Subject: ACC MOC Survey

May 6, 2015
Anuj Gupta, MD, FACC (anujslink@gmail.com)

Rich Pomerantz, a previous chapter President for New York, now resides in Maryland. He forwarded me an email that he sent to Rich Baron, MD of ABIM. Since we haven't asked Dr. Baron, I have not posted his reply, but it was polite and reasonable. I asked if I could share with the BOG listserv, and he said he would be happy to have it shared, and is curious to the response.

Thanks,

Anuj Gupta
Governor, Maryland ACC

To Rich Baron, MD: I was previously a faculty Professor of Cardiology, a cardiology fellowship director for 12 years and the NY State Chapter President for the ACC. I have been in clinical leadership and teaching positions both in academic medicine and now as a chairman of medicine at a community teaching hospital. I have therefore seen both sides of that street, and have been involved in MOC since its inception in 1991, when I finished my fellowship. I am board certified in internal medicine, cardiovascular diseases and interventional cardiology. I keep up regularly with CMEs, journals, and organize our weekly grand rounds here at the hospital. I am Chairman of the Dept. of Medicine here at our hospital and well understand the need for our physicians to stay current for quality, safety and risk management reasons. However, I think the ABIM has really lost sight of their focus here. Until most recently, I don't think the board seemed to understand how this unhelpful, very costly, time consuming and often useless process has impacted the already harried clinical practitioner.
I am part of the first "fellowship graduating class" that had to always recertify (1991) so I know a lot about the process since its inception and how it has evolved. I have recertified 3 times in CV diseases and twice in interventional cardiology. I don't do intervention anymore and so I will only recertify in CV diseases by 2021. I am currently meeting all MOC requirements for cardiovascular diseases and am actually well ahead in the process.
The process (never very good) has become just incredibly onerous and expensive. My colleagues have been doing the PIM's, patient surveys and patient voice requirements recently and these in particular are unhelpful, a lot of useless paperwork, and a waste of time, both for the physician and the patient. They also are somewhat demeaning. I have taken the "secure exam" now ***6 times*** *(1 in IM, 3 in CVD and 2 in interventional cardiology) and it is essentially the same exam as the graduating fellows take. Meaning I need to review all areas of cardiology, not just new knowledge, including areas that I don't do in my practice. I really don't' think we need to take a secure exam every 10 years covering the entire volume of knowledge in cardiology, (what other professionals do that?) especially one that doesn't at least focus only on* ***new knowledge*** *to see if you are keeping up.*
I then have to take time away, study a cardiology textbook regularly for many months, and then go and take a Cardiology Board review (5 days away) at a cost of about $3000 total. I then need to restudy areas of cardiology that have absolutely nothing to do with my day to day practice. That is quite expensive in time and money and is in addition to the $3800 or so (for 2 certificates) the ABIM charges as well. I also just did a recertification module on patient safety from Society of Hospital Medicine and that costs $100 more.
If the ABIM wishes to continue a maintenance of certification process, it should be streamlined, relatively inexpensive and focus on making sure the practitioner keeps up with ***new knowledge in the field*** *since their initial certification. One or two, on-line, open book modules of a series of clinically based questions*

*focusing on **new knowledge**, new important published studies and updates could easily be completed every two years. It would also more readily replicate how people learn, acquire and maintain knowledge in this new day of "information at your fingertips.". I would discontinue the PIMs, patient surveys, etc. as well as the repeated secure every 10 year general specialty maintenance of certification examinations after the initial certification exam. These are time consuming, unfocused, expensive, redundant of the initial exam and don't really serve the purpose of keeping up with the expanding knowledge base in your field of practice. 5-10 of these on-line modules over the 10 year recertification time period would be more than sufficient to assess one's ongoing knowledge base. As an example, in cardiology this could include topics like the new JNC hypertension guidelines, use of the new oral anticoagulants, the new lipid guidelines, etc. which are important to daily patient care and clinical practice. This would be very time efficient, streamlined, relatively inexpensive and would serve to make sure practitioners are staying current with the expanding knowledge base in their fields, which is the primary goal of maintenance of certification.*

May 6, 2015
Daniel Humiston, MD, FACC (dhumiston@utahcardiology.com)

Thanks Anuj. I suspect I can guess what Dr. Baron's "polite and reasonable" reply was. Now that SGR is no longer the primary target of our advocacy efforts, ABIM and MOC should remain squarely in the ACC crosshairs.

Dan

May 6, 2015
Timothy Malins, MD, FACC (tmalins@me.com)

Thanks Anuj,
I know Rich very well and in fact he was my fellowship director and now a friend. The letter was very well stated. Rich is guy who is not known to suffer fools gladly. This is in no way to imply Dr Baron a fool, but in my opinion (as Rich stated) "the incredibly onerous and expensive" process that highly trained and educated physicians must navigate IS quite foolish.
I'd like to see the response.

May 8, 2015
Douglas Pearce, MD, FACC (djpearcemdacc@gmail.com)

Dr Pomerantz has nicely stated the opinion of nearly every cardiologist that I have spoken with on this subject. I understand that Dr Baron, et al, "want to get it right" with a new MOC process. However, with each passing day my colleagues are increasingly vocal about having nothing to do with the ABIM whatsoever. Period. My personal feeling is that pulling out of the ABIM completely would be a long, costly, and disruptive process. I truly hope that they (ABIM) are working day and night on an embraceable solution. We MUST press on. Doug Pearce

May 8, 2015
Norman Lepor, MD, FACC (norman.lepor@gmail.com)

Rick B and the ABIM are just trying to wait us out. They figure they have more staying power then we do and they also know they have a lot to lose especially those huge salaries and perks. That is why we cannot just let this percolate for months and months and years. And if they can "talk the talk" to placate us and freeze us from acting and not have to "walk the walk", they win

May 9, 2015
Edward Fry, MD, FACC (fry5@comcast.net)

If you think the Cardiology community is P.O.'d (professionally offended), check out the results of a survey of 2500 PCP's published in the most recent edition of *Medical Economics:*

- 96% not satisfied with MOC
- 95% - MOC "does not make one a better physician."
- 85% - MOC is no more effective than CME
- 75% - There should be alternative methods for recertification, other than current MOC.

Although our cardiology brothers and sisters must lock arms in unity against the forces of evil, we also need to join in a broad based, diverse coalition of physicians to either force ABIM to make real and substantive changes rapidly, or to secede together, each to their own professional body that can effectively promote life long learning, professional competence, and reflect the actual clinical environment they work in. *Vive la Revolution!*

Ed

May 10, 2015
Anuj Gupta, MD, FACC (anujslink@gmail.com)

Dr. Oetgen emailed Rich Baron, MD who stated that he would be happy to have me forward his response, and has valued the interaction with the ACC over the MOC.

Thanks for your patience.

Anuj

May 10, 2015
Lawrence Rudski, MD, CM, FACC (Lawrence.rudski@gmail.com)

Another Canadian perspective.
MOC is tied to licensure and not to specialization or sub-specialization. Licensure is an annual process whereby the MD is asked to attest that they participate in a MOC program.
Licensure is a provincial responsibility - just as it is a state jurisdiction in the USA.
Most provinces require Royal College MOC. In Quebec, the College of Physicians accepts either the Royal College program or others, including a self-directed program (no administrtive costs but can be exactly the same as the Royal College in terms of content). There are audits, and if someone does not meet thier MOC requirements, the Provincial College assigns a tutor to help the MD who is in "default".The main reason that I am bringing this up is that perhaps the ACC and other similar organizations, should meet with the state licensing boards to get their read in whether they would be

willing to entertain another option for MOC other than the ABIM. This would be an important starting point.

Lawrence