



COUNCIL OF MEDICAL SPECIALTY SOCIETIES

COMMITTED TO EXCELLENCE IN PROFESSIONALISM, EDUCATION AND QUALITY OF CARE

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February 28, 2011

F. Daniel Duffy MD, Chair, MOC Committee
Richard E. Hawkins MD, Senior Vice-president for Professional and Scientific Affairs
American Board of Medical Specialties
222 North LaSalle Street, Suite 1500
Chicago, IL 60601

Dear Drs. Duffy and Hawkins,

The Council of Medical Specialty Societies, whose 37 Member Organizations represent more than 700,000 physicians in the US, appreciates the opportunity to comment on the January 2011 draft of the ABMS/ACCME Joint Working Group on MOC CME entitled "White Paper: CME for MOC."

CMSS Support for ABMS MOC:

CMSS has been supportive of ABMS Maintenance of Certification, as it is consistent with the strategic priorities of CMSS, including facilitating a culture of performance improvement in practice. CMSS has also been supportive of the position of certifying boards to require CME on the part of diplomates, having made this recommendation to ABMS prior to its adoption by the ABMS Assembly in March of 2009. Finally, CMSS has written CMS in support of participation in ABMS MOC as qualifying for an additional 0.5% bonus through the PQRS program.

We appreciate the invitation from ABMS to Ajit Sachdeva MD, CMSS President-elect at the time, and Norman Kahn MD, CMSS EVP, to participate in two of the three meetings of the MOC CME Joint Working Group last summer. Following those meetings, Drs. Kahn and Sachdeva communicated suggestions for improvements in the document in the early fall. Dr. Kahn then had a phone conversation with Dr. Weiss, followed by a written summary of the points discussed in the call. Our suggestions focused mostly on a few content areas, although some referenced a lack of clarity in the wording of the document.

CMSS concerns and recommendations for improving plans for ABMS MOC CME:

In reading the January 2011 draft of the White paper, we recognize the addition of a background section, and find that the wording of a few sentences has been changed from the August 2010 draft. Regrettably, we find that quite a few of our previous suggestions for improvements, both in content and clarity, have not found their way into the document since last August. As such, we are not ready to support MOC CME as described in the current draft.

Lines 26-29:

"MOC CME has relevance to all 4 parts of MOC creating a cyclical linkage between guided self-assessment of knowledge and practice and education and practice improvement activities across the



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MOC framework. Strengthening this linkage could stimulate and promote diplomate practice improvement and professional growth.”

Several parts of this statement are unclear. In what way does MOC CME have relevance to all four parts of MOC? Reading the first sentence does not communicate the full intent here – although the author may know what is intended to be said, the reader is unclear as to the picture the entire first sentence is painting.

Clarity aside, we remain with significant concerns about implications for roles of certifying boards in this finding. Are we to infer that MOC CME is being designed to create the ability for certifying boards to cyclically link knowledge (parts II and III) and practice assessment (part IV), both the purviews of certifying boards, with education and practice improvement activities, which are the purview of specialty societies and others? If so, is that link intended to link the diplomate to the educational offerings of the specialty societies, or to justify the entry of ABMS and its member boards into the realm of continuing medical education?

In the US, the profession has established separate roles for entities assessing physicians (certifying boards) and educating physicians (specialty societies and others), so as to eliminate the perception and reality of conflicts of interest. This finding of the MOC CME White Paper seems to blur those boundaries and mix those roles, which risks placing certifying boards in positions of conflict of interest that the US system has avoided since the inception of certifying boards (Ophthalmology in 1916 and Otolaryngology in 1924) and ABMS (in 1933). As such, we cannot support language in this document that does not clearly separate the roles of certifying boards as standard setters and assessors of physician knowledge and practice, with the roles of specialty societies and others as educators and facilitators of practice improvement among physicians.

CMSS recommends clarifying the language in the above referenced lines so that the language clearly states what is meant for the reader to understand.

CMSS further recommends that this finding clearly articulate the separate roles for certifying boards as standard setters and assessors of physician knowledge and performance, and for specialty societies and others as educators and facilitators of physician performance improvement in practice.

Lines 31-49:

“The characteristics of CME that are of specific relevance for MOC were divided into three focus areas and include the following:

- *Clinical (and Professional) Content*

Learner Centered--diplomates are expected to ensure the practice relevance of the educational or practice improvement activity and to demonstrate learning and/or improvement outcomes.

- *Educational Format and Quality*

CME Provider (program) Centered--characteristics of CME programs would include the deployment of appropriate learning needs and practice outcomes assessments, the use of educational formats that have been shown to correlate with desired learning outcomes, and compliance with commercial support/influence requirements subsequently approved for MOC CME. The clinical content of the educational program must be supported by the best available evidence, and the level of evidence supporting the educational content must be transparent to the learner.



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- *Requirement for Proportional Coverage of the ABMS/ACGME Competencies*
Historically, CME has been heavily oriented toward acquisition of medical/clinical knowledge. MOC CME must include education and skill development that addresses the broader set of ABMS/ACGME competencies; learners should ensure that their CPD/CME efforts, in sum, include learning in all six competencies.”

CMSS appreciates that these lines fulfill the role and responsibility of ABMS to set standards for MOC CME, which we find appropriate.

Lines 58-62:

“ABMS serves as a public trust and published articles suggest the public’s perception concerning commercial funding of CME for physicians is not positive. As such, it is important for ABMS to reflect both the reality and perception of the consequences of relationships between industry and physicians, as well as between industry and CME providers. Both sets of relationships have come under public scrutiny, and both deserve consideration.”

We recognize that these lines have changed since the August draft. The phrase “published articles” has been inserted prior to the phrase “the public’s perception”, and the second sentence has been added to include concerns about direct financial relationships between physicians and industry. We appreciate that this sentence may have been added in response to our previous communication.

Our concerns remain nonetheless. Let us be clear: the overwhelming evidence from articles published in the peer reviewed literature calls attention to the documented influence on prescribing practices and practice behaviors of direct financial relationships between industry and physicians. The same influence is not documented in the peer reviewed literature for commercial support of CME in the 20 years since the adoption and implementation, and 7 years since the revision of the ACCME Standards for Commercial Support: Standards to Ensure the Independence of CME (ACCME SCS).

Public perception is shaped more by public media than by peer reviewed literature. We grant that the media have been unclear as to the differences between direct financial relationships of industry with physicians, compared with industry support of CME providers under the ACCME SCS. It is therefore incumbent on the profession to perform the public service of being clear in our understanding and communication of these relationships. Unfortunately, the current draft of the MOC CME White Paper fails to draw the appropriate distinctions between the consequences, in perception and in reality, of direct financial relationships of industry with physicians, and of industry support of CME providers under the ACCME-SCS. In so doing, this draft does a disservice to the profession, and to the public whose trust the profession seeks to serve.

CMSS recommends that these lines be amended to read:

“The profession of medicine, stewarded by ABMS, by specialty societies and by others, is continually challenged to serve responsibly in the public’s interest and trust. As such, it is important for ABMS through setting standards for MOC CME to reflect both the reality and perception of the consequences of relationships between industry and physicians, as well as between industry and CME providers. Both sets of relationships have come under public scrutiny, and both deserve consideration. Articles published in the peer reviewed literature reveal that direct financial relationships between physicians and industry



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influence physician prescribing practices and practice behaviors. In contrast, strict adherence to the ACCME Standards for Commercial Support: Standards to Ensure the Independence of CME results in continuing education for physicians which is independent and unbiased, regardless of the source of financial support. It is therefore incumbent on the profession, through certifying boards setting standards for MOC CME, and through specialty societies and others providing independent and unbiased programming and activities for physicians participating in MOC CME, to incorporate these realities into the design MOC CME.”

Lines 85-113:

1. *ABMS and the MOC Committee should assist the Member Boards in facilitating the development of approaches to CME for MOC Part II and Part IV that emphasize “informed learning” or “formative CME/CPD” for diplomates that incorporates the following characteristics:*
 - a. *Addresses self- or externally-identified practice gap(s)*
 - b. *Is relevant to the physician’s scope of practice*
 - c. *Utilizes evidenced-based content (best available which is shared with diplomates)*
 - d. *Includes established professional standards of care/behavior (when available)*
 - e. *Demonstrates that planning, delivery, and evaluation is independent of commercial influence*
 - f. *Reflects preference for sequential programming (presented in multiple formats) to reinforce learning*
 - g. *Includes formative and/or summative assessments*
 - h. *Documents learning and performance or outcome improvement*
 - i. *Utilizes effective instructional approaches such as interactive, case-based, team-based learning*
 - j. *Includes concepts of quality improvement and patient safety*

2. *The ABMS and the MOC Committee should assist the Member Boards in developing approaches to Part II and Part IV MOC CME that emphasize coverage of all core competencies. These approaches should:*
 - a. *Address the unique educational needs of each Member Board’s scope of practice*
 - b. *Be based on formative and/or summative assessment (including Part I peer/patient surveys and Part III examination results to further integrate all parts of MOC)*
 - c. *Encourage the integration of multiple competencies within single programs (i.e., medical knowledge, system-based practice, and communication), and inclusion of all competencies within the entirety of a diplomate’s CPD program*
 - d. *Ensure that Part II activities inform Part IV participation, and that Part IV activities inform Part II educational needs*

We find, with the exception of the wording of two phrases, that these recommendations set standards for MOC CME, which is the appropriate role for ABMS, and as such, we support them. The following phrases are unclear, however:

1. Lines 85-86: *“ABMS and the MOC Committee should assist the Member Boards in facilitating the development of approaches to CME for MOC...”*

2. Lines 103-104: *The ABMS and the MOC Committee should assist the Member Boards in developing approaches to Part II and Part IV MOC CME...”*

We are unclear what is meant by “developing approaches”, nor are we clear on what is intended in the recommendation to “assist member boards.” If “developing approaches” means setting standards, then



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we would support this concept, as standard setting is an appropriate professional role for both ABMS and for its certifying boards. If this is the case, we would recommend clarifying this language to state its intent.

If “assist member boards” means that ABMS will develop programs, activities, registries for physician data or other elements of implementing knowledge or performance assessment coupled as part of a performance improvement cycle with educational intervention and/or practice improvement, then we would have significant concerns. These roles are separate from and beyond standard setting or assessment, which are the purview of ABMS and its certifying boards, and fall within the purview of specialty societies and others. Again, clarification of this language to reflect the separate roles of certifying boards and specialty societies would be key to our support of this document.

To maintain the appropriate separation of roles, and to avoid conflicts of interest, ABMS should limit its activities to standard setting and assessment of physician knowledge and performance, and should not enter into activities which develop programming, including registries, for intervening in the education of physicians or facilitating the improvement of the performance of physicians in practice, which are the roles of specialty societies and others.

CMSS recommends that the wording of lines 85-86 and 103-104 be modified to read “ABMS should assist member boards in setting standards for and assessing physician knowledge and performance that incorporate the following characteristics:”

Lines 119-121:

“A general framework for MOC CME must be developed that assures the public trust by progressively eliminating or reducing, to the extent possible, influence exerted by commercial entities.”

In this recommendation, it is unclear what is meant by “a general framework.” Clarifying this concept would be important before we can comment on it.

In “eliminating or reducing, to the extent possible, influence exerted by commercial entities”, we assume that this refers to managing in some way relationships between physicians and industry. It is not clear how certifying boards would accomplish that task, nor is it clear that it is the purview of certifying boards to do so.

Should, on the other hand, this phrase be directed toward commercial support of CME used for MOC, then it ignores the current function of the ACCME-SCS, which serve to eliminate influence exerted by commercial entities. Since strict adherence to the ACCME-SCS eliminates influence, there is no further need to recommend that it be reduced to the extent possible.

CMSS recommends that lines 119-121 be eliminated.

ABMS should support the profession’s self regulation of direct financial relationships with industry and commercial support of CME rather than proposing to establish separate policy and procedure in these areas. ABMS should express its support of the strong language and strict requirements of the professional self-regulatory bodies and codes that govern relationships between industry, physicians and physician organizations. Should ABMS wish to express concerns or recommendations for modifications to



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professional self-regulation of relationships between physicians and industry, such communications should be directed to the entities whose Codes govern such relationships, such as the AMA CEJA Ethical Opinions on Gifts to Physicians from Industry, the CMSS Code for Interactions with Companies, and the ACCME Standards for Commercial Support: Standards to Ensure the Independence of CME.

Lines 128-131:

“The MOC Committee should continue discussions with the ACCME and others regarding the development of a “standard currency” for MOC CME that would ensure interchangeability of programming between Member Boards, and other stakeholders, and would also identify the special nature of CME programming that meets the identified characteristics of MOC CME.”

We remind ABMS that the CME landscape is populated by three CME Accreditation agencies (AAFP, since 1948; AOA, since 1972, and ACCME, since 1981) and three CME credit systems (AAFP, since 1948; AMA, since 1968; and AOA, since 1972). These CME agencies have successfully achieved consistency in setting standards for CME in the US. In particular, the nation’s CME system has adopted, and on January 1, 2005 implemented consistent standards for Performance Improvement CME (PI-CME). Adhering to those consistent national standards, seventeen specialty societies now have Performance-improvement CME programs which qualify for MOC Part IV through the certifying boards in their specialties.

CMSS recommends that ABMS have conversations with the CME Credit Systems and Accreditors in the US to ensure that ABMS is not unilaterally creating a new system of CME credit or accreditation. Moreover, we recommend that ABMS explicitly support acceptance of nationally standardized PI-CME as meeting the standards for MOC CME.

Conclusion:

The Council of Medical Specialty Societies appreciates the opportunity to comment on the January 2011 draft of the ABMS White Paper on MOC CME. We look forward to the next version which will clarify appropriate wording and content. We also trust that the next version will clarify appropriate relationships between and among ABMS, CMSS, certifying boards, specialty societies, CME agencies and others as we fulfill our collective professional responsibility for self-regulation, transparency, and altruism, ensuring that the needs of patients have primacy.

Sincerely,

Norman Kahn, MD
Executive Vice President and CEO

Cc:

Kevin Weiss MD, President and CEO
Mellie Villahermosa Pouwels, Manager, ABMS MOC Program Support



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American Academy of Family Physicians (AAFP)
American Academy of Hospice and Palliative Medicine (AAHPM)
American Academy of Neurology (AAN)
American Academy of Ophthalmology (AAO)
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