Maintenance of Certification (MOC), and Now Maintenance of Licensure (MOL): Wrong Methodologies to Improve Medical Care

Paul Martin Kempen, M.D., Ph.D.

Background: the Federation of State Medical Boards (FSMB) and American Board of Medical Specialists (ABMS)

The FSMB is a national non-profit corporation claiming representation of the 70 American medical and osteopathic boards. Founded in 1912, FSMB currently specializes in promoting legislation to state medical boards to regulate the practice of medicine on a national level.

The organization provides no physician continuing medical educational (CME) programs or patient care; rather, it educates lawyers and state regulators under its current mission statement saying it is a "leader in medical regulation," and with a specific corporate lobbying budget of $221,222.[1]

FSMB and ABMS are non-profit private business entities, whose annual IRS Forms 990 are available at www2.Guidestar.org. Annual gross receipts of the two groups combined exceed $350 million—a significant annual healthcare cost for bureaucracy alone.

According to statements from the FSMB website, the FSMB is a parent organization of the Accreditation Council for Continuing Medical Education (ACCME) and the Educational Commission for Foreign Medical Graduates (ECFMG). FSMB memberships include the National Board of Medical Examiners (NBME), the Accreditation Counsel for Graduate Medical Education (ACGME), and the ABMS. FSMB was a founding member of what was to become ABMS and remains an associate member of that body. One FSMB board member also serves as the federation's liaison with the ACGME.

These organizations, above all, sell "tests," not education, as a "corporate product." Historically, they have facilitated the establishment of significant modern national standards for physicians in education, residency training, and state licensure acquisition over the past century. These stringent and uniform training regulations have now been established as basic requirements for initial state licensure. However, these corporations continue imposing more testing bureaucracies on physicians as a means to somehow improve quality of care further, in what is already recognized as one of the best medical systems in the world. The next goal is to impose additional, lifelong, expensive mandatory hurdles to jump in order to maintain professional licensure.

These increased bureaucratic requirements clearly expand the power and revenue of these organizations, but there is no evidence of better protection of the public. Rather, the transgressions of practitioners who have lost their licenses typically have had little to do with inadequate knowledge; rather, they are ethical or drug-related issues, often involving individuals likely capable of passing testing hurdles. While physicians have commonly striven to obtain board certification as an index of superior competency, the FSMB is now striving to impose this as a recurrent basic requirement for licensure, at significant cost to physicians and the general population as everyone ultimately pays the bills to finance this unproven method. As such, board certification is being degraded from a mark of excellence to become a common requirement to practice medicine.

Requirements for Practicing Medicine v. Recertification Hurdles

As a practicing anesthesiologist with 30 years' experience in academic and private practice, I have never learned anything from these board certification tests or preparation for them. All physicians have many educational opportunities through national programs, enabling us to tailor our continuing education to specifically meet all personal, professional, and licensure needs. ABMS's testing is associated with increasing requirements on physicians to subscribe to newly mandated programs that meet its approval. These programs, with their mutually beneficial affiliations with the recertification authorities, jeopardize the viability of other non-aligned, independent, effective CME programs.

While the frequency of testing in individual specialties varies from yearly to every 10 years, I will focus primarily on the American Board of Anesthesiology (ABA), as it demonstrates the political and financial motivations involved.[2] This is the only specialty to threaten expulsion from the board if a physician were to "participate in a state-sanctioned execution." The political motivation is presented as a moral indicator for physicians over the clear mandates of the court's verdicts "of the people." The innovative introduction of a very expensive "simulation requirement" occurred with no proven validation, testing, or curriculum. These human simulators are extremely expensive to acquire and maintain, and physicians again appear to be the ideal deep pocket to finance this relatively new industry. While simulation is useful in motor-skills training for individuals who are unfamiliar with procedures and situations, there is no validation that skilled and experienced individuals profit from this type of training for any length of time. The benefit to professionals of advanced cardiac life support (ACLS) training has been shown to disappear after 6–9 months.[3,4]

ABMS's newly mandated Practice Performance Assessment and Improvement Requirements (PPAIR) were recently described by Harvard professor and ABA board member Mark Rockoff, M.D., as specifically difficult to implement in anesthesia. The requirement demands an internal practice study, along the lines of a term or master's degree paper. Rockoff recommended that candidates first take simulation training to fulfill Maintenance of Certification (MOC) requirements and allow the ABA 5 years to adequately "figure this out." Clearly, the ABMS program is not tailored to each individual specialty, but nevertheless appears to be enforced uniformly and arbitrarily upon the individual specialty franchises. Rockoff further indicated that recertification is voluntary, and that individuals could choose to "not recertify, as certification is not required to practice medicine."[5] Such reassurance is misleading, as these organizations now actively press to require all physicians to

buy their "product" to maintain a license to practice under FSMB's proposed Maintenance of Licensure (MOL).[6]

While physicians are typically involved in many administrative positions in these non-profit corporations, they are selected through political or professional affiliations, not elected, and in order to advance to board status are typically subject to, and screened for, the political missions promoted by the ABMS. These physician administrators are typically from large academic institutions, and often have master of business administration (MBA) degrees. They typically spend little time in actual patient care. They are provided ample time, money, and secretarial and library support, enabling them to comply easily with any level of requirements, current or in development.

In contrast, especially among practitioners in rural America, physicians are busy with the tasks of running a business in a competitive environment characterized by increasing costs, declining payment, and limited vacations or cross-coverage. They face significant state-mandated CME impositions and endure 12-hour workdays plus "on call" care. Work weeks of 50–75 hours are a setup for burnout.[7] We doctors are very good at caring for patients and solving problems, and at referring those patients in need of very specialized care. No one is or can be or need be an expert at everything, but proposed standardized testing would require expertise on the rarest of problems in order to restrict physician availability in the name of quality care (and corporate profits). While a national shortage of physicians in rural areas has long been a significant and well noted problem without simple answers, increasing demands on those who are most stressed to comply will continue to limit medical care where it is needed most. At the same time, we now find increasing federal mandates authorizing less-educated "physician extenders" (nurses, pharmacists, physician assistants) to receive diagnostic or prescription authority to "fill in these physician deficits."

Physicians are highly educated, intelligent, and responsible individuals typically recruited from the best of all college graduates, who now daily pass the test of patient care, or succumb to expulsion from hospital staffs or professional liability insurance programs, or lose state licensure or federal funding following review by a state medical board or the Center for Medicare and Medicaid Services (CMS).[8]

Many physicians have obtained certification in multiple specialties; there are four in anesthesia alone! Increasing testing requirements will serve to eliminate this multi-certification and limit the scope of practice, while needlessly driving physicians into early retirement. Now, as the Baby Boomers approach retirement, we need to retain experienced physicians to treat the increasingly complicated and growing numbers of geriatric patients. The effect of the loss of experienced physicians will be especially severe in rural areas.

Subjugation to private corporate testing programs developed in the past fails to provide the innovative changes needed for meaningful continuing education for practitioners in our Internet age.[8-10]

ABMS franchises attempt to appease physicians with suggestions that "minimal requirements" will result in greater than 99 percent pass rates. What is the value of a test no one fails? Conversely, what is the utility of testing to remove competent people from practice by maintaining an admittedly arbitrary "failure curve"? The tests are secret, proprietary, and never published or open for public review. We are simply forced to believe that these tests are clinically relevant and fairly administered. Physicians disclosing test content from memory, or even only soliciting such questions from a third party, have been reprimanded, sued, had board certification suspended for up to 5 years, and barred from re-testing by the American Board of Internal Medicine (ABIM).[11] There is no purpose to restricting physicians from practice based on these secret methods.

While proof of efficacy of the testing methods is lacking, a documented physician shortage already exists, and replacements will expectedly decline as resident medical education funding will be strongly curtailed under Obama's Affordable Care Act.[12]

Dangers of Non-validated Programs

ABMS-mandated PPAIR also remains untested, unproven, and poorly conceived. It may actually be detrimental if indiscriminately applied by individual physicians.[9,10] In anesthesia, perioperative beta-blockade and tight glucose control almost became standard of care, until recent studies demonstrated greater harm than good.[13,14] Forcing physicians to implement "things to improve" is an open prescription to tinker with patients' lives, merely to meet a licensure requirement. This goes against the proven methodology leading to valid practice guidelines, involving methodological input from large numbers of practicing specialists. The simulation requirements for anesthesiologists have unproven value to those actually practicing the skills daily, yet this is currently mandated without any validation or outcomes testing, even though the price is known to be thousands of dollars in participation fees alone.[15]

MOC vs. CME

FSMB/ABMS would better serve the patients and physicians by working with state governments (which have the authority and mandate for ensuring physician competency and licensure) to provide, regulate, and confirm educational opportunities and open access to current clinical information online, inexpensively or at minimum in a cost-neutral fashion.[8-10] CME is not broken and is increasingly accessible at very little expense, in contrast to antiquated and profitable methods, which currently impose significant time and costs (annually in the billions nationally) on physicians. CME is currently validated through certified sponsorship and evaluation, while typically without outcomes testing. If outcomes testing for CME courses is necessary, this should be developed through state legislation. This allows practicing physicians at least an opportunity to participate through state political referenda, rather than being subject to nationally imposed decisions made in private behind corporate board rooms' closed doors.

With CME requirements of 50 hours per year, weekly Internet education and testing in one's own home/office currently ensures and verifies effective and continuing education, as opposed to "cramming" for ABMS decennial tests. An intensive spurt of memorization just before a test is a well-documented non-learning mechanism familiar to any high school or college graduate. Minutiae memorized for the test are rapidly forgotten. ABMS requirements to travel and be physically present at testing centers at 10-year intervals are obsolete, and remove physicians from their patients while further inflating costs.

Our Internet age has online universities, making CME conveniently possible and readily validated online. Such programs

include testing and identity verification. I undergo such Internet programs yearly to validate my federal compliance requirements regarding HIPAA, OSHA, patient safety, billing, etc., as a condition of employment at my institution, through programs developed there. Extremely rigorous ID testing beyond simple or multiple passwords is possible (if really necessary) using home computers and video cams, fingerprinting (I do this for every hospital drug prescription per electronic medical records), and other modalities. Providing private corporations the monopoly on education, validation, certification (and soon licensure itself!) is limiting and anti-competitive. It further erodes state sovereignty, robbing states of the authority to license physicians in accordance with the state's needs, and physicians of the ability to be represented in the process. Any university or medical center could form its own corporation to meet regional certification requirements for its hundreds of practitioners, and thus create competitive means to meet the educational needs of its own faculty and staff, and of practitioners in the area. However, with increasing national FSMB/ABMS lobbying, this opportunity may soon be lost to the established boards' monopolistic endeavor.

Physicians who practice in hospitals are already subjected to continuing review of their clinical care. If this is considered necessary for others, local answers are possible. This would limit costs to physicians but also limit revenues to self-appointed watchdog agencies, which continue to lobby hard to tap physician time and incomes to test in vacation destinations, benefiting mainly the test-giving elite.

FSMB/ABMS assert that government and patients demand recertification. While I have personally never been asked in 30 years of practice about my board certification status by any patient, I am regularly asked about my years of experience. Thus I strongly question FSMB and affiliates' assertions, as self-interested regulatory or testing bureaucracies, that they are the only ones with the answer—more mandatory testing—to the question that they themselves make up. Patients, on the other hand, are content to see a caring, concerned, familiar, experienced, and competent physician, who is available in their community at a cost within their financial reach. While patients and government clamor for affordable and available care, the MOC or MOL process[3] promises only to increase costs, reduce physician availability, consume physicians' time excessively and non-productively, and invite physicians' early retirement. This is counter-productive for our current and future needs.

Call to Action

Physicians! It is only a matter of time before MOL is imposed, unless these corporate plans can be countered now. Previous attempts to create constructive discussion have been met with strong resistance from leaders of specialty societies and boards, which both have vested financial interests in moving MOC and MOL forward.[9,10] Immediate action is needed and appears limited to state political or professional society levels at this time. MOC and MOL would have to be implemented through state legislation and by state licensure boards. The FSMB does not speak for individual state medical boards, but rather lobbies to control them. The battle is weighted against physicians, who do not have the financial or lobbying resources of these multi-million dollar "non-profit" corporations that are promoting their national MOC/MOL agenda.

The FSMB's pragmatically defined MOL goals have been excessively expanded by the ABMS: "A condition for license renewal, a physician's commitment to lifelong learning that is objective, relevant to their [*sic*] area of practice and contributory to improved health care."[3] This statement is redundant with modern license and CME requirements. After rigorous educational and initial certification requirements, physicians continue to be overseen by colleagues, patients and their families, professional liability insurers, and licensure boards. Many physicians are further under the ubiquitous impositions by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which had gross receipts of $148,737,915, according to its 2009 IRS form 990, as a significant component of their community-based practice within hospitals. Constantly increasing requirements by "non-profit" corporate bureaucracies only serve to limit physician availability. Why should the CME industry and state medical boards outsource their job to national agents of the ABMS and their non-transparent, monopolistic testing machine?

Why are physicians mistrusted, while agents of the FSMB and ABMS are accepted as the authorities on competence and quality in the absence of evidence or validation?

Physicians are at a crossroads. They must either resist this corporate agenda, or surrender their claim to be a profession.

Paul Martin Kempen, M.D., Ph.D., practices general anesthesiology in Broadview Heights, Ohio. Contact: kmpnpm@yahoo.com.

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