A Sign of Hope on MOC?

Andy Walker, MD FAAEM
Editor, ***Common Sense***

In the May/June 2015 issue of *Common Sense*, my "From the Editor's Desk" column was titled, "Is MOC an RPITA?" (Is Maintenance of Certification a Royal Pain in the Ass?), and I was invited to give a lecture by that title at AAEM's Scientific Assembly in February of 2016. From what many of you have told me in person or through your letters to the editor, many of you agree that the answer to that question is: *Yes!* As I explained in that column:

...neither I nor any emergency physician I know believes that board certification should be for life. In a constantly changing medical world some form of regular recertification or maintenance of certification (MOC) is necessary. That's why, from the beginning, ABEM and AOBEM have required retesting every ten years. I never objected to that or even questioned it. It seems perfectly reasonable. Over the last several years, however, I have come to regard ABEM's MOC program more and more as a royal pain in the ass (RPITA, pronounced ar-peet'-a). I began to feel this way when ABEM added a small annual test (the LLSA) to its big test every ten years (the ConCert exam). Now, I don't really care if I take a small test every year or a big test every decade, but why both? Why not fold the ConCert into the LLSA and drop the big test every ten years, or make sure the critical literature of the last decade is covered in the ConCert and drop the LLSA? Doing both strikes me as a redundant and unnecessary waste of my time and money.

...Since then, things have only gotten worse — much, much worse. Now ABEM, like the other member boards of the American Board of Medical Specialties (ABMS), requires an Assessment of Practice Performance (APP) as part of MOC, on top of both the Concert and LLSA tests. And the APP includes both a Practice Improvement (PI) activity and a Communications/Professionalism (CP) activity, ***both of which must be done every five years****. So, over each ten year period between ConCert exams, an ABEM diplomate must pass eight LLSAs (four in each five year period between ConCerts), perform two PI projects and two CP projects, and then pass the ConCert.*

I went on to point out that,

*In 2013 ABEM took in over $13 million, for a profit of just under $3 million, and reported net assets of almost $27 million. I'll let you look up the compensation of its executive director, directors, and staff for yourself. ABMS took in over $18 million for a profit of just under $2 million, and is sitting on net assets of over $16 million. Its CEO earned almost $800,000.** I also reviewed the results of the Academy's survey on MOC, which showed most of you feel the same way I do about it, and reported that, *The Academy has passed the results of this new survey, including the comments, on to ABEM. AAEM continues to engage in dialogue with ABEM in an attempt to make sure its MOC requirements are evidence-based, cost-effective, not excessively burdensome to emergency physicians, and of proven benefit to patients.*

Well, in the last few months there have been small signs of progress. As you can see from the announcements below, ABEM has temporarily suspended the communication/professionalism component of its Assessment of Practice Improvement. (This part of MOC has since been renamed Improvement in Medical Practice.) This suspension will last until December 31, 2018. ABEM has also folded the eight self-assessment CME credits required each year (out of 25 total CME credits required per year) into the LLSA tests, essentially eliminating this as an extra requirement. These are small gestures to be sure, but are still hopeful signs that bigger changes might come with continued pressure on ABEM and the ABMS.

> "In the last few months there have been small signs of progress … ABEM has temporarily suspended the communication/professionalism component of its Assessment of Practice Improvement."

Unfortunately, based on the article "Myth Busters" in the July 2016 *ABEM Update*, ABEM continues to underestimate and downplay the time and expense of MOC, neglecting all the time and money emergency physicians must spend to obtain the LLSA articles and prepare for the LLSA and ConCert tests, as well as take the exams. And ABEM continues to vastly underestimate the burden of the Practice Improvement component of the Improvement in Medical Practice part of MOC, especially for those of us who work part-time, in multiple hospitals, in small hospitals, or practice locum tenens emergency medicine.

In that same issue of *ABEM Updates*, ABEM claims that, *"it welcomes the feedback provided by candidates and diplomates, and your ideas*

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do result in changes and improvement to ABEM examinations and the ABEM MOC program." So keep up the pressure! Contact ABEM and the ABMS and tell them what you think of MOC. If board-certified specialists in emergency medicine like you don't do this, it won't get done at all. ABEM needs to hear from all its diplomates, not just AAEM's leadership. The information you need is below.

American Board of Emergency Medicine (ABEM)
www.abem.org
moc@abem.org
3000 Coolidge Road
East Lansing, MI 48823-6319
Office hours are 8:30 a.m.to 4:30 p.m. ET, Monday through Friday
(517) 332-4800

American Board of Medical Specialties (ABMS)
http://www.abms.org/contact-us/
353 North Clark Street
Suite 1400
Chicago, IL 60654
(312) 436-2600

* This information may be found at www.guidestar.org, where you can see the IRS Form 990 for every nonprofit corporation in the United States — ABEM and the ABMS, AAEM and ACEP, etc. I urge you to go to GuideStar, set up a free account, and take a look at these documents. They make for **very** interesting reading. You will be amazed at how much money some of these nonprofits are sitting on, as well as what they pay their leadership and staff. ■

ABEM Updates

Patient Satisfaction Surveys Not Required

On June 21, 2016, ABEM implemented a pilot to no longer require diplomates to attest to completion of a communication/professionalism (C/P) activity. This requirement is typically met by the physician attesting that she or he is participating in a patient satisfaction survey. During the pilot, diplomates will see the status "You do not have a requirement," or in some cases, "Future requirement on hold" on their ABEM MOC Personal Page. The pilot extends through December 31, 2018. During this pilot, ABEM will seek a more meaningful way to assess a physician's contribution to the patient's experience of care. Whether this requirement is permanently discontinued is, in part, dependent on a final decision by the American Board of Medical Specialties.

Self-Assessment Credits Covered by LLSAs

As part of the CME requirement, diplomates were asked to attest that eight of their 25 annual CME credits be self-assessment credits. Because LLSA tests are self-assessment activities, the self-assessment credit requirement is automatically met by physicians who have met the LLSA requirement. As of August 30, 2016, ABEM no longer requires that diplomates attest to completing "self-assessment" CME credits.

Questions?

If you have questions about these or any other ABEM-related topic, contact ABEM at abem@abem.org, or 517-332-4800. ■

Letters to the Editor

Letter in response to the September/October 2016 article titled "Who Cares About Due Process?"

I have practiced emergency medicine since 1986 and had planned to continue to practice for another 4 years. This article was almost too personal. ABEM certification was established in 1980 with re-certification mandated every 10 years. Continuous certification was established by 2000. I am sure ABEM thought that rigorous testing would bring credibility and respect to our specialty. I cannot speak about what happens in academic centers, but I certainly can confirm that emergency physicians are the stepchildren of the hospital. It has nothing to do with competency. The medical staff is often rude, and if the right buttons are pushed by the medical staff, nursing, or administration, the ED medical director is summoned to the CEO's office.

He or she is told to dismiss the ED staff physician who has somehow attracted the anger of someone in the hospital. And the CEO holds the director hostage by threatening to terminate the contract. Thus the ED physician is abruptly terminated.

Up until the last year, if I left an ED position, it was my decision. I have been terminated four times since then, but let me elaborate. I was terminated after 4 years at a hospital in Houston when a new CEO was named. I was quite vocal about lack of equipment. We did not even have an oto-opthalamoscope in every room. The nurses were incompetent and had no clinical experience. The medical staff never came into the hospital at night when one of their patients would crash and burn. I came back to Houston at the end of a one week vacation in March and found that I was not scheduled for April. That is how much notice I received.

It isn't rocket science when an ED physician starts at a new facility, that there is a learning curve, because every hospital runs their department differently. A two week grace period to adjust was more or less accepted. The introduction of computerized medical records changed all of that.

I have been exposed to four different ED computer programs. The learning curve for each ED physician is variable. However, these programs take away valuable patient time. The expectation in my experience (and I was actually told this) is to shot gun lab and radiology. How do you know what to look for if you haven't done a thorough history and physical? The following is an example of one of my short-lived jobs: the ED director sat outside the exam room while I was working up a new patient, and timed me. My maximum time allowed was four minutes. That is a physical impossibility.

My last few jobs have lasted 4 days, 3 days, and 3 days respectively.

Can any ED physician come into a new department and reach maximum efficiency within one or two days. So much for fairness and due process. That would never happen to a staff physician. In fact, it takes an act of God to get an incompetent staff physician off staff.

I am still at the top of my game. ED physicians used to leave the profession because of burn out from shift work. Now I expect that our specialty will reach critical mass because respect by the hospital staff has reached an all-time low.

For me, the handwriting is on the wall. I can only take so many punches. If AAEM does not take a leadership role in ending a very disturbing double standard, the public will be seeing unqualified primary physicians when they are critically ill.

— Evan B. Tow, DO FAAEM

Dear Dr. Tow:

Thank you for writing. It takes courage to tell a story like yours. Unfortunately, your story is not unique — it isn't even unusual. I promise you that AAEM is doing everything possible to assure that emergency physicians have the same due process and peer review protections as all other members of the hospital medical staff. Our progress has been slow, however, largely because so many with deep pockets want to be able to get rid of emergency physicians without any inconvenience — and because the Academy is fighting this battle with little or no help from other professional societies in emergency medicine.

Please hang in there and keep trying. You might consider an academic job or even look into nontraditional ways to practice emergency medicine, such as critical access hospitals; VA, military, or American Indian reservation hospitals; overseas practice settings; or locum tenens. There are lots of hospitals out there that are desperate for board-certified specialists in emergency medicine, and there are still hospitals and EDs that care more about quality, patient welfare, and doing the right thing than about speed and metrics.

— The Editor

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Letter in Response to September/October 2016 "From the Editor's Desk" article titled "Crossing the Line"

Dear Dr. Walker,

Reading your editorial in the September/October issue, you discussed CMG travelling docs (special ops, the hit team, the strike team, etc.) and you discussed how they make it easier for a CMG to attack and take over emergency departments. Often those "special ops" guys and gals are the ones that make it easier for a CMG to steal a contract from a long-standing independent and democratic group or from another CMG. This is a fact.

There is something else, however, that you didn't touch on: special ops physicians make it so much easier for a CMG or hospital administration to deny physicians due process.

I know because I used to be a special ops physician for a CMG long before the term "special ops" was even invented. Early in my career, I worked for a medium sized CMG (that is now a large CMG). It was a frequent occurrence that I would get a call that a certain ED needed someone urgently and that they would pay me an extra amount to go cover a shift or group of shifts.

I usually would get to that hospital and realize that someone had been "taken off of the schedule." As a young and slightly arrogant physician, I would be proud that I was called in to cover for the "less than adequate" physician.

Nowadays, I regret that I was ever used that way and I regret that I was part of the process. I now realize that almost all of the physicians that I replaced at the last minute were denied due process. I am ashamed of that.

Due process is important. It is important that we stand up for each other. If you are reading this letter and you are a special ops physician, think about it.

Sincerely,

— Terence J. Alost, MD MBA FAAEM

Thank you for writing. You make an excellent and important point, one I had not considered. I hope our colleagues who now fill your former role will think long and hard about the ethics of what they are doing and how it effects our specialty.

— The Editor ■

Response to an Article? Write to Us!

We encourage all readers of *Common Sense* to respond to articles you find interesting, entertaining, educational, or provocative. Help us stimulate a conversation among AAEM members.

www.aaem.org/publications/common-sense