

2. Maintenance of Certification

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A. Introduction

1. Definition of Maintenance of Certification

Maintenance of Certification (MOC) is the documentation of a personal program of continuous learning and improvement. MOC is required for ongoing certification by the American Board of Surgery and starts immediately upon initial certification or recertification. MOC crosses all specialties. It was established in 2002 by the American Board of Medical Specialties, a federation of 24 member boards. It is the logical continued growth of the process of board certification and also answers the public demand for demonstration of quality and ongoing acquisition of knowledge.

2. History of Board Certification

Board certification in the USA has evolved since its inception in 1917. The American Board of Ophthalmology was the first board formed, inspired by a 1908 speech to the American Academy of Ophthalmology and Otolaryngology by Derrick Vail, an ophthalmologist. He stated:

I hope to see the time when ophthalmology will be taught in this country as it should be taught. That day will come when we demand... that a certain amount of preliminary education and training be enforced before a man may be licensed to practice ophthalmology. After a sufficiently long term of service in an ophthalmic institution ... he should be permitted to appear before a proper examining board for examination... and if he is found competent let him then be permitted and licensed to practice ophthalmology.

That speech inspired the formation of the American Board of Ophthalmology in 1917, and in 1937 the American Board of Surgery was formed. The original mission statement of the ABS notes that the Board is formed to “**protect the public and improve the specialty**” which was to be accomplished by the establishment of a comprehensive, standardized certification process, including periodic assessment of individual hospitals as appropriate places of training, the requirement of 5 years of training beyond internship, and the development of an examination process designed to assess both knowledge and judgment.

3. *Background of MOC*

From 1937 until 1976 certification was lifelong: once certified, nothing further was required for the duration of one’s surgical career. In 1976, the American Board of Surgery formally recognized that surgery is a field that requires ongoing active engagement in learning and that this should be supported by requiring recertification. Recertification requirements included: submission of a case log, assessment of knowledge by a broad-based multiple choice exam with a passing score, proof of active license and hospital privileges, and testimonials from hospital officials including the chief of surgery. The decision to implement intermittent reassessment for recertification was supported by the outcome. The results of those first recertification exams confirmed that the body of knowledge of surgeons 20 or 30 years out of training was not the same as that of surgeons within 10 years of their training; the former group failed the exam in high numbers.

A confluence of events at the turn of the century caused the specialty boards to revisit the duration of certification yet again. Increased public scrutiny of patient safety, the issuance of the IOM report “To Err is Human” in 1999, and the highly successful safety campaign by the airline industry all drove focus towards more oversight of knowledge and training. In addition, surgery underwent a series of rapid changes, including the widespread adoption of laparoscopy, the development of endovascular surgery, the introduction of sentinel node technology, the discovery of *Helicobacter pylori*, the penetration of interventional endoscopy, and the increased use of noninvasive management of blunt trauma. All these things combined to make it clear that surgical training and practice were dynamic arenas that required ongoing attention and self-education.

B. Defining MOC

MOC is a result of that reassessment. MOC changes the emphasis from a burst of studying every 10 years to that of an ongoing process of learning and assessment. It is broken into four categories, based upon the ABMS/ACGME Six Competencies, adopted in 1999. The Six Competencies are a rubric for resident education and assessment across all specialties. Programs are required to demonstrate that their curriculum addresses these arenas.

The competencies are as follows:

- **Patient Care and Procedural Skills:** Provide care that is compassionate, appropriate and effective treatment for health problems and to promote health.
- **Medical Knowledge:** Demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and their application in patient care.
- **Interpersonal and Communication Skills:** Demonstrate skills that result in effective information exchange and teaming with patients, their families, and professional associates (e.g., fostering a therapeutic relationship that is ethically sound, uses effective listening skills with nonverbal and verbal communication; working as both a team member and at times as a leader).
- **Professionalism:** Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to diverse patient populations.
- **Systems-Based Practice:** Demonstrate awareness of and responsibility to larger context and systems of health care. Be able to call on system resources to provide optimal care (e.g., coordinating care across sites or serving as the primary case manager when care involves multiple specialties, professions or sites).
- **Practice-Based Learning and Improvement:** Able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their practice of medicine.

C. Components of MOC

1. Categories/Components of MOC for Surgeons

MOC combines the Six Competencies and condenses them into four categories. The components of MOC are as follows:

- **Part 1—Professional standing** through maintenance of an unrestricted medical license, hospital privileges and satisfactory references.
- **Part 2—Lifelong learning and self-assessment** through continuing education and periodic self-assessment.
- **Part 3—Cognitive expertise** based on performance on a secure examination.
- **Part 4—Evaluation of performance in practice** through tools such as outcome measures and quality improvement programs, and the evaluation of behaviors such as communication and professionalism.

2. Fulfilling the MOC Requirements for Surgery

As is true of the field of surgery, MOC is an evolving field. Parts I and 3 are straightforward. Part 1 includes submission of documentation of an unrestricted license, and hospital privileges, as well as a testimonial form filled out by the chief of surgery and chair of the credentials committee. This is to be submitted once every 3 years.

Part 3 is the familiar “recertification” examination, which still must be taken once every 10 years. Admissibility to that exam will include timely fulfillment of all other MOC requirements, as well as a case log.

Parts 2 and 4 have a lot of promise, and are both more complicated and more interesting. Part 2 is self-assessment. In surgery, this will be fulfilled by CME I credits, especially those that require self-assessment. 30 credits will be required each year, 20 of which must be self-assessment. Standards for satisfactory self-assessment are under development by the ABS. Standards currently include CME 1 products that include a self test, which must be passed with a minimum 75% correct. Live activities, enduring materials, journal-based reading, and skills training are all offerings eligible for self-assessment. SAGES offers vehicles for self-assessment, both at the annual meeting and via the online SAGES University (<http://www.sages.org/education/university.php>).

SAGES University is available free to SAGES members and includes SAGES Journal Club, Online Self-Assessment Program (OSAP), and my CME/MY MOC Web page. A partial list of other self-assessment vehicles are listed on the ABS Web page (<http://home.absurgery.org/default.jsp?exam-mocme>). Part II MOC reporting to the ABS will be required each 3-year cycle, along with Parts 1 and 4. Future plans for Part 2 MOC include linking the CME subject areas to case logs and practice, as well as using this venue for continuing education in ethics, professionalism, and perhaps systems-based practice. Ideally, Part 2 requirements will eventually link to requirements of other certifying and licensing groups, such as state licensing boards, hospital credential committees, the Joint Commission, and others. Professional societies including SAGES are providing multiple pathways to achieve those self-assessments credits that are meaningful to an individual's learning and pertinent to his or her practice.

Part 4 is the evaluation of performance in practice. To fulfill Part IV, the ABS currently requires participation in an outcomes database. At present a wide variety of databases fulfills this requirement, including the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP), the American College of Surgeons Case Log, Mastery of Breast Surgery (The American Society of Breast Surgeons), participation in the United Network for Organ Sharing (UNOS), participation in bariatric surgery databases offered either by the American College of Surgeons or the American Society of Metabolic and Bariatric Surgery, and many others (for a partial list see <http://home.absurgery.org/default.jsp?exam-mocpa>). Currently, participation alone is adequate to fulfill requirements; practice data does not need to be provided. Although the ABS recognizes that actual analysis of one's own practice and outcomes compared those of one's peers is ideal, at present no one perfect database exists that allows for such a requirement. Therefore, for now, participation alone is adequate, on the theory that the process of recording one's own practices is valuable in and of itself. Future plans for Part 4 MOC include a single, unified database for ABS use that is currently under development by the American College of Surgeons. In addition, a requirement of assessment of communication skills based upon patient surveys will likely be included in Part IV as well (Table 2.1).

MOC, when mature, will provide both a vehicle and a requirement for surgeons to structure their learning and measure their practices and outcomes. In practice, the ABS Web site will guide practitioners through the existing requirements, as well as updates as high-quality vehicles for Parts 2 and 4 continue to emerge.

Table 2.1. ABS MOC requirements timeline.

MOC year	MOC requirement
0	Year of certification or recertification
1	Yearly CME (30 h Category I, 50 overall)
2	Yearly CME
3	Yearly CME → Diplomate submits information through the ABS Web site regarding medical license, hospital privileges, references, CME and practice assessment participation
4	Same as Year 1
5	Same as Year 2
6	Same as Year 3
7	Same as Year 1
8	Same as Year 2
9	Same as Year 3
8–10	Secure examination (application and 12-month operative log required)

MOC Year July 1 to June 30, starting July 1 following certification or recertification
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Selected References

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