Editorial

Maintenance of certification and maintenance of professionalism

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The most treasured and valued gift given by the public to the medical profession is that of self-regulation. However, the ability of professionals in many fields to self-regulate has come into question. Self-regulation of the medical profession by physicians is no exception and is currently under siege. Many different societal, professional, and regulatory forces have combined into what some have termed a perfect storm to question the wisdom of permitting physicians to continue their privileged status of self-regulation. These forces have raised concerns about the ability of the profession to effectively, efficiently, and transparently perform this critical function. Such forces include increased governmental oversight, especially of government-funded programs (which now comprise approximately half of all medical expenditures), and concerns by large businesses about unexplained variation in medical costs for their workers, by insurers concerned with controlling their "medical loss ratio," and by the public and patients accustomed to the rules of the marketplace and consumerism, which they are increasingly applying to medical decision making.

One of the mainstays of physicians' self-regulation was the development of specialty certifying boards in the 1930s. Certification by such specialty boards quickly became a measure by which a physician could demonstrate reaching a "profession-defined" level of quality and expertise. Board certification by one of the 24 boards recognized by the American Board of Medical Specialties (ABMS) is currently seen as a hallmark of a high-quality, well-trained, and knowledgeable physician. It is a status now achieved by approximately 85% of all physicians in practice in the United States. Over the past several decades, the certifying boards have moved from a once-in-a-career certifying event to a more continuous lifelong program termed Maintenance of Certification (MOC), a change that has been coupled to the provision of time-limited, as opposed to lifetime, board certificates. For the allergy and immunology community, such time-limited certification began in 1989.

In the December 2010 issue of the *Annals of Allergy, Asthma and Immunology*, James and Corbett[1] have provided the rationale for the MOC program of the American Board of Allergy and Immunology (ABAI), a program that meets ABMS-defined standards and that has been endorsed by the ABMS and by the parent boards of the ABAI, the American Board of Internal Medicine, and the American Board of Pediatrics. This MOC program consists of 4 parts (professional standing, self-assessment, knowledge, and performance in practice) that assess the 6 competencies of medical practice (patient care, medical knowledge, interpersonal and communication skills, system-based practice, practice-based learning and improvement, and professionalism) defined by the ABMS and the ACGME. These activities express physician behaviors inherent in professionalism, as noted in a recent publication.[2] The authors of this article state that "professionalism may not be sufficient to drive the profound and far reaching changes needed in the US health care system, but without it the health care enterprise is lost."

As described by James and Corbett,[1] the ABAI program is based on a physician-specific assessment of professional standing, continued professional development, demonstration of specialty-specific knowledge, and assessment of performance in practice. The ABAI MOC program is based on lifelong learning, an activity in which all physicians regularly engage. This learning occurs from our interactions with professional colleagues, from patients, from our teachers, from our peers, from our health systems, and from ourselves. Examples of such self-directed lifelong learning include traditional continuing medical education, surveys of patients' experience of care, practice-improvement exercises, and self-assessment.

If MOC is based to a great degree on what physicians already do and if it meets an important professional goal of fostering continued self-regulation of the medical profession, why is there any question as to whether MOC should be an activity not only supported by but engaged in by all physicians and not just those with time-limited certificates? When examined from the physician's perspective, several criticisms of MOC have emerged.[3] These surround cost in terms of both money and time, a perceived lack of evidence that MOC "works" to improve practice, and a belief that a secure examination is unnecessary because physicians can always "look it up," all coupled with the lament that there are already too many cooks looking into the clinical broth (eg, insurers and hospital groups) and that MOC requirements are therefore redundant.

In my opinion these criticisms are, to a large degree, inaccurate and, more importantly, perceived by those outside the profession as self-serving and a ploy to avoid transparent evaluation of quality. For example, there is abundant research in the field of

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quality of care demonstrating that knowledge and judgment do matter, that clinical skills diminish with time, that mere repetition does not necessarily lead to improvement in quality, and that those physicians engaged in quality improvement programs do better and have better outcomes.[1,4,5] It is quite clear that well-designed quality improvement programs "move the needle" and truly improve care. However, research demonstrates that only a minority of physicians examine their own performance data and that most are poor at accurately and independently self-evaluating their performance.[6] Do we not all know of colleagues not practicing up-to-date medicine and not following recognized standards of care yet who feel very comfortable that they are high-quality physicians?

Research into these issues initially focused on certification status and more recently on maintenance of certification and has demonstrated that those physicians maintaining certification do better on a number of clinical measures.[1] The American Board of Internal Medicine has recently published on the role of a secure examination in the MOC process and noted that "physicians are not skilled at identifying their knowledge gaps" and thus cannot be the only arbiters of what they should review and relearn.[1] Additionally, the criticism that such examinations are focused on unusual disorders falls apart when one considers that patients come to specialists because they expect their physician to recognize both the unusual and the commonplace. Experience at ABAI with our Recent Advances module, which is designed to have physicians use internet search engines to answer questions regarding recent scientific and clinical research, indicate that finding such answers is difficult. This experience indicates to the ABAI that a secure examination has merit because "I can look it up" is not as easy as assumed. Parenthetically, this experience also has led the ABAI to change its Recent Advances module to provide references in advance so that this exercise is less time consuming and more reasonably accomplished by a busy clinician.

However, the most important constituencies in the maintenance of professional self-regulation are not the "quality" community or we physicians but rather our patients and the public. Any program that does not meet their expectations in terms of rigor or transparency is unlikely to suffice. Two studies carried out independently by the American Board of Internal Medicine and the American Board of Pediatrics[7,8] show that the public believes in certification and in the processes engrained in MOC, even if their understanding of these terms are imprecise. These studies found that a large percentage of respondents believed it important or very important for physicians to be assessed on their knowledge and quality of care, receive high ratings from patients, and undergo such assessments on a regular and recurring basis. In fact, more than three quarters stated they would change their child's physician if their physician did not maintain certification. To transparently respond to such concerns, the Society of Thoracic Surgeons has publicly reported surgical group–specific outcomes of coronary artery bypass grafting procedures at 221 US cardiac surgery programs.[9] Such reports, based on agreed measures that have been validated, are likely to become more common and expand beyond the procedural specialties and might well become the expectations of patients and the public for all physicians. In addition to those areas already accepted by the ABAI (as noted by James and Corbett[1]), the board is currently developing a number of tools for physicians to examine their practice in such areas as atopic dermatitis, immune deficiency, and immunotherapy. Additionally, the board is planning to put in place a mechanism to accept for MOC credit rigorous quality assurance/quality improvement projects developed locally by academic institutions, health care systems, and physicians' groups instead of by the board itself. The board acknowledges that not all such efforts have led to recognized quality improvement in the past, and it will be necessary to rigorously evaluate MOC and its components as they mature.

The goal of MOC is to become the gold standard by which physicians demonstrate professionalism and commitment to lifelong learning and improvement in a manner that satisfies both those concerned with physician performance and quality and the busy professional. The ABAI recognizes that MOC must become more robust, relevant, and efficient. It is also essential to rigorously assess MOC to ensure it is effective in demonstrating and improving quality of care. Although the aspirations behind this goal have not yet been fully realized, it remains the best hope we have to maintain the professional self-regulation so valued by physicians while satisfying the reasonable demands that physician quality be regularly evaluated and transparently reported.

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