Maintenance of Certification (MOC), Maintenance of Licensure (MOL), and Continuing Medical Education (CME): the Regulatory Capture of Medicine

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Medical Education

As medical school admission is a highly competitive process, applicants are typically drawn from the highest academic ranks, displaying a proven ability to learn and ability to document these achievements.

Additionally, demonstration of moral commitment, academic drive, and ability are typical prerequisites, as pre-admission involvement in research, humanitarian activities, and personal achievements are basic "extras" needed to secure admission in this competition. Thus, the ability to learn, teach, and interact personably are essential attributes in admission to medical school.

In the early history of American medical training, great variability in medical school size, in political and personal admission criteria, and in national origin of graduates caused growth of accreditation and testing of postgraduate candidates for, and through residency training. This facilitated comparative assessment of the individual training programs.

Multiple accreditation agencies developed. The Federation of State Medical Boards (FSMB), National Board of Medical Examiners, and the Educational Commission for Foreign Medical Graduates (ECFMG) are all examples of nongovernment organizations, which together developed national qualifying examinations including the ECFMG, FLEX (Federal Licensure Examination), and the USMLE (United States Medical Licensing Examination). Subsequently, medical licensing boards increasingly required these tests for licensure of newly educated and immigrating physicians. These tests served to validate basic medical educational thresholds (and English language proficiency) for entrance into residency training programs, and ultimately for unrestricted licensure in the U.S.

The cost of medical school tuition continues to rise, and with the financial limitations of residency training poses a significant economic burden on postgraduate professional choices.

Continuing Medical Education (CME) of Physicians as a Lifelong Commitment

In the late 1960s, public demonstration of continuing education of physicians culminated in the introduction of continuing education certification and accreditation. The American Medical Association (AMA) at that time had a very high physician membership and thus moved forward to represent all physicians in this matter.

The AMA introduced the concept of CME credits and the AMA Physician Recognition Award (PRA) to document physician participation and the credibility of the activities. Increasingly, state medical boards followed by imposing relicensure requirements and documentation of CME credits as they saw fit.

Subsequently, a significant CME industry resulted and included accreditation and documentation industries for these CME providers, which were restricted to medical and physician organizations under the monopoly of the AMA accreditation system.

Table 1. Income of ACCME-Accredited CME Companies[1]

Year	Number of CME organizations	Total Income
2010	694	$2,242,328,250
2009	707	$2,184,353,716
2008	728	$2,367,173,663
2007	736	$2,539,198,656
2006	729	$2,384,581,430
2005	716	$2,250,468,669
2004	716	$2,052,577,784
2003	697	$1,774,516,395
2002	686	$1,596,198,865
2001	674	$1,393,926,271
2000	680	$1,271,189,580
1999	655	$1,110,482,468

As shown in Table 1, the total income for CME companies accredited by the Accreditation Council for Continuing Medical Education (ACCME) was stated in its annual report to be $2,242,328,250 in 2010. With 850,000 licensed U.S. physicians, that comes to $2,638 average tuition costs per physician. This attests to the strength of this CME industry, the profitability of educating doctors, and physicians' commitment to lifelong education. These 2010 ACCME figures are slightly down from the peak of $2,539,198,656 in 2007. The amount had doubled from $1,271,189,580 in 2000, in only seven years. The decline in the past 3 years likely indicates the increasing amount and use of free CME on the Internet and also a danger to the industry's profits. These costs do not include the travel, hotel, miscellaneous, or especially the "locums practice coverage costs," which typically greatly exceed tuition costs and particularly strain independent and rural private practitioners.

Physicians were and remain typically concerned about maintaining "lifelong continuing education" to update knowledge to meet advances in medicine and the needs of their practice and their patients. Thus, these CME requirements occurred with little opposition and demonstrated significant variability as individual jurisdictions developed local protocols that were not overtly intrusive into practice or care. Some states

Table 2. CME Requirements of Selected States[2]

State	Number of AMA PRA hours/renewal interval in years	Per Year
Ohio	100/2	50
New Jersey	100/2	50
Massachusetts	100/2	50
Pennsylvania	100/2	50
Illinois	150/3	50
Kansas	150/3	50
Michigan	150/3	50
Wisconsin	30/2	15
Alabama	24/2	12
New York	No Requirement	
Colorado	No Requirement	
Connecticut	No Requirement	
Indiana	No Requirement	
Montana	No Requirement	
Oregon	No Requirement	
South Dakota	No Requirement	
Vermont	No Requirement	

Table 3. ACCME Accreditation Fees[5]

Fee	Year	Amount
Annual accreditation fee	2012	$3,000
	2013	$3,300
	2014	$5,300
Preapplication fee	2012	$1,000
	2013	TBD
	2014	TBD
Initial Accreditation fee	2012	$7,500
	2013	TBD
	2014	TBD
Reaccreditation fee	2012	$7,500
	2013	TBD
	2014	TBD

(TBD=to be determined)

Table 4. Income of Three ABMS Specialty Boards from 2009 IRS Forms 990[6]

Specialty board	Pediatrics	Internal Medicine	Family Practice
Gross receipts	$19,460,766	$42,295,876	$34,451,861
2009 total assets	$65,179,009	$35,762,331	$72,398,498
CEO compensation reportable on 990*	$1,193,191	$861,691	$699,831

*See 990 Part VII for CEO compensation.

imposed no formal CME requirements, while as many as 50 hours per year of documented CME were imposed by some states, including Ohio (see Table 2).

CME programs grew in scope, types, formats, and quantity over the years, adapting to Internet technology and including, in addition to lecture and written educational programs, live patient or procedure presentations; animal, cadaver, and simulated reality sessions; and virtual reality programs. Recently, with increased Internet availability, programs are offered online and often without cost to physicians. Similarly, medical journals proliferated in number and in scope so as to make any attempt at a complete overview of topics impossible for the practicing physician. As W.F. Miser, director of the Ohio State University family medicine residency program and vice-chair for the OSU biomedical institutional review board (IRB) wrote: "If physicians would read two articles per day out of the six million medical articles published annually, in one year, they would fall 82 centuries behind in their reading!"[3]

While most of the printed medical literature is of limited credibility, objectivity, or practical consequence to contemporary patient care, these developments continue to lead academic and private interest groups to push harder to require ever-increasing educational demands on practicing physicians. While the CME concept allowed physicians to select programs and materials germane to their personal practices, nongovernmental corporate entities continue to strive to impose ever-increasing protocols, requirements, and mandated programs.

CME programs are rarely proven to improve patient care, but they do present physicians with considerable costs and obstacles to care delivery, while providing corporate profits to the CME industry. The American Board of Medical Specialties (ABMS) has led the quest for profit from the recertification programs, and together with the FSMB has produced multiple papers, typically industry sponsored and written by leaders and employees of the respective testing institutions. These include Eric S. Holmboe, vice-president for evaluation research, American Board of Internal Medicine (ABIM); Christine K. Cassel, president of ABIM; Harry R. Kimball, former president of ABIM; Humayun J. Chaudhry, president and CEO of the FSMB; and Rebecca S. Lipner, senior vice-president for evaluation, research and development, ABIM.[4]

As the AMA initiated the CME program in the latter half of the 1960s, it became central to the certification industry and has copyrighted and trademarked the "AMA PRA™ Credit" as the unit of recognition. The AMA charges for the yearly certification associated with CME credits and presentation of the AMA PRA, which attests to Category 1 and 2 credits thus reported. This created a monopoly on CME credit certification and resulted in the emergence of agencies (and another profitable industry) to certify the CME "certifying agents" (see Table 3).

As all the costs of the certification process are added to physician practice costs and ultimately to healthcare itself, considerable expense and time is accrued by each physician for certification of previously spontaneous lifelong learning programs. As AMA membership has numerically declined to only 17 percent of practicing physicians, other nongovernmental organizations (NGOs) have increasingly tapped into the profitability of physician education, now under the guise of board recertification by ABMS specialty organizations (see Table 4).

While patients trust doctors more than any other professionals, it is apparent that state medical boards do not, and are requiring increasingly more intermediaries to certify, test, and re-test every doctor in the land for the duration of practice, despite the resultant decrease in physician availability, without

Table 5. Numbers and Leading Causes of State Medical Board of Ohio Actions against Physicians

	2006	2007	2008	2009	2010	2011
Total number of actions taken	183	175	187	211	208	217
Actions by other state medical boards or other agencies	29	15	16	15	22	21
Continuing medical education (CME) violations	3	5	4	4	12	6
Child support suspension	0	2	1	3	2	2
Criminal actions/convictions	23	33	25	36	36	24
Ethics violations	1	4	2	0	3	1
Failure to cooperate with a Board investigation	0	3	3	1	1	1
Failure to fully and accurately disclose information to Board	16	13	15	13	5	7
Fraudulent misrepresentation in course of practice	0	0	0	3	0	2
Impairment	79	70	92	96	84	90
Prescribing issues	6	4	1	1	6	38
Licensure application/renewal issues	1	0	2	0	0	0
Minimal standards of care violations	6	13	9	14	15	6*
Sexual improprieties	1	1	1	6	3	1
Unlicensed/illegal practice	0	2	4	6	4	5
Other	0	0	3	1	0	1‡
Violation of a license limitation	18	10	9	12	15	12

Source: SMBO files, using the Freedom of Information Act
*13 of the prescribing issues cases also included findings of a failure to conform to minimal standards of care
‡The only action based on lack of competence

Table 6. Total Assets and Gross Receipts of ABMS Boards[6]

Year	Board	Total assets*	Gross receipts*
2009	FSMB	28	48.8
2009	Internal Medicine	32.4	42.3
2009	Anesthesiology	21.4	40.1
2009	Family Medicine	72.4	32.4
2009	Radiology	33.4	29
2009	Psychiatry and Neurology	46.7	27.6
2009	Pediatrics	65.2	19.5
2009	Obstetrics and Gynecology	27.2	16.7
2009	Emergency Medicine	20.1	15.9
2009	Surgery	16.6	15.6
2009	Orthopaedic Surgery	22.8	11.6
2009	ABMS	12.5	10.2
2010	Pathology	9.8	6.3
2010	Thoracic Surgery	10.5	4
2009	Physical Medicine & Rehabilitation	8.3	3.7
2009	Urology	4.8	3.6
2010	Plastic Surgery	3.4	3.5
2008	Ophthalmology	5	3.5
2009	Emergency Medicine	1.7	3.3
2009	Otolaryngology	7	3
2008	Dermatology	3.7	2.9
2009	Neurological Surgery	2.7	2.6
2009	Preventive Medicine	2.5	1.7
2010	Allergy and Immunology	3.4	1.3
2009	Medical Genetics	1.3	1
2009	Nuclear Medicine	2	0.8

*Amounts are in millions of dollars.

any evidence for the validity of these assessments or the need for them. Lack of competency is a very rare problem in licensing actions and review, as evident in data from the State Medical Board of Ohio (SMBO) in Table 5. In 2011, it was the cause of action for only one of 42,000 practicing physicians in Ohio. It is so rare that it is listed under "other" in Table 5. The main cause of actions over the years is consistently impairment, which is defined as follows in chapter 4731-16 of the Ohio Administrative Code:[7]

> (A) "Impairment" means impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice. Impairment includes inability to practice in accordance with such standards, and inability to practice in accordance with such standards without appropriate treatment, monitoring or supervision.

Note that "prescribing issues" jumped to being the second most common reason for actions in 2011, owing to the targeting of pain clinics as "pill mills" to support changes in regulations for physician prescribing and the establishment of pain clinics.

The familiar corporate nongovernmental agencies continue to create market share and profit increases under the guise of improving medical care by attempting to incorporate the ABMS Maintenance of Certification (MOC) program into the renewal process for a basic medical license. This is being promoted under the FSMB "Maintenance of Licensure" (MOL) program, conceived and driven by the FSMB now for more than a decade.[8]

This FSMB program began in 2002 and in 2012 has reached the point of "pilot implementation" in 11 states: Ohio, California, Colorado, Delaware, Iowa, Massachusetts, Mississippi, Oklahoma, Oregon, Virginia, and Wisconsin. This has resulted in significant opposition by practicing physicians for multiple and obvious reasons. On May 19, 2012, the Ohio State Medical Association's council was confronted with MOL as the first of all pilot-program states. Its House of Delegates passed the following resolution and issued this statement to oppose MOL:

> Consistent with OSMA policy, the OSMA actively opposes any efforts by the State Medical Board of Ohio to unilaterally implement different MOL requirements other than those currently in place for physicians in Ohio. There is no data that demonstrates implementing MOL requirements beyond Ohio's prescribed Continuing Medical Education (CME) requirements would provide enhanced quality of care to patients. The State Medical Board of Ohio already requires more prescribed CME than several other states. In fact, there are several states that do not require physicians to meet any CME requirements.
>
> OSMA supports the concepts of lifelong learning and physician self-assessment and improvement, but until there is evidenced-based data proving that additional MOL requirements in Ohio would equate to more competent physicians, OSMA cannot support this effort in its current form.

While the ABMS MOC is a specialty certification beyond that of basic licensure, the conscription of physicians into mandated MOL programs is clearly an effective strategy to combat the recognized decline in corporate profits and to secure the income of ABMS CEOs. These CEOs continue to earn around $1 million ($800,000–$1.2 million) annually.[6] These salaries greatly exceed those of practitioners in the respective specialties, where practicing physicians earn far less at the patient bedside! These three ABMS specialty board corporations in Table 4 have the further distinction of being the first to initiate the 10-year cycle of MOL, as well as having the largest yearly total assets among the board corporations (see Table 6). This suggests introduction of 10-year limited certificates as a useful tool for corporate profits.

This report from a family practice colleague demonstrates the ingenuity of the MOC process in creating increased physician obligations to secure the industry's brazen economic interests: "On Sunday I spent 5 hours on the computer completing a course

to be accepted as my Part IV module for maintaining my board certification in Family Medicine. The course was free. Today I found out that in order for the course to be credited to my MOC, I have to pay the American Board of Family Medicine $625!! How do they justify this?"

It's logical to ask why state boards require increasingly more intermediaries to issue and renew licenses. Ohio physicians are currently paying $310 every two years to renew their license. SMBO's current biannual budget is $16,686,707. The state nursing board does the same job for four times as many licensees for only $11,224,349 biannually. How much more in time and money will the proposed MOL cost? Just what will that yield, and for whom? How much is enough? Why does a state board require increasing re-certification hurdles, when multiple agencies are reviewing physicians, along with peers, hospital administrations, families, and patients themselves? These agencies include the Drug Enforcement Administration (DEA), the Inspector General, the Ohio Attorney General, the Ohio Industrial Commission, peer review bodies, the Ohio Pharmacy Board, law enforcement, plaintiff's bar, and third-party payers.

Regulatory Capture of Medicine by the Certification Industry

'"Regulatory capture' occurs when special interests co-opt policymakers or political bodies, regulatory agencies in particular, to further their own ends," writes Adam Thierer.[9]

The AMA introduced CME in the late 1960s with the authority of the overwhelming membership of physicians at that time, the support of academic institutions eager to provide this service, and the benevolence of the medical profession's commitment to lifelong learning. Over decades, the FSMB and affiliates within the certification-industrial complex have now, as private corporations exhibiting nongovernmental organization status, without the legal authority to license imparted by legislation to individual state boards, gained considerable influence over this governmental function. The FSMB reported more than $221,222 in lobbying fees to the Prime Policy Group alone on its 2009 IRS Form 990. The imposition of the authority of the FSMB and its affiliates in initial licensing of medical graduates evolved from the initial desire to limit the influx of foreign medical school graduates into the country. This developed onto a national licensure requirement for all graduates, including those of U.S. medical schools.

The FSMB now asserts significant control over medical education requirements for licensure by exclusive marketing of standardized tests in the U.S. In the past decade, the FSMB has worked to expand this authority in a national program to all practicing physicians based on its MOL program.[10]

The private regulatory and academic industries that now monopolize medical education and certification testing are detached from, and independent of the medical profession. They typically operate behind closed boardroom doors. They use the political process to institute changes that are without significant regulatory oversight by government or working professionals. In conjunction with the ABMS, another private and nongovernmental corporation with monopoly status, the FSMB is attempting to capture all physicians in expensive subspecialty education and testing as a requirement for basic medical license renewal, using the state's governmental authority to gain control of the CME industry's $2.3 billion market.

Conclusion

It is time for medical professionals to re-assert their rights and professional obligations to renounce the self-serving, unfounded, and expensive goals of the certification industry monopoly, in the interests of patient care and cost containment. It is astounding that this increase in regulation of physician certification is allowed at a time when independent practice in the profession of medicine is being increasingly delegated by law to nonphysicians with less education and fewer licensure requirements. It is ironic that the ABIM proposes to impose the wasteful, expensive re-testing program of MOC at the same time that its president Christine Cassel suggests, in the "Choosing Wisely" campaign, that the costs of extended coverage under "ObamaCare" would be offset if physicians stopped wasteful testing.[11]

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