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Is Maintenance of Certification Working in Surgery?

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Keywords

• Surgical maintenance of certification • MOC controversy • Physician burnout

Key points

- Medical knowledge is increasing at an exponential pace; a process of continuous learning for physicians is essential.
- Time-honored, continuous learning requirements to maintain American Board of Surgery (ABS) certification (recertification examination required since 1976) are criticized as burdensome, expensive, and irrelevant to practice.
- Controversy is fueled by unprecedented rates of physician burnout, where the administrative burden of practice (including Maintenance of Certification [MOC]) is a major contributor.
- The ABS is taking steps to make MOC less onerous, more user friendly, and more applicable—to include replacing the 10-year recertification examination.

INTRODUCTION

For most health professionals, American Board of Medical Specialties (ABMS) board certification signifies the pinnacle of a long educational process and the ultimate goal of medical training. Surgery is no exception. The ABMS consists of 24 member boards certifying physicians in 39 specialties and 86 subspecialties–resulting in more than 880,000 physician diplomates, 27% of whom are surgical subspecialists. For years, beginning in the 1930s, board certification represented a brand of excellence, a milestone to be achieved at the beginning of practice and a distinction earned forever. With the explosion of new medical knowledge in the latter half of the twentieth century, however, several member boards questioned the premise that completion of an examination process at

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the end of training could assure lifelong competency in a given medical specialty. Verification of ongoing competency became a reality in the 1970s when member boards began introducing the idea of recertification for senior diplomates. Recertification in the form of a written summative examination was adopted and proactively enacted by various specialties including surgery. Over time, all member boards adopted some process to prove maintenance of certification (MOC) for diplomates and by 2005 MOC became an ABMS expectation.

The purpose of this article is to address the question, "Is MOC working in surgery?" Before this question is debated, it may be important to consider the value of board certification in general. Although board certification, as discussed later, has increasingly become a minimum standard for various credentialing bodies and processes, the ABMS ostensibly considers certification and MOC a voluntary process, chosen by a physician or surgeon as a means to document expertise in a medical specialty by meeting the profession-driven standards and requirements. Or, as stated on the ABMS Web site, "…(board certification is a) highly-visible indicator that physicians know today's standards of practice." Originally, hospitals, patients, payors, and other institutions, such as the medical-legal system, considered board certification a distinction beyond that of basic medical licensure (not a minimum standard), especially for specialty care–a peer-controlled standard of excellence. Therefore, the question posed by this article is an interesting and of considerable debate.

At the outset, to ask if board certification "is working" infers that the process is actually designed to accomplish some meaningful purpose or task. Currently, the ABMS and its member boards are struggling with this–how can (or even should) attainment of a measurable standard of medical knowledge and professionalism, which the boards ostensibly accomplish, equate to some outcome? And what outcome should be accomplished and measured? Currently, most member boards, including the American Board of Surgery (ABS), target lifelong learning and assessment as the task to be accomplished. If the outcome desired, however, is improved patient care, then data to support board certification in these terms are only minimally supportive. There have been a few published systematic reviews of the literature and clinical outcome correlation studies that have suggested board certification and MOC result in better clinical outcomes, but none of these has been in surgical practices [1–3]. Additionally, there have been several trade journals suggesting that board certification correlated with higher surgeon reimbursement and personal income–hardly an altruistic call for wide-scale endorsement. As such, endorsement of board certification and MOC are mostly intuitive; it makes sense that surgeons who stay current with the latest medical and professional trends will be better doctors. Despite this, there is no consensus as to the value of MOC. This article provides an overview regarding the need for monitored lifelong learning as well as a historical perspective on licensure, credentialing, and board certification. Next, it reviews the current controversies related to MOC, the association