



Five myths

About ABIM's MOC Program

Physician feedback has led to enhancements to ABIM's Maintenance of Certification (MOC) program over the years; if it's been a little while since you've engaged with it, we invite you to take a moment to read over some of the claims that have been made in the past, and what ABIM has done in response to requests from the physician community it serves:

1. **Claim** *"There is no evidence supporting MOC."*

Four out of five physicians who have recently taken an MOC exam said they gained knowledge related to their practice, and [79% saw a positive effect on their practice](#). ABIM's MOC program provides an independent, third-party avenue for physicians to validate and demonstrate that they are keeping their knowledge current over time and how it improves outcomes.

Studies done with Harvard University, Harvard School of Public Health and the Foundation for Advancement of International Medical Education and Research found a strong link between a [physician's diagnostic knowledge and likelihood of patient death](#), ED visits or hospitalizations, that physicians who score higher on ABIM MOC assessments are [less likely to prescribe inappropriate medication to geriatric patients](#) and [are less likely to over-prescribe opioids for back pain](#). Studies also suggest [MOC reduces U.S. spending on Medicare by approximately \\$5 billion per year](#) and doctors who pass a knowledge assessment and participate in MOC are more than two times [less likely to face state medical board disciplinary actions](#) than those who do not pass the exam.

2. **Claim** *"ABIM MOC fees are too expensive."*

A physician maintaining one certificate with ABIM pays \$220 a year; for each additional certificate, it's \$120. The LKA is included at no additional cost, meaning if that's the assessment option a physician chooses, that's the total amount they pay ABIM. ABIM has not increased its fees in years; and physicians choosing the LKA now pay less than they did under the previous fee model retired at the end of 2021.

Physicians may be used to paying their MOC fee at the time they took an assessment. **Under ABIM's current fee model, that cost is spread out over a longer period of time, which allows more flexibility and the option to realize a savings over what they paid previously.**

3. **Claim** *"ABIM MOC is too time-consuming."*

ABIM heard concerns from diplomates about the amount of time maintaining their certification took, and in response created [the Longitudinal Knowledge Assessment \(LKA®\)](#). Available in 15 specialties, the LKA allows physicians to participate in MOC in an affordable, flexible, responsive manner without needing to ever go to a test center.

On average, physicians participating in the LKA spend about four hours a year answering questions (30 questions are offered each quarter, and average time to answer is two minutes). The LKA is intended to test "walking around knowledge," so there is no expectation that a physician would spend significant time or any money outside of taking it.

4. **Claim** *“ABIM MOC assessments aren’t relevant to what physicians see in practice.”*

ABIM is a physician-led organization, meaning physicians in each specialty write questions for the assessments. This work is carried out by [ABIM’s Item-Writing Task Force](#) – comprised of diplomates who are representative of their discipline. Questions generated by this group then go to discipline-specific Approval Committees before appearing on live exams.

The assessments themselves go through a thorough review process with question responses and scores monitored for potential problems. Diplomates also provide feedback on assessment questions based on how frequently they see certain topics and how critical they are to their practice. ABIM does everything it can to ensure its assessments are measuring what is seen in current medical practice.

5. **Claim** *“MOC isn’t necessary because self-selected, accredited continuing medical education (CME) alone is a reliable way for physicians to stay current.”*

The Dunning-Kruger effect has shown us that clearly self-selected CME is not enough. Dunning-Kruger is a cognitive bias whereby people with low ability tend to overestimate their ability or knowledge. Physicians who think they need self-selected study [often don’t know the areas in which they are weak](#).

There is also empirical peer-reviewed published evidence that this statement is false for patient relevant outcomes, in particular state medical board disciplinary actions where the amount of CME a state requires to maintain a license had no association with subsequent disciplinary actions, while demonstrating that a physician was staying current with knowledge and practice in their discipline by taking and passing the ABIM MOC exam by a diplomate’s “due year” had the [strongest association with fewer disciplinary actions](#).

