Current dilemma: To certify or not to certify?

Dear Medical Staff Institute Members:

In 2006, the American Board of Medical Specialties (ABMS) adopted a formal “Maintenance of Certification” (MOC) policy that represented our profession’s commitment to lifelong learning and competency. Few would disagree that the establishment and maintenance of certification seems intuitively to be a good idea, particularly with the rapid evolution of medical information, the erosion of cognitive knowledge over time, and the public’s need to be reassured of a basic level of educational attainment and expertise. Interestingly, there is growing scientific evidence that the attainment of certification leads to better outcomes; however, there is no current evidence that maintenance of certification has a measurable impact upon patient outcomes, despite the clear erosion of skills over time.

In response to the public’s demand to assure quality and competence, many medical staffs and hospitals rushed to reassure their governing boards and communities that they were committed to a fully “certified” medical staff and modified their bylaws accordingly. It is not uncommon to encounter the following bylaws language:

“A practitioner who submits an application for initial appointment after [DATE] must be Board certified by the appropriate specialty Board (ABMS and/or AOA) or offer written proof that he/she has met the requirements for examination for certification by the appropriate specialty Board. Board Certification must be attained within five (5) years of completion of Residency or Fellowship training.

A practitioner who submitted an application prior to [DATE] and who is not Board certified at the time of initial appointment is not required to obtain or to maintain Board certification."

This raises several interesting questions:

- Since the dates may either be recent or more remote, does this imply that a variable number of medical staff members are not required to be certified or to maintain certification?
- Does this create a double standard of competence for younger (with time-limited certification) and older (with time-unlimited certification) medical staff members?
- Will applicants for appointment and reappointment be handled differently if they are or are not board certified?
- What if a younger physician is on staff for a significant period of time, demonstrates ongoing competence through solid performance metrics, and fails a recertification exam; must the medical staff exclude that individual?
- What will be the position of the hospital regarding maintenance of certification? If a board certified physician who has been on your medical staff with good quality care chooses not to recertify, will that physician no longer be eligible for continued membership and privileges?
- How should the field treat practitioners who fail the exam? Should they be excluded from insurance panels or lose their professional appointments/positions?
• How should the medical staff handle members of certain specialties (e.g. pediatrics and orthopedics), whose boards are contemplated taking maintenance of certification (MOC) to the next level by eliminating an expiration date for certification as long as the maintenance requirements are met?

The current group of new graduate physicians makes up the first generation in history that is required to maintain certification throughout their professional lives through ongoing education and recertification. Many older physicians never became board certified, became board certified then allowed their certification to lapse, or were certified “for life” following graduation years ago.

Interestingly, the house of medicine is divided on the issue. In a recent publication of the New England Journal of Medicine (NEJM362:10, March 11, 2010), a case presentation poses the question whether an experienced physician with a time-unlimited (non-expiring) certification should voluntarily participate in the internal medicine maintenance of certification (MOC) program when 47% of current diplomats in his specialty have declined to do so. Drs. Wendy Levinson and Talmadge E. King, Jr argue for support of the current ongoing maintenance of certification (MOC) program citing the lack of usefulness of traditional CME, the documentation of better clinical outcomes for those initially certified, and the well documented decline in physician performance over time with greater numbers of years in practice (Ann Intern Med 2005;142:260-273). Drs. Lee Goldman, Allan H. Goroll and Bruce Kessler argue against support of the current ongoing maintenance of certification (MOC) program citing no evidence demonstrating improved clinical outcomes with MOC, the lack of relevance of the recertification examination with physicians increasingly reducing the scope of their practices, and the over-reliance on “recertified memories” (examinations based upon memory based factual recall) in a profession that teaches everyone to “always use the best sources of information rather than relying on your memory alone.” In summary, the authors agree that maintenance of certification (MOC) as a goal is a good idea; however, there is sharp division as to whether the current MOC process is effective or even accurate in accomplishing the goal of improved clinical outcomes based upon improved professional performance.

How should the medical staff handle this dilemma?

There is no question that a policy of mandatory board certification and maintenance of certification sends a powerful message to the community that the medical staff is committed to excellence and a high level of competence. Few would argue that everyone on the medical staff should be strongly encouraged to be board certified and to maintain certification throughout their professional lives. However, with the coming physician shortage and the evolution of ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE), should certification have the potential to be the sole inclusionary criteria for membership and privileges on the medical staff?

The Center for Medicare and Medicaid Services (CMS) says “no.” According to CMS:

§482.12(a)(7) Ensure that under no circumstances is the accordancc of staff membership or professional privileges in the hospital dependent solely upon
certification, fellowship or membership in a specialty body or society.

On the other hand, this is clarified by the same section’s interpretive guidelines by emphasizing certification’s important role within the context of evaluating overall competence:

Interpretive Guidelines §482.12(a)(7)
In making a judgment on medical staff membership, a hospital may not rely solely on the fact that a MD/DO is, or is not, board-certified. This does not mean that a hospital is prohibited from requiring board certification when considering a MD/DO for medical staff membership, but only that such certification must not be the only factor that the hospital considers. In addition to matters of board certification, a hospital must also consider other criteria such as training, character, competence and judgment. After analysis of all of the criteria, if all criteria are met except for board certification, the hospital has the discretion to decide not to select that individual to the medical staff.

Some medical staffs have adopted language that holds the potential to satisfy the medical staff, the governing board, and the community at large:

1.1 The following qualifications must be met by all applicants for medical staff appointment, reappointment, initial requests for clinical privileges, or renewal of clinical privileges:

A physician applicant, MD or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and be currently board certified or become board certified within (5) five years of completing formal training as defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association;

1.2 Exceptions

1.2.1 All practitioners who are current medical staff members and/or hold privileges as of [current date] and who have met prior qualifications for membership and/or privileges shall be exempt from board certification requirements.

1.2.2 Only the Board may create additional exceptions but only after consultation with the MEC and if there is documented evidence that a practitioner demonstrates an equivalent competence in the areas of requested privileges.

These exceptions permit:

a. Physicians who are long standing members of the medical staff and who have consistently demonstrated their competence to be exempt from the certification requirement by the Board with MEC input

b. Physicians who are otherwise determined to be competent by the MEC and the Board may be permitted an exception.

c. Physicians who are not determined to be competent may be excluded from eligibility based, in part, upon a lack of certification.
As you can see, this is a complex topic and there are many options to consider when deciding how to confirm competence of practitioners privileged through the medical staff ranging from mandatory maintenance of certification through a more flexible approach that includes: creating a “grandfather clause”, exempting individuals on a case specific basis, creating other measures of performance as a proxy or supplement to certification, to utilizing certification as a part of the overall measurement process.

There is no simple solution to the issue and your medical staff and governing board should have a thoughtful discussion of where you want your current and future culture to be in light of your contemporary challenges, your ability to recruit and retain a qualified medical staff, and how you would like to communicate your culture to your community.

The overall goal is to utilize the best process available to support improved professional performance that leads to evidence based improved clinical outcomes. Hopefully, the specialty boards will continue improve the relevancy of the MOC process and provide a cost effective approach towards assuring that forthcoming generations will benefit.

Please contact your senior advisor if you have any questions with regards to this controversial issue or you need help in modifying your medical staff bylaws language to address this and other contemporary credentialing and privileging challenges.

Wishing you continued success,

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