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Correspondence

Recertification and Maintenance of Certification

I thank the editors for their publishing Dr. Dubravec's insightful article on board certification and recertification.[1] As an obstetrician/gynecologist who finished my residency in 1985, I earned only a 10-year certificate when taking my boards. If I had graduated in 1984, I would have been boarded for life. The ABOG requires a two-part exam, the first written and the second a three-hour oral examination, part of which is based on the entire list of all the physician's hospitalized patients plus a significant number of representative outpatient visits. I passed both examinations the first time and was re-boarded 10 years later. In 2001, my specialty board modified the certificate to be valid for 6 years. In 2008, it changed the rules once again and now requires a yearly exam, the completion of modules over a 6-year period, and still another written exam every 6 years.

In Los Angeles where I practice, we have fewer younger physicians participating in our local specialty meetings. The Los Angeles OB/Gyn Society is a skeleton of what it once was. Its annual assembly, which was once world renowned, with more than 700 participants, barely has 150 attendees, many of whom are retired. I hypothesize that the numerous hours and costs required to maintain our certification have contributed to the demise of these once impressive meetings and organizations. Another unfortunate outcome is the destruction of the collegial relationships developed by OB/GYNs in our region. I would scientifically study my theory, but I am too busy preparing for yet another annual examination. Perhaps the ABMS or any of the individual subspecialties can spend some of their resources on studying why camaraderie, collegiality, and membership in local organized medicine has plummeted since the introduction of recertification.

Howard C. Mandel M.D., F.A.C.O.G.
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I would like to thank Dr. Dubravec for his excellent article.[1] I am an allergist who completed my boards in 1987. At my hospital I am vice president of medical staff, chairman of performance improvement, and peer review chairman. I have an active role in evaluating physician quality. I have admonished our hospitals not to use ongoing MOC as a criterion for privileges, as it has not been proven to be a good indicator of quality.

What outcomes research has validated this MOC process? The answer is: none. And, what is the cost in money and time to a busy practitioner? Dr. Mark Corbett, 2010 chair of the board of directors of the American Board of Allergy and Immunology (ABAI), spoke to a universally hostile audience at our Illinois allergy meeting. We felt the board had mandated this expensive, complex, unproven pathway to MOC without adequate member input or evaluation. He told us that regulatory agencies, HMOs, insurers, and patients have demanded MOC. However, he offered no evidence to support this claim. My patients have no idea what MOC or even board certification means. Insurers pay a family practitioner the same amount as an allergist for skin testing. My HMO and IPA are concerned about my following formulary and point-of-care guidelines, not about participation in MOC.

I see MOC as nothing more than a power play by the boards, and ultimately taxation without representation. If MOC were truly of value, it would not need to be mandated. No one who is directly affected by this set of unfunded mandates and requirements has any representation.

I spoke to Dr. Wasserman, president of the ABAI, about his decision to degrade my status as "board certified" to "time unlimited certificate; NOT participating in MOC," thus changing my contract with the board from 24 years ago; he had no reply. I have tried as a member to engage the board. What do I really get for my MOC cost of $5,000 to $9,000 every 10 years? I have gone to national allergy meetings every year for 26 years because I perceive value. What value does this MOC have?

What's next on the agenda for our boards? One only has to read ABAI PowerPoint slides. Soon MOC will be required to receive Medicare incentives and for hospital medical staff privileges. This will mean still less participation in hospital staffs already devoid of good allergist/immunologists and other physicians. With licenses dependent on MOC participation, we will see early retirement of good doctors. Why am I asked to donate to training programs for future allergists when my allergist friends are threatening to leave this profession because of MOC?

With no evidence of real value in terms of relevant improvement in clinical practice, MOC is just a despicable power grab by boards.

Greg E. Sharon, M.D., F.A.C.A.A.I.
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It is not well known that the U.S. is the only developed nation that for years has insisted on recertification. The others, until recently, have had continuing medical education (CME) only, and there is no evidence that their citizens have been harmed.

During my more than 40 years in practice, I have had the privilege of working with many outstanding physicians in Canada, where physicians do not have to recertify, and the U.S., where they must. Medical opinion leaders in the two nations have a major difference of opinion on the value of recertification as a quality promoter.

A natural experiment to answer the question is possible but has never been done. Let us take two cohorts of physicians, same specialty, same location, with one group starting practice in the late 1980s just prior to mandatory recertification and the second just after. Let us see how they compare on quality-of-care metrics. I predict that there would be no substantive differences.

The longer we keep up our present inadequate system, the longer we delay finding a method that really would improve the quality of our care. The present method is just a cash machine for the medical-educational complex, composed of certifying bodies (ABMS) and education providers (including our own specialty societies).

The notion that this process may now be extended to become a relicensure issue is very troubling. It makes it even more important that good evidence on the real-world effect of the recertification/MOC processes be obtained. We should apply the same evidence-based standards to our certification system as we would to anything else we do.

John V. Mackel, M.D., M.S.H.A.
Cape Girardeau, Mo.

1 Dubravec M. Board certification/recertification/maintenance of certification—a malignant growth. *J Am Phys Surg* 2011;16:52-53.

Co-mingled Insurance Steals Patient Power

Dr. Lawrence Huntoon exposes how insurance companies have inappropriately co-mingled cost-conscious individuals, who have high deductible health plans (HDHP) linked to health savings accounts (HSAs), with individuals who have traditional HMO plans with nearly first-dollar coverage.[1]

Subscribers with nearly first-dollar coverage often suffer from addiction to OPM (other people's money) or what they perceive to be OPM—employer's money, for instance.

We see another example of inappropriate co-mingling of groups in the NIH's Women's Health Initiative study, which co-mingled smokers with other women receiving hormone replacement therapy. Although the study showed an increased risk of myocardial infarction in women receiving hormone replacement, the total death rate was actually lower for women receiving hormone replacement therapy, including smokers.

Inappropriate and unfair co-mingling also occurs in states that have guaranteed-issue and community-rated insurance plans. Individuals who have chosen to drink too much, smoke too much, and engage in promiscuous and unprotected sex are co-mingled with individuals who have made wiser and less risky lifestyle choices. Like the individuals who have HDHPs, who are forced to subsidize those with the spending restraint of "drunken sailors," those who make prudent and less risky lifestyle choices are forced to subsidize those who make unhealthy choices in states that have community rating.

Personal responsibility is the only hope for restraining out-of-control medical care costs caused by government distortion of the market. Unfortunately, ObamaCare, if it survives constitutional challenges, will effectively destroy any remaining vestige of personal responsibility and freedom in medicine. For those who believe in freedom, personal responsibility and upholding the U.S. Constitution, let us hope that the AAPS lawsuit and other lawsuits challenging the constitutionality of ObamaCare succeed.

Howard F. Long, M.D., M.P.H.
Pleasanton, Calif.

1 Huntoon LR. What have they done to my HDHP? *J Am Phys Surg* 2011;16:34-35.

Affability

I found Dr. Robert Peraino's article concerning affability[1] to be right on target.

I am medical director of the Healthcare Reform Educational Institute (HCREI) located in Lincoln, California. We strongly support the practice of private medicine. We've maintained a website since 1998, which is designed to educate the public in matters related to the "health care reform" effort.

I became familiar with the word "affability" as a result of my readings of the works of Machiavelli. I agree that it will lead to mediocrity in the medical profession.

Vincent Cangello, M.D.
Lincoln, Calif.

1 Peraino RA. Affability: desirable physician attribute, or synonym for mediocrity—a case study. *J Am Phys Surg* 2011;14-16.

Errata

The study of cultured mesenchymal stem cells referred to by Centeno and Faulkner[1] recruited 19 untreated patients, not 24 (see abstract and p 40). For the untreated controls, n = 19, not 25 (see abstract and p 40).

In the article concerning biological effects of ionizing radiation,[2] the expected mortality in Co-60 contaminated apartments in Taiwan was 116 per 100,000 person-years, not 116 per 1,000 person-years as stated on p 46. The cancer mortality rate in the 7,430 Hiroshima/Nagasaki survivors who received 10–19 mSv was 68.5 per 1,000, as shown in Fig. 2, not 68.5% of control, as stated on p 46.

1 Centeno CJ, Faulkner S. The use of mesenchymal stem cells in orthopedics: review of the literature, current research, and regulatory landscape. *J Am Phys Surg* 2011;16:38-44.
2 Luckey TD. Biological effects of ionizing radiation. *J Am Phys Surg* 2011;16:45-46.