

## American Board of Internal Medicine and the Maintenance of Transparency

**To the Editor:** In the May 2013 issue of *Mayo Clinic Proceedings*, a compelling editorial by the American Board of Internal Medicine (ABIM) leadership entitled “Physician Responsibility and Certifying Examinations” outlined a continual need for integrity and a high standard of ethical behavior.<sup>1</sup> Using the search function on the ABIM website for the terms *transparency* or *transparent*, these terms are used at least 14 times in reference to various topics.<sup>2</sup> However, in remodeling their maintenance of certification (MOC) program and its expectations, the ABIM has taken a large step backward in its efforts to make board certification status more transparent to members, patients, hospitals, and care organizations.

The ABIM strongly encourages all diplomates certified before 1990 to complete the MOC process. In the past, the ABIM website clearly identified whether “grandfathered” diplomates had voluntarily recertified. However, when one attempts to verify internal medicine board certification status on the current ABIM website (“Verify a Physician’s ABIM Certification” window), it is no longer possible to differentiate certificate holders who are grandfathered and voluntarily recertified from those who are grandfathered without recertification. Furthermore, for non-grandfathered diplomates, the ABIM no longer identifies the most recent board recertification.<sup>2</sup>

In 2003, the ABIM commissioned a Gallup poll to survey patients’ awareness and attitudes toward board certification of physicians. The survey found that 90% of patients thought that physicians being “re-evaluated on their qualifications every so many years” was important or very important, and 95% of survey respondents felt that recertification of physicians

was either very important or somewhat important.<sup>3</sup> Despite this nearly unanimous view from the consumers of health care, few of the ABIM physician leaders had actually successfully completed the recertification process if they held grandfathered status.<sup>4</sup> With the latest changes in ABIM reporting methods, this type of credential review of ABIM leadership is no longer possible.

With little evidence in hand to support the MOC process, recent ABIM leadership has dusted off a 10-year-old study of patient attitudes to justify pushing ahead MOC changes.<sup>5</sup> Perhaps the ABIM would bolster its credibility if it would keep its message straight. If the purpose of the MOC process is to benefit patients, why wasn’t grandfathered status addressed in 2003? If it’s about physician quality, where is the strong evidence to support such a claim?

Unfortunately, the ABIM diplomates remain caught in the middle of a costly, time-consuming MOC process that fails to pass even the most basic evidenced-based scrutiny. Further, the ABIM leadership team has decided to provide patients with inadequate information about the recertification status of their physicians.

**John Hayes, MD**

Milwaukee VA Medical Center  
Milwaukee, WI

The views expressed in this letter are the private opinions of the author and do not represent the official policy of the Milwaukee VA Medical Center or the Department of Veterans Affairs.

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## In reply—American Board of Internal Medicine and the Maintenance of Transparency

We thank Dr Hayes for his feedback about the changes to the American Board of Internal Medicine (ABIM) maintenance of certification (MOC) process. Dr Hayes contends that the recent changes to the ABIM’s certification status reporting format “provide patients with inadequate information about the recertification status of their physicians”; however, these changes are intended to do the opposite. By paring down the amount of information publicly reported about ABIM diplomates, we believe the certification status reporting on our website is now clearer and more understandable to the public and other stakeholders. Although we applaud physicians who have voluntarily recertified in the past, our new reporting focuses on recency—whether physicians are *currently* and *continuously* engaged in activities to stay up-to-date.

The new reporting format is also designed to enhance clarity regarding the certification status of physicians with multiple certifications. The ABIM encourages diplomates to maintain only the certifications that are relevant to their practice. However, before the recent reporting changes, the way certification status was reported could appear misleading to patients. For example, if a cardiologist decided to maintain only his cardiovascular disease certification because his internal medicine certification was not relevant to his current practice, he would be listed under the old reporting format on the ABIM’s website as “Not Certified” in internal medicine. With the new reporting format, this diplomate would be listed as

“Certified” in cardiovascular disease, and internal medicine would be listed only with the date of initial certification, without designating lapsed certifications as “Not Certified.” The only physicians who are reported as “Not Certified” under the new reporting format are those who no longer have any valid certifications. Diplomates can access their complete certification history by logging in to their account on the ABIM website.

Dr Hayes asks why the ABIM did not address the “grandfather” issue sooner. Incidentally, the ABIM Board of Directors decided to discontinue issuing “lifetime” certifications in 1968, but they concluded at the time that the ABIM did not yet have the capacity to develop a comprehensive recertification program. When the ABIM rolled out recertification and began issuing time-limited certifications in the late 1980s, they made the decision to honor certifications that had been issued without expiration dates, thus creating the grandfathers. The ABIM has sought ways to engage grandfathers in the MOC process for many years. The new MOC requirements do not take away the certification of physicians with lifetime certifications, but the ABIM now reports whether all physicians, including grandfathers, are “Meeting MOC Requirements” on a continuous basis. Since the new program launched on January 1, 2014, more than 8000 grandfathers have chosen to enroll in MOC.

The ABIM believes it is critical that its leadership be held to the same or higher standard for MOC participation as its diplomates. All physicians in service to the ABIM—including staff, directors, councilors, and members of ABIM committees—are required to adhere to the ABIM’s MOC Policy for Physicians Serving ABIM.<sup>1</sup> This policy includes the requirement that internists/subspecialists who have valid-indefinitely certification (grandfathers) must take and pass an MOC secure examination within the first 3 years of

service (or within 3 years of the date this updated policy was enacted in 2013) if they have not passed an ABIM secure examination within 10 years before starting ABIM service. The policy also requires that all internists/subspecialists serving the ABIM, including grandfathers, must continuously meet MOC requirements throughout their ABIM service.

The principles behind MOC are, in fact, based on evidence. Studies have shown that a physician’s overconfidence<sup>2</sup> inhibits his or her diagnostic accuracy. A physician’s ability to independently and accurately self-assess is poor,<sup>3,4</sup> and more clinical experience does not necessarily lead to better outcomes of care.<sup>5</sup> Studies have also found that fewer than 30% of physicians examine their own performance data and try to improve.<sup>6</sup> The MOC program structure tries to address these concerns with a sound theoretical rationale via the Accreditation Council for Graduate Medical Education’s 6 competencies framework. There is also a respectable body of scientific evidence regarding MOC’s relationship to patient outcomes, physician performance, and validity of the assessment or educational methods utilized in the program and its learning or improvement potential.<sup>7,8</sup>

The ABIM is a physician-led, non-profit, independent evaluation organization with the mission of enhancing the quality of health care by certifying internists and subspecialists who have the knowledge, skills, and attitudes essential for excellent patient care. Ensuring that our MOC program contributes to improved health care delivery is as important to us as it is to our diplomates. We recognize that there is currently a limited evidence base regarding the impact of MOC on patient outcomes. Thus, over the next several years, we will continue to evaluate our MOC program and its recent changes. The results of this evaluation will help us to further enhance the

value of MOC to both physicians and the patients they serve.

Although this reply may not address all of Dr Hayes’ concerns, we have a continuing and robust research program regarding MOC and welcome outside, well-designed research as well. Through a new initiative called Assessment 2020, the ABIM is also actively reaching out to physicians and the broader community to help define what competencies physicians will need as the field of medicine continues to evolve. For more information and to participate in this conversation, we encourage readers to visit the Assessment 2020 website.<sup>9</sup>

We appreciate Dr Hayes’ feedback, which is precisely the kind of engagement and input that helps our process continue to get better.

**Richard J. Baron, MD, MACP**  
**Lorie B. Slass, MA**

American Board of Internal Medicine  
Philadelphia, PA

Drs Cassel and Holmboe, who coauthored the editorial to which Dr Hayes’ letter refers, no longer work at the ABIM.

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## Long-term Effects of the 2003 ACGME Resident Duty Hour Reform on Hospital Mortality

**To the Editor:** In 2003, the Accreditation Council for Graduate Medical Education (ACGME) implemented resident duty hour reform that established a maximum 80-hour workweek among other provisions. Despite an important series of studies that analyzed the reform's short-term impact on mortality in teaching hospitals (2003-2005), long-term studies have been lacking.<sup>1-4</sup> The long-term effects of reform are

important to consider because adherence to duty hour restrictions was limited in the first few years after the transition,<sup>5</sup> and oversight of residents since the transition may have changed. A single recent study of the long-term effects of the 2003 duty hour reforms focused on Medicare beneficiaries and found that duty hour reforms had no short-term effects on mortality for several medical and surgical conditions but were associated with long-term reductions in mortality 4 to 5 years after reform.<sup>6</sup> This study, however, focused on the Medicare population and did not separately study the long-term effects of duty hour reforms on patients at low vs high predicted risk of inpatient mortality. Other studies have argued that it is important to study the effects of duty hour reforms on both high- and low-risk inpatients because adverse morbidity and mortality effects of resident inexperience and increased patient handoffs attributable to duty hour

restrictions may be more pronounced among high-risk inpatients.

**Methods.** We used the Nationwide Inpatient Sample to analyze inpatient mortality for medical patients hospitalized with acute myocardial infarction (AMI), congestive heart failure (CHF), pneumonia, or stroke during July 2000-June 2003 (prereform), July 2003-June 2006 (short-term after reform), and July 2006-June 2009 (long-term). The Nationwide Inpatient Sample is a nationally representative 20% sample of patients discharged from a rotating set of US hospitals. Hospitals were divided into 3 categories: (1) nonteaching, (2) very minor or minor (>0-0.249 residents per bed), and (3) major or very major (>0.25 residents per bed).<sup>1,2</sup> Data were exempt from institutional review at Harvard Medical School.

We used difference-in-difference analysis to estimate the short- and

**TABLE 1. Characteristics of the Study Population<sup>a</sup>**

| Medical condition and teaching hospital status | No. of cases (% unadjusted mortality)  |                                  |                                 |
|--|--|----------------------------------|---------------------------------|
|  | Pre-ACGME reform (July 2000-June 2003) | Post-ACMGE reform                |                                 |
|  |  | Short-term (July 2003-June 2006) | Long-term (July 2006-June 2009) |
| <b>Pneumonia</b>                               |  |                                  |                                 |
| Nonteaching                                    | 184,858 (6.2)                          | 162,230 (5.2)                    | 106,803 (4.2)                   |
| Very minor or minor teaching                   | 65,395 (7.1)                           | 46,190 (5.4)                     | 30,324 (4.3)                    |
| Major or very major teaching                   | 54,933 (7.0)                           | 48,065 (5.4)                     | 27,535 (3.9)                    |
| <b>Congestive heart failure</b>                |  |                                  |                                 |
| Nonteaching                                    | 173,963 (4.6)                          | 148,975 (4.4)                    | 105,393 (3.6)                   |
| Very minor or minor teaching                   | 71,298 (4.7)                           | 48,856 (4.3)                     | 35,369 (3.5)                    |
| Major or very major teaching                   | 69,656 (4.1)                           | 64,853 (3.7)                     | 37,784 (3.0)                    |
| <b>Acute myocardial infarction</b>             |  |                                  |                                 |
| Nonteaching                                    | 87,689 (10.3)                          | 71,093 (8.7)                     | 53,944 (7.4)                    |
| Very minor or minor teaching                   | 47,336 (9.1)                           | 29,720 (8.1)                     | 19,424 (7.1)                    |
| Major or very major teaching                   | 51,785 (7.9)                           | 42,744 (6.8)                     | 24,838 (5.8)                    |
| <b>Stroke</b>                                  |  |                                  |                                 |
| Nonteaching                                    | 82,570 (11.0)                          | 65,049 (10.9)                    | 50,489 (9.9)                    |
| Very minor or minor teaching                   | 36,221 (11.5)                          | 23,931 (11.0)                    | 17,803 (10.0)                   |
| Major or very major teaching                   | 35,837 (12.3)                          | 32,044 (11.6)                    | 23,433 (11.5)                   |

<sup>a</sup>Table reports mortality for the overall population in each disease (ie, without discrimination between low- and high-risk patients). Teaching hospital status was obtained from the American Hospital Association. Very minor or minor teaching hospitals were those with >0-0.249 residents per bed. Major or very major teaching hospitals were those with >0.25 residents per bed. The number of hospitals of each type varied across periods. For example, in the prereform period, patients with acute myocardial infarction were admitted to 792 nonteaching hospitals, 150 very minor or minor teaching hospitals, and 101 major or very major teaching hospitals. In the long-term period (July 2006-June 2009), patients with acute myocardial infarction were admitted to 469 nonteaching hospitals, 95 very minor or minor teaching hospitals, and 58 major or very major teaching hospitals.