

Why Do Patients Select and Stay with Their Doctor? Implications Regarding Board Certification and Maintenance of Certification and of Licensure (MOC/MOL)

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The ABIM/Gallup Survey

In 2003, the American Board of Internal Medicine (ABIM) contracted with the Gallup Organization for a survey via telephone interviews to produce the document entitled: *Awareness of, and Attitudes Toward Board-Certification of Physicians*.¹

While the Gallup study found only 33% of all adults surveyed said they have at some point inquired as to whether a physician was board-certified, 72% reported they did know whether their doctor was board-certified. This is clearly a paradox and a finding not supported by personal experience: Never in 30 years have I been questioned by a patient as to board status.

While the Gallup statement on methodology does not indicate that any education of polled individuals occurred, the summary of findings indicates that respondents were “read a definition of board-certification.” The wording of the questions is quoted, and the statement is apparently this:

Board certification is a voluntary process whereby doctors must meet rigorous standards of medical knowledge, clinical skills, and judgment. These standards are set by an independent, professional organization made up of medical doctors.¹

The survey finds that “Most adults (79%) **once informed of what certification involves**, feel that recertification of physicians is very important” [emphasis added]. The respondents apparently are informed by the above statement.

Typically, surveys are conducted using specific questions while presenting answer choices that may be inherently suggestive and thus influence results. It is quite unusual to provide information during a survey, but rather “don’t know” or N/A answers if material is not relevant or known to the subject. ABIM sponsorship possibly introduces motivation to provide this active education to insure findings supportive to ABIM corporate goals. It is less common to ask open-ended questions (without specific and limited predetermined possible answers), as the tabulation of answers is complicated by the vocabulary of the respondent, and it may be difficult to group these responses effectively, especially in large numbers of polled individuals.

Purpose of This Study

This study specifically attempted to see whether the results of the ABIM/Gallup poll could be replicated and to quantify the important reasons leading to selection of a physician and the

decision to continue receiving care from that physician, while minimizing the potential for suggesting any desired answer. A single open-ended question was specifically designed to facilitate spontaneous responses.

If the Gallup report that patients “overwhelmingly” prefer board-certified physicians is accurate, this should be clearly evident even in a survey limited to 100 people.

Methods

A suburban location bordering on urban and rural populations outside Cleveland was chosen to include a broad sample of Americans of driving age who were able to travel outside their own neighborhood. Adults entering a convenience store in residential suburban areas were surveyed while walking from their cars into a store. Locations were chosen on major thoroughfares. A total of 101 people were questioned, while tabulating numbers of non-respondents.

Persons were approached with the single question: “I am doing a one-question survey and would like your opinion, please.” Any indication of desire to not participate was immediately respected. Persons indicating an interest to participate were questioned as follows: “When you go to a physician for medical care, what factors, considerations, or decisions, in the order of importance to you, lead you to go to or stay in the care of this physician versus getting care from any other physician.” Whenever the subjects responded with any question showing a need for clarification, the following was stated: “I am trying to find the reasons you would seek care from one physician ‘X’ over that care from a physician ‘Y’, where both would otherwise seem equal to each other as being a licensed physician.”

Every attempt was made to prohibit all suggestion of terms or ideas beyond this single question, and to secure only information that the subjects could present spontaneously. No time limits were imposed, waiting for any and all answers supplied by the subjects as their own considerations and words came to mind. When subjects stopped listing reasons/answers to the question, they were again asked if there were any further answers to add, and subsequently age, race, insurance provider, and gender were ascertained as electively provided. Significant variation in descriptive words was found, but answers were grouped according to generalized categories in the analysis. All single answers were then tabulated as first through sixth (the maximum number encountered), noting their serial order.

Results

The interview of 101 subjects took 3.5 hours on a temperate, sunny, dry Saturday, Oct 22, 2011. The mean age of interviewed subjects was 49 +/-20.3 years and ranged from 17 to 82 years, with three individuals declining to provide age. Of the 168 persons encountered, five individuals specifically declined questioning based on language barrier, and a foreign accent was evident. An additional 62 individuals declined to answer upon initial inquiry, yielding a non-response rate of 39% of all individuals encountered. Of the 101 individuals answering, 36 were female and 65 were male. Four respondents were black, and 96 were white. Thirteen respondents declined to name, while nine specifically indicated they "did not know" their health insurance provider, totaling 22 individuals failing to provide information on the type of insurance. Eleven individuals specifically indicated they were uninsured, with mean age 39.5 +/-11.9 years, ranging from 24–55 years. Sixty-eight individuals indicated some form of third party payment/insurance coverage as indicated in Table 1.

Respondents provided one (25%), two (75%), three (36%) four (20%), five (8%), or six (1%) reasons for their choice of physician, yielding 239 individual responses (see Table 2).

The responses could be grouped into six areas of response: physician availability, physician competency, physician personality, insurance factors, referral, and "other."

Specific Reasons

Specific responses in the order of most frequent responses for each group were as follows (N is only listed where greater than three responses were noted):

Referral: family/friend or doctor referrals (27); referred based on coverage [insurance plan/family plan/family doctor/parents] (11); hospital referral (5); online recommendation/data, researched reputation (6).

Personality: like doctor (11); personable (6); trust (5); comfortable with him/her (6); bedside manner (4); caring, compassionate, concerned, courteous (5); honest (4); communicates well (4); overall personality (3); knows me personally, my history (3); tells all, listens, factual, doesn't talk down, will talk to family, will call back, truthful, answers all questions (13); patient, provides good service, relates well, respectful, takes his time, professionalism.

Competency: "good doctor" (8); comments related to quality of care, such as best care, best I know, best in specialty, quality

Table 1. Payer distribution of surveyed individuals:

11	Medicare
22	Failed to respond to question of insurance coverage
13	Declined to answer
9	Did not know provider
11	NO insurance/"self pay"
56	Private insurance indicated
1	Veterans Administration care

care (5); knowledge, qualifications, reputation, skill, saved my life (7); specialty (4); gives good advice, gets it right first time, licensed, answers questions well, skill, confident, decisive, cured my pain, education, experience.

Other reasons: long-standing relationship (10); miscellaneous personal preferences, such as wanting osteopathic care or a physician of a certain sex; membership in specialty society; clean litigation history.

Insurance/payment factors: care was covered (15); cost low (10); cash accepted or will work pro bono.

Reasons Not Given

None of the respondents mentioned board-certification status or specific educational background, such as U.S. vs. foreign medical graduate, or specific residency program. Apparently, none of them considered these factors important enough to mention in an open-ended response, without prompting. Instead, they thought about how the physician related to or treated them, as well as referral sources, cost, and availability. Apparently, patients are not troubled by lack of confidence in their own assessment or that of their referring physicians or other advisors, and thus did not feel a need to seek any validation from a certifying agency.

Discussion

First, this study failed to detect any level of awareness of the American Board of Medical Specialties (ABMS) or ABIM or any other board in the population surveyed. This implies that in the Gallup survey, respondents may have based their replies on the impression they had of the surveyors' presentation rather than on any independent knowledge of specialty boards.

The method of open-ended questioning circumvents bias introduced by the survey itself, but imposes the challenge of tabulating and grouping answers. The number of individuals doing the polling was small, to limit variability introduced by having different surveyors.

Surveyors were physicians dressed in street clothing to avoid any pressure that might have resulted from perceived differences in status. The method of approaching unselected persons who happened to come to a public location provided anonymity.

Table 2. Reasons for choosing a physician

Reason	Of first response only, N = %	Of all responses	
		N	(%)
Referral	34	49	20.5
Personality	29	82	34.3
Competency	15	34	14.2
"Other"	12	26	10.9
Insurance factors	8	27	11.3
Availability	3	21	8.8

Multiple answers by one individual within the same general response category generally focused on the same aspect of personality or competency.

Several individual comments were particularly interesting. Two persons indicated the need to find care from physicians who specifically do *not* require insurance coverage to schedule service. In a post-survey discussion, one of them, a self-employed, financially solvent individual said that for his family of four, cash payments for episodes of care were much more affordable than paying more than \$1,400 per month for family coverage. It was, however, difficult to schedule initial elective care without the ability to provide insurance plan data to the practice staff.

The current climate of economic downturn may have suggested the importance of financial considerations in seeking medical care. This factor may have been minimized in the demographic area surveyed, in which the population was generally well-insured.

Those surveyed placed overwhelming importance on perceived general competency, based on referral source and interpersonal characteristics of the doctor. Insurance plans may encourage patients to seek in-network providers, but patients apparently feel that they still have the ability to find and select competent and compatible professionals.

As mentioned above, several issues were noticeable by their absence in the answers. Some individuals used the internet to find and “rate” doctors, but they did not report seeking information on board certification or interval testing, in clear contrast to the ABIM/Gallup findings.¹ Experience was mentioned infrequently, generally in association with the history of a patient-doctor relationship.

Both board certification and testing have been increasingly described, by organizations with a vested financial interest in promoting the linking of board certification to maintenance of medical licensure (MOL), as important for assuring quality in the patient-physician relationship. The programs are complex, expensive, include interval testing methods but are not validated by clinical outcomes.² Our survey shows that the quality of the patient-physician relationship is indeed important to respondents—none of whom connected it to board certification. Likewise, while competency is important, it is not perceived to be connected to certification. The Gallup language quoted above does not necessarily imply ABIM or other board certification; “evaluation by an independent board of doctors” could easily be interpreted to apply to residency training or hospital credentialing.

The factors that respondents find to be important to good medical care are all increasingly difficult to maintain under the pressures of cost containment and reduced fees leading to “high throughput healthcare” or “corporate medicine.” The costs and time demands of Maintenance of Certification/Maintenance of Licensure (MOC/MOL) add to these pressures.

Beyond public demand, which ABIM appears to be trying to create with the Gallup survey, there is no evidence that MOC is

required for competency. In fact, there is no evidence that significant levels of physician incompetence prevail based on available data from large and active state medical board information:

The State Medical Board of Ohio (SMBO) publishes all “actions” as Freedom of Information online at <http://www.med.ohio.gov/professionals-mfal.htm>. While more than 4,000 complaints are registered each year, fewer than 10% lead to actions, and 25% of SMBO actions involve non-physicians! A review of the first three months of 2011, with 69 physician “actions” and 35,562 physicians in active practice in the state (0.8% of all physicians a year are subject to “actions”) shows that physician competence is an unusual cause for action, and this is recognized by the state board members: only four individuals were subject to actions (mental health/retirement, wrong-site surgery, history of substandard care on license application, yielding a rate of 0.04% per year) based on this quarter’s analysis. Roughly 80% of all actions deal, however, with physician drug and prescription abuse, alcoholism, and moral turpitude/financial fraud.

Availability was recognized by respondents as important, and might well have ranked much higher if current availability were not relatively good. That situation could change dramatically with proposed imposition of MOC/MOL requirements.

Significant numbers of physicians in practice are not board certified: only 200,000 of the practicing 759,000 U.S. physicians are enrolled in Maintenance of Certification (MOC), and many have not recertified in the past decade.³ Women and under-represented minority students were found to display significantly lower levels of board certification. Nine years after medical school graduation in 2000, only 34.9% of female OB/GYNs were certified in 2009.⁴ Only 73% of all practicing anesthesiologists are board certified in 2011.⁵ Also, roughly half of practicing anesthesiologists currently possess lifelong certification obtained prior to 2000 and may thus be actively excluded from entering the available MOC programs, now designed to require prior ongoing participation for enrollment.⁶ State medical boards do not consistently tabulate rates of certified vs. non-certified physicians, while non-specialist (non-certified) numbers appear to run around 37% in Ohio, as found in available SMBO data.

Great numbers of physicians may be enticed to retire early, especially in the absence of specific programs to easily attain required certification or recertification, at a time when resident training funding is threatened and Baby Boomer retirement will compromise physician access as demand increases.⁷

The Push for MOC/MOL: Why?

Maintenance of Licensure (MOL) has resulted in significant controversy,⁸ yet there is a powerful movement to require MOC/MOL. Periodic testing during “continual” MOC is being actively mandated by multiple private organizations (FSMB and

ABMS). MOC/MOL is currently being advocated by FSMB, and is being actively considered in 11 states (Ohio, California, Colorado, Delaware, Iowa, Massachusetts, Mississippi, Oklahoma, Oregon, Virginia, and Wisconsin).

Why are these costly programs advocated, in the absence of evidence of benefit or even of genuine public demand, at a time when a decrease in bureaucracy and costs is urgently needed? Apparently the ABMS has forced all 24 subsidiaries to adopt this plan, some against their own better judgment, and under the threat of losing their "charter," according to a personal communication from a medical board member.

The most likely reason is a desire for profit by the board-certification industry. The combined annual revenue of the relevant organization, as tabulated from the most recent official IRS 990 forms, available for review at www.changeboardrecert.com, is more than \$350 million, and accrued assets total more than \$400 million.

Conclusions

Physicians are highly trained professionals who are well motivated to maintain and improve their skills through continuing medical education and other means they find most helpful. In the absence of evidence that their current competency is inadequate or that MOC/MOL would bring any improvement, physicians may be increasingly conscripted to support the certification industry's ever-increasing bureaucratic costs and time commitments.

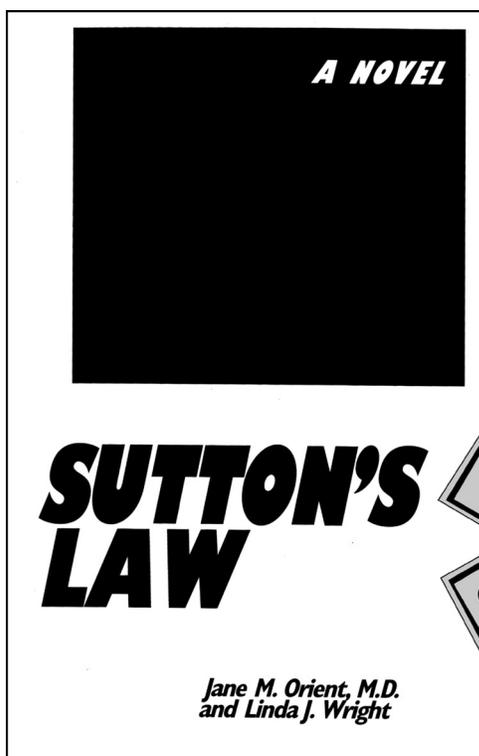
Our survey showed lack of patient concern about certification. With regard to the factors they do consider in choosing their physician, MOC/MOL is likely to be of negative value.

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