us the randomized controlled trial demonstrating that recertification works. Bueller?…..Bueller?…..Bueller?…..

REPLY

Dr. Mike Ruddy August 28, 2012 at 10:15 pm #

Dr. Wachter, I wanted to add my thoughts that I think speak for those posting here who, like me, oppose recertification.

I'm a doctor, and I'm damn good at it. Why? Because I learned to be a doctor the old-fashioned way: gumption, elbow grease, and trial and error. I'm not one of these blowhards in a white coat who'll wear your ears out with 10 hours of mumbo-jumbo technical jargon about "diagnosis" this and "prognosis" that, just because he loves the sound of his own voice. No sir. I just get the job done.

Those fancy-pants college-boy doctors are always making a big deal about their "credentials." But I'm no show-off phony with a lot of framed pieces of paper on the wall—I'm the real deal. I got my M.D. on the street. These people think they're suddenly a "doctor" because they memorized a lot of big words and took a bunch of formal tests. But there's plenty of things about being a doctor they'll never learn in their ivory-tower medical school.

For example, did you know that human intestines, if they spill out of the abdomen during surgery, can spool out all over the floor if you're not careful? You won't find that in a book, my friend.

When it comes to practicing medicine, I focus on the basics. In a life-threatening situation,

you've got to think on your feet. I don't waste time going on and on about which virus is which or whose blood type is whose. I get out the tools, roll up the shirt sleeves, slick back my hair, and get in there all the way up to the elbows. The patient's not going to magically heal just because you know a lot of complicated terms like "bovine spongiform encephalitis," or "antibiotics."

You want to know where I got my doctor's degree? At the Medical School of Hard Knocks, that's where. No matter what they say, advanced graduate studies won't teach you when somebody needs a shot of whiskey. Yale and Harvard don't tell you when to throw a bucket of water on a patient. And they can never teach you how to tell when someone just needs a good solid punch in the nose to bring them around.

While they were cooped up in some dorm room reading about being a doctor, I was out there in the real world, being a doctor. And there's no substitute for hands-on experience.

Not to mention, my rates are a hell of a lot more reasonable than what one of those college- and med-school-educated doctors will charge you, because I take out all the bells and whistles. You won't catch me pressuring my customers into paying for expensive MRIs and IV drips and electronic X-Ray Vision machines and who the hell knows what else.

Jesus, you ever look at one of those scans? They're just a lot of crazy shapes. The only sure-fire method for figuring out what's inside a man's body is to go in there and take a look for yourself. And if you want to put a shunt or a valve into a person, you don't rely on gimmicks like tubes and syringes. You get your hands a little dirty, you open them up, and shove it right in there where it belongs.

I hate these elitist doctors almost as much as I hate their Ivy League glee-club buddies, the lawyers. Between their constant "writs" and "summons" and all their hot air about "malpractice" and "licenses," they're enough to drive a man to the point where he can't even practice medicine under his own name anymore, and is forced to pull all his ads from bus-stop benches.

If you need a good doctor, you just keep your ears to the ground, and my name will eventually come up—people know how to get ahold of me. When all is said and done, the customer can tell the difference between a real doctor and some dime-store college-educated phony decked out in stethoscopes and ear-flashing things who's never put in an honest day's work in his life. But me, I'm the real deal, salt of the earth, and I don't need a diploma to tell me that.

(Let me give full credit for the above which is from http://www.theonion.com)

REPLY

Mark Rosen August 30, 2012 at 9:59 pm #

Hilarious

REPLY

K. Sennholz MD August 29, 2012 at 1:24 am #

I agree with the vast majority of posts which say that board certification requirements and MOC are an unmitigated disaster. I want to add just a couple of points:

1. Sequestering the flow of medical information by overloading and inundating the physician's time, mind and money, creates a system which is ripe for extreme abuse. If the physician only has time to do MOC/board study for their CME instead of topics chosen by the physician as essential to their knowledge and practice, you hand over to the pharmaceutical companies, the medical device companies and others, the very HEARTS AND MINDS OF ALL DOCTORS. This is morally, intellectually, scientifically and practically wrong. I feel quite confident that physicians are aware of the areas in which they need work and areas in which they are up to

date. Like the democratic system we have, this is a proper check and balance on the practice of medicine. These excessive tests remove that natural check and balance.
2. By stealing the physician's time without reimbursement, it very practically precludes the part time practice of medicine. In this time of increasing numbers of covered patients, that is also a BAD BAD BAD idea to limit the flow of physicians in this way. If a physician has to do one unreimbursed weekend for ATLS, one unreimbursed weekend for ACLS, one unreimbursed weekend for PALS, one week to study for boards and another to take it, in addition to all the moc requirements, you are talking about a GROSS and SIGNIFICANT amount of not only unreimbursed time, lost wages. AND the physician has to pay for the privilege of being away from loved ones and their precious time off. If you get out your little calculator, you will see that part time medicine will be a thing of the past. Why is this bad? It decreases diversity in medicine. It shrinks the pool of eligible physicians to take up slack in times of distress. It eliminates a period of part time practice as a remedy for burnout, which is currently epidemic. This is bad planning and bad implementation.

All of this, without improving the lives/health/happiness of patients, physicians, or medicine, one single iota.

REPLY

David Langdon August 29, 2012 at 1:52 am #

Doctors in every specialty are familiar with the temptation to do a test that can be done to confirm or diagnose a disease for which there is no good test. Fifty years ago, when the only head image we could order was a skull xray, doing skull xrays was a routine part of headache and short stature workups, even though we knew it could only detect a very tiny percentage of brain tumors. I'll bet every specialist can give you examples of tests that are nearly worthless for a given condition but are done because they can be ordered and because the test that would really answer the question does not exist: a couple of examples in endocrinology are OGTTs for hypoglycemia and nerve conduction velocity measurements for early sensory neuropathy.

The MOC is just such a test. It pretends to answer a question that it has never been proven to answer: is this doctor a good doctor? If only it were as easy as a quick skull film. Instead it is as expensive, painful, and useful as a pneumoencephalogram.

Do NOT accuse doctors who are offended by the pretension of accuracy and the balk at the waste of effort and money involved of being less conscientious at keeping up or caring less about the quality of their care. Instead, put all that effort into more effective ways of improving medical care. It's not like there are not lots of other directions to look.

REPLY

David Flemming August 29, 2012 at 2:27 am #

Boards is a great hurdle confirming ability to use brains, study, be methodical and so on. But experience is the best teacher after the hurdle is past. Continued MOC challenge maintains obsolete methods and tends to block advancement. Huge financial drain and should not happen.

REPLY

claire fabian August 29, 2012 at 2:01 pm #

I'm a pathologist and support your resistence to MOC. Every year pathologists are

required to pass a test in cytology (10 slides) so we can continue reading pap smears. This exercise is useless and costly. IF we allow these so called important educational exercises to consume our time and money, then we have truely lost all our power as physicians. We know these tests are not effective learning tools and do not effectively evaluate our competency. CME requirements are enough to ensure our competency.

REPLY

sopsam August 29, 2012 at 2:29 pm #

Dr.Watcher,

I find it deplorable that there is a “strange fascination” by third-parties to regulate doctors.
To add insult to injury the supposed regulations are done by using our money. Two things come to mind:

1. If the idea is to regulate doctors to protect patients from them, why not have the state fund your ventures?

2. In case you have not noticed, mid-level providers trained medical personnel are also being called healthcare providers. Perhaps your board should ask them to take these very expensive exams when your supposed goal is to improve quality of medical care given to patients.

This selective regulation being imposed on doctors is nothing but a money making scam.
By creating MOC, you are addressing an issue which does not exist!!

We can not be in a life-long school to continuously stay up to date with medicine which we have to stay up to date just because we are practicing.

Would you care to comment which one is a better way of staying up to date with medicine:

1. Practice of clinical medicine itself
OR
2. Taking endless textbook-based tests?

Until your board requires and implements the same quality of care from all medical providers, we are going to stay immune to MOC.

REPLY

Ailing August 29, 2012 at 4:19 pm #

I past the boards in 1985, specialty boards in 1987. Both were life time certificates. YOU are now changing the requirements and de facto changing my contract with you unilaterally. Prove to me that the MOC will increase my practice, my training, my care and I will do it without your steel gloved hand on my throat! I do 200 hours of CME a year now. I am VP of staff and do peer review and Performance Improvement as the chairman. I meet physicians weekly and do quality improvement. I have not seen MOC in either IM or may specialty boards worth my time. Really do we need to focus on basic science when soon I will be replaced by an NP with a PA? What have you done to make Board Certified a distinction? NOTHING. My patient don’t have a clue what that is.
Transparency would include a page on how much you are getting paid and what percent of our board costs are going for our benefit??? Look at the amount of cash on hand the boards are now reporting on their tax forms. Wow. Looks like a cash cow to me.
I sound negative but it may be that the new EMR with increased 10% in my time at clinic along with my falling reimbursements make me grouchy. As I see it another unfunded mandate from you the board in the name of Quality that you can’t even measure accurately.

REPLY

Mt Doc August 29, 2012 at 6:56 pm #

Dr Wachter, a lot has been said here which I hope you are paying attention to. One recurrent point is that a closed examination has very little resemblance to how we act in the real world. In the real world one can and does spend a lot of time on Uptodate or other resources if one has any question about the patient in question. A good doctor also has to know his or her limitations and know when to refer for a subspecialty opinion. I've yet to see a question where a possible answer is "I am not sure of the answer but know where to look it up" or "The complexity of this case exceeds my level of expertise so I will refer". Yet these situations happen all the time in actual practice. I dont know anyone who depends on their memory alone to guide them taking care of patients with uncommon or unfamiliar diseases.

Nobody is denying the value or benefit of CME. I agree however with Dr Sennholz that the current cme format often ignores the particulars of a doctor's individual practice. I personally breath a little sigh of relief when I've completed my CME requirements for the year because it frees up more time to spend on educating myself about the problems my own patients have. I wasted a lot of time in my training memorizing the Krebs cycle and studying the embryology of a fetal pig. If I don't take care of post-transplant patients now (to use the example of a previous poster) why should I waste my time studying about that?

While I'm on the subject, I believe medical schools have a societal duty to help doctors with continuing education after graduation, which responsibility they have turned into a cash cow. Who came up with a system requiring doctors to travel from all parts of the country at great expense and time committment to hear lecturers who also fly long distances, usually to give one or two lectures apiece? As part of their academic employment these lecturers should be required to tape their lectures at their own institutions and make the tapes available at MINIMAL expense to any physician interested. Additionally, while most of the lecturers I have heard are good speakers, many of the written CME materials are poorly written. I am talking specifically about MKSAP. Some of the authors of this have the ability to take an interesting subject and make reading about it as interesting as reading a phone directory.

One final point that has been made is about the endless stream of things physicians now have to hassle with that does not help us take care of our patients, indeed detracts from this ability. Both CME and any mandatory testing you saddle us with should be PERTINENT, cheap, convenient, and of some value to us in taking care of patients above just getting a certificate. It's hard not to get angry about how things currently are.

REPLY

Marc S Frager MD August 29, 2012 at 7:30 pm #

Dear Bob:

The CEO of the ABIM has not issued a statement regarding this discussion and the one on Sermo. I find it very strange that she would not support her board chair. But in all fairness, there may be several reasons why she hasn't responded. Perhaps she is too arrogant to respond. Perhaps she does not have time in her contractual 35 hour workweek to respond. Perhaps $800,000.00/yr + spousal travel is not enough for her to respond. In any case, since she is unwilling and/or unable to respond, in my role as ABIM CEO applicant I have drafted a response. I think the board should consider it:

Ladies and gentlemen, diplomates of the ABIM:

We have heard your complaints. We understand your problems with mandatory MOC. We understand it was wrong to implement and mandate an expensive and intrusive process with absolutely no data to support its efficacy.

Therefore we are immediately ceasing implementation of mandatory MOC. We hope to work

closely going forward with the ACP and medical specialty societies to strengthen VOLUNTARY self-assessment. We will be issuing refunds to those currently involved in the MOC process: further details to follow.

We understand we can mandate a process but we cannot mandate the respect of our diplomates and the respect of our peers.

Thank you for your support

Marc S. Frager MD
ABIM CEO Applicant

REPLY

Steven Reznick MD August 29, 2012 at 11:32 pm #

I vote for Dr Frager !!!!

REPLY

River MD August 30, 2012 at 6:52 am #

That you would consider HealthGrades to be a bastion of transparency, and that you would thus ally your organization by the comparison is appalling.
http://www.consumeraffairs.com/online/healthgrades.html

Personal attacks on physicians with differing views is similarly distressing.

But most distressing is the lack of an answer to all those who have asked about the necessity for MOC of physicians to preserve patient safety whilst ignoring the (uncertified and unMOC'd) role of midlevel providers.

Credibility is lacking.

But, hey – congrats on the new job and all.

REPLY

Stan Jackson, MD August 30, 2012 at 12:36 pm #

The ABIM has relationships with the JC. ABIM will say jump, and the JC wll enforce it, and the hospitals' paid sham peer reviewers will shaft competent doctors who, indeed, care about the safety of their patients.

Soon, NPs and PAs will be on the sham peer review committees.

If Wachter and the ABIM are so concerned about safety, they should demand that the EMR and CPOE devices be vetted for safety as required by the Federal Food Drug and Cosmetic Act.

They should also demand the credentials of those on the MU committees and proof that the MU rules will improve outcomes, safety, usability, and reduce costs.

What a flagrant experiment on the patients and their doctors.

REPLY

Hunter Thomas, MD August 30, 2012 at 1:19 pm #

Dear Dr. Wachter,

I am disappointed in you for issuing disparaging comments about the leadership of AAPS. They and their organizatiopn have a right to their viewponts without being chastised.

Was it that you were slected for this position because you agreed to the MOC, even though there is not any evidence for benefit?

Considering the valid comments of those posting here, there appears to be more harm than good.

Is there anybody actively taking care of patients out there who is going to defend Dr. Wachter's unilateral perspective?

REPLY

Alieta Eck, MD August 30, 2012 at 1:29 pm #

My husband was trained for three years in general surgery, and then switched to Family Medicine. He was board certified in Family Medicine in 1988. He worked as a first surgical assistant for several years and then established a general medical practice with me. I was board certified and grandfathered in Internal Medicine. My husband has served the community for many years and has always been in good standing at the hospital. No complaints. Then, last year he refused to go through the time away and expense to re-certify in Family Medicine.

With all of his experience, he argued that taking more tests was a waste. But the hospital boasted that all their physicians were board certified and there could be no exception. The hospital threw him off the staff. I obtained 130 signatures of staff physicians who wanted to bring this up to vote to change the by-laws and allow physicians to avoid re-certifying if they have been in good standing for, say, over 15 years.

So now nurse practitioners and physicians assistants are allowed to write orders and see patients, but my highly experienced physician partner cannot. They won't even allow him to take the role as a nurse practitioner! How crazy is that?

End re-certification! It is unnecessary, and expensive in time and money. And hospitals DO require it. It is not optional, Dr. Wachter.

REPLY

Diane Eisman August 30, 2012 at 3:05 pm #

Recertification is absolutely absurd.

This does not measure the competency of a physician.

It measures the ability to pass an exam.

the time and expense required to pass these exams is horrendous.

Obviously, these recertifications are simply another way to get rid of physicians and install those midlevels in our places.

Obviously, this recertification burden is another way to make money…of the backs of hardworking and caring physicians

REPLY

Paul Kempen August 30, 2012 at 3:35 pm #

Dear BOB and everyone: Take a look at the following article:What my doctor thinks of ObamaCare @ http://theweek.com/bullpen/column/232510/what-my-doctor-thinks-of-obamacare
"Don't make the same mistake that Washington did. In formulating ObamaCare, the politicians listened to lobbyists, policy wonks, academics, health theorists, regulators, and occasionally to each other. But they failed to listen to the people who actually care for patients: Doctors. "
SHould we substitute MOC for Obamacare in that sentence and the analysis-it seems appropriate. When will working physicians have a word in the ABIM money-machine? (I am not referring to hired employees and coroprate policy wonks either!) We are working harder than ever and just falling behind under government and now ABIM mandates which are only selfserving!

REPLY

Mt Doc August 30, 2012 at 6:35 pm #

An example of mandatory testing that physicians have undertaken with no documented benefit in outcome for patients was demonstrated by an article in 2009 in the NEJM dealing with survival rates for in-hospital CPR from 1992 to 2005. During that time I have had to recertify for ACLS every two years, trying to forget old algorithms and learn new algorithms. The end result of all these courses and recertification has been no improvement in patient survival for in-hospital codes. Whether we stacked respirations or not, performed various permutations of compression/ventilation ratios, gave bretylium or not, bicarb or not, lidocaine or not, various protocols for giving epi, etc etc seemed to have had no effect on patient outcome. Despite that I have seen students flunked in the past for such things as not being able to calculate a bicarb dose in their head when given a blood gas value during a mega code, in the days before we learned bicarb was generally a bad thing to give. I'm not saying that having to take these repeated courses was necessarily all bad – it had an effect on decreasing my anxiety levels during codes – at least we had a plan of action, even if it wasn't the right plan. But patient outcomes apparently weren't affected much.

This article came out before the recent revisions in ACLS. Thankfully ACLS has become more evidence based and hopefully when this is restudied we will find some improvement in outcomes with the new protocols I await these results with bated breath..

REPLY

Marc S Frager August 31, 2012 at 11:24 am #

Dear Bob:

Please give Dr. Krumholtz the holiday off. I can tell you now what physician assessment should look like in five to seven years as well as right now: VOLUNTARY SELF-ASSESSMENT…

REPLY

Kim Lavigne September 1, 2012 at 2:44 am #

I am, personally, struggling with this issue right now. I tend to agree with the majority of the posters but I would really like to hear what Dr. Watcher's response is and what the ABIM and or the ABMS response is. Dr. Watcher, would you kindly address these concerns? They are mine, they are very real, and they have me very weary that organized boards do not have

my best interest in mind – especially when a majority of members opposes something but it is pushed forward and then not adequately addressed as appears to be on your blog. This is the perfect place to address all of thes concern and I am looking forward to your reply with the hopes that I may be wrong about my position of boards and their representation. If I am not, membership (across all specialties) will continue to see a steep decline in the years to come.
Thank you,
Kim
Again,
I look forward to a response soon!

REPLY

Mark September 6, 2012 at 9:37 pm #

Anecdotal evidence presented here suggests that present ABIM policies and plans are severely misaligned with the need of its diplomates. Out of touch. Out of the mainstream. So maybe there is some commonality with Mr. Akin after all. On the other hand, Mr. Akin does not seem disingenuous.

REPLY

Eric N. Grosch, MD, JD September 7, 2012 at 6:40 pm #

I recently attended the annual meeting of the American Bar Association in Chicago. The emblematic moment came when a judge from Louisiana complained about statutory sentencing guidelines and about how the Louisiana legislature was thereby usurping the judgment of judges, in the absence of any consideration of individual circumstances of any given case. Legislative interference in the business of courts occurs throughout the nation, not just in Louisiana.

1848 was the year of the founding of the American Medical Association (AMA). The AMA's first Code of Medical Ethics included a provision to the effect that the only tribunal for the quality of the clinical care that a physician delivered to a patient was the physician's own conscience. That was the best and greatest idea that the AMA ever had. Even the current AMA Code of Medical Ethics includes a provision to the effect that the patient-physician relationship must be given foremost consideration at all times.

Two years later, 1850, Texas established the first medical regulatory board in the union, under the police (not scientific) powers of the state, and swept aside all such ethical considerations. The rest is history. Every state in the union now has a regulatory board of medical examiners, established under the police (not scientific) powers of the state and they all disregard ethical considerations.

Now "expert" witnesses for the state, who have no patient physician relationship with the patient or patients whose physician-licensee is under regulatory scrutiny, and who have never taken a history or examined any of those patients, provide "expert" testimony to which hearing officers attribute far greater weight than to the testimony of the only physician who had a patient-physician relatiionship with the patient or patients in question, namely the respondent in the case.

Physicians undergo a more extensive and profound course of education and training than does any other walk of life, yet we submit to the judgments of popinjays (regulatory attorneys, attorneys in black robes, whom we laughingly refer to as "judges," attorneys as legislators, etc., each of whose course of education and training consists of four udergraduate years and three law-school years, no residency training beyond that) and to physician "opinion-leaders," such as Christine Cassell and her specialty board of internal medicine, who have no patient-physician relationship with our patients.

The complaint of the judge from Louisiana, about his legislature's interference with his proper discretionary judgment in sentencing applies a thousand fold to each and every practicing physician in this nation, with respect to the interference with his or her discretionary judgment in clinical management by the limitless flock of medical and legalistic popinjays who claim to know more and better than the physician who has the patient-physician relationship with his or her patients.

The time is overdue to reinstate the AMA's original Code of Medical Ethics, leave judgments about quality of patient care to the conscience of the individual physician, limit the function of every state board of medical examiners to licensure, based on satisfactory completion of a medical degree, to dismantle every specialty board and to scatter the medical and legalistic popinjays to the four winds.

REPLY

Jeffrey M. Goldberg September 9, 2012 at 6:43 pm #

No one can argue against continuing education. The concept of life-long learning was instilled in all of us as a core part of our medical training. In this day and age, proof that you are following the mantra of continuing education is expected, not just in medicine, but among firefighters, airline transport pilots, and others whose jobs have life-or-death responsibilities.

One critical difference, though: when a commercial pilot goes for annual simulator training, his or her time is on the company clock. The company pays for the simulator, too. And the time in the simulator is a learning experience, not just a test. It's not a hurdle to be overcome so that you can get back to flying. It's an opportunity to take a few days to continue being the best pilot you can be.

I propose that we model medical safety and quality training after the proven methods used in aviation, on aircraft carriers and in other high-reliability organizations. Design annual certification so that it is a welcome opportunity, not a barrier. The public rightly demands doctors that are "certified" to a new, higher standard, so let the public pay the costs of better certification and annual training. And make annual maintenance of competency a meaningful, productive experience, not the tedious and trivial exercise that largely describes our current methods.

Redesigning what we now call MOC into a publicly financed, effective educational and certification process will not be easy, but it will represent what both doctors and the public actually want and expect. Dr. Wachter, I hope you and the ABIM will take up the challenge.

REPLY

Paul Kempen September 9, 2012 at 9:22 pm #

The Public does NOT demand certification at all. The whole certification INDUSTRY is the only one pushing the whole business. They are unfortunately all NON-Profit organizations, which affords them a shroud of "humanitarianism, but they are only out there making money. The ABIM and all the ABMS affiliates are practicing "Regulatory Capture":

"Regulatory capture" occurs when special interests co-opt policymakers or political bodies — regulatory agencies, in particular — to further their own ends.

The whole board certification arose as an outcome project to allow correlation of residency training programs-Educational programs- as well as the physician's needs to "feel excellent" and also to exclude others from a specific realm of practice. Well that has failed miserably with NP and PAs now "filling the void!

So the "industry" has decided to "milk the working physicians" to improve the lot of the

academics-those who really do not or dislike actually providing direct medical care to patients!

It is time to make this industry accountable! They have been "regulating" the physician industry COMPLETELY WITHOUT ANY OVERSIGHT from Government or the practicing professionals for too long-this truth needs to be exposed!

REPLY

Donte McClary, MD September 11, 2012 at 9:09 am #

I strongly agree that physicians must remain competent. The only way this can be proven by medical boards, insurance companies and hospitals is through testing, rather oral or written. As a younger physician who re-certified for the first time last year, I realized during my preparation that I forgot a lot of information I once took pride in knowing well. As a full-time hospitalist, for 8 years I thought that when I had to take the board exam, I could just show up and pass. I sat for the new Hospital medicine exam in 2011 and I know for a fact I would have failed if I had not intensely reviewed. I strongly feel that my review over several months has made me a better hospitalist. There were new treatment guidelines that I was not aware of. I realized that new tests and protocols have been developed since I finished my residency in 2001. Example, things like JAK 2 mutation and Arixtra therapy did not exist in 2001. I have never had any quality or patient safety issues noted during my 8 years as a full-time hospitalist, but going through the MOC process has made me a more knowledgeable hospitalist. The modules I did still help me in practice now. I recently started a CQI project to improve my personal HCAP scores. Having done the hospital based medicine PIM and studying CQI theory and PDSA concepts during my MOC process, I now am better equipped to make improvements in my clinical practice when needed. I simply did not know all of this stuff before going through the Focused practice hospital medicine MOC last year. It actually feels good being current and having reviewed all of the IM sub-specialties again. As a hospitalist I really respect Dr. Wachter's contributions to my field and leadership in projects like the UCSF fellowship for hospitalist. I concur that as a physician ages, there is no way he/she can remain current without intense review and an MOC process. Doing 25 hours of yearly State board required CME just will not cut it. In my opinion, if a grandfathered physician thinks he is really providing quality care without going through some kind of MOC process every 10 to 12 years, he is just fooling himself.

REPLY

Steven Reznick MD September 23, 2012 at 10:04 pm #

You need to know where to access and find the data no longer at your fingertips. You need to know your limitations and where and when to ask for assistance. Medicine has been kidnapped by insurers and employers using their lobbying money to coerce legislatures to pass rules for our profession that no other profession or industry would accept. Our board re certification is financially driven by the insurers , employers and medical organizations profiting from the education and testing.
It is our individual responsibility to stay current and at the top of our game. More rules and mandatory tests are unnecessary. Dr Wachter created a subspecialty and with the support of monied interests from the insurance industry and employers desperately searching for the definition of quality, bankrolled it into a non practicing financially rewarding career. I still believe we do not need hospitalists. We need more thoroughly and broadly trained generalists who are compensated for their time and evaluation and management skills and provide longitudinal care in and out of the hospital!

REPLY

Eric N. Grosch, MD, JD September 11, 2012 at 3:56 pm #

The ABIM's claims on its website about "what the evidence shows" consists of retrospective data-dredging studies that demonstrate only marginal distinctions between board-certified and non-certified physicians' clinical outcomes and those distinctions and others variably favor board-certified physicians and non-certified physicians. No study can ever adduce credible evidence that will definitively discern distinctions independently attributable to board-certification because education and training are confounders. That is, board-certified physicians and non-certified physicians have similar education and training, so to isolate and distinguish the independent effect of board-certification on clinical outcomes or any other index of quality of care, one would have to discern and compare the clinical distinctions attributable to four groups of physicians:

1. Residency-trained and board-certified
2. Residency-trained, not board-certified
3. Not residency-trained, board-certified
4. Not residency-trained, not board-certified

Since residency training is a prerequisite for eligibility to take the examination for board-certification, group 3 does not exist. Since most or all state boards of medical examiners require residency training for licensure, group 4 probably does not exist or is very small. The only extant studies of the distinctions between board-certified and non-certified physicians confine their comparisons to groups 1 and 2 and, since residency-training confounds the distinction in clinical outcomes and in other distinctions, the clinical differences in clinical outcomes and in other distinctions between board-certified and non-certified physicians chatter about zero.

Furthermore, the only extant studies of such distinctions treat distinctions in common, straightforward, bread-and-butter interventions that the practicing internist does every day or at least rather often, such as, for example, advising patients to stop smoking (see Ramsey PG et al. Predictive validity of certification by the American Board of Internal Medicine. Annals Int Med. 1989 May 1;110(9):719-26 PMID: 2930109) or prescribing beta-blockers and aspirin to patients with myocardial infarctions (see Chen Jersey MD, MPH, Rathore Saif S MPH, Wang Yongfei MS, Radford Martha J. MD, Krumholz Harlan M. MD, SM. Physician Board Certification and the Care and Outcomes of Elderly Patients with Acute Myocardial Infarction. Journal of General Internal Medicine. 2006 Mar;21(3):238-44), interventions for which large numbers of published instances exist in the medical literature and for which, therefore, some distinctions among practitioners might reach statistical significance. The trouble is that passing a board-certification examination does not depend on knowing about such obvious and straightforward interventions. Does telling a patient to stop smoking for the good of his or her health or prescribing aspirin to a patient suffering chest-pain really require board-certification? Not likely. Instead, passing a board-certification examination ostensibly requires quite esoteric knowledge about obscure conditions, such as idiopathic thrombocytopenic purpura or Wegener's granulomatosis, conditions that the general internist might encounter once or never in a lifetime, both because nobody often encounters such conditions and because subspecialists, such as hematologists, pulmonologists or nephrologists, would most likely manage them, as a general internist would be foolish to try to manage them and wise to refer them to such subspecialists. Accordingly, the general internist is unlikely ever to apply the obscure, cutting-edge, esoteric knowledge, that he or she must acquire to pass the examination and which is likely to obsolesce between recertification-examinations, long before the general internist may happen to encounter such a rare patient. No study exists of how well general internists manage the many esoteric conditions, the characteristics, diagnosis and management of which they must book-learn to pass the board-certification examination in general internal medicine, compared to how well applicable subspecialists manage those esoteric conditions because the numbers needed to generate statistical significance do not arise and the number of general internists, whether board-certified or not, whose experiences in managing such patients appear in the published literature, is or approaches zero.

See my published, scientific peer-reviewed article, Does specialty board certification influence clinical outcomes? Journal of Evaluation in Clinical Practice, 2006 Jun;12(5):473–481, and its

companion-article, Sharp Lisa K, Bashook Philip G, Lipsky Martin S, Horowitz Sheldon D, Miller Stephen H. Specialty board certification and clinical outcomes: the missing link. Acad Med. 2002 Jun;77(6):534-42..

REPLY

Hospital MD September 22, 2012 at 1:06 pm #

Classic case of believing in the healing/rejuvenating/invigorating properties of one's own elixir

MOC is a check-the-box type of event that does not lead to lasting changes in physician practice or behavior. Rather, it is a tool to keep the board and the board prep industry in business. It does not take a neurosurgeon to see through these conflicts of interest

Physicians who are truly interested in impacting population health, healthcare quality and health policy, would do well to move out of the comfort zone of a 1:1 patient engagement of their practices and enter the arena of payers, policy makers and industry

Board & board-prep industry, heal thyself. Or, face the exodus

REPLY

Hector Derreza October 3, 2012 at 5:41 pm #

Dr Wachter,

I concur with most of your views. We need to have a professionally driven method to ensure competency for physicians.
Keep up with the battle.
Hector Derreza

REPLY

mj October 6, 2012 at 6:47 am #

why does MOC cost so much ?

ethical doctors in primary care are drowning in overhead costs….MOC /board prep courses like the one given by UCSF are breaking us financially. why cant you cut the costs in half of your board review course and do the same with MOC moduless?

REPLY

Narayanachar S. Murali, MD, FACP, FACG October 30, 2012 at 3:29 pm #

On a different note.. Who really cares for boards or for any of those alphabets after our names? I accidentally forgot to put up the new cert on the wall (the oldest cert still hands on the wall behind the fridge!). To this day, I have seen 27,000 patients in my practice. Most come to me referred by other patients through word of mouth. No one has told me they came to me because I am board certified and doing MOC or because they saw my health-grades rating! BTW.. I am doing MOC still. Do not know if I want to continue to do it since ABIM has taken an aggressive, hostile stance against physicians in private practice with their novel ways of revenue capture and imposition of their presence. . I have also decided to stop being a member of multiple organizations of my specialty because they tend to align with boards for

political and monetary reasons. Everyone is trying to grab a piece of physician liver. But…like the proverbial Prometheus we still linger.

REPLY

Irate Doc October 31, 2012 at 1:12 pm #

Dr. Wachter: During the past two days the ABIM has been closed while those of us working physicians worked tiredless, risked our lives, and sacrificed to serve our hospital, one of eleven public facilities in New York City despite personal hardship. Around here, we have always put patient care first. Mayor Michael Bloomberg has acknowledged this and has been very supportive of our efforts.

The ABIM has been exceptionally proficient in imposing it's clinically ridiculous "secure exam" full of decade old buzzwords and clinically puzzling content. One would imagine that an organization of ABIM's supposed esteem would have a back up plan since "the public" that it keeps referring to would certainly assume that maintaining standards is an important job, yet the Board of Directors doesn't seem to notice this problem. Where's the professionalism, Dr. Cassel?

REPLY

Marc S Frager MD November 1, 2012 at 4:42 pm #

As the author of the 100th post I would like to ask if ABIM is helping the public, helping the patients, by angering the diplomates who have to participate in the MOC process?

Can MOC be truly voluntary if hospitals and insurance companies use participation to credential physicians?

While you say it is understandable that busy physicians want MOC to go away, isn't it true that the flip side of that coin is that self-important, overpaid bureaucrats want to maintain the status quo as long as possible?

When is the ABIM going to be transparent and tell us how it is making the horrid process of MOC more relevant?

How can you justify such a ridiculous price for MOC, when an internist can self-assess with MKSAP, for example, at a fraction of the MOC cost?

To whom does the ABIM and ABMS answer? How did these organizations get the ability to impose their rules on diplomates? What rights do diplomates have to object to outrageous MOC policies and outrageous ABIM salaries?

REPLY

Paul Kempen November 1, 2012 at 5:58 pm #

Dr Frager states the issues clearly. The only oversight of the ABIM is the ABMS-if they are not just one and the same. That is 12 Board members in a room behind closed doors with no oversight or responsibility to the professionals themselves! It is time everyone accessed the literature at:
http://www.jpands.org/vol17no3/christman.pdf
where you find:

Proposed Model Legislation
Patient Access Expansion Act (Draft, July 26,2012)

If MOL develops roots in any state, it will quickly spread to other states, subjecting all physicians to the“unsheathed sword.” This is why the AAPS presented model legislation to state legislators across the country at the July 2012 meeting of the American Legislative Exchange Council (ALEC). That model legislation is as follows:

Summary
This Act prohibits maintenance of licensure, Maintenance of certification, and specialty certification as requirements to practice medicine. It also prohibits the state medical board from funding the Federation of State Medical boards.
Definitions:
Maintenance of Licensure (MOL) is defined as state medical board requirements for physician re-licensure above and beyond current continuing medical education (CME)requirements.
Provisions
Maintenance of Certification (MOC) is defined as periodic recertification requirements as specified by various specialty medical boards in order for a physician to represent himself/herself as being board certified.
Section 1. Short Title. This act shall be known as the “Patient Access Expansion Act.”
Section 2. Prohibition of Maintenance of Licensure, Maintenance of Certification, Specialty Certification to Practice Medicine.
The state of {insert state} is prohibited from requiring any form of maintenance of licensure, maintenance of certification, or original certification by a specialty medical board, in order to practice medicine within the state. This Act shall apply to hospitals, insurers, other third-party payers,and the {insert state medical board}

Section 3. Prohibition of State Funding of Federation of State Medical Boards.
The {insert state medical board} is prohibited from funding the Federation of State Medical Boards (FSMB). Funds from physician licensures shall not be sent to FSMB and the state of {insert state} shall not permit any money to be forwarded to FSMB from this state.

Where rational approaches to the MOC/MOL issue is available. In Ohio, the physicians soundly rejected MOL, leading to the ousting of the Exec director of the medical board as a direct result. See:
http://www.dispatch.com/content/stories/local/2012/10/18/state-medical-board-ousts-chief.html

REPLY

Thomas B. Francis, MD November 5, 2012 at 9:06 pm #

The above comments validate the diversity of opinion as well as the magnitude of dissatisfaction with ABIM MOC practices. I missed the grandfather year exemption but not only endorse recertification for all but continue to participate as a valuable means to upgrade my knowledge base. I am quite certain ABIM knowledge testing could be validated to somewhat correlate clinical aptitude(not perfectly) . However the ABIM PIM modules have no documented validity in measuring individual or practice quality. For those of us who have seen the JCAHO

dog and pony shows regularly take place through the years, the ABIM is just following the federal government and other bureaucratic organizations in requiring this “exercise” which depending on the PIM, adds quality or is a total waste for the physican(s) doing that particular PIM. The PIMs can be gamed and in my own view are an extremely poor markers of clinical quality albeit if done properly an excellent opportunity for practice improvements. The diversity of the PIMs although necessary for the diversity of medical practices and individual subspecilaties of medicine make it impossible to fairly certify one individual over another. As such, I would highly suggest the ABIM either remove the PIM requirement or make it an optional exercise which can be addended to any re-certification to show the physican has participated in it but was not required to do so.

REPLY

dr x November 27, 2012 at 10:46 pm #

I recently suffered through the process. It was a costly, a waste of time and degrading. I was practically strip searched just to get into the room to take the test. In addition I was palm printed and given a mug shot.
The test itself was absurd. Questions covering obscure zebras-like some question on a parasite that forms liver cysts in China, had ZERO relevance to my practice.

This is a racket and a nightmare. Luckily, this will be my last recertification.

I AM LEAVING MEDICINE EARLY-PRIOR TO AGE 55-EXACTLY BECAUSE OF THIS STUPID PROCESS.

If your goal is to chase doctors out of practice early congratulations-you are doing a great job.

REPLY

recent recert November 29, 2012 at 7:28 pm #

Dear Dr. Wachter:

I recently completed recertification and I have three suggestions:

1) Eliminate the secure exam for MOC. Yes, I think getting an initial certification via a secure exam is appropriate. But for MOC it is not appropriate. I am a practicing doctor seeing about 30 patients a day. I am employed and I have to take vacation time and travel to the exam site which is a real issue. And I also think the process of getting searched prior to the exam is degrading. I thought I was going to get a cavity search going into the exam room. It was worse than going through airport security. And the whole idea of taking an exam that requires memorization is just not appropriate in this day and age.

I had to laugh at the rote memorization required on this exam. I practice in a large office as an employed doctor. When I want to know what the latest test required for a rheumatologic condition is I look it up. I would never use my memory. I have a computer screen at my side that has several online data bases that help me with rote memorization.

I also want to echo what was said about midlevel providers. In my practice there are three nurse practitioners seeing patients. They see exactly the same patient mix as I do despite having far less training. Yes, they curbside me fairly often for guidance. But they look stuff up too and we often do this together. This is how medicine is practiced today.

The bottom line is the actual practice of medicine is not reflected in this “secure” exam. The secure exam is not only degrading but a test of your raw memory. I confess, I couldn’t remember whether anti-Ro or anti-La was the marker associated with neonatal heart block. In clinical practice, if I needed that piece of data I would look it up online in about two seconds. My ability to recall this fact on a secure exam neither proves or disproves my competence as

an internist.

2) In place of this secure exam I suggest an online syllabus of material that needs to be studied and an online exam the doctor could take to test their knowledge. I like the idea of an online test because it is easier for the doctor and it reflects what we really do in practice. If doctors wanted to look something up online they could do this-just as they do in practice. The purpose of the MOC exam, as I see it, is to make sure board certified doctor is keeping up to date with the latest practice guidelines. This goal could be met with a required reading/study syllabus and an online, at home, exam. Furthermore, this model could be spaced out over two year periods and end the whole idea of a ten year certificate. Once certified, the practicing doctor would have ongoing study and regular assessment to make sure his or her skills were up to date. I would be very much against increasing the frequency of the humiliating memory test that is the secure exam. Every ten years is too often for this type of exam! But I would not mind, indeed I would even enjoy, a home based tool that I would do every couple of years.

3) The Clinical Study. In addition to the secure exam, we are required to do some online exam modules which I thought were pretty good. The questions were hard and they were an excellent tool for study and reading. But there is also a clinical study that must be performed in the office. This was a real problem for me. I am an employee and as such I had to do all of the work required on my own with no help whatsoever from nursing. I did a diabetes study (as I see a lot of diabetic patients) and I had to administer surveys, data mine, make a practice plan, implement it and do a repeat study all on my own. I also had to do all this while maintaining my volumes and seeing most patients in 15 minute time slots. Goodness gracious this was a chore. Again, I can't staff out any of this work. While I did learn a little bit doing this study it was a huge amount of busy work and the amount of effort vs. the amount learned was not worth it.

The reality of my practice situation is I have no control over the flow of the office. None. I am a cog in a much larger machine and when it comes to changing how clinic-wide processes are implemented I am not the decision maker. Sure, I can pass along my thoughts to a medical director. But that's the limit of my role in these sorts of decisions.
For me, this clinical study was just a burden that gave me little in return.

In conclusion, I want to state from my own personal experience that while the goals of MOC-having an internist who is up to date and practicing the best of evidence based medicine-are what everyone wants the process as it stands now is broken. The recertification process still follows "old school" model that focuses on memorization of tiny factual details and test taking. The process also clearly does not reflect the realities of the practicing physician. Many of us now are employees of large organizations not solo practice docs who have set up their own business. Our employers are not that interested in helping us get recertified and will not give resources-time, money or staff-to help us along.

The process is very much a burden. And I do not feel it reaches the goal of determining whether or not a practicing internist is truly up to date and practicing the best of evidence based medicine. And unless this process changes, like some other posters here, this will be my last 10 year recertification. I am preparing to retire early at the expiration of my current certificate because I am not going to put myself through the process as it stands now when I am 60 years old. And as my employer requires board certification, I do not have the option of practicing without it. Thus, my choice will be to retire just shy of my 60th birthday less than ten years from now.

Thank you for taking the time to read my post.

Sincerely,
a recently recertified practicing internist

REPLY

william reichert December 9, 2012 at 5:46 pm #

I would like to expand on the above comment regarding" looking it up". In the

board review booklets, issued by the board there is a one paragraph statement about prostate cancer. A few facts. Well recently I was found to have a rise in my PSA and went thru the whole process of evaluation and treatment such that i am now recovering from robotic surgery. Between the start and the end of this process I must have read 60 papers, visited multiple websites with guidelines . SO NOW I really do know something about prostate cancer/. There was a HUGE disconnect between what the board required and what I needed to know. This is the problem with the board tests. You are better off being unsure of your knowledge and searching for answers than to be misled that your are competent enough by passing the test.

REPLY

Narayanachar S. Murali, MD, FACP, FACG November 29, 2012 at 9:25 pm #

I have no problems with the exams, secure exams, tough questions..and all that stuff medical. What I will not put up with is the board trying to tell me how to run my private practice. Get rid of the MOC activities outside the once in 10 year exam. I went through this PIM module, a truly meaningless exercise and it did not help my practice. Many of my patients thought it was a joke to grade me after being in practice for decades!!
I see no reason why I have to pay ABIM to accept CME credits from our specialty societies. This is nothing short of grand larceny.
Expect a bruising fight if you try to tie state licensure to MOC.
I wish the board had not lost its credibility and respectability among doctors from these recent unnecessary, ill-planned, horribly executed intrusions into physician practice. ABIM is ill-qualified to evaluate private practices, especially when the bulk of ABIM board members are not even in private practice. For those in private practice, our patients hold our feet to fire every day.

REPLY

Isaac Gorbaty MD December 3, 2012 at 1:42 am #

Dear Dr Wachter, and any fellow physicians reading this blog,
I am one of the “grandfathered physicians” having Boards without expiration in Internal Medicine and Nephrology. I have time limited Boards in Geriatrics and Critical Care. Before the ABIM unilaterally imposed time limitation on their certificates Medicine was a learned profession. The other learned professions had certifications such as PhD, CPA, LLB that were obtained once, after which the holders of those certificates were held to professional standards by Universities and State Licensing Boards. None of these other learned professions have changed to time limited certification and there is no public outcry asking for PhDs, CPAs or LLBs to be recertified. There has been no expose on 60 Minutes, Frontline, or other similar venues documenting the damage to the public safety or trust from lawyers, CPAs, and University professors not being recertified. When I was first certified in 1980, recertification was voluntary. Less than 5% of certified physicians took recertification.The ABIM unilaterally imposed recertification without a vote of the Certificates. It is arbitrary and grossly unfair. At the present time the ABIM newsletters show that some 40% of certified physicians choose not to recertify.Since the imposition of time limits,each Head of the ABIM has in turn sent out newsletters trumpeting the relevance of recertification and its salutory effects on medical care.This claim has actually been looked at. It is never cited in the Newsletters of the ABIM. I was one of the Certificates who participated in a study that was published in the Annals of Internal Medicine in the late 1980s. I was asked to take an shortened Board exam at home and the ABIM sent people to my office to examine charts and had my permission to interact with my patients and the Hospitals where I had privileges to judge my care.The assumption of the study was that Board certication and the percentile achieved on the exam would be reflected in the quality of care when judged by charts, hospitals, and patient feedback. The study found no

correlation. The discussion section of this study asserted that, surely there was a correlation, but their methodology was faulty and they had missed it.Each ABIM Newsletter predictably has testimonials asserting the beneficial effects of recertification without contrary views. In short, in the age of “evidence based medicine”, there is no evidence that recertification serves any purpose, other than monetary emolument for the members of the Board of the ABIM. In my opinion we physicians should treat each other no better and no worse than other professionals are treated. Let the hospitals, state Boards, and insurance companies regulate us and let this suffice. We should return to certification without time limitation.
I am,
Isaac Gorbaty MD

REPLY

Paul Kempen December 3, 2012 at 9:40 am #

Dr Gorbaty: You have hit this nail precisely on the head. Your message and your facts need to be published in the medical journals, journals which are controlled by the certification industrial complex (consisting of the ABMS, FSMB, JCAOH, ACCME, ACGME and the multiple specialty societies) hell bent on the regulatory capture of medicine. PLEASE contact me at kmpnpm@yahoo.com and lets get this message-the TRUTH about MOC and MOL- into the mainstream media ASAP. The PQRS 0.5% payments that ABMS bullied onto us via the CMS needs to be brought to the attention of the FBI as the medicare fraud it is!The FTC may need to attack the restraint of trade that imposition of MOL and MOC as a requirement for hospital privileges or insurance payments represents. SEE:
http://www.cbsnews.com/8301-18560_162-57556670/hospitals-the-cost-of-admission/ and
http://www.nytimes.com/2012/12/01/business/a-hospital-war-reflects-a-tightening-bind-for-doctors-nationwide.html?pagewanted=1&_r=2&hpw
to illustrate the corporate greed that is pushing medicine, physicians and the economy over the fiscal cliff with unnecessary testing and admissions. MOC is exactly the same process of unnecessary testing causing massive costs and NO BENEFITS (except the corporate profits to the non-profit certification industrial complex and the lackies like Dr Wachter who are earning from the machine).

REPLY

Jonathan Weiss, MD December 4, 2012 at 4:05 am #

The following is a letter I just sent to Dr. Cassel; I do not expect a response:
Dear Dr. Cassel,
I have just received my diplomate certificate for passing my MOC boards in IM this past summer, along with your accompanying letter. I found your letter to be egregiously patronizing, self-serving and generally offensive.
The sentence about my being part of “200,000 physicians who have made the commitment to assess and update their knowledge and improve their practice…” is absurd. Here is the real story: from the moment we graduate our residency or fellowship programs and take our initial boards, when we are far too young, naive and inexperienced to question anything, we are conditioned, by what amounts to a propaganda program, to accept the MOC program as valid, something that is necessary and to be expected. Ten years later, I survived the fantastically onerous, costly and time consuming burden of MOC, not only in IM, but also in pulmonary and critical care, all the while continuing to accept what I had been conditioned to accept since graduation, that MOC has value, when the knowledge and experience I gained from my first ten years of practice, along with instinct, told me otherwise.
Now, twenty years after certifying, as I have just started to repeat the MOC process for the second time, I find myself asking all the same questions that I did at my ten year interval regarding MOC’s value, and I also find myself reliving all of the same feelings of anger and

outrage at being made to go through this onerous dog and pony show once again. I know of no doctor who feels MOC, as currently structured and implemented by the ABIM, improves any aspect of their ability to provide quality care. Being the historically passive profession that we are (unlike our legal friends), we have unquestioningly accepted this premise and burden. But, as the ABIM makes MOC ever more onerous, with the addition or persistence of the following, that passivity is coming to an end:

1) the valueless time-consuming busy-work PIM (performance improvement module)
2) the effort to link MOC to MOL (thereby removing any illusion as to the "voluntary" nature of MOC, and with the likely consequence of having to complete even more MOC requirements even more frequently, possibly as often as every two years, the same interval as licensure)
3) the insulting and ludicrous patient and peer reviews
4) a secure exam whose content is largely irrelevant to what I do on a daily basis and whose secure nature is so insulting that I cannot even have a handkerchief in my back pocket during the exam
5) open book home test modules, much of whose content is irrelevant to what I do on a daily basis.

The other offensive part of your letter was this: "Research suggests that board certified physicians deliver higher care than their not-certified colleges…" None of that "research", much of which can be found on the ABIM website, meets any rigorous scientifically controlled standards. The very fact that you use the word "suggests" is outrageous. Ours is a scientifically based profession, and if the Board you represent is prepared to subject hard working clinicians to the fantastically costly, time-consuming and burdensome process known as MOC, it better be because rigorous scientific research has proven the value, not "suggests" the value. Of further note is that a substantial number of the "research" articles on the ABIM website that tout the value of MOC have ABIM members as authors, which is a clear conflict of interest.

It is in fact very clear why the ABIM, and other specially boards, promote MOC and that is because the MOC process is very lucrative for board members (this financial information is readily available on the internet) and there is clear self-interest in perpetuating it. So yes, I do have a question, as your letter solicits. When will MOC either be eliminated or sufficiently reformed so as to be of true and proven value without being unduly onerous in terms of time and money? Because make no mistake, clinicians are waking up to the truth of what MOC is really all about, and we are shedding our passivity, we are speaking out, we are organizing and we are seeking ways to put an end to this.

Jonathan Weiss, MD

REPLY

22 percenter December 18, 2012 at 2:45 pm #

Dear Board:

I just received my fail letter. And I quote from that letter:

The passing score is based on an ABSOLUTE standard developed by the Internal Medicine Test Committee.

And

For your information 5047 candidates too this examination and 78% passed.

This was a recertification exam-are you really telling me that 22% of practicing doctors taking this exam are not competent? Do you understand that doctors who are not required by their employers to have this certification don't even bother taking the test? Do you know the hardship you are causing by setting this ABSOLUTE standard to the level where a quarter of test takers fail is a NIGHTMARE for doctors who have given their whole lives to the practice of Internal Medicine.

I regret the day I choose Internal Medicine as a residency. I should have chosen Family Practice. Other primary care boards have 90% pass rates or higher. The bar is set too high on these exams.

I beg you to curve the test and set the standard so no more than 10% fail-even this is too high but you must be reasonable.

I am having the test re-scored just to buy time so I am not booted off the medical staff and lose my job in the process. I studied pretty hard and thought I did well on the test. The passing score was 366 and my score 360.

Those 6 points are the undoing of my career.

Anyone reading this in medical school needs to think carefully before going into Internal Medicine. You are warned.

A 22%'er

REPLY

Dr M December 19, 2012 at 12:33 am #

Why blame the ABIM if you can't pass the exam? Maybe you didn't study the right way or you can't process things well. I believe that an internist must be thorough to properly care for patients, especially in the hospital setting.

REPLY

22 percenter December 20, 2012 at 1:05 am #

I accept what you are saying.

Maybe I am getting too old for these exams and it's time to hang it up.

Let us assume I, personally, am not a good doctor and need to be put out to pasture.

But this is my question to you, Dr. M:

Is it true that 1/4 of all test takers are also bad doctors? Remember, this is a recertification test and all takers were certified. Also remember that there is a subset of doctors who don't even bother getting recertified because they don't need to.

Are 1/4 of all certificate holders unfit?

If the answer is yes then this means we have a good test in place and a large number of quacks.

If the answer is no then the test itself is broken.

I can accept and even live with the fact that I am no longer a good doctor and a failure.

What I cannot accept is that 1/4 of all the doctors taking the test are also bad doctors and failures.

That just cannot be correct.

The test is broken.

REPLY

Dr M December 20, 2012 at 2:46 am #

Look here. If you can't stay current and pass the board exam don't complain. One should take pride in passing the boards. How can your patients trust that you are current? Go pass the boards and stop complaining. I had to take the ABIM hospital medicine board which has only been given since 2010. I had very few references and established study aids for this new board exam. I felt it was much harder than the IM board exam I took 10 years ago. I buckled down and study my butt off and passed the test. I ACED step 1/2/3 and the initial IM certifying exam. I knew I passed these tests as I was taking them. But this hospital medicine board was tough as heck and I thought I failed it. But I passed and got through it. Just buckle down and go make the grade 22percenter.

REPLY

22 percenter December 21, 2012 at 1:02 am #

Hi Dr. M.

You missed my entire point in your "Look Here" reply. I didn't pass the exam. This is a fact. And the consequences are a fact as well. I will probably get my job termination notice in a couple of weeks. It just depends how quickly they post and my employer checks the website. And I will get booted from the medical staff although that doesn't matter as much as losing my job.

I am not asking for sympathy I am just stating facts.

And I ask you again Dr M. This is NOT regarding me. It is regarding the FACT that 22% of the people who took this exam failed.

Do you think it fair, not to mention just and accurate that a FULL ONE QUARTER of doctors sitting for recertification are not competent?

Let's say I am a quack and incompetent-that's not the point of my question.

This board is failing 1/4 of the recertifications and if they are doing it for financial motivation, as I suspect, then shame on them.

They are destroying lives and careers.

And know this, Dr M, Mr. hard studier, your recertification will come again.

You may yet know what it is like to suffer an early end to your career.

tantheman December 22, 2012 at 2:47 am #

Wow Dr. M., such naive, condescending and narrow-minded comments. Unfortunately you seem to not realize it. Because you "aced" some ridiculous tests you think you are a better doctor than those who did not? And big deal, you got some certificate in hospital medicine. Congratulations, you know how to fill out an order set properly and can figure out if someone is more appropriate for inpatient versus observation.

I supervise residents who I'm sure scored higher than you did on any

step test. Yet, sadly enough, many are mediocre residents at best, seriously lacking in critical thinking skills. This is the predominant point brought up in all these comments–passing these tests has zero (ok, I'll give you 2%) relevance on clinical competence.

And in case I come off as a hater wannabe, I scored top 10% on my ABIM and graduated magna cum laude in mechanical engineering. But the difference between you and most others posting is that we recognize critical thinking is the hallmark of a good physician, not the ability to pass a test and memorize "facts" which will be outdated by the time of our next recert.

Jonathan December 20, 2012 at 2:15 am #

I have just passed my second recert in IM; I am 50 years old and consider myself a good physician. The test, as well as all of MOC, is clearly broken. It took a superhuman effort, at great time and cost to me personally and financially and to my patients and family, for me to do what it took to pass a test in which the vast majority of questions were on arcane esoterica that had nothing to do with what I do on a daily basis. With all due respect to you Dr. M, you are off base and 22 percenter is on target. MOC is a dog and pony show being sold to the public as having value and which is being forced down the throats of hard working docs so that a select group, on various boards, reap enormous financial rewards. MOC must be eliminated or dramatically reformed and MOC must never be linked to MOL.

REPLY

Dr M December 20, 2012 at 4:13 am #

This is your opinion. I enjoy having Board Certification on my CV and as a hard earned recognition. Not every doc wants to do away with MOC, speak for yourself. If I didn't have to take my recert, there is no way I would have studied the way I did. I revisited a lot of stuff I had forgotten and have learned a lot of new information. MOC and ABIM board certification is what separates docs from mid levels. We complain about the threat of NPs and PAs, yet some of us do not want to maintain the credentials that makes us more valuable.

REPLY

rada ivanov December 20, 2012 at 5:44 am #

Being an MD or DO is what separates us from the midlevels. MOC and ABIM have absolutely nothing to do with that. How about having MOC and ABIM for them, too?

22 percenter December 21, 2012 at 1:23 am #

Congratulations Jonathan:

We are much alike although you are one year my senior. Like you, I passed

the recertification exam ten years ago. I guess we both took the fall 2012 exam. But this time I fell a few points under the pass cutoff while you passed.

I spent 2 hours a night during the weekdays and 5-6 hours each Saturday and Sunday almost without exception for almost one full year. I re-read Harrisons, twice, carefully, highlighting important points in the latest edition. I went through all sorts of test questions and preparation books. I even used my vacation time to go to a board review class. It cost me a fortune prepping, money I really didn't have to spare. I made it a priority.

I made a huge effort and not just to get "board certification" on my C.V. Board certification is my livelyhood. The hospital I am on staff at made board certification a requirement a couple years before I came on staff-grandfathering in everyone on staff at that time of course including docs who never even sat for the boards-and my employer also makes board certification a requirement. Although I also have to be on staff-so either way I am done having not gotten recertification. It's just a matter of how long the process of booting me will take.

I had hoped to be able to set up a private practice some years back, but with a divorce, big child support payments and a mortgage payment on a house that I don't even live in (the wife's) I just didn't have the money. I needed to be an employee and most docs aren't going solo anymore anyway due to the finances.

I guess I should have studied harder, but I don't know really what more I could do. Between work, call and all the studying it was worse than internship. Or maybe it's just that at almost 50 my brain isn't as sharp at memorizing all the crazy little facts like I was when younger.

I know someone will say just try again but it's not that simple. I am sick to my stomach at the thought of months more study day and night. And the financial ramifications are starting to sink in. If I lose my job I am ruined. Without boards I don't know if I could find another job and I have monthly payments that if I don't make I will (by the state) have my license suspended. (Not sure how many you have to miss for that.) I'm thinking the Ex isn't going to be too sympathetic either. And my experience in divorce court doesn't lead me to believe the judge will be very sympathetic to my job loss.

Since getting my fail letter I feel like I am sinking in quicksand. I'm terrified the medical director will ask me about the results. I'm not saying anything and can probably keep this disgrace hidden-for a while. I just don't know what is going to happen to me now. I feel like I am standing on ice on top a deep pond and the ice is melting-fast.

I'm glad you passed.

If your religious, you should be thanking God.

And don't hesitate to put in an S.O.S. for me.

Best Regards,
22 percenter, failure and soon to be unemployed doctor.

REPLY

Jonathan Weiss December 21, 2012 at 10:55 pm #

Feel terrible for you; you are in a tight spot on many fronts. Wish I had some specific helpful advise to give you other than to just hang in there and maybe someone unexpected and good will come your

way. MANY docs feel the way you do about this.

Cohee London December 18, 2012 at 8:44 pm #

Fellow Physicians,

You want to solve this problem. DONT TAKE THIS TEST EVER!!!!!!!!!!!!!!!! IF noone takes it, what are they going to do? Go to Nurse Practicioners LOL

REPLY

22 percenter December 21, 2012 at 1:29 am #

My hospital requires it for membership on the medical staff;
My employer, due I believe to the insurance contracts they have signed, requires it as well.
I am an employee of a large (physician owned) multispecialty group.
Thus, if I didn't take the test I would lose my job and staff priviliges. In hindsight, I should have taken a position where certification was not required although I don't know how hard those positions are to find.

And as for N.P.'s, we have a ton of them. I work with them all the time, getting "curbsided" for really sick, complicated patients. They are a nice bunch and I like working with them, but we have pretty high turnover as they are treated exactly like doctors in terms of patient mix in the clinic and some of them are in over their head.

REPLY

Marc S Frager MD December 18, 2012 at 11:41 pm #

Dr Wachter, it occurred to me while reading these posts, that perhaps the ABIM and ABMS are denying reality about a bad prognosis, just as you have blogged. It is clear that even in the face of good intentions the MOC process is failing those with time limited certification.

Now is the time to minimize the MOC burden on those with time limited certification. It is likely that this will happen with or without ABIM participation, but it would be so incredible to see some institutional leadership directed at the issues described above, and some transparency about the process.

Unless MOC only exists to increase the cash reserves of the ABIM and ABMS, in which case we should expect business as usual and secrecy as usual, we should be expecting some answers and some communications regarding MOC soon.

In my estimation, MOC should be voluntary and competence can be acknowledged by completeing state required CME; we all are aware that there is absolutely no data suggesting the superiority of either approach.

REPLY

* December 19, 2012 at 1:32 pm #

Dr M it is not the test, it is the practice module that is a burden

REPLY

Paul Kempen December 19, 2012 at 2:33 pm #

NO, NO, NO! The whole MOC and MOL is all a burden IN ITS ENTIRETY. It is a financial burden on the national healthcare economy. It is a waste of time for physicians, removing them from their patients to “Play and PAY” for the MOC game. There is no disregard for lifelong learning, as implemented in the 1960’s by the AMA, with CME currently costing over $2.3 Billion annually for registration fees alone, as documented by the ACCME in their annual reports! NO-physicians ARE keeping up, while the cost of healthcare is driving patients into the care of non-physician providers. Physician self education has become very inexpensive through the internet programs (including online journal access-or even programs like the NEJM CME!). The corporate profits are failing and in need of conscription programs like MOC and MOL simply because COMPETITION is unable to lure physicians into the MOC payment plan. The government and other payers are not going to keep paying for this nonsense either. They are switching to “providers” who they believe (while less educated) should reduce costs. Rather, these less educated spend more on testing, adverse care, referrals and return visits! It is time for physicians to identify the fallacy of the MOC and MOL-estation. OHIO physicians defeated MOL in October: See http://www.jpands.org/vol17no4/kempen.pdf
Also recently published these facts:
From Crosby G, Culley DJ: Anesthesia & analgesia by the numbers: then & now.
Anesth Analg. 2012 Dec;115(6):1265-7

“Medicine is now a hyperregulated industry. Licensing
and regulatory bodies are too numerous to count, much less
understand. There are hospital credentialing committees,
state Boards of Medicine, the NBME, ACGME, ACCME,
RRC, ABA, ABMS, and JAHCO to mention just a few.
Testing and paperwork are seemingly endless.
You’ve got the MCAT, USMLE or ECFMG, ITE, and board examinations.
Just when you think you are done, there is CME, MOC, and SEE.
There are now 132 accredited anesthesia residency programs
in the United States, and there are strictures on what
trainees can do and when they can do it. The accrediting
body that regards professionalism as a “core competency”
for trainees also imposes work hour limits that encourage
the opposite.

We are not a profession any longer- physicians are simply the teat from which all medical cash-flow originates. “I have met the enemy and he is us.” JOi8n active opposition at every state level.

REPLY

* December 20, 2012 at 3:34 pm #

I agree with you Dr Kempen. My response was to Dr M with his condescending comment. I have not taken the re-certification test yet.
The majority of my patients are elderly who can barely make a short phone call.
How could I expect them to complete a patient survey answering 51 questions!!
“Grandfathering” MUST be abolished which is merely discriminatory.

REPLY

Paul Kermpen December 20, 2012 at 4:02 pm #

The problem is NOT the grandfathering-it is rather the shameless regulatory capture of physicians to finance the ABMS Boards as a profiteering CORPORATION providing a meaningless “attestation” of competency-something these tests do NOT provide. “Certified” is past tense-something done once as an “achievement status”. Repetitive “recertification” because of some arbitrary “validation date” is simply nonsense. Years of practice leads to specialization while the “recertification testing” simply leads to rote memorization, “Cram testing” as it were and we all remember how useful that was 4 weeks after the finals-when vast amounts are again relegated to the forgotten or “return to the reference book” for a specific detail. Esoteric testing is not valid for daily practice. Experience teaches one to refer, review and rethink as needed. Not sit and read the phonebook-i.e. rote memorization! That form of “education” has been revamped with the internet and electronic references. I suppose old Bob Wachter still uses his slide rule daily also!

REPLY

gsterba December 21, 2012 at 7:46 pm #

I undestand exactly what you are saying two of my friens , did not pass the boards , lost their jobs and lost the visa status …..
one of them didi not pass the boiards by one point .
How many Drs are there , with no recertification and remain in their jobs simply because hospitals cannot replace them ??

I understand that people are not cpomplaining
Pleople are telling their point of wiev , if somebody has the boards is easy to see how other that don t have are cry babies , but I really don t think that the majority of people that tell their story or point of view are crying , they just don t fell that there is fair ness

REPLY

gsterba December 21, 2012 at 9:57 pm #

I perfectly understand you , study more than what you did , two hoiurs a day a six to five hours on wekengd two courses . You got to be kidding . Dont fell bad , I don t think the boards defines ytoiur knowlegde or your expertise in medicine , but it is very very unfair that you have to fell fell the way you fell . I started feeling like that but NO mORE , I am 62 …. but I know I am a good physician , and in my 62 years , and almost 36 of been a doctor I can tell you I know I have done A grEAT JOB IN MY PROFESION

REPLY

willaim reichert December 22, 2012 at 1:14 am #

I think there would be more acceptance of the board certification process if the test was
fair and relevant. To make it fair the board should print a text. All questions should arise from the text. The vastness of the sea of information possibly pertaining to the wide ranging subject of “internal medicine” makes it impossible for the physician to guess what topics and what depth of information the board will decide to test for.The text would answer that question
Furthermore to make the test relevant the board should do empirical research to define what internists really do (as opposed to refer out). Test for this.
Do internists actually treat patients for myeloma?. If not there is no need to test for when bone marrow transplant is indicated, what drugs are currently favored,etc.

The text should represent the knowledge internists need to know to practice their craft. If the test represented this concept I believe physicians would not only embrace it but actually learn something that would translate in to better patient care. Asking about the current state of drug resistant malaria would be out of bounds. Knowing when to screen for it would be allowable,ect. Internal medicine abuts many sub specialties. Internists should not be expected to be knowledgeable in all of them.

REPLY

Marc S Frager MD December 22, 2012 at 2:35 am #

There might be more acceptance of the process if there were any valid evidence that MOC participation positively affects some worthwhile parameter of physician performance. This hypothetical study would have to compare age matched physicians who participate in MOC vs those who complete the CME requirements for the state in which they practice and not participate in MOC

Meanwhile the ABIM depends upon its employees to write drivel about the worth of MOC and call that evidence. It is likely the hypothetical study would never show any real difference and if ABIM did that study and it showed nothing then we would really know MOC is worthless.

In all probability we know that anyway. Besides it is clear that many very important components of physician care cannot be quantified.

Bottom line it is truly a crime that MOC can affect physicians such as 22 percenter in such a horrible manner as he describes. Perhaps the ABIM and ABMS can show some compassion and professionalism and hire 22 percenter and pay him a decent salary from their ill-gotten MOC receipts to help him recover from the unintended consequences of their MOC process.

REPLY

Dr M December 22, 2012 at 8:22 am #

Come on now people. 22percent is only 49 years old, not 69 and passed his first MOC exam. Now he wants to cry foul play against the ABIM because he failed his exam. Medicine has no place for mediocrity. If one could not pass their med school classes or Step 1/2, he would not have gotten his MD or DO degree. This same standard should continue with the MOC. 22percent likely didn't study with the same vigor he did 10 years ago. I went through the process last year and studied like a mad man for 6 months straight while balancing a family and work life. You guys can complain all day. As long as you work for someone or reimbursed by an insurance that requires this standard you have to man up. If you don't want to deal with this you should go private and cash only.

REPLY

22 percenter December 26, 2012 at 10:13 pm #

Hi Dr. M:

I guess I wasn't clear. I accept my own failure. But I ask you-again-do you think it right that the MOC test failed 1/4 of ALL TAKERS.

This is not about me. 1/4 of all takers (22 percent to be exact) of the current

batch of test takers-folks who passed step 1/2, received their MD and passed the boards at least once failed. These are the data.

I put forth that it is unfair, unjust and unreasonable that an M.O.C. exam fail 1/4 of the takers. This is too high. Ten percent would be too high in my opinion but would certainly be more just than 22%.

Again, Dr. M. Forget about me, personally. I am not looking for sympathy. I am a failure. And I will pay for my failure. But it is not right that 1/4 of all test takers fail this re-certification exam.

It's just not right.

Best Regards,

22 percenter

REPLY

22 percenter January 7, 2013 at 5:15 pm #

Well, it happened. Honestly, I figured it would happen sooner. I got a 30 day termination notice. They handed it to me first thing this Monday morning.

Here's the irony. I have about 35 patients already booked today. Out of "kindness" they told me that they wanted me to keep working right to the end of the notice! Fat chance. I told them, in Clint Eastwood Style, what they could go do with themselves.

I am finished as a doctor. Everything's over. I have a stack of bills each month including court ordered child support and alimony as well as a mortgage payment on a house I don't even live in anymore. No way I can make the payments. No way.

Oh well.

The ex is going to have to learn how to live on less; She better update her nursing resume because she is going to have to look for work.

I'm going out, buying a bottle of good champaign and having a nice dinner and I am putting it on the credit card. It just doesn't matter anymore. I actually feel relieved in a way. Truth be told, I feel the best I have felt in weeks.

It's been a great run and a good enough life but it's all over name. Game Over. The buzzer has rung.

22 percenter signing off, for good.

goodbye.

RM Medical Director January 11, 2013 at 4:28 am #

Dr M.
I am a Medical Director for one of the country's largest healthcare companies. My job is to manage internists employed in ambulatory medical clinic settings.

Every year I find myself fighting a losing battle with "operational administrators" with no medical training and barely any understanding of medical management. The war I constantly fight is for good medical care for

our patients while attempting to protect my doctors from unrealistic and even dangerous “productivity” goals. These goals are based solely in business matters and not patient care.

Our system has a requirement for Board Certification to maintain employment. While it might appear to be a minor inconvenience to study for this test, my physicians are required every year to take on sicker patients and more of them per day. Not only are my doctors not compensated for their time away from patient care to study, they are now being told that to compete with urgent cares and “minute” clinics, they will have to work after hours and weekends.

I have attempted for years to develop a region wide study group. I have contacted the ABIM, the ACP and my Organization’s headquarters to no avail. I attempted to set up MKSAP based study platforms with discussions of questions and answers. I wanted to have courses videotaped and placed on our intranet portal for review by our physicians at their convenience.

I was unable to secure help from any of these organizations. In fact most of my phone calls and emails went unanswered. At best I might have received two curt emails stating there was no ability to help.

Mind you my department would have paid for the use of the MKSAP material and we were attempting to support the MOC process. Unfortunately the responses that were received stated that my physicians were welcomed to attend an official ACP MOC review meeting (and of course pay for the meeting and travel needed.)

For physicians that are already overwhelmed by minutiae and ridiculous regulatory requirements studying “6 months straight while balancing a family and a work life” is too onerous. Consequently excellent physicians are leaving internal medicine and pursuing everything from concierge medicine to “botox” injections and other ridiculous (but very profitable) fields.

It saddens me that a field I love has become so difficult and unrewarding from a personal and financial standpoint. It is particularly difficult to condone the unrealistic topics tested on the IM boards. I review each of the MKSAP versions regularly and I am struck by the lack of clinical relevance. The authors of the questions are clearly not seeing the same patient population as I and my 120 internists.

Having said all of that, please know that I come to this website trying to find a way to have all of my doctors remain board certified. I have passed the MOC two times since taking and passing the boards originally following residency myself.

As someone who has managed physicians for the last 10 years, I can vouch for the fact that Board recertification has a poor correlation to good medical decision making. In fact, the best physicians are those who enjoy speaking to people and have great empathy.

Dr M, I can tell by your emails that you would not last long in my department.

REPLY

Dr M January 12, 2013 at 4:06 pm #

RM, I wouldn’t work for your crappy company anyway. You couldn’t afford me. It appears that your docs are grossly underpaid. Anyway I own one of those “urgicares” that you fear. Mine is an after hours urgicare. Docs like I do not have to take orders from you. It is a new day in medicine and every doc will not have to succumb to

employment. Leave big business to pragmatic and innovative docs like myself pal. I still feel that board certification is appropriate.

Jon January 13, 2013 at 8:56 pm #

Dear RM Medical Director,
There are MANY of us who feel as you do. If you are interested, here is a weblink to a site where like-minded physicians have started to band together to discuss and address the whole issue of MOC. Hopefully, you will find it interesting and helpful and it will enhance your ability to correspond with others who understand that MOC, in its current manifestation, has to end or be reformed.
http://www.changeboardrecert.com/tax-returns.html

Paul Kermpen December 22, 2012 at 9:25 am #

M: YOU should get real. Overwhelmingly problems with the whole financial scam known as MOC have been presented here, often by physicians like me who are currently recertified and yes recognize that MOC and MOL are NOT Board Certification, but have evolved inot a "new corporate Product" enabling ABMS to scam physicians continually and forever-if they chose to believe and remain afraid of the consequences of stupid individuals as yourself who will require nonsense certifications from the ABIM that they are "enrolled in MOC". I for one will NOT believe in this religion any longer and am actively opposing it. 15,000 physicians in OHIO stopped the MOL for many very good reasons.
Board certification is as important as paying "protection" to Organized Crime! It should and will eventually fall to legal challenge as the criminal entity it is-a protection racket for insiders and a means to exclude competition in the workplace while inflating the cost of medicine and allowing non-physicians to be competitive "providers"!

REPLY

Marc S Frager MD December 22, 2012 at 12:41 pm #

Dr. M, are you saying it is okay to sacrifice a few careers to the MOC process? Isn't that really a bit heartless? Don't you have any compassion for someone in mid-career to have to start over again because of some exam of dubious value?

Are you that insecure that you have to step over the bodies of your colleagues to promote yourself?

Medicine has no place for lack of empathy……..

REPLY

gsterba December 22, 2012 at 3:48 pm #

I like your comment . I guess , he has a different attitude with his patients

REPLY

* December 22, 2012 at 5:11 pm #

I finally realized what Dr M stands or “mad man” who wasted “6 months straight ” memorizing/regurgitating facts instead of focusing on evidence based medicine.

REPLY

Bob Wachter December 27, 2012 at 12:27 am #

In this week’s New England Journal of Medicine, a fair, well researched piece by John Iglehart and Bobby Baron on many of the issues surrounding Maintenance of Certification that have been discussed in this post and in these comments. Worth a read.

REPLY

Rada Ivanov December 29, 2012 at 5:38 am #

The article is certainly worth a read. But to me it is more of a journalistic piece, presenting one viewpoint. I, and I am sure many of the other bloggers, would like to see good data showing how MOC and Board recertification helps improve patient outcomes and restrain healthcare expenditure. The only reference to that is a study showing that doctors who performed better in MOC, did better in conforming to diabetes testing and mammograms than their colleagues, yet no better in heart disease prevention, not to mention that these measures are all part of MOC to begin with. There is no direct link to outcomes. Very unimpressive.

REPLY

Marc S Frager MD December 27, 2012 at 2:23 am #

There are problems with this NEJM article, however; whether or not it is fair is a judgment decision. The problems include comments made by Dr. Grosch earlier in this blog. He stated that “no study can ever adduce credible evidence that will definitively discern distinctions independently attributable to board certification because education and training are confounders.” “Furthermore, the only extant studies of such distinctions treat distinctions in common, straightforward, bread-and-butter interventions that the practicing internist does every day or at least rather often, such as, for example, advising patients to stop smoking (see Ramsey PG et al. Predictive validity of certification by the American Board of Internal Medicine. Annals Int Med. 1989 May 1;110(9):719-26 PMID: 2930109) or prescribing beta-blockers and aspirin to patients with myocardial infarctions (see Chen Jersey MD, MPH, Rathore Saif S MPH, Wang Yongfei MS, Radford Martha J. MD, Krumholz Harlan M. MD, SM. Physician Board Certification and the Care and Outcomes of Elderly Patients with Acute Myocardial Infarction. Journal of General Internal Medicine. 2006 Mar;21(3):238-44), interventions for which large numbers of published instances exist in the medical literature and for which, therefore, some distinctions among practitioners might reach statistical significance. The trouble is that passing a board-certification examination does not depend on knowing about such obvious and straightforward interventions.”

Essentially, assessing physician quality is not much different from ascertaining which child with high functioning autism will commit a heinous crime. While it would be ideal to do so, it is not possible with current methods. We all recognize there is no real evidence that MOC accomplishes any goal. As Dr. Grosch so beautifully states: “The ABIM’s claims on its website about “what the evidence shows” consists of retrospective data-dredging studies that

demonstrate only marginal distinctions between board-certified and non-certified physicians' clinical outcomes and those distinctions and others variably favor board-certified physicians and non-certified physicians. Furthermore, the authors of these studies invariably include ABIM employees such as Dr. Holmboe, who are hardly impartial.
In her answer to my letter to the editor also published today (JAMA 308:24 2562 Dec 26,2012) Dr. Cassel states that MOC is necessary because "clinical skills decline over time." Perhaps, but there is certainly no evidence participating in MOC affects this decline more than any other method of self-assessment or even "just" participating in self-directed education.

We have been told since 2010 that according to Dr. Levinson and Dr. King that "The ABIM's MOC program is not perfect, and we on the Board of Directors have been working with input from our diplomates to address many shortcomings of the program." To date, we have seen none of the contentious issues addressed. It is remarkable how easily the ABIM admits to lack of perfection and how diligently it is using its $40 million annual revenue to promote relevant changes in MOC, but the absence of changes convinces me that nothing serious will be forthcoming soon, and the admission of lack of perfection is just a smokescreen to stall and continue the status quo.

You state that if MOC went away, it would be quickly replaced by other regulatory bodies. The answer to that is to demand that any regulatory body, new or pre-existing has actual data that its goals are being accomplished. In my opinion, MOC is a horrible experiment with potentially devastating side-effects on its participants as clearly documented in this blog. Perhaps we should be aware of the classical mandate to first do no harm, and put MOC on hold until the serious issues are resolved.

REPLY

a bali December 27, 2012 at 7:04 am #

I have read with interest all the comments posted in this section. My personal view is no matter how bad we feel,MOC in some from or other is going to stay ,Again this is my personal opinion that Boards should stop categorising certified diplomates in to two categories . MOC should be for every body ,may be there would be less complaints and heart burns since every body is being treated equally and fairly. There should not be any division between pre 1990 diplomates and post 1990 diplomates , the one getting life long certification and other has to certify every 10 years ,there should not be exemption for any body
Thanks

REPLY

Marc S Frager MD December 30, 2012 at 12:43 pm #

Let us not forget the immortal words of the Nobel Laureate in economics, Milton Friedman, and his thoughts regarding regulation: "The justification offered is always the same: to protect the consumer. However, the reason is demonstrated by observing who lobbies for the imposition or strengthening of licensure. The lobbyists are invariably representatives of the occupation in question rather than of the customers. True enough, plumbers presumably know better than anyone else what their customers need to be protected against. However, it is hard to regard altruistic concern for their customers as the primary motive behind their determined efforts to get legal power to decide who may be a plumber."

REPLY

william reichert January 7, 2013 at 6:18 pm #

I retired 18 months ago. I get job offers DAILY; hospitalist or internal medicine. Never do they require recertification.Many not even certification, just training. With your experience, training and certification you should have NO Trouble finding a job. Check out placement outfits. There are many on the web. You will get so many calls your will have your choice of locations.

REPLY

Paul Kempen January 12, 2013 at 3:38 pm #

Dear RM Med Director: It is time you and everyone else simply realizes:
1)That the ABMS and the 24 “affiliates” are CORPORATIONS. They sell TESTS!. They do not produce ANY educational materials. They have coerced the 24 specialty societies to provide the educational materials FOR PROFIT!. Do we want McDonald’s and Burger King dictating what we EAT?
2) “Board Certified” is past tense. Everyone needs to see a one time pass as an eternal pass with recognition of specialty achievement. The 10 year “purchase” is nonsense and only the people pushing for this are the problem. Lifelong certification was SOLD FOR DECADES and was accepted until the Certification Industrial Complex noticed there was more $$$$$ to be made and went first to 10 year certificates and then the continual scamming of physicians with MOC and MOL
3)State Licensure is the means to acknowledge ability to practice medicine and Certification is intended to be specialist beyond basics-MOC and MOL destroy that elevation of competence
4) Anyone can advertise as “specializing in the treatment of XXXYYY without board certification and in any state.
5).Because the ABMS is only in the BUSINESS of sellilng TESTS, do NOT look to them for any educational materials-if they provided concise study guides, we would be taking less retests, and when a single book contained all the requisite material, the public would only ask What the HELL-is that all one needs to know? exposing the scam publicly.
6) and most importantly, Bob Wachter and Christine Cassel NEVER in decades chose to recertify in Internal Medicine until Bob needed to “eat from their won restaurant and Cassel remains to this day non recertified in IM even though she was pushing this for everyone as early as the late ’90s-see:Ann Intern Med. 2000;133:202-208:
“As is now the case, recertification in a subspecialty,
such as cardiology or gastroenterology, will not require the
maintenance of an active internal medicine certificate; certificates
of added qualifications, such as geriatric medicine
or clinical cardiac electrophysiology, will continue to require
an active certificate in the underlying discipline.”

Appendix
The following persons are members of the Task Force on
Recertification:
Christine K. Cassel, MD;

David R. Dantzker,
MD; Lee Goldman, MD; Leslie D. Goode; Elizabeth A. Hopkins;
Mark A. Kelley, MD; Theodore C.M. Li, MD; Ronald V.
Loge, MD; Harvinder S. Luthra, MD; Anne Moore, MD; James
L. Naughton, MD; John J. Norcini, PhD; James R. Patterson,
MD; Don W. Powell, MD; Paul G. Ramsey, MD; James L.
Reinertsen, MD; and Douglas P. Zipes, MD.

REPLY

Matthew R. W. Smolin, MD FACC January 15, 2013 at 7:25 pm #

I can't help but wonder whether the ABIM leadership includes practicing physicians or academics. Over the last twenty years I have watched the practice of medicine become more onerous each year. In fact physicians practice under an enormous and growing plague of laws, regulations, and administrative requirements. We need to keep federal agencies, state agencies, insurance companies, hospital administrations, referring physicians, partners, not to mention patients and their family's satisfied. I think the time has come for someone, e.g. ABIM, to advocate on behalf of physicians rather than to add to the burdens we already face. More MOC, more study, more testing, uncompensated and on our own time will just drive more physicians into early retirement.

Furthermore, it is time for ABIM to start providing a service that is responsive to the needs of the physicians. Please explain to me why in this day and age it takes over 10 weeks to get the results of the Cardiology recertification exam. I got my MCAT scaores (answers were filled out with number 2 pencils) in less time in 1979. What on earth can possibly justify the delay in grading today's exams?

REPLY

Paul Kempen January 15, 2013 at 8:41 pm #

Anyone wondering about the leaders of the MOC program should definitely see the Jan 15th posting on this web site!
http://ip4pi.wordpress.com/

The leaders of the ABMS do not participate in MOC or recertification. As in Bob's case, Only when they are "forced to eat at their own restaurant" do they even do that-the "food" of MOC just is not that tasty or nourishing I will comment.

REPLY

Thomas H. McGreen,M.D. January 16, 2013 at 3:45 am #

Based on the previous comments I believe there is a place for an alternative organization to be formed.Perhaps name it "The American Society of Practicing Physicians".This organization could then certify physicians who have passed the ABIM certification exam with criteria more in line with the reality of a practicing physician's world.Suggestions are a peer review by members of a hospital committee that the physicianis is on staff , with accompanying CME credits perhaps using the MKSP or a comparable study guide take home exams to be completed over an acceptable time period.This would make more sense and be more practical then a one day do or die exam.The key is to form a alternative organization as it does not appear that the ABIM is going to willing change its current position on this issue .Once formed it will take some work to have the organization recognized by the various interested parties ie; hospitals ,payors,ect.To do this the organization would need to have a critical mass as its membership.Perhaps one of the companies that provides CME credits could help with the nuts and bolts as there would be a finacial interest for them and if my instincts are correct the membership would reach a critical mass in the first year so that the hosptals and payors could not ignore it,remember they still need us to do what they do.

REPLY

Hemadri January 19, 2013 at 2:41 pm #

I agree with Dr Thomas H McGreen who suggests the very American method of competing by starting a new certification organisation and breaking the monopoly. When many universities can create doctors there is no reason why there cannot be many organisations offering certification and or recertification. Surely American law will allow a number of good quality and competing organisations in the provision of post graduate certification or re-certification by other methods than the ones suggested by these monopolies.

It is no use fighting the monopolies by asking them to change; why would they, after all they also have very good doctors who obviously believe in the methods they profess. Why should they change?

Wonder if Dr Watcher was much influenced by his time in UK as a Fulbright scholar in 2011 when the revalidation debate for doctors in UK was really raging and now the revalidation has become a reality.

REPLY

James Roth February 14, 2013 at 5:24 am #

I strongly agree with the critics of MOC.

I just completed and passed my 3rd board recertification in cardiac electrophysiology. I am now 20 years out from my original board exam. However as of December 31st, 2012 my board certification lapsed for the first time in 20 years. Not because I am not qualified to practice, not because I did not pass the board exam, but because I have not completed the mandatory PIM module of MOC, something which is important for CQI but has nothing to do with board certification.

The MOC modules may have some role in CME but there are much more effective means of obtaining CME such as attending annual meetings or taking a board review course. I learned extensively from the board review course I attended prior to taking the board exam. I learned nothing from the MOC modules. I can't even remember what was in them. In addition, because only a few MOC modules are available in my field, satisfying the MOC requirement required me to take modules in general cardiology and internal medicine which are not my areas of specialty.

Taking the board exam the first time in 1991 was straightforward. I studied for the exam, took the board review course offered by our specialty organization and took the exam. The MOC modules were not required for my initial certfication, even though I had been out of training for a number of years. Taking the board the second time was more burdensome because of the MOC modules but still acceptable as there was no PIM requirement. Now in addition to the useless MOC modules (which can each be completed in an hour or two), the PIM requirement requires substantial time and potentially up to 3 months of work to assess the results of an"intervention" artificially performed to satisfy ABIM requirements, not per se driven by patient care.

Let's stop the ridiculous MOC program, make the MOC modules optional for the purpose of preparing for the exam,and simply require the recertification exam at 10 year intervals in the same way that the initial board certification exam and evidence of training in an accredited program is all that was required for initial board certification. There is a role for CQI, but board recertfication is not the place.

REPLY

Hospital MD February 19, 2013 at 3:14 am #

I have curb-sided numerous 'Board Certified' colleagues on the real-life cases that one sees in MKSAP or board-exam vignettes. Received responses ranging from – 'Its what you read for the exam and forget afterwards' and 'Lets consult the specialist'.

There are numerous ways to deliver a better product at the bedside – standardized protocols, integrated delivery systems, emphasis on building shared values of team work, cohesion and stewardship – unfortunately, 'Board Certification' fails to make the grade

REPLY

Jon February 19, 2013 at 11:06 pm #

James Roth, Hospital MD, many of us strongly agree with you. Suggest you take a look at this: http://dox.im/78ucp3

REPLY

Paul Tourigny MD February 24, 2013 at 8:26 pm #

I believe the MOC program is here to stay. It needs to work better for us, to keep us more up to date on what the leading boards feels is important in our fields. I would eliminate the requirement for the final test after passing it twice making the program less punitive. Once a physician passes an exam, in my case three times, it becomes to great a burden. A lot of Physicians are opting not to be tested again leading some to retire, change jobs or quite. This is in part why only 25% are certified and the physician pool decreasing in size over time leading to the silent exodus. Instead of testing, we should be required to take a well organized board review or update course every five years. Eliminating the test requirement after two passes stands a better chance at maintaining the current physician pool.

REPLY

Marc S Frager MD February 26, 2013 at 1:09 pm #

There is absolutely no reason MOC is here to stay. One can self-assess with products such as MKSAP at a fraction of the cost of MOC. The ABIM is only interested in selling tests, not your well-being. Do it yourself MOC is much more efficient, much cheaper, and allows each practitioner to focus on what is important to them. Why have an ABIM middle man with the excess costs going directly to excessive ABIM salaries? No study exists to show that MOC is superior to any other method of self-assessment and continuing education, and it is likely that there never will be. Accordingly, there is absolutely no reason MOC is here to stay. In fact if the ABIM and ABMS were honest, MOC would be gone today!

REPLY

Marc S Frager MD March 8, 2013 at 12:41 pm #

In the NEJM published yesterday there was a great study about how part 2 of the USMLE licensing exam "provides a poor return on investment and little appreciable value to the US health care system- and should therefore be eliminated."

I wonder if this does not apply to MOC as well.

And, the pathetic response from the FSMB and NBME sounds so similar to those defending MOC. Of course, NMBE and FSMB are the financial beneficiaries of the test in question.

Isn't it time to reconsider the MOC plague?

REPLY

Alessandro Testori March 28, 2013 at 3:37 am #

I feel that the ABIM has effectively destroyed Internal Medicine. First by splitting it between "traditional" internal medicine and hospital medicine. Many hospitals now DO NOT ALLOW THE PRIMARY CARE DOC to follow the patient while in the hospital, requiring that hospitalist follow the patient. Thus continuity of care has been lost. Secondly because it has become so expensive to employ physicians, most clinics now use only a FEW physicians and SCORES of NURSE PRACTITIONERS and PAs. Thus your clever policies are effectively causing internal medicine physicians to go extinct. Anybody in his/her right mind will leave this specialty which no longer has a role or a purpose, to go into a specialty. I think the most logical thing to do is to let med school graduates go directly into a specialty saving them 3 years of residency in IM which has become pointless since the 3 years of residency gets you a 10 year certificate which then expires worthless! A Bad investment. IM docs will be supplanted by PAs and RN practitioners.
I think the last remaining IM docs should NO LONGER participate in ANY insurance plans and just charge cash for their services (PAs and RN will of course win out because they can afford to charge less). As for the hospitals, who cares about the privileges, they have PAs and RN practitioners too….so Congratulations you have WIPED OUT IM as a specialty!!

Then the brilliance of your MOC program can be viewed by its results: since the mid 1980s (roughly when MOC was introduced) your misguided educational efforts have contributed to the spread of the OBESITY epidemic. It is your fault because physicians are applying the guidelines that you are teaching through MOC. In the ensuing years we should see a dramatic decline in the life expectancy of the average american. I suggest you take a trip to France or Italy, and take a walk down a busy street in Milan or Paris. You will immediately notice that the people in those cities DO NOT HAVE the same degree of obesity and are generally healthier. Who is to blame for this catastrophic debacle in the health of the Nation? I think it is MOC that is responsible. Not only it is useless, it is also detrimental to the health of the nation. I think there is nothing wrong with American Physicians, I think it is the GUIDELINES and the TEACHINGS that you impose that are causing the sorry state of the health of the american people.

REPLY

Alessandro Testori March 28, 2013 at 4:51 am #

ABIM should let new medical graduates go directly into one of the subspecialties of IM straight out of medical school. There is no point in them wasting 3 years in an IM residency to gain a certificate that expires in 10 years and that you only use as a stepping stone to get into a sub-specialty. The way the system is set up the 3 years of Internal Medicine residency are just 3 years of slave labor for something that you will anyway drop as soon as you get into a sub-specialty. It is not fair to con medical students into going to "Primary Care" in a system that sucks as bad as this. Let them go directly into sub-specialties….NO SLAVE LABOR….no sacrifice for NO Return. YOU WASTE 3 YEARS OF YOUR LIFE FOR A 10 YEAR CERTIFICATE, it is a VERY POOR INVESTMENT. INTERNAL MEDICINE IS NO LONGER A SPECIALTY WITH A CLEAR PURPOSE! MANY IM GRADUATES WILL EVENTUALLY DROP THE BOARD CERTIFICATION IF THEY ARE CERTIFIED IN A SUB_SPECIALTY. RECERTIFICATION RATE WAS 84% LATELY BUT I AM CERTAIN THIS NUMBER WILL FALL LOWER AND LOWER AS TIME GOES BY.

REPLY

Alessandro Testori March 28, 2013 at 5:07 am #

I can see your board meetings. The CEO says “we will charge for MOC whatever the Market will carry”. You have broken the mule’s back long ago.

REPLY

Alessandro Testori March 30, 2013 at 5:50 am #

How does MOC fuel the obesity epidemic? By perpetuating the notion that cholesterol is evil. With this concept in mind physicians recommend their patients to go on “low fat” diets to try and control the cholesterol levels. The media picked up on this and broadcast the same message for years. A low fat diet has to be rich in carbohydrates. Trouble is…..it is the carbohydrates that make you fat and obese over time. There is now lots of literature proving this, so the science is in, but it has been ignored. You are responsible for the consequences of what you teach and divulge.

This is what William P Castelli who was the director of the Framingham Study had to say about cholesterol

Archives of Internal Medicine, Volume 152, July 1992, pp. 1371-2

The findings reported by Fraser et al1 from the Adventist Health Study revive our interest in looking for data from prospective studies that show diet factors associated with favorable blood cholesterol or lipoprotein levels in free-living populations eventually lead to lower rates of coronary heart disease (CHD). Most of what we know about the effects of diet factors, particularly the saturation of fat and cholesterol, on serum lipid parameters derives from metabolic ward-type studies.2,3 Alas, such findings, within a cohort studied over time have been disappointing, indeed the findings have been contradictory. For example, in Framingham, Mass, the more saturated fat one ate, the more cholesterol one ate, the more calories one ate, the lower the person’s serum cholesterol. The opposite of what one saw in the 26 metabolic ward studies, the opposite of what the equations provided by Hegsted et al2 and Keys et al3 would predict. Only the international comparisons showed that the world could be lined up on cholesterol intake or saturated fat intake, and it would correlate with the rate of CHD.4 Of course, since these countries differed in many other ways, the possibility that some unidentified factor might explain the rate of CHD, loomed in one’s thoughts. Eventually, diet intervention trials were done, and where the follow-up got out beyond 3 years, they all show the same thing. The larger the percentage fall in cholesterol, the larger the percentage fall in CHD.5
In view of this, this study fails to describe a relationship of those traditional dietary constituents, saturated fat and cholesterol, known to have an adverse effect on blood lip-ids, and thereby, on the subsequent development of coronary disease end points. Only the Western Electric study6 has shown dietary cholesterol to be related to the later development of CHD in a population study. However, the authors of this Adventist study did show a slight increase in definite nonfatal myocardial infarction with eating cheese one to two times per week (RR = 1.97; 95% confidence interval, 1.27 to 3.04) and, in men, a relationship of eating beef to fatal CHD. Whole wheat bread, thank goodness, lowered the nonfatal coronary disease rate.

William P. Castelli, MD.

REPLY

william reichert March 30, 2013 at 12:17 pm #

I doubt that there is evidence that patients who go to doctors who tell,them to go on a reduced calorie low fat diet(that is where total calories including fat) are reduced have worse
outcomes than. who are told nothing.
in fact I doubt that physician advice no matter what. it is has any impact on the diet that patients consume. Of course this is untestable since patients reports onwhatbthey eat are like reports on how much they drink.
I also doubt. the board has a question relating to the idea that cholesterol is " evil".

REPLY

Alessandro Testori March 30, 2013 at 6:03 am #

This you tube video will explain the above even better

REPLY

william reichert April 1, 2013 at 12:54 am #

That was a nice clear talk.

I am glad that guy has solved the obesity problem inSweden. I rode my bike for4 hours yesterday over 3 mountains and drank a coke after. I hope that will not be the end of me.

REPLY

Anon April 7, 2013 at 12:48 am #

ABIM Board Member William J. Bremner certified for the only time in 1972. How do these folks live with themselves?

REPLY

Jon April 7, 2013 at 3:36 pm #

It's easy. They have no shame, they answer to no one, and they have our money, which we give them year in and year out.

REPLY

Paul Kempen April 7, 2013 at 8:05 pm #

Dear Jon: Not me no more, I am done paying the extortion money. I am doing my AMA PRA CME and that is IT! I will also oppose any more ABMS shenanigans. I am a good doc and that was why I certified. I am not good BECAUSE I certified and don't need that piece of paper any longer. Why would anyone volunteer to continue to "rent" their certifications and subscribe to the never ending and always increasingly demanding C-MOC (continuous MOC)?

REPLY

Dr. T April 19, 2013 at 8:16 am #

I'm 61 and my board certification expires at the end of 2014. The hospital I work at requires that I maintain board certification. Well, it's not going to happen.

I've re-certified in the past, but the process has become too onerous — it's not worth my time and effort. I have nothing against like-time learning and CME, but this practice performance nonsense is just too much. Also, my wife recently completed treatment for breast cancer and I think I have better things to do with my free time then spend it all studying for a test that isn't relevant to what I see in my practice.

I'm not going to say I'm a great doctor, but I must have been doing something right over the years — the hospital CEO and my colleagues have repeatedly asked me to jump through the ABIM hoops so I won't have to leave when my certification lapses. As I said, however, it isn't going to happen — I'm tired of being pushed around by the government and organizations such as the ABIM.

REPLY

Paul Kempen April 19, 2013 at 12:57 pm #

Dr T: It is time for everyone to change the bylaws to exclude Board Certification expiration as requirement for hospital privileges, insurance payment or participation and yes, even state licensure, as the FSMB MOL program is another corporate "product" being thrust down the throats of physicians to simply provide the "bean counters" and politicians the "data" they need to feel reassured.
OHIO and NY State Medical Societies recently passed firm resolutions to this effect. WE need to protect the profession from the money-making testing juggernauts of the ABMS and FSMB. There is no education in testing and CME has been doing the job for DECADES. If we do not step up and stop this needless testing, no one will. The biggest JOKE is the continuing ABIM Choosing wisely program to " limit needless testing of patients" to stop waste in medicine, while these same ABIM organizations are forcing needless testing of physicians because THEY are making the money!!!
Waste is waste and board certified is PAST tense. I for example have been certified in 1989 and 2005 and I too will never continue with MOC simply because it is a bad idea, does nothing for my ability to practice and wastes my time and healthcare dollars.
The ABMS lobbied Congress to pay PQRS-MOC payments to assure THEIR incomes. this will become a penalty in 2014 of 2%. People worry about the sequestration-hell the ABMS and affiliates are worse-they are throwing the physicians on the fire to simply keep

thier business afloat- a very needless business at that.

REPLY

Sylvie March 11, 2014 at 2:57 am #

I agree with all those who agree with dr Eck.
I have a remark to the ABIM president, when patients look for a Physician they ask friends and relatives about who they go to and they think is competent.
They do not care about our certification. A lot of my patients do not even know that I am required to recertify every 10 years.
The MOC does not add anything to my competence but take away a great chunk of my life that I would otherwise use to keep myself updated. As you know , most of us have families and can give so much time of our life to our career and job.

I have withdrawn all my membership from medical societies because I feel that my peer in the upper echelon are not there to protect my rights and competency but side up with the very people who are assaulting physicians day and night.

FYI , many very competent physicians, left medicine, in the prime of their career because they are disgusted .
My question to all my colleagues who posted their remarks is: why don't we organize ourselves and sue the ABIM ?

REPLY

Jonathan March 11, 2014 at 3:36 am #

Many of us agree with you. Go to this site: http://www.changeboardrecert.com/index.php and also join Linkedin, if you haven't, and look for the group NoMOC.

REPLY

Paul Kempen April 19, 2013 at 1:00 pm #

Also see: http://www.jchimp.net/index.php/jchimp/article/view/20326
Maintenance of Certification – important and to whom?
and these are the resolutions passed in NY this year at the medical Society At:
http://www.aapsonline.org/index.php/site/article/medical_society_state_of_ny_house_of_delegates_adopted_resolutions_in_oppos/

On the weekend of April 13, 2013, the Medical Society State of New York House of Delegates adopted resolutions in opposition to MOC and MOL.

RESOLUTION IN OPPOSITION TO MANDATORY MAINTENANCE OF CERTIFICATION

Resolutions 165 and 168, Opposition to Mandatory Maintenance of Certification, were combined. A substitute resolution was offered by the Reference Committee and the House added an additional resolved between the third and fourth resolveds. What was adopted reads as follows:

RESOLVED, That the Medical Society of the State of New York acknowledges that the certification requirements within the Maintenance of Certification process are costly, time intensive and result in significant disruptions to the availability of physicians for patient care; and be it further

RESOLVED, That MSSNY acknowledges and affirms the professionalism of individual

physicians to self-determine the best means and methods for maintenance of their knowledge and skills; and be it further

RESOLVED, That MSSNY communicate to the American Medical Association (AMA) and American Board of Medical Specialties (ABMS) examples of disproportional fees, onerous time requirements and unnecessary fragmentation of commonly recognized specialties; and be it further

RESOLVED, That MSSNY oppose mandating Maintenance of Certification until such time as evidence-based research demonstrates MOC is linked to improved patient outcomes; and be it further

RESOLVED, That a copy of this resolution be transmitted to the AMA House of Delegates for its consideration.

RESOLUTION IN OPPOSITION TO FSMB MAINTENANCE OF LICENSURE PROGRAM

Resolution 166 and 167 (Opposition to Maintenance of Licensure) were combined and a substitute resolution was adopted. This is what the HOD adopted:

RESOLVED, That MSSNY oppose any efforts by the New York State Education Department, Office of the Professions, to require the Federation of State Medical Boards (FSMB) maintenance of licensure (MOL) program as a condition of medical licensure.

REPLY

Paul Kempen April 19, 2013 at 3:24 pm #

As for Opposition-go to your state medical societies and pass resolutions, legislation, change hospital bylaws and form action against the regulatory capture attempts of business entities over physicians and medical care. Ohio has led the way and other states are following. There is no evidence after 5 decades of an army of ABMS executives writing papers demonstrating “associations” of better care to their certification programs that this matters! Life is associated with death and day with night-100%yet they are not causative of each other! The battle is NOW!
See the following for a through discussion:
http://www.jchimp.net/index.php/jchimp/article/view/20326/html
SEE this for summary of NY resolutions of opposition for every state to emulate:
http://www.aapsonline.org/index.php/site/article/medical_society_state_of_ny_house_of_delegates_adopted_resolutions_in_oppos/

and join the societies fighting this “good fight”.

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REPLY

Mt Doc April 24, 2013 at 10:18 pm #

Dr T

You might be interested in the following news from the AAPS website, which I have copied and pasted:

“The Association of American Physicians & Surgeons (AAPS) has filed suit today in federal court against the American Board of Medical Specialties (ABMS) for restraining trade and causing a reduction in access by patients to their physicians. The ABMS has entered into agreements with 24 other corporations to impose enormous “recertification” burdens on physicians, which are not justified by any significant improvements in patient care.

ABMS has a proprietary, trademarked program of recertification, called the “ABMS Maintenance of Certification®” or “ABMS MOC®”, which brings in many tens of millions of dollars in revenue to ABMS and the 24 allied corporations. Though ostensibly non-profit, these corporations then pay prodigious salaries to their executives, often in excess of $700,000 per year. But their recertification demands take physicians away from their patients, and result in hospitals denying patients access to their physicians.

In a case cited in this lawsuit, a first-rate physician in New Jersey was excluded from the medical staff at a hospital in New Jersey simply because he had not paid for and spent time on recertification with one of these private corporations. He runs a charity clinic that has logged more than 30,000 visits, but now none of those patients can see him at the local hospital because of the money-making scheme of recertification.

There is a worsening doctor shortage in the United States, such that the average physician has the time to spend only 7 minutes with each patient. Roughly half the counties in our nation lack a single OB/GYN physician to care for women. There are long delays to see primary care physicians in Massachusetts, and about half of them are not even taking new patients.

Money-making schemes that reduce access by patients to physicians, as “maintenance of certification” does, are against public policy and harmful to the timely delivery of medical care. AAPS’s lawsuit states, “There is no justification for requiring the purchase of Defendant’s product as a condition of practicing medicine or being on hospital medical staffs, yet ABMS has agreed with others to cause exclusion of physicians who do not purchase or comply with Defendant’s program.” AAPS adds that ABMS’s “program is a moneymaking, self-enrichment scheme that reduces the supply of hospital-based physicians and decreases the time physicians have available for patients, in violation of Section 1 of the Sherman Act.”

Note that this is a restraint of trade lawsuit. It will be interesting to see how this plays out.

REPLY

Craig, MD June 10, 2013 at 7:28 pm #

As someone currenty undergoing re-certification, I have been met with nothing but frustration. First, to call it “maintenance” of certification is a joke. It’s basically re-doing certification all over again. Second, just to figure out exactly what needs to be done is a challenge. The mailings, webinars, online tutorials, etc do very little to help. As physicians, we are constantly told to explain things simply and in ways patients can understand them. Why doesn’t the ABIM do the same? I’ve shown the MOC pamphlets and mailings to non-physician colleagues of mine, asking them to simply explain the steps/instructions involved in the MOC program, and it all sounds like gobblygook to them. Now ABIM is changing the MOC program next year, and it’s only going to cost “around $200 a year.” — What does that get me? A chance to maintain what I worked so hard for and have already accomplished? Rubbish!

Board certification is meaningless and is a racket. It might sound good to the public, like “miracle cure” sounds good to the public, but let’s face it: it means nothing. Ask the average patient “is your doctor board certified,” and most of them don’t know. I work with board certified doctors that I won’t let within 85 miles of my patients. They’re idiots, uncaring, and only out for the money (but they’re board certified, woo hoo!). On the other hand, I know which doctors are good, and I don’t know if they are board certified or not. Frankly, I don’t care. It doesn’t matter.

Not one bit.

REPLY

Jon June 11, 2013 at 2:15 am #

Most front line clinicians, including most of the docs who added comments to Bob’s WW thread here, could not agree with you more. Go to this website to learn about who is fighting this madness and what you can do to join the fight:
http://www.changeboardrecert.com/

REPLY

Just a muggle June 19, 2013 at 2:14 am #

I think it will change after the grandfathered bastards are all retired and dead (not necessarily in that order, by the way). Unfortunately for me, I will not see this happen in my lifetime because I took time to earn a PhD during medical school, and those 3 extra years placed me among the first cohort to have expiring boards, making me older than some of my ‘grandfathers.’

I see that many people here are in full time clinical practice. I can tell you that as an academic physician, maintaining board certification is just as, if not more, burdensome and meaningless, yet still demanded even for those whose clinical practice is only part time. I’ve renewed twice. It’s hugely expensive and a lame and pointless exam. I am outraged that members of the board themselves don’t engage in recertification and that some make millions of dollars a year for a largely honorific position at a supposedly non-profit organization.

The security measures of the exam are especially obnoxious. I teach medical school classes, and I distribute the exams and a detailed answer key after each test. If I can write a new exam every year with a staff of one (i.e. me), no secretarial assistance, and no salary support for teaching, then why can’t the ABIM do the same with their vast resources?

As far as I’m concerned, the ABIM is just a bunch of hypocritical idiotic freeloaders who

diminish the stature of my chosen profession.

REPLY

Jon June 19, 2013 at 2:51 am #

Loved your comments. Many of us agree with you. Would love to contact you and discuss further. How can you be reached?

REPLY

just recertified June 22, 2013 at 9:06 pm #

I just got the good news. I have recertified for the next ten years. Of course, I will have to continue to pay the fees, do the modules and do the ridiculous surveys and whatever else they dream up over the next ten years with their new “MOC” requirement.

Know this-I’ll pay your fees and do your modules. But this is my last exam. I am retiring early. I’m more than half way to “my number” and I will work extra hard to get there in the next ten years. It’s a huge motivating factor, getting out before going through that again. I don’t care about obamacare, the pain of going to EMR’s or anything else. It is this board recertification process that is driving me to retire. I’m out at 55.

I am deeply upset over the fact that 1/3 of those who took the exam this spring failed.

1/3.

To be exact, from the letter I received, 2971 candidates took this examination and 67% passed.

That means that 1,000 poor souls-doctors who were board certified-failed and now are at risk of losing their jobs and their careers.

Really? 1/3 of prior certified internal medicine doctors are not competent? Or is this bar set so high so as to have them retake the test and pay more fees?

Maybe-Maybe!-5% should fail an exam like this. For everyone’s information I spent the last 18 months completely devoted almost every waking moment outside of my work studying for this bear of an exam. That was 2-3 hours a night during the week and 5-6 hours on the weeks. For 18 months.

I ended up in the 50th percentile, right smack dab in the middle of the pack.

The exam was very, very hard and asked all kinds of stuff that was not related to my practice. If I had failed I would have been crushed. I busted my behind on this test and with 1/3 failing still barely made it across the finish line.

The process of failing 1/3 of test takers is a disgrace.

The cost of this process is a disgrace.

I passed and am furious at the process. I can’t imagine how the 1,000 doctors who failed are feeling right now.

Doctors, we need to do something about this. We need to revolt.

Medical students-STAY AWAY FROM INTERNAL MEDICINE.

Go into Family Practice or something. You don’t want to be 45 years old taking this blood recertification exam. Believe me.

Shame on your, ABIM for failing such a high percentage of good doctors.

Shame on you, ABIM, for hurting so many good people and ruining careers.

Shame!

REPLY

Jon June 22, 2013 at 9:40 pm #

Loved your comments. Many of us agree with you. Would love to contact you and discuss further. How can you be reached? Or you can reach out to like minded physicians who are fighting MOC at this site:
http://www.changeboardrecert.com/index.php

REPLY

just recertified June 24, 2013 at 8:53 pm #

I clicked on your link and submitted a comment for your site.

I love what you are doing. When I get back home from the office I will make a donation.

Thank you for your work and good luck in fighting this ridiculous recertification system.

REPLY

Jon June 25, 2013 at 2:56 am #

We got your email at ChangeBoardRecert, but the contact info (phone and email) do not work; if that is by design, so be it, but we would love to contact you directly; if you are so inclined, resend email to ChangeBoardRecert with correct contact info.

REPLY

just recertified June 25, 2013 at 5:29 pm #

Hi Jon:

Yes, I put a phony email in the message just like I did here. I did it here as I didn't want my reply to potentially lead to any retaliation although I know that probably sounds paranoid. Still, I felt it better to be safe than sorry as this "for profit" corporation might take a dim view of my negative board recertification comments.

I will have to think on sending you my actual contact information. I will send a donation-I didn't get to that yesterday. But I just don't know if I want to get more involved. I'm just trying to focus on doing my job, saving for a couple more years and then quitting.

It's sad really. I actually love Internal Medicine. But this exam and the failing of 1/3 of all takers is a great example of what is wrong with Internal Medicine today. I've decided the best path for me is to just quit. I've been saving for years in my low cost Vanguard index funds and before age 55 I am going to quit medicine altogether. I am lucky that I will be able to get out and live happily ever after in my early 50's.

I wonder how many other doctors are quitting-or wishing their circumstances allowed them to quit.

How did we let it come to this.

REPLY

drcoqui74 July 8, 2013 at 12:40 am #

I am not in primary care, but my board has also created onerous and expensive requirements for physicians initially certified after a specific time to re-certify. We have to take a written exam that like the IM boards is esoteric and hardly correlates with concerns encountered in day to day practice. We also have to complete 350 CME credits AND take a $2000 simulator course. Bear in mind that the simulator course is only offered in certain cities so the examinee must take time off work, pay for a flight and hotel for the privilege of taking a simulator course as part of the process of re-certifying.

We must take medicine back from those who care nothing about us and only want our money. These unethical individuals (and I'm looking at you, Bob) don't deserve our support or our money.

REPLY

Jon July 8, 2013 at 1:23 am #

Many docs agree with you; go to this website and learn more.

http://www.changeboardrecert.com/index.php

REPLY

JediPD July 8, 2013 at 2:04 am #

Dear Dr. Wachter,
Even though your tenure has come to an end. Your time has been in vain, since you failed to address the good people's concern listed above.
It is sad to see the bias that controls one's thoughts and actions.
It could have been great, had the time been used wisely.
But wisdom is drowned out by the banter of self-serving passion.
You could have made a name for yourself.
But the die has been cast.
And the screw has turned.
Yeats reminds us:

" Turning and turning in the widening gyre
The falcon cannot hear the falconer;
Things fall apart; the centre cannot hold;
Mere anarchy is loosed upon the world,
The blood-dimmed tide is loosed, and everywhere
The ceremony of innocence is drowned;
The best lack all conviction, while the worst
Are full of passionate intensity."

Finally the BEST are showing their Conviction. And the worst can only use cognitive dissonance of self-service.
Yours truely,
A Physician!

REPLY

Jon July 8, 2013 at 3:12 am #

Many docs agree with you; go to this website and learn more.

http://www.changeboardrecert.com/index.php

REPLY

howie mandel July 8, 2013 at 2:29 am #

Why don't lawyers have to be recertified?

As an obstetrician/gynecologist who finished my residency in 1985, I earned a 10-year certificate when taking my boards. If I had graduated in 1984, I would have been certified for life. My wife, an internist passed her boards at the same time and is grandfathered for life.

The American Board of Obstetrics and Gynecology (ABOG) requires a two-part exam. The first part is written, and the second is a 3-hour oral examination, part of which is based on the entire list of all the physician's hospitalized patients plus representative outpatient visits. I passed and was recertified 10 years later. In 2001, my specialty board modified the certificate to be valid for 6 years. In 2008, it changed the rules again to require a yearly exam. I also have to take an extensive written exam every six years at a "secure" site.

Why do doctors have to be recertified and maintain certification, but lawyers and accountants do not?

Clearly, MOC has evolved into a costly burden to physicians, patients, and healthcare. The boards and their MOC program have become a profiteering juggernaut without any reasonable proof of benefit, efficacy, or patient protection, and compliance is slowly being tied to the privilege of practicing medicine.

As physicians, we should demand evidence-based analysis of strategies proposed to improve our ability to practice, just as we do our research. We should not give in to potential threats of government mandates.

Currently, more than 50% of the counties in America do not have one obstetrician who can deliver a baby. I predict that MOC and other external rules and regulations will worsen this public health travesty. Perhaps the lawyers and accountants who only have to pass one exam in their lifetimes can fill the void. ABIM needs to wake up and smell the coffee. My wife currently doesn't care but she would if she had to take MOC. I am angered by those leading the boards as they are dividing the houses of medicine. Remember the lawyers, accountants, regulators and pontificators are not in the trenches. "A house divided can not stand". Wake up ABIM or soon you will be regulated by those who say "you are an academician" you can't practice medicine because you "haven't" done enough of this case or that case.

HOWARD C. MANDEL, MD
Los Angeles, California

REPLY

Constantine Palamas October 22, 2013 at 4:01 pm #

"The public grants to professions the privilege of self-regulation. For physicians, our ability to retain that privilege will be determined by the public's trust that we can deliver on it."

The public grants NOTHING. They have no idea about any of this. They do not understand physician training in the slightest. ABMS even did surveys and overwhelming majorities have no idea what board certification is. This is the biggest lie set forth by these board members to continually justify large board salaries precisely because they see it as a better alternative to

practicing medicine in a time that it is becoming more demanding and harder to earn the same dollar as yesteryear.

As others have said, lawyers and others don't have to do it. There is no public demand and it's obvious, the only likely conclusion. This canard is also based on defrauding the public, as the boards have been doing by the grandfather clauses, which are hypocritical if not illegal entirely.

It's about time to call it for what it is. After steps 1-2-3 and even the addition of step 2 CS there will be no end. SAY NO TO THESE GREEDY, IRRELEVANT boards who make 50% more revenue now off of MOC. Stop wasting physicians time and practice away from patients. Patients are hurt more and more while people on boards literally make more than a HALF MILLION dollars each. Look it up.

RESIST BOARD RECERT

REPLY

kmpnpm October 22, 2013 at 4:41 pm #

Constantine Palamas has explicitly summarized a very real assessment of this issue.

REPLY

Constantine Palamas October 22, 2013 at 5:36 pm #

kmpnpm,

I am really quite a reasonable person, but am made righteously angry by the lack of common sense and real injustice/scam this all is. I am not against board certification (one time, past tense "I am/have been board certiFIED). as a prestige and standing measure. All of this other jazz is more bureaucracy and hurts the majority will only a benefit to the boards of the member ABMS.

Spread the word and tell your legislature we will not stand for it. If we don't, they will only get more and more onerous. The history has already shown it. Time to do something, physicians. Let's go.

REPLY

Eugene Eisman October 22, 2013 at 10:43 pm #

Took them once and that was enough.
this is simply a big expense 'enough is enough."

REPLY

Jon October 24, 2013 at 2:46 pm #

Constantine,
Go to this website and leave a message there as to how best you can be reached. The website was created and maintained by docs who feel the same as you about the MOC.

http://www.changeboardrecert.com/index.php

REPLY

SarcDoc November 27, 2013 at 3:47 am #

Recertification is just an scam! Worse is the practice improvement module, which does not make any sense. I am working in an academic setting and in the last 10 years, I trained more than 40 fellows and 100 residents, who all passed their boards, yet I have to take MOC!
I am director of Interstitial lung disease (ILD) in my hospital and wanted to do Practice improvement module in osteoporosis. Guess what, ABIM does not recognize ILD as a disease or pulmonary entity. Additionally, patients have to be older than 65 y to develop Osteoporosis! Viva practice improvement!

REPLY

william reichert November 27, 2013 at 4:03 pm #

A very important point. In my experience the stuff in the review material was irrelevant
to what I did day after day and offered no educational assistance to dealing with the problems I did have. SUch as ILD as explained above. And when the material seemed relevant it was often wrong or inadequately detailed to be useful.
Teaching material should be based on the needs of the physician's practice and evidence based instead of "expert" based.

REPLY

fedup December 15, 2013 at 6:45 am #

What a bloviating bureaucrat caught up in his own egocentric urge for praise and approval.
His article made me tired just reading it. In typical fashion he expounds upon his particular brand of fantasy, spoken like the small minded lover of myriad rules and regulations that he is. This guy is obviously a socialist and I guarantee will continually tighten the reigns of control over internists nationwide. His stated goals of course will be to improve education, patient care etc. The real goal is to bend practicing physicians to fit his warped socialist ideals. Instead of working for rational requirement of physicians he advocates jumping through the never ending hoops that will be imposed by an increasingly dictatorial federal government. As a profession its time we had organizations that represent practicing doctors. Most of the current organizations that should help up have sold out for money or power. Perhaps we could use an organization that truly represents its members as a model. I guarantee the American Bar Association laughs at how our profession continues to betray its members and I'm certain they enjoy the profits of the same.

REPLY

Robert LeCoultre December 29, 2013 at 5:55 am #

Looked over this blog and had to make a few quick comments.
1. 836,000 a year?! How dare you. Do you even still have a practice – or are you just an academic that already sold out the private sector because your out of touch. This is the same thoughts that killed big corporate america with the board members (who end of hiring other family members or friends) that tried to justify billion dollar salaries for really just keeping the status quo. What do you do for 836,000 dollars that justifies your existence. You make about 3

to 4 time more than I do and I see crashing patients and take incredible risk with every decision I make. Can I have your job? Where is your risk? When you used the argument you are "helping us" defend ourselves with lawyers… Did you march on Washington and try to change the tort law? Did you do anything?
2. I understand you facility is based up in Maryland? or is it Baltimore? I don't really care where you are based. Apparently you have a 4 to 5 percent local tax hike your dealing with? Is this how you are paying for it?
3. One of the things I liked about being "a grown up" and being allowed "to pick my own educators" after graduation is that I could get an actual good program or spend my time reading a good worthwhile article or book. At best your telling me you want to have my CME spent on you? Do I have a choice who to get this from?
4. I am really tired of the arrogance and outright abuse I see by self-elected leaders… That is another reason physicians have lost power – we do not play well together. Lawyers band to together over mutual greed.. We fight over ego and pride.

REPLY

Jon December 29, 2013 at 4:55 pm #

Robert, we could not agree with you more; go to this website and get involved.
http://www.changeboardrecert.com/index.php

REPLY

Eugene Benjamin December 30, 2013 at 5:36 pm #

I am a Neurologist (Triple boarded), not an Internist, but we have MOC established in Neurology for boards and subspecialty certifications.

Two relevant questions which come to mind for me:

1. What is the correlation between a Physician's demonstrated clinical competency and Board Certification? Evidence, please. For example please cite a list of studies which demonstrate Clinical Outcome measures which have a significant positive correlation coefficient, when comparing such outcomes with the Board Certification of the provider.

2. By extrapolation, should the thinking behind the need for MOC be applied to College Degrees? For example should your Bachelor of Science, Bachelor of Arts, Law Degree, B.Arch etc.. or PhD be time-limited?

Thank-you for your reply.

REPLY

Jon January 5, 2014 at 2:17 am #

Eugene, we could not agree with you more about the flaws of MOC; go to this website and get involved to put a stop to MOC.
http://www.changeboardrecert.com/index.php

REPLY

Eugene Benjamin January 6, 2014 at 5:17 pm #

Will do, Jon. thanks for the information.

REPLY

StopMOC January 6, 2014 at 2:05 am #

5634 took recertification exam in IM in Oct 2013 and
29% did not pass. just think about it
this test is highly flawed and you know it.

REPLY

Paul Kempen January 6, 2014 at 1:37 pm #

So how about this? The ABIM sues 80+ docs in 2010 and retracts their certifications after the Aurora question sharing fiasco (http://www.abim.org/news/news/ABIM-files-complaint.aspx) and the ABA are now publishing test questions on line? see bottom
The ASA's journal Anesthesiology in Jan 2014 has published a whole edition on Education and it reads like an advertisement for ABA protocols. On pages 4-6 is an editorial as well as this statement regarding the authors:
"Competing Interests The authors are not supported by, nor maintain any financial interest in, any commercial activity that may be associated with the topic of this article."

Upon review of the most recent ABA 990 tax return (Guidestar.com) from calendar year (Jan 1 -Dec 31) 2011, the two board member (1+2nd) authors were listed as earning $18,000 and $78,000 respectively, while the third author is ABA Chief Assessment Officer author who earned $127,000. It is assured that all authors still earn significant sums. They are currently listed on the ABA webpage as retaining the same offices in 2013, when this editorial was submitted.

Finally the ABMS "sponsored" (means paid for) in Dec: The Journal of Continuing Education in the Health Professions 33(S1):S1–S66, 2013 recently published a 66 page supplemental issue on maintenance of certification (MOC), sponsored by the American Board of Medical Specialties (ABMS)

It would seem the ABMS is on a public campaign to advertise in every way to assure promotion and acceptance of their products as response to the growing resistance to these programs!

There is no mention of the costs of course, because COSTS=Corporate Profits and we wouldn't want any doctors getting wind of THAT!

On Monday, January 6, 2014 12:10 AM, "mocaminute@theaba.org" wrote:

Here is this week's MOCA Minute Question. You'll have 1 minute to answer once you click on the "I'm ready" link below. This question will be available for 1 week.

I'm ready — Ask me a MOCA question!

I'll skip the question this week.

REPLY

whatever January 20, 2014 at 9:56 pm #

Dr Wachter
Hi
Have you read this article
http://www.jneurosci.org/content/32/30/10146.full.pdf+html

will you ask your friends at ABIM to make this exam and its process less stressful?

REPLY

Robert LeCoultre February 15, 2014 at 1:31 am #

1. I have looked over the MOC modules and PIMs – they look amateurish and wasteful of time.
2. PIMs – they do not apply to me as a hospitalist and when I asked the ABIM for help – they said "JUST DO IT."
3. Other societies just have articles they give to read and some questions to answer to enforce learning the material. I would much rather (and be more useful of my time) to have an article bank of topics I could choose from and do some CME styles points to show I read it (like uptodate). I would even read more than these current modules demand.
4. The rumor I have heard is the new director wants us to take the big certification test every 5 years….
5. Those survey's he makes us do (I assume to help their research goals) are very hard to get done. My hospital sends out 400 to 500 one month and only 5 got returned. I asked my hospital for help and the nursing staff filed complaints against me for any request of help (even volunteer help) I asked. I am now going to try to paying staff 20$ dollars a survey to "voluntarily" help me gather them.
6. Being an MD – especially an internist – has become very difficult in this time of massive paperwork by governmental agencies bent on their own arrogant agendas – It saddens me to no end that we are getting this from our own ABIM chair.
7. The ABIM chair should be a voted position (maybe it was – I never got a notice) – maybe then we would have more power. Reminds me of a friend who complained about a problem in his clerkship in IM and ended up having to do his clerkship over again at another facility because of vindictiveness of the MD administrator – I get the feeling that would happen here as well to the most outspoken of us. The image of an MD as an uncaring narcissist does have some roots in a few of our colleagues – my experience more the academics. Maybe because they have animosity towards the private working sector. Like we need "them" to make us good physicians…..

REPLY

Robert LeCoultre February 15, 2014 at 1:37 am #

As far as the supporters they hand picked for the ABIM website. Physicians psychologically are a funny group. As a group they are trained to get approval from their peers. If they wanted to be fair they would show one against their changes for every cherry picked one they showed supporting it. As a point I could get 10,000 people out of the world to support ANY topic. It is like statistics you can present it in a way to make yourself look as good as your ego demands. Apparently our director has a lot of demands…. and a lot of ego.

REPLY

Robert LeCoultre February 15, 2014 at 2:08 am #

Do you even read these comments anymore or in your impossible arrogance stopped even looking – as in your mind "I am the only one that is right" view – like every good narcissist.

You have become another force to kill the joy of medicine for me – making it into a job like any other – a Government job! Full of bureaucracy and corruption.

Also – as far as the MOC and forced research projects as PIM – they are poorly done. Its like I am being forced to go listen to the worst of the worst Medical school teachers we had – over and over and over again…. I hoped to go to outside agencies to at least to they time wasting projects – but the ones I have asked so far are closed out to us (WHY EVEN LIST THEM!).

REPLY

Robert LeCoultre February 15, 2014 at 2:26 am #

As a point. People tend to discount those who disagree with them. Especially those who see themselves as "leaders." As a point I have no fear of tests. I have always scored well. I was top 5% or higher on my Steps in medical school. I took my ABIM exam and to this day do not even know my score – that is how useless I see it.

The ACP has an excellent update series in IM. Why not make this mandatory every 2 years (or let us choose an equivalent course – the ABIM can make its own and have what it is terrified of – competition). Of course it is an outside source and the ABIM can not make money off it – but if this whole drive is to make us better physicians then that should not matter.

My feeling is that it is the money – and the feeling of power exerted by our "representatives."

REPLY

Robert LeCoultre February 15, 2014 at 2:42 am #

I had to comment again. I just reviewed one of the "survey's" they make us do for the PIM.

51 questions – are you serious? My hospital has enough problems getting patients to answer 8 questions…. Who designed these? I left a hospital once because it was being run by a non-physician. Is that what is happening here? Have you ever completed a research project??

REPLY

Jonathan February 15, 2014 at 5:02 pm #

Robert, we could not agree with you more; we would like to make contact with you. Please take a look at this website: http://www.changeboardrecert.com/index.php There is a link called Contact Us; use it to reach out to like minded physicians and join the fight against this MOC madness.

REPLY

Robert LeCoultre February 15, 2014 at 12:12 pm #

This looks like bad training material forced down our throats without consent is Dr. Watcher world…. Aren't you a licensing organization? We have an ACP? At least stop the forced research projects – HOW DO THEY HELP US STAY UP TO DATE? Who gets this research data and when are you publishing your next paper based on our work? When I entered the private sector was the joy that I would no longer be given "busy work" by angry, vindictive physicians… You are a leader in your own mind….. How about I find another slew of sycophants to list on your ABIM website shining your ego on. How about the majority of us that do not like what you are doing? As a young MD I was taught (rather incorrectly) that we are not the patients parents (wrong a lot view us that way and a lot expect it – heck we are responsible

for everything they do in this society – even if they stop taking their Lipitor and claim we did not stress the importance enough – a real case!). So your now our daddy… Telling us what to do and how to do it… When we object… We are told "JUST DO IT." You live in a world full of students that would not dare disagree with you… In fact they glorify every idea ever had since your letter of rec affects their life's blood… Their future. Well unless you start coming after all of us on an individual basis and make our personal experience in certifying more difficult (I suspect you probably would or at least may try). This is the voice of one adult (and not your child) who is standing up and saying ENOUGH!

REPLY

Robert LeCoultre February 23, 2014 at 6:36 pm #

After looking at the endless time wasting projects the new director has us basically doing with a knife to our throats – threatening our very livelihood. I would argue how the forced research projects help us become better practitioners. I left academic medicine because I enjoy working with patients and find that my "personal" reading and patient contacts do more for my clinical skills then you ever could – I actually can survive in the "real" world – although people like you are making it harder and harder. Did you think of a cheap way to make ABIM its own society – aren't you just a licensing committee. I pose the fact the the forced projects and staged questions do not add to our ability as physicians. The arrogance you have…. That you can control the quality of physician care by treating use like newbie interns forcing useless time wasting projects down our throat to because "only you can save us." I say if do not already have the chair an elected position (I never saw a vote) by the members of our society – in other words not the hand picked sycophants you list on the ABIM site agreeing with your decisions.

As far as your argument that we can not have a bank of recent articles to read and that is not enough for an internal medicine education – the stuff you have online is????

A better idea would be to have a group of core topics and recent recommended articles to read. We have a required number to read (and yes I read other sources besides this – give us the respect we deserve) and we could even choose the topics that most apply to use. Add this to the ten year re-cert test to review topics we do not see every day (this test still proves nothing and does NOT NEED TO BE EVERY 5 YEARS as I have heard the rumor your pushing in this direction).

Your supposed to represent us – not be another (un-friendly) hurdle we have to face.

I have talked to friends in other specialties that pay a whole lot more than IM does and also have a LOT more risk and their process is no where near as in your face confrontational as yours is. One specialty just reads a required number of articles a year – and we go to this specially for consults! The requirements are more strict… and strict does not mean worthwhile.

REPLY

Michael Tanner March 20, 2014 at 3:23 pm #

The American Board of Internal Medicine deserves to get sued, and it's going to be. Its paying members are not voting members. The expansion of the horrible Performance Improvement Modules is particularly infuriating. They are so badly designed and such a waste of time that highly honorable people like doctors "make stuff up" just get through them. Sic simper tyrannis!

REPLY

Jonathan March 21, 2014 at 1:27 pm #

We all agree; take a look at this: http://www.changeboardrecert.com

REPLY

Ketan Doshi, Md August 5, 2014 at 3:27 am #

It is a well known fact that if you want to pass the oncology Board you have to think what would be answer to this question 3 years ago and you will get the anwer correct. IF you answer based on latest publication or trial you will fail the board. I scored really high in my boards just by reading NCCN guidlines while I practice Inalsatest oncolgy by reading uptodate and journals.

SO READING FOR MOC AND BOARDS WILL BE COMPLETELY WASTE OF TIME.

WHY DO WE HAVE TO PAY ASCO/ASH/ACP TO AQUIRE KNOWLEGE WHICH THEY WANT/Force us to have.

REPLY

Herb Kunkle August 7, 2014 at 9:40 am #

'Of all tyrannies, that which says it is doing (a process) for your own good, is most oppressive'
CS Lewis or Thomas Jefferson.

We all know the many probs in HC and the reasons the system is imploding. In large part because of too many middlemen, regulators, and money changers c their mandates, who add no value to our HC system, waste our time, and erode the patient-physician relationship.

So, can someone please tell me- How do the C Cassels, R Barons, M Noras, H Chaudrys, B Wackers, Lipners, Puffers et all (who at one time were our colleagues), and are mostly internists/ PCPs, get away c the crap and process they espouse, that has no evidence base, and has potential serious consequences if one doesn't comply? And they state this is 'voluntary', knowing this.

There is mounting concern with the stress and burnout of our profession. The divorce rate, substance abuse, marital discord, family problems, even suicide that occurs c docs.
Knowing this; Understanding this; yet continuing to promote a folly of a process such as MOC using the false narratives and talking points the above do is almost criminal.
We must all hold the above accountable. And ask- Why do we allow this to continue?
What can we do to change or abolish this?

REPLY

Guna Subedi November 19, 2014 at 9:37 am #

For those out there taking care of patients in real world, passing the tests and doing the surveys do not make any physician a better doctor. There are those who make living by imposing on others and there are us who take care of patients. The bureaucrats will continue to make others life measurable so that they justify their positions and we everyday physicians will take that as part of necessary social structure and keep doing our job. PEACE!!!

REPLY

Tarang December 5, 2014 at 11:56 pm #

Why does medicine insist on closed book exams as some sort of proof of competency? It is one thing to be asked to keep up on education and read and document that as completion of modules and renewal of information, it is entirely another to subject a working professional to the illogical hoop of a closed exam with a 'pass' 'fail' line to cross that is hardly any true test of someone expertise (or lack of it). Which profession asks one to sit in a timed test and await a pass/fail result like a school child to determine their competency? Yes, the medical profession is special but in this particular instance we as physicians are inflicting mindless torture on each other without assessing anything. That's how ABIM makes me feel – that if I do not 'pass' I am somehow second class – no matter that the pass-fail difference maybe a point here and there. If one doctor cannot understand this about another then we really are a poor lot as a professional community

REPLY

Pkd October 10, 2015 at 11:25 pm #

Physicians should stop joining organizations like AMA,ACP,ACC and many more. Stop paying fees to them and soon they will learn to do things for the practicing physicians and not against them. As Cardiologist, I stopped being member of ACC,AHA, HRS.

REPLY

Trackbacks/Pingbacks

1. **A Time of Change at the American Board of Internal Medicine | The Health Care Blog** - July 1, 2013

   […] of the ABIM, and the end of my eight-year tenure on the Board. In this blog – a bookend to the one I wrote at the start of the year, which went near-viral – I'll describe some of our accomplishments this year and a few of the […]

2. **For whose benefit do boards certify?--e-Patient Dave « Knowledge of MedicineKnowledge of Medicine** - November 25, 2013

   […] services. One thing to look for is board certification. While there's much controversy (see Bob Wachter's blog) about the details of the process,board certification is intended to weed out docs who are […]

3. **The Digital Doctor–the review | The Health Care Blog** - April 8, 2015

   […] safety, and even dressed up and sang as Elton John at the conference he runs! (He's also pissed off lots of doctors by being a recent one year chair of the newly controversial and perhaps scandalous ABIM). But for […]

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