Grandfathered Physicians: A Few Choose to Recertify

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While the prospect of maintaining certification is met with resistance by many physicians, some internists say the process is useful and relevant.

In a recent issue of the New England Journal of Medicine, two internists who were certified before 1990 and therefore have grandfathered lifetime certifications detailed their experiences of going through the maintenance of certification process.

Troyen A. Brennan, M.D., president of Brigham and Women's Hospital Physician's Organization and past chair of the American Board of Internal Medicine (ABIM), was motivated to voluntarily recertify by a feeling of hypocrisy in advocating the process for his younger colleagues but not going through it himself.

The process is very low risk. Physicians with time-limited certificates could lose certification, but grandfathered doctors always have a lifetime certificate.

And he was growing uncomfortable with some relevant clinical issues such as new antiretroviral drugs for HIV infection. "I was not just letting myself down: I had patients to consider," Dr. Brennan wrote (N. Engl. J. Med. 2005;353:1989-92).

He allotted 2 years to complete the maintenance of certification process. The biggest hurdle, Dr. Brennan wrote, was the exam. Even after reviewing the literature and online textbooks, he found the ABIM's self-evaluation program modules difficult. But despite his struggle to prepare for the exam, Dr. Brennan wrote that the material was both relevant and useful.

"My review improved my hunches about common medical problems and made me comfortable in areas that used to be somewhat murky," he wrote.

Another grandfathered internist, Richard J. Baron, M.D., has also been through the process of voluntary maintenance of certification and described his experience completing an ABIM practice improvement module for diabetes (N. Engl. J. Med. 2005;353:1992-3).

Dr. Baron, an internist in Philadelphia and a director at ABIM, found mixed results in his practice. To complete the module, he mailed a structured patient survey to a random sample of 21 patients with diabetes and audited their charts.

All of the patients surveyed reported that it wasn't a problem to reach the office with a question or get a referral. However, only 60% of patients said they "definitely" knew what to do to alleviate symptoms of low blood sugar, and only half of the patients rated their overall diabetes care as "excellent" or "very good."

Dr. Baron also found out that while all 21 patients had current glycosylated hemoglobin measurements, only 15 of the 21 patients had urinary microalbumin results available.

The results will help him to improve patient education and implement systems designed to increase the number of diabetes patients who undergo annual urinary microalbumin testing, he wrote.

One of the big challenges facing officials at the ABIM is convincing grandfathered physicians to recertify, ABIM's President and CEO Christine K. Cassel, M.D., said in an interview.

About 80,000 internists—out of approximately 180,000 ABIM diplomates—hold only lifetime certificates. Of those, about 3% have voluntarily participated in maintenance of certification, according to ABIM.

Part of the problem is that physicians don't realize the process is very low risk. Physicians with time-limited certificates may stress over the test because they could lose their certification, but grandfathered physicians will always have their lifetime certificate, she noted.

Dr. Cassel said she is hopeful that more grandfathered physicians will volunteer for recertification, especially if it can help them in other areas such as gaining recognition or higher payments from a health plan.

Starting in January, internists will face new requirements for maintenance of certification. The practice assessment component, which is currently voluntary, will become a requirement next month.

Physicians will have a number of options for fulfilling this requirement, including using any of the ABIM's practice-improvement modules, its peer-and-patient feedback module, or existing patient data from an insurer. Another option is participating in an approved quality-improvement program.

Also in January, ABIM will introduce a point system to eliminate the need to count modules. Instead of a requirement to complete five self-evaluation modules with one medical knowledge module in the physician's area, the new process will call for completing self-evaluation models to earn 100 points.

Physicians must earn 20 points in medical knowledge, 20 points in practice performance, and 60 points in electives. The points are valid for 10 years from the date the modules are completed.

The point system will make it easier for physicians to renew certificates in more than one area, according to ABIM. The same 100 points will satisfy all self-evaluation requirements regardless of how many certificates the physicians renews. So to renew a second certificate, physicians will only need to be licensed and in good standing, to pass the secure exam in the two areas, and to earn 100 points. ■

Details on changes to ABIM's maintenance of certification process are available online at www.abim.org/moc/moc_new.shtm.

POLICY & PRACTICE

Part D Enrollment Begins

Starting last month, Medicare beneficiaries began enrolling in prescription drug plans as part of the new Medicare Part D benefit that will begin on Jan. 1. Beneficiaries who enroll in drug plans by the end of this year can begin receiving benefits on Jan. 1, but individuals who haven't made up their minds can continue to enroll until May 15, 2006. As the enrollment period kicked off last month, the health insurance industry was optimistic. Karen Ignagni, president and CEO of America's Health Insurance Plans (AHIP), said its member health plans were seeing higher than expected numbers of calls from Medicare beneficiaries with questions about the plans. And the questions are specific, with beneficiaries asking about drug availability, which pharmacies are participating in plans, and how much their out-of-pocket expenses will be with a plan, Ms. Ignagni said at a press conference. She recommended that Medicare beneficiaries who are evaluating different prescription drug plans consider five issues: Do they have drug coverage now? What drugs do they take? Do they purchase drugs from a particular pharmacy? How much will they pay in out-of-pocket costs for a particular plan? And, finally, do they want to stay in traditional Medicare and choose a separate drug plan or switch to a Medicare managed care plan that includes prescription drugs, physician services, and hospital care?

Groups Sue Over Part D

Countless numbers of poor men and women "will fall through the cracks" during the transition to the new Part D drug benefit, medical groups stated in a lawsuit against the federal government. More than 6 million "dual eligible" patients—those who are enrolled in both Medicare and Medicaid—lost their Medicaid drug coverage on Jan. 1. The groups said that they're seeking protections for patients who are not seamlessly and immediately transitioned to the new drug program. "The poorest, sickest, and oldest Americans face grave risk of losing their life-saving medications once the clock strikes twelve on New Year's," said Robert M. Hayes, president of the Medicare Rights Center, a national consumer service group and one of the plaintiffs. In particular, those beneficiaries who are cognitively impaired or have only a high school diploma will have problems mastering the complexity of the new drug benefit, the lawsuit indicated. A spokesman with the Centers for Medicare and Medicaid Services said that the agency was not commenting on the pending lawsuit.

New Head for FDA Women's Health

Kathleen Uhl, M.D., has been named director of the Office of Women's Health at the Food and Drug Administration. Dr. Uhl, a family physician and a captain in the U.S. Public Health Service, most recently served as a supervisory medical officer in the FDA's Center for Drug Evaluation and Research. "Kathleen brings a breadth of professional experience, as well as a strong science background and passion for women's health, to her new position," said FDA Acting Commissioner Andrew von Eschenbach, M.D. Dr. Uhl's experience includes clinical practice, basic science and clinical research, drug application review, drug safety oversight, and women's health issues. She also holds dual faculty appointments at the Uniformed Services University of the Health Sciences in family medicine and internal medicine.

Patients Satisfied Despite Cost

Most Americans remain satisfied with the quality of their health care despite rising health care costs, according to a survey from the Employee Benefit Research Institute (EBRI), a nonprofit group that disseminates data on employee benefits. "Satisfaction with health care quality is high, but few are happy about the cost of health care," EBRI President Dallas Salisbury said in a statement. "Beyond that, the survey appears to confirm the notion that Americans tend to leave cost out of the equation when considering health care quality." Almost 6 in 10 Americans who were surveyed were extremely or very satisfied with the quality of medical care that they receive. However, only 28% were satisfied with the cost of their health coverage. The survey revealed a difference of opinion between lower and higher income patients about quality of care. Those with household incomes under $35,000 a year were less than half as likely as those with incomes of at least $75,000 to describe the health care system as excellent or very good. The survey represented telephone interviews with 1,003 individuals aged 21 and older.

Improving Uncompensated Care

Hospitals have established more generous uncompensated-care guidelines for uninsured patients after a torrent of publicity about aggressive hospital billing and collection practices and a series of lawsuits alleging that hospitals overcharge these patients, the Center for Studying Health System Change (HSC) reported. The study is based on HSC's 2005 site visits to 12 nationally representative communities. "In every HSC community, most hospitals have either recently changed their pricing, billing, and collection policies or tried to improve the clarity of the information provided to patients," said HSC research analyst Andrea B. Staiti, coauthor of the study. For example, it is now common for hospitals in the 12 surveyed communities to provide uncompensated care to uninsured patients with incomes less than 200% of the federal poverty level, and to offer sliding-scale discounts for patients with incomes up to 400% or 500% of the poverty level.

—Jennifer Lubell