The ongoing debate about maintenance of certification (MOC) among internists, nephrologists, and other subspecialists continued unabated after the American Board of Internal Medicine (ABIM) announced on May 5, 2016, that it would provide more details about the changes it is considering to its MOC program or “alternative assessment options” by the end of the year.

In the meantime, an alternative certifying body, the San Francisco National Board of Physicians and Surgeons (NBPCS), has issued board certifications to more than 3,300 practitioners in 39 states. A nonprofit launched in early 2015, NBPCS requires initial certification by an American Board of Medical Specialties (ABMS) board and 50 hours of continuing medical education every 2 years. The cost? $169 for two years at NBPCS, compared with thousands of dollars for ABIM initial and continuing certification.

Also, Oklahoma became the first state to enact legislation that aims to remove MOC as a requirement for physicians to obtain a license or secure hospital admitting privileges. Passed with bipartisan support, the law frees physicians to certify through alternative boards like NBPCS or not at all. Other states may follow suit: 19 state medical societies have passed resolutions opposing compulsory MOC, and some are working to turn those efforts into legislation.

The Oklahoma move may be a big deal if other states follow suit because now “insurance companies [in Oklahoma] cannot use MOC as a criterion for payment,” said NBPCS President Paul Teitzen, MD. “Insurance companies often have contracts that require providers be ABMS-certified,” and that has been one of the biggest impediments to more institutions accepting NBPCS certification.

Several nephrologists took their concerns about the need for recertification every 10 years—or at all—to a recent thread on the ASN Communities website.

“As there is unison in the opinion of the entire medical field that an initial Board Certification upon completion of a residency/fellowship training program is a must (although not required to practice medicine in the US), whether or not we as physicians need to take a “recertification exam” every 10 years is highly debatable,” noted Mukesh Sharma, MD, of the Arkansas Renal Group on the ASN Communities discussion, “MOC Debate and Where Do We Stand?”

In a follow-up interview, Sharma stated: “NBPCS is trying not to mitigate ABIM regarding initial certification. Instead, many physicians are against having to take an exam every 10 years and with having to pay so much for an exam that’s out of touch with practice. I am all for initial certification, but I want choice when it comes to recertification—exam, CME, MOC, open book.”

“There are so many resources a physician uses today,” Sharma said. “If they come across something they don’t understand in a publication, they may use UptoDate—doing so makes them a better physician. With [recertification] exams, you should have similar resources.”

The medical knowledge tested on the recertification exams continues to be a sticking point with practitioners.

“The aim should be to keep up with fresh medical knowledge, not a punishment-like system that threatens livelihood, because at 50-plus age, some people might not be in the habit of taking hourlong tests but are excellent physicians and provide good care, but may lose their board status and have trouble in jobs,” said Farhan Ali MD, MBBS, of the University of Maryland. “Board questions are mostly research-based and add to knowledge, not treatment paradigms so they do not impair clinical practice on a large scale. In addition, my argument always is . . . that if recertification is such a good thing, it should be for all physicians. Why are some physicians (who graduated before 1991) exempt?”

Search for Agents to Prevent Contrast Nephropathy Continues

The recent finding that the experimental drug CMX-2043—developed to prevent ischemic-reperfusion injury (IRI)—does not reduce the risk of contrast-induced kidney injury compared to placebo dealt a setback to the clinical development of CMX-2043 as a preventive strategy. The negative clinical results with CMX-2043 don’t necessarily close off the possibility of some effective intervention targeting the α-lipoic acid pathway, according to Bhatt.

CMX-2043 was given at one of three fixed doses: a single dose of 2.4 or 3.6 mg/kg or two doses of 2.4 mg/kg. The primary outcome was reduction in the incidence of AKI, based on KDIGO criteria. Biomarkers of renal and cardiac injury and 90-day clinical outcomes and adverse events were evaluated as well.

At four days, the incidence of AKI was not significantly different across the four study groups: 25.6 percent for the single low dose of CMX-2043, 25.3 percent for the single low dose, 18.0 percent for two low doses, and 18.6 percent for placebo.

There were also no differences in adverse cardiac and kidney events, and no evidence of major side effects related to the CMX-2043 doses used. The study did not confirm the previously reported reduction in myocardial damage during stent placement.

The final results of the phase 2 CARIN trial showed no reduction in the primary outcome of contrast-induced acute kidney injury, as it had done in pre-clinical models. “Contrast-induced acute kidney injury remains a really significant problem in the population,” Bhatt said. “It remains an unmet clinical need to find drugs or devices or strategies to help reduce the risk.”

The thought was that this drug had antioxidant and cell membrane stabilizing effects and that these benefits would translate into less kidney cell damage and heart muscle damage, Bhatt commented. “But as is often the case in this field, drugs that seem to be good based on preclinical work, when used in humans don’t always have an effect.”

A previous randomized trial (SUPPORT-1) found that patients receiving the 2.4 mg/kg dose of CMX-2043 had a significant reduction in cardiac injury after percutaneous coronary intervention, based on standard cardiac biomarkers.

The negative clinical results with CMX-2043 don’t necessarily close off the possibility of some effective intervention targeting the α-lipoic acid pathway, according to Bhatt.

“The thought was that this drug had antioxidant and cell membrane stabilizing effects and that these benefits would translate into less kidney cell damage and heart muscle damage,” Bhatt commented. “But as is often the case in this field, drugs that seem to be good based on preclinical work, when used in humans don’t always have an effect.”

A previous randomized trial (SUPPORT-1) found that patients receiving the 2.4 mg/kg dose of CMX-2043 had a significant reduction in cardiac injury after percutaneous coronary intervention, based on standard cardiac biomarkers.

The negative clinical results with CMX-2043 don’t necessarily close off the possibility of some effective intervention targeting the α-lipoic acid pathway, according to Bhatt.

“The thought was that this drug had antioxidant and cell membrane stabilizing effects and that these benefits would translate into less kidney cell damage and heart muscle damage,” Bhatt commented. “But as is often the case in this field, drugs that seem to be good based on preclinical work, when used in humans don’t always have an effect.”

A previous randomized trial (SUPPORT-1) found that patients receiving the 2.4 mg/kg dose of CMX-2043 had a significant reduction in cardiac injury after percutaneous coronary intervention, based on standard cardiac biomarkers.

The negative clinical results with CMX-2043 don’t necessarily close off the possibility of some effective intervention targeting the α-lipoic acid pathway, according to Bhatt.