AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 319
(A-17)

Introduced by: Michigan

Subject: Public Access to Initial Board Certification Status of Time-Limited ABMS Diplomates

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

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1 Whereas, Initial American Board of Medical Specialties (ABMS) board certification is a
2 credential of great accomplishment for many physicians; and
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4 Whereas, Initial ABMS board certification is all that is required of time-unlimited or
5 "grandfathered" physicians; and
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7 Whereas, Existing AMA Policy H-275.924, "Maintenance of Certification," protects the status of
8 "grandfathered" physicians, stating "No qualifiers or restrictions should be placed on diplomates
9 with lifetime board certification recognized by the ABMS related to their participation in MOC;"
10 and
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12 Whereas, The names of grandfathered physicians are available when verifying certification
13 status on ABMS credentialing websites, indicating the date of initial certification, regardless of
14 their participation in Maintenance of Certification (MOC); and
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16 Whereas, Similar protections for physicians holding time-limited certificates do not exist; and
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18 Whereas, The ABMS and ABMS member boards erase the name of time-limited physicians
19 when they choose not to participate in any of the four parts of MOC, regardless of how many
20 times the physician has passed his or her board examinations; and
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22 Whereas, Under this punitive system that erases the name of time-limited physicians, the only
23 way for the public to verify initial certification is via formal inquiry and a fee; and
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25 Whereas, This punitive system causes great harm to time-limited diplomates during professional
26 physician credentialing, when initial certification is not readily available; and
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28 Whereas, This punitive system causes great harm to time-limited diplomates in terms of patient
29 trust under the current direct-to-consumer advertising campaigns directing patients and families
30 to "verify if your doctor is board certified," when patients and families are not able to access
31 initial board certification status of time-limited diplomates; therefore be it

1 RESOLVED, That our American Medical Association amend the AMA Principles of Maintenance
2 of Certification (MOC), AMA Policy H-275.924, “Maintenance of Certification,” by addition as
3 follows:
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5 26. The initial certification status of time-limited diplomates shall be listed and publicly
6 available on all American Board of Medical Specialties (ABMS) and ABMS Member
7 Boards’ websites and physician certification databases. The names and initial certification
8 status of time-limited diplomates shall not be removed from ABMS and ABMS Member
9 Boards’ websites or physician certification databases even if the diplomate chooses not
10 to participate in MOC. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

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.
15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.
19. The MOC process should not be cost prohibitive or present barriers to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
CME Rep. 16, A-09 Reaffirmed: CME Rep. 11, A-12 Reaffirmed: CME Rep. 10, A-12 Reaffirmed in lieu of Res. 313, A-12 Reaffirmed: CME Rep. 4, A-13 Reaffirmed in lieu of Res. 919, I-13 Appended: Sub. Res. 920, I-14 Reaffirmed: CME Rep. 2, A-15 Appended: Res. 314, A-15 Modified: CME Rep. 2, I-15 Reaffirmation A-16 Reaffirmed: Res. 309, A-16 Modified: Res. 307, I-16 Reaffirmed: BOT Rep. 05, I-16