AMERICAN COLLEGE OF GASTROENTEROLOGY
6400 Goldsboro Road, Suite 200, Bethesda, Maryland 20817-5842
P: 301-263-9000; F: 301-263-9025; Website: www.gi.org

November 6, 2015

Richard J. Baron, President and CEO
American Board of Internal Medicine
510 Walnut Street
Philadelphia, PA 19106

Dear Dr. Baron:

The American College of Gastroenterology (ACG) has carefully reviewed the "ABIM Assessment 2020 Task Force Report". We very much appreciated the opportunity to participate in the meeting convened by ABIM on Monday November 2, 2015 and felt that there was a great deal of positive discussion and ideas to improve the MOC process.

ACG is grateful for the forward-thinking approach of the ABIM Task Force in re-imagining physician recertification and maintenance of certification (MOC) As you know, we have been working with our sister societies to develop core principles to shape our collective MOC efforts in gastroenterology. Those principles were shared with the ABIM in a joint letter from the College and our GI societal colleagues.

ACG has been concerned about the ABIM MOC program since inception and was not supportive of instituting a largely duplicative, time consuming and expensive new certification requirement, which was in addition to existing requirements for institutional credentialing and state licensure. Our concerns were based on the relevance of the program and the unacceptable, and at times, clinically irrelevant content of the recertification exam. In the College's experience, virtually all practicing clinicians take great care to stay up to date to assure they are delivering high quality patient care. We appreciate the realization by ABIM that the existing MOC model and recertification process has failed to be practical and effective and look forward to working collaboratively to fix these problems. Below, we expand on some specific concerns of our organization and propose some alternative solutions to meet the needs of our clinical membership.

Assessment Methods

Replace the 10-year Recertification Exam

ACG believes replacing the 10-year recertification exam with more frequent, less burdensome assessments has the potential to be a positive step. Any method of assessment must allow for options that accommodate different learning styles and time pressures of our clinical membership. For example, an open-book exam that permits gastroenterologists to confer with colleagues or to research answers using readily available digital and published content is preferable to a high-stakes, multiple-choice exam. Not only would an open-book test reflect the way people practice medicine today, this option may work well for someone who has the ability to set aside time to study and complete an exam. For others, the model employed by the anesthesiologists of sending a single question regularly to their membership for completion with the requirement that 30 questions be completed each quarter, could be another alternative. ACG has successfully used a weekly question with our trainee members to test their knowledge. Regardless of the testing model, it is critical that the questions be relevant and up to date.

ACG also believes there should be an alternate pathway to recertification that does not rely on examinations. As a provider of continuing medical education (CME) credit, we believe nationally accredited GI societies who already provide and track CME activity participation, should be entrusted to provide the MOC content and benchmarks that need to be attained for re-certification and maintenance of competence. This alternative model would better meet the needs of some of our clinicians. A similar system has been successfully employed in Canada where the bar for MOC in a subspecialty requires attainment of a prescribed number of CME hours from an accredited organization. The ACG is a not for profit professional organization that rigorously plans CME activities based on a dynamic and thorough needs assessment process. We would propose partnering with the ABIM to build on our existing oversight structure and comprehensive program of CME activities to ensure physicians are earning an appropriate number of CME activities for MOC credit, in lieu of a high-stakes periodic examination or question-based assessments.

ACG also endorses the concept of individualized self-assessment pathways which give more control to physicians for their MOC. ACG believes that the professional societies are best positioned to define the key competencies that should be assessed and the appropriate assessment format (learning modules, didactic learning, small group discussion, self-directed reading or hands-on course for technical skills). ACG would like to see less emphasis on "busy work" and more opportunities to participate in activities that are useful, efficient and engaging. Physicians should also be credited for activities they are already doing (e.g. CME, programmed readings, participation in quality improvement initiatives).

Focusing Assessments

Institutions may be better suited to address doctor-patient communication, teamwork, and the ability to apply technology to patient care with systems that are already in place, though organizations like ours do have learning platforms that lend themselves to both scientific and other types of education. For example, ACG has developed a program called Hepatitis School that seeks to educate physicians and their non-physician healthcare providers as a team to reflect the real world models employed by many practices in treating hepatitis patients. Similar care delivery models are used in other gastroenterological conditions. There are also on-line educational platforms that enable learning on both scientific and other important topics where progress can be tracked and additional support can be provided when necessary. ABIM should be careful to avoid unnecessary duplication and instead provide opportunities to credit clinicians for participating in these existing types of programs.

Simulation environments and hands-on training are useful tools for assessing technical skills such as a colonoscopy or endoscopy, but access to these environments is somewhat limited and can be expensive for both the educational provider and the learner. Additionally, the need for commercial technology in hands-on and simulation environments makes it difficult to accredit this type of education for physicians under current ACCME rules. There are excellent quality improvement registries, such as the GI Quality Improvement Consortium (GIQuIC), which fulfill a similar goal of skill improvement while also allowing physicians to demonstrate quality improvement within their current practice environments based on standards developed jointly by the professional gastroenterology organizations. As per the 2020 report: "Consumer groups also expressed the opinion that giving physicians the ability to make modifications to their practice

with a measurable impact on patient outcomes is one of the most important values for physician assessment."

The Role of Sub-Specialization

While it is important to develop a system that recognizes each physician's background and clinical expertise, ACG feels that all testing should still occur under the larger GI umbrella. There is a basic level of clinical gastroenterology knowledge that any board certified gastroenterologist should master. However, in an era of increased specialization within practices, it is appropriate to have a multi-pronged approach to MOC and recertification that covers tenets of basic gastroenterology, but permits those who have sub-specialized to be assessed based on their clinical expertise. The vast majority of GIs will have the opportunity to see a broad variety of cases and, on an individual basis, they can choose to refer challenging cases to other specialists or they can use the challenging cases as a way to expand their own knowledge and practice. In a similar fashion, MOC assessment needs to be flexible and dynamic to be relevant in gastroenterology where sub-specialization and tailoring of clinical practice is common. ACG does not believe, however, that there should be further board certification sub-specialization in gastroenterology.

Summary

ACG encourages ABIM to consider offering multiple formats to assess competence including an open-book test or sending individual or small question sets regularly. Regardless of the model, it is critical that the questions be relevant and up to date. Additionally, ACG believes that an alternate pathway to recertification should exist that does not rely on a periodic high-stakes examination or question sets. We should be leveraging the existing high quality CME of professional societies who are properly positioned to define the key competencies required by our membership to clinically succeed and providing physicians credit for the activities in which they are already engaged to maintain state licensure and institutional credentialing.

We need to re-orient our focus from "busy-work" to the promotion of meaningful life-long learning. Healthcare institutions and other professional organizations may be better suited than ABIM to address doctor-patient communication, teamwork, quality improvement, and the ability to apply technology to patient care within their current practice environments. ABIM should be careful to avoid unnecessary duplication and instead provide opportunities to credit clinicians for their current participation in these programs.

ACG does not believe that there should be further board certification sub-specialization in gastroenterology. There is a basic level of clinical gastroenterology that any board certified gastroenterologist should know. However, MOC needs to be sufficiently flexible to be relevant to those gastroenterologists who have a clinical sub-specialty and permit those gastroenterologists to tailor their learning and subsequent assessment to their clinical areas of practice.

Conclusion

ACG is very gratified to see the progress that is being made by the ABIM to re-imagine the recertification and MOC process to better reflect the diversity of practice in clinical medicine.

We stand ready to work with ABIM and our colleagues in gastroenterology to ensure important, practical changes to the process are made and look forward to coming together to do so in the near future. Feel free to contact us or ACG's chief executive, Brad Stillman (bstillman@gi.org, 301-263-9000) for any further information.

Sincerely,

Kenneth R. DeVault, M.D., FACG
President

Neena S. Abraham, M.D., FACG
Chair, ACG MOC Task Force