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A Vision of the Platinum Rule

Over the past 50 years, specialty board certification has evolved from a lifetime credential bestowed upon diplomates after successfully completing a postgraduate medical training program and passing a secure examination to a time-limited certificate, requiring diplomates to engage in continuous certification programs, referred to as Maintenance of Certification (MOC) by the American Board of Medical Specialties (ABMS). As the practice of medicine advanced, the MOC process was developed so that diplomates could report that their knowledge and skills remained up to date by passing a periodic secure pass-fail examination. Subsequently, several other parts were added to the MOC process. In addition to maintaining unrestricted state medical licensure and requiring proof of participation in self-assessment activities, competency-based MOC programs included components designed to evaluate practice improvement and patient safety along with the traditional assessments of knowledge and skills, often in the form of periodic secure high-stakes examinations.[1] Although a fundamental goal of MOC is to indicate to patients and the public that individual physicians display competence in their fields and provide safe patient care, multiple concerns about the process have been raised. Notably, the appropriateness of periodic high-stakes multiple-choice examinations to evaluate physician competence has been questioned, and evidence to establish that participating in MOC leads to sustained improvements in knowledge and patient outcomes is limited.[1-4] In addition, many physicians believe that MOC activities carry an unacceptably high burden, not only in terms of the direct financial costs of the program but also by requiring time away from patient care, reducing personal and family time to complete activities they do not perceive to be relevant to their own practices, and experiencing the emotional stress of preparing for and taking a high-stakes examination for which failure would result in considerable personal and professional consequences.[2,4,5] Some ABMS boards, such as the American Board of Anesthesiology with its MOCA Minute, have already abandoned the periodic secure high-stakes examination in favor of electronic platforms incorporating longitudinal formative assessment with frequent knowledge testing and real-time feedback.[4,6]

Surveys to further delineate physician perspectives on MOC have been administered to diplomates in different specialties. For example, Cook et al[7] surveyed a random sample of physicians across specialties and found that 81% of respondents believed that MOC activities were a burden. Moreover, a minority (24%) agreed that MOC activities were relevant to their patients, and fewer yet (15%) considered these activities to be worth the time and effort.[7] In addition, among board-certified neurosurgeons who completed an anonymous survey administered by the American Board of Neurological Surgery (ABNS), Babu et al[8] determined that only 18% of respondents agreed that the MOC process provided value, though the majority (75%) believed that neurosurgeons should be required to participate in continuing professional development activities.[8] A similar percentage of respondents (76%) considered self-assessment tests to constitute meaningful activities, whereas review of case logs or quality improvement projects were each deemed meaningful by only 33%.[8] Although Cook et al noted that respondents' opinions about MOC revealed statistically significant variation across specialties, general dissatisfaction existed in all subsets analyzed, a finding that is also supported by Babu's study.[7,8]

Frank opponents of MOC have approached the issue through multiple means, including alternate board recertification and legislative efforts. The National Board of Physicians and Surgeons was established as an alternate recertifying entity for physicians with previous initial

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certification by one of the ABMS or American Osteopathic Association member boards, unrestricted state medical licensure, and active hospital privileges or medical staff appointment.[4,9] Rather than require a periodic high-stakes examination or completion of practice improvement activities, the National Board of Physicians and Surgeons asserts that submitting evidence of at least 50 hours of specialty-focused continuing medical education every 2 years is sufficient to indicate lifelong learning.[9] Another strategy used includes introduction of anti-MOC legislation in multiple states. These laws vary from state to state, from stipulating only that participation in MOC cannot be a requirement for state licensure to restricting the use of MOC participation as a criterion for staff appointments, preferred provider designation by insurance companies, and reimbursement.[10] In addition to anti-MOC legislative efforts aimed at limiting MOC, a group of 4 internists filed a lawsuit against the American Board of Internal Medicine (ABIM) in 2018 alleging that by mandating physicians to participate in its MOC program, which is required for employment in many institutions, ABIM had created a monopoly and "inflate[d]" the cost of the MOC program, thereby violating antitrust laws.[11] Although the lawsuit against ABIM was dismissed in its entirety in September 2019, 3 similar class action lawsuits filed against other specialty boards are still pending.[11]

To confront the aforementioned issues in a systematic manner, ABMS convened the Continuing Board Certification: Vision for the Future process in 2018, led by a commission composed of stakeholders across medicine and health care, including patient advocacy groups.[1] The commission released a report in early 2019 with numerous short-term, intermediate, and aspirational recommendations. In a groundbreaking statement, the commission recommended that "the ABMS Boards must offer an alternative to burdensome, highly-secure, point-in-time examinations of knowledge" and endorsed longitudinal formative assessments.[1(p9)]

In this issue of *Mayo Clinic Proceedings*, Ellenbogen et al[12] highlight the "existential crisis" surrounding MOC, note that several ABMS boards have become grossly "misaligned" with their diplomates, and postulate that the certification standards that ultimately serve to protect patients will change for the worse as less stringent alternate certification pathways are created. The authors invoked the "Platinum Rule," which promotes "treat[ing] others the way they want to be treated," as the philosophy that ABMS boards should adopt toward their diplomates rather than continuing to impose the costly, unproven MOC process with its "rigid" periodic high-stakes examination once every 10 years.[12] To accomplish this, ABNS developed an affordable "adaptive e-learning tool" that addresses both regulatory requirements and the educational needs of approximately 90% of diplomates who cover trauma and emergency call with the hope of reducing burnout as well by eliminating the high-stakes examination and revamping other aspects of the MOC process.[12] Importantly, going forward, ABNS plans to study the efficacy and validity of the e-learning tool and then modify it accordingly as part of an iterative process.[12] Recalling the survey data from Babu et al[8] indicating that 76% of respondents considered self-assessment tests to be a meaningful learning activity, ABNS invoked the Platinum Rule, redesigning the MOC program in neurosurgery to deliver an educational product while treating diplomates how they want to be treated.[12] Overall, ABNS approached the challenges raised by MOC in a thoughtful, elegant manner, which also closely aligns with recommendations set forth by the Vision Commission.

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