AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 318
(A-17)

Introduced by: Michigan

Subject: Oppose Direct to Consumer Advertising of the ABMS MOC Product

Referred to: Reference Committee C
(Kenneth M. Certa, MD, Chair)

Whereas, There are no studies linking physician's participation in the American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC) product with a positive effect on the quality or cost of care; and

Whereas, Advertising medical products and processes directly to patients bypasses the critical filter of physicians who can help patients decipher complicated medical concepts; and

Whereas, There is no regulatory proof required for these direct-to-consumer advertising campaigns, making it difficult to refute these claims in the marketplace of ideas; and

Whereas, Existing AMA Policy H-105.988 opposes direct-to-consumer advertising of prescription drugs and implantable devices for the ethical concerns of misleading information and corporate interference with the doctor-patient relationship; and

Whereas, The American Board of Medical Specialties has launched a direct-to-consumer campaign at certificationmatters.org; and

Whereas, Subspecialty boards such as the American Board of Pediatrics are following suit with mycertifiedpediatrician.org; and

Whereas, These advertising campaigns contain misleading information linking quality care to the board certification product; and

Whereas, These advertising campaigns direct patients and families to search misleading databases that eliminate the names of physicians who have passed multiple board exams over decades, but choose not to participate in MOC; and

Whereas, These campaigns do not mention alternate certification boards where a physician may be certified; and

Whereas, These direct-to-consumer campaigns with misleading and incomplete information have potential to harm the physician-patient trust and relationship; therefore be it

RESOLVED, That our American Medical Association oppose direct-to-consumer marketing of the American Board of Medical Specialties Maintenance of Certification (MOC) product in the form of print media, social media, apps, and websites that specifically target patients and their families including but not limited to the promotion of false or misleading claims linking MOC participation with improved patient health outcomes and experiences where limited evidence exists (Directive to Take Action); and be it further

RESOLVED, That our AMA amend existing AMA Policy D-275.954, “Maintenance of Certification and Osteopathic Continuous Certification” by addition as follows:

36. Direct the ABMS to ensure that any publicly accessible information pertaining to maintenance of certification (MOC) available on ABMS and ABMS Member Boards’ websites or via promotional materials includes only statistically validated, evidence based, data linking MOC to patient health outcomes. (Modify Current HOD Policy)

Fiscal Note: Not yet determined

Received: 05/11/17

RELEVANT AMA POLICY

Maintenance of Certification H-275.924
AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 CreditTM, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOC should be used as a tool for continuous improvement.