My name is Richard G. Lane and I am an ABIM (American Board of Internal Medicine) board certified Internal medicine physician and have been practicing adult primary care internal medicine in Franklin, Tennessee for the past 40 years. I am representing the position of the Tennessee Chapter of the American College of Physicians (TNACP) regarding MOC (maintenance of certification) as its immediate past Governor and current member of its Health and Public Policy Committee. ACP is a national organization of internists, the largest medical-specialty organization, and second-largest physician group in the United States. Our 152,000 members include internists, internal medicine subspecialists, medical students, residents, and fellows. The Tennessee Chapter represents about 2,000 of these members. For those who confuse the designation internist with intern: “Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.”

*ACP recognizes the medical profession's responsibility to ensure quality medical care and supports the concept of lifelong learning and the need for ongoing physician accountability. ACP's Professional Accountability Principles outline the important attributes and standards for any organization that is involved in assuring physician accountability.*

*Because a wide variety of attributes contribute to a physician’s competence and quality of care, ACP believes that participation in programs for physician accountability such as maintenance of*
certification (MOC) should not be an absolute prerequisite for licensure and credentialing including acceptance into health plan networks, reimbursement, hospital medical staff privileges, medical liability coverage, and/or state licensing bodies, and other purposes.

ACP's Position Statement on Regulation of Credentialing and Licensing outlines a variety of issues, including the potential for adverse unintended consequences, for consideration regarding legislation to regulate MOC. The primary determinants should be demonstrated performance for providing high quality, compassionate care and a commitment to continuous professional development.

During my four-year term as Governor for the Tennessee Chapter, ACP has working aggressively to address the concerns about ABIM's MOC program expressed by our members and the internal medicine community, and to achieve reform through active discussion with ABIM at many levels. Based on the accountability principles and the feedback from ACP members, advocacy efforts with ABIM have focused on the need for MOC to be more relevant, more valuable, less burdensome, and less time-consuming. TNACP’s position is congruent with ACP’s. We are in agreement with initial board certification as we all come out of post graduate medical education with a similar broad core curriculum background in general internal medicine and the initial boards are relevant to that educational and practice base. However once leaving residency training the clinical practice pathway taken by internal medicine specialists becomes quite diverse. For example, when I finished three years of Internal Medicine residency I took an additional year of training as a Chief Resident prior to taking my boards and going into practice as I knew I wanted to be a general internist. Several of the residents who finished 3 years with me took additional 2-3 year fellowship training in medical subspecialty areas like cardiology, pulmonary, endocrinology etc. Overtime these physicians focused their continuing medical education in their subspecialty. Likewise many
physicians have an interest in research and teaching physicians-in-training so they entered an academic track of professional development. Others, such as myself, chose to focus full time in direct patient care as a clinical pathway. As our careers move along our educational focus changes to coincide with what we feel our educational needs are. For example, as an internist it became apparent very early to me that I was seeing a significant amount of older patients with multiple chronic diseases and I was also seeing nursing home patients and had little more than the basics in medical background for this subgroup. The result was I became an active member of the American Geriatrics Society and its state chapter and an active member of the American Medical Director’s Association and it’s state chapter to avail myself of their educational courses becoming board certified in geriatrics, referred to as Advanced Achievement in Geriatrics in 1988 and a Certified Medical Director in Long Term Care about the same time. I chose not to recertify in either due to expense, time away from practice, and frankly because spending the time and money on taking a test did not result in any increased reimbursement for the clinical expertise this allegedly would recognize. I still continue to do focused education in geriatrics since over 50% of my practice is Medicare eligible aged patients but I no longer belong to either of these organizations due to cost as well as the fact that about 3 years ago I gave up my nursing home practice and a few years before that I stepped down as medical director at one of our local nursing homes a position I held for over 30 years. Another example of a different road traveled is about 20 years ago I became a part-time medical director for a life insurance company. The skill set for what they needed while in part required a general knowledge base in medicine also needed a knowledge of long term actuarial risks of 20-30 years prognosis rather than the usual 3-5-year survival statistics in most general medical articles as well as an understanding of disability medicine adverse selection risks. So, for the last 20 years I have been a member of the American Academy of Insurance Medicine to avail myself of the
educational knowledge base to deal with this aspect of patient management. I, do in fact, get reimbursed for this specialized knowledge even though I chose not to pursue their certification board. Lastly, I would suggest that the trend around the country is for hospital inpatient medicine to be handled by a new emerging specialty called hospitalists that include both internal medicine and family practice specialists. I along with my internal medicine group associates gave up our hospital practice about 7 years ago and our practice is limited to outpatient ambulatory internal medicine. We really would not need hospital credentials except for private insurers choosing to offload the cost of credentialing to hospitals to choose physicians for their panels.

This then has become the dilemma faced by many internal medicine physicians. The maintenance of certification still tests the broad core curriculum of initial training which does not reflect adequately the educational focus of the physician out in practice for several years. There may be some evidenced-based number of CME hours needed in a specialty to assure competency and the CME needs to be accredited but the selection of educational focus needs to be decided by the professional based on his assessment of what he needs to know to practice well in his clinical setting. As previously stated TNACP believes in lifelong learning but we do not believe licensure, hospital credentialing for staff membership, nor qualification for being on an insurance panel of physician providers should be based on a certifying exam that may or may not actual test the competency of the physicians area and focus of day to day practice.