

climate is hostile to the ACA in nearly all of them. Just seven of them will be led by Democratic governors in 2015; of those governors, all but Delaware's Jack Markell will face a Republican-controlled legislature. Not all Republican governors oppose state-based insurance exchanges: both Rick Snyder of Michigan and Rick Scott of Florida have lent their support to state exchanges. In the November elections, however, the states that would have been considered most likely to establish their own exchanges (in particular, those that expanded Medicaid) either sent Republican governors to the statehouse or saw Republicans increase their margins in the legislature. Many of those Republicans campaigned on their ardent opposition to Obamacare.

Unquestionably, state officials

would face enormous pressure — from taxpayers, health plans, and hospitals — to set up exchanges. In a volatile political environment, some states might well do so. But ACA opponents' commitment to resisting the temptation of federal money should not be underestimated: witness the refusal of nearly two dozen states to expand Medicaid even though the federal government would cover almost all the costs.

ACA supporters thus have good reason to worry. For at least several years, and perhaps for much longer, the outcome in *King* could determine whether millions of people continue to have access to affordable, comprehensive health insurance.

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Maintenance of Certification 2.0 — Strong Start, Continued Evolution

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An anesthesiologist inserts an intraosseous line to administer lifesaving medication, as he learned to do during a simulation exercise; office-based pediatricians collaborate to improve the care of children with asthma; family-medicine physicians improve the care of their diabetic patients. These are examples of why we became physicians and the types of outcomes we hope to see in our patients. They're also improvements in care and skills that have resulted from participation in maintenance of certification (MOC) activities. So why is MOC so controversial?

Some older physicians resent MOC's new requirements associated with the board certification they worked hard to earn years ago; some younger physicians can't understand why the requirement to prove current competence doesn't apply to colleagues who are further removed from training than they are. Some physicians argue that MOC's burdens, including time and cost, are unjustified in an era when other regulatory requirements are already unmanageable and are pulling us away from our patients. Many physicians who find value in the MOC program never-

theless propose potential improvements to its structure and delivery. There's also broad understanding that the member boards of the American Board of Medical Specialties (ABMS), in collaboration with external researchers, must ensure that the program's research base expands and its quality is continuously improved.

For many years, board certification was granted at a single point in a physician's career. Certification by one of the ABMS member boards was meant to uphold the trust-based relationship between medical professionals and patients: the profession

commits to using its knowledge and skills for the good of society, and society grants it substantial autonomy to determine its own educational standards and the right of self-regulation through external assessment holding it to high standards.

But by the mid-1970s, it was widely recognized that with scientific knowledge growing exponentially and research revealing the extent to which skills declined with age, the medical profession would need a more consistent way to ensure each physician's continued expertise, judgment, and skills if we wanted to retain our privilege of self-regulation. Information regarding certification processes in other high-stakes fields, such as the airline and nuclear power industries, also became more readily available. Studies indicating that physicians can't always assess themselves accurately¹ provided further impetus for a more continuous process of ensuring physician competence — one that included traditional accredited continuing medical education (CME) and a high-stakes secure examination, in addition to a focus on practice assessment and improvement.

To address these changing needs and expectations, in 2000, the U.S. medical specialty boards adopted MOC, a program grounded in educational and assessment research and implemented as part of an integrated quality-improvement framework that recognized physician performance as a crucial contributor to health outcomes. MOC focused on the six core competencies embraced by the ABMS and the Accreditation Council for Graduate Medical Education (ACGME) and included elements of professional standing

and licensure, lifelong learning and self-assessment, cognitive expertise, and performance in practice. The program was not meant to replace CME; rather, it added practice assessment that could guide both the choice of practice-relevant CME and practice improvement.

As the boards' MOC programs matured, many partners in the health care system began developing educational, assessment, and performance-measurement activities to support physicians in achieving MOC and using the MOC process to support quality-improvement activities. Examples include CME activities developed by specialty societies for which physicians can receive MOC credit and performance-improvement modules using recognized performance measures or evidence-based practice guidelines to address requirements for measuring performance in practice. Some boards develop reading lists of articles on recent advances in their specialty to facilitate lifelong learning and self-assessment. And the ABMS Multi-Specialty Portfolio Approval Program grants MOC credits for institutional, multispecialty-team-based quality-improvement projects. That program addresses physicians' concerns about MOC's relevance to practice and the work it adds to their burden, since it provides credit for activities that are part of physicians' daily practice.

There's growing evidence that MOC can improve physicians' performance and patients' outcomes. For example, a prospective validation study, performed at the Mayo Clinic, of a measure of the extent of physicians' critical reflection on their MOC quality-improvement activities demon-

strated a positive association between their reflection scores and the quality-improvement project's impact, including its effects on physician engagement and practice improvement.² An analysis of the results of nearly 8000 performance-in-practice modules for diabetes care completed by family physicians revealed improvements in glycated hemoglobin levels and blood-pressure control and increased regularity of foot and eye exams for their diabetic patients.³ Both asthma care and recruitment of pediatric practices for practice-based research were improved through MOC performance-improvement projects for pediatricians.^{4,5}

As with any new and evolving program, periodic reevaluation is necessary to ensure that the MOC program meets the needs of patients, physicians, and the greater community. During a 2-year review of the program, it became clear that both the public and the profession valued a rigorous program of assessment and self-regulation and that many physicians saw value in the concept and philosophy of MOC. However, valid concerns and even anger were expressed about program elements, including the breadth and scope of the periodic secure examination for physicians whose practices have narrowed over time, the experience of testing in secure computer-based testing facilities, the financial and emotional costs of preparing for and taking the examination, and the challenges of finding performance-improvement activities that are relevant to physicians' practice and easily integrated into their clinical environments. The results of this review process indicated that MOC

standards could be further refined to reflect the changing educational and practice environments and address the needs of the physicians it is intended to support.

The recently approved 2015 ABMS standards for MOC are the result of this refinement process. These standards (available at www.abms.org) include general standards pertaining to the member boards themselves, outlining expectations for them to incorporate all six ABMS-ACGME core competencies throughout their MOC programs, to enhance the value and relevance of their MOC programs for their diplomates by being sensitive to time, administrative burden, and cost, and to engage in continuous quality improvement of their MOC programs, in part through regular review incorporating input from diplomates and the public. The new standards place greater emphasis on professionalism and patient safety, and they include a requirement that examinations assess physicians' judgment as well as knowledge.

The 2015 standards retain program elements that incorporate both physician self-assessment

and assessment by the boards. They also encourage innovation. In the area of lifelong learning, for example, some boards are e-mailing "questions of the week" to stimulate learning through self-assessment activities. Thanks to technological advances, some boards are investigating the possibility of developing a secure examination that can be delivered in various settings and for expanding access to approved reference materials during the examination process. Under the new standards, boards are also expected to provide feedback from the examination to guide physicians' self-assessment and individual learning; they are also expected to provide MOC credit for meaningful participation in system- and team-based quality-improvement activities in physicians' practice settings.

We see the 2015 MOC standards as providing the medical community, the member boards, and ABMS with an opportunity to work together to positively affect the care of patients and communities, to support the social compact between the public and the profession, and thereby to help maintain medicine as a profession and support physicians

throughout their careers. We believe that high standards of specialty certification are important to health care, and we hope our medical-community partners will work with us to continue to evolve our certification systems to ensure that the standards they set continue to be highly valued in the future.


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 An audio interview on MOC with Steven Weinberger of the American College of Physicians is available at NEJM.org

Boarded to Death — Why Maintenance of Certification Is Bad for Doctors and Patients

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In January 2014, the American Board of Internal Medicine (ABIM) changed its certification policies for physicians. Instead of being listed by the ABIM as "certified," physicians are now

listed as "certified, meeting maintenance of certification (MOC) requirements" or "certified, not meeting MOC requirements." MOC requirements include ongoing engagement in various medical

knowledge, practice-assessment, and patient-safety activities, on which physicians are assessed every 2 years, and passage of a secure exam in one's specialty every 10 years.