Successful Opposition to Maintenance of Licensure: the Ohio Experience as an Educational Template

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Introduction

On Oct 11, 2012, the State Medical Board of Ohio (SMBO) voted to not proceed with "pilot" plans for formal introduction of Maintenance of Licensure (MOL) plans of the Federation of State Medical Boards Inc. (FSMB).[1] This outcome documents that resistance to the machine of MOL and Maintenance of Certification (MOC) is not futile.

The purpose of this paper is to outline the history, strategy, and implementation of this effective resistance, as this battle must be fought in every state by the professionals located there, because licensure is regulated by state governments.

Ohio had been targeted as the first state for MOL implementation. The infiltration of two FSMB board members at high levels of the SMBO was thought to assure enactment. Rejection by the SMBO followed a long and intense battle led by a few committed and relentless physicians, who activated the political process.[2-5]

In early reports from 2011, FSMB indicated that 11 states had already chosen to set up pilot projects.[6] In August 2012, this number had been reduced to nine.[7] After the Ohio decision, there may only be eight, although FSMB had already claimed in 2011 that "there was wide interest among the state boards in the ultimate implementation of as many as 20 to 30 pilot projects, with perhaps a third of that number developed for implementation by early 2012."[6]

These statements represent FSMB's corporate strategy to over-represent the need or interest in imposing this unnecessary plan. This tenacity, despite slow acceptance, is evident in the long history of FSMB MOL corporate strategy dating back to 2002. At that time the FSMB Board of Directors first approved a motion to include the issue of physicians' continued competence in its FY 2004 action plan. Only in April of 2010 was the FSMB House of Delegates able to formally adopt a model MOL policy to present for implementation and consideration in each state.[8]

The Certification Industry

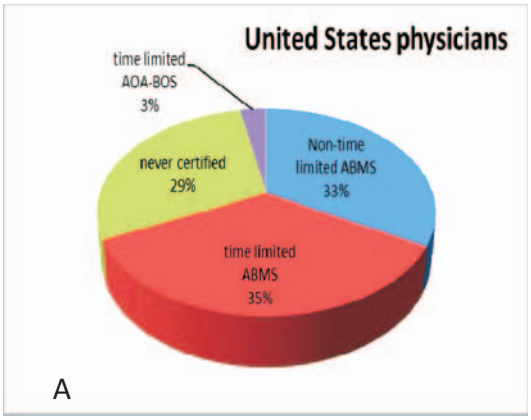
The cost of medical care is grossly inflated by government and multiple secondary industries. These include a vast, expensive, and intrusive certification industry that has arisen over the past century, "assuring" consumers of quality products, including medical care. The American Board of Medical Specialties (ABMS) began in 1933 and now oversees 24 specialties with more than 167 certifications, while absorbing $350 million in "gross revenues" each year. ABMS corporate MOC first appeared in family practice around 40 years ago and became mandatory for all specialties in 2000. Those who entered the profession after 2000 fail to appreciate the long historical basis of voluntary lifelong certification, which developed a means of national standardization and evaluation of residency training programs. Board certification represented an "outcome measure" for residency training programs, which provided lifetime validation of "specialist qualifications" through a single interview/"test." Now the certification industry has developed recurrent, lifelong testing and busywork to ensure steady profits from MOC. This conglomerate of "nonprofit" organizations has amassed more than $450 million in net assets.

The FSMB aspired to regulatory capture of the medical profession through MOL, using licensing legislation to insure mandatory compliance and enrollment into MOC, but physicians have rejected it in high numbers.[4,9] Less than 33 percent of U.S. physicians (that is, less than 80 percent of those who hold time-limited certificates) are currently enrolled in MOC. This clearly shows physician disinterest in this corporate product as an elective means of lifelong professional learning.[10,11]

The ABMS/FSMB testing and certification industry machine recently enticed the many national medical specialty groups (also nonprofit corporations purported to "represent" physicians) to provide the lucrative educational components of MOC. This financial coercion and proclaimed "voluntary participation" apparently assures success of the program on the national level, while the threat of MOL couples MOC to the ability to obtain state licensure, ensuring that all physicians participate by conscription. Limited numbers of academic physicians, department chairmen, ABMS executives, and "educators," all providing little or no patient care themselves, are thus ensuring the financing of this vast corporate industry on the backs of working physicians.

While the industry finances and publishes documents reporting the "efficacy and importance" of MOC, such papers are grossly tainted by corporate authorship.[12] As "retrospective chart review" data, they fail to reach any significant "level of evidence."[13] They are little more than opinion papers with suspicious research designs and corporate agendas, written by individuals with pre-conceived conclusions.[12,13] MOC under MOL is an unproven, non-validated corporate program, closely resembling racketeering—or, to put the best construction on it, a religious belief.

While ABMS espouses its MOC as a long-standing mechanism fundamental to the welfare of American patients, America led the world in medical innovation before the existence of MOC, and foreign dignitaries routinely traveled to America to receive a higher quality of care unavailable in their own countries.



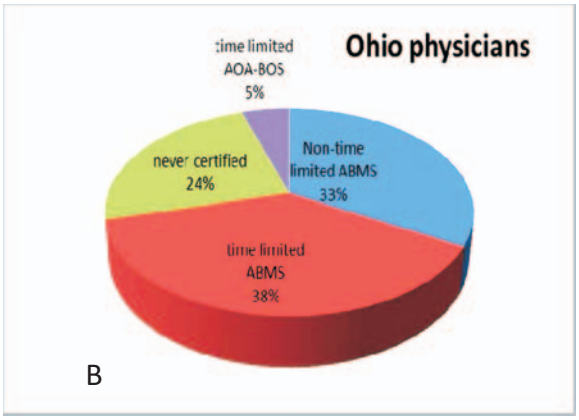


Figure 1. Board Certification Status of Licensed Physicians. A. In the U.S. B. In Ohio. Source: State Medical Board of Ohio files, 2011, through FOIA request

Board certification has long been recognized as little more than a "Good Housekeeping Seal of Approval."[14] Based on my perspective gained from two decades of teaching residents, these certifications are useful as a tool to promote learning beyond simple "on the job training" by providing for an intellectual measurement of knowledge and professional presentation. Certification is a measure of individual and residency training program success. "Board certified" used to refer to a singular achievement occurring in the past. But under MOC and MOL it has evolved into the complicated, costly, and needless rehash of basic textbook knowledge rather than becoming continuing education to improve the knowledge and skills of the advanced specialist.

Challenging the Religion of MOC

During my education and practice in Europe, I have been actively exposed to Hippocratic, communist, socialist, fascist, British, and American fiscal and political foundations and medical theologies over 3 decades. I have learned to question and seek scientific truth.

Personally attaining board certification in 1989 and recertification in 2005, I can state that I never learned anything for, or from this testing. I learn every day and am glad to teach all colleagues.

Lifelong education was supposed to be the foundation of the Continuing Medical Education programs that the American Medical Association established in the late 1960s and which consumed more than $2.5 billion in registration fees in 2010 alone. The amount doubled from 2000-2007, as basic CME requirements for license renewal increased in most, but not all states, but have declined since with the advent of free internet courses.

It is important to recognize that learning, not testing, is fundamental to competency, and states have had requirements for license renewal for decades.[3] Physicians are already evaluated by a host of professional, legal, liability insurance, governmental, and other institutional systems. Does anyone need profitable "nonprofit" corporations to control requirements and testing at great cost? No. Recognizing this fact was the first step in fighting the certification industry's abuse of power.

At present, only 35 percent of physicians are currently practicing with a time-limited certificate (see Figure 1), and at most 79 percent of this 35 percent of physicians are voluntarily enrolled in the MOC program. The new ABIM chairman, Dr. Robert Wachter, disclosed that even though he was initially certified in 1986, only 3 years before the ABIM re-certification cycle was introduced, he chose to recertify only shortly before needing to "punch his ABIM paycheck" and qualify for his new position as ABIM chairman. He writes that all ABIM board members are required to participate in MOC—to "eat at our own restaurant." The majority of physicians do not believe that MOC itself is of any significant importance, and this is very evident in the comments that followed Dr. Wachter's presentation.[15]

Public-Private Collusion

The certification industry is widespread throughout the U.S. economy and exists alongside government agencies. Thus, we pay at least twice for regulation. The tests are proprietary. Examinees are contractually, and under copyright law, obliged to refrain from any discussion or disclosure of test content, and have been subjected to lawsuit, ridicule, revocation of certification, destruction of professional livelihood, and gross monetary damages by the ABIM to enforce this secrecy.[16,17] This also ensures that the test itself is never validated independently, or reviewed by the working professionals who constitute the specialty. While the combination of board certification and MOC is officially declared to be a voluntary measure by ABMS and affiliates, introduction of MOL as a government license requirement changes the equation. While government is obliged to submit to oversight, regulation, and disclosure under the Freedom of Information Act (FOIA), these private corporations make their own rules, often of a very political nature, behind closed doors and without oversight or open review. It is time that physicians begin to regulate these regulatory corporations, individually and through representative state organizations.

Fortunately, as in Ohio, state medical boards must get legislative approval to change the law. It is important to recognize that your licensure board works for you as a citizen and a professional and must comply with FOIA when you present a specific question regarding professional affairs. FOIA becomes your leverage to obtain the truth. It is essential to ask the correct specific question to obtain the desired response.

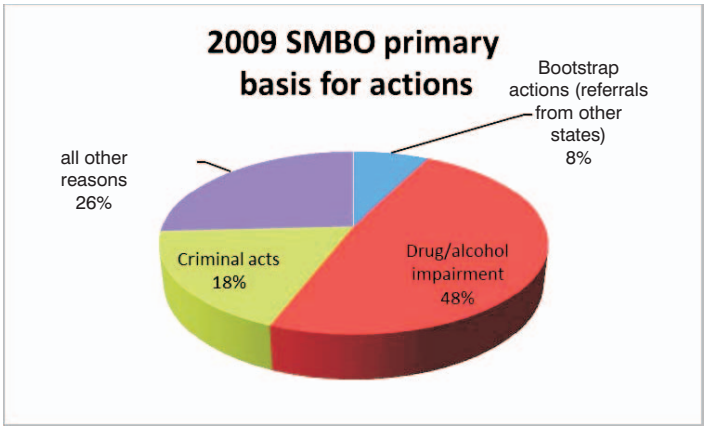


Figure 2. Reasons for Ohio Medical Board Actions Source: SMBO data obtained through FOIA request

MOC, because it does not require legislation, is harder to oppose than MOL. Noncompliance with MOC is the most effective countermeasure, but physicians often comply with MOC as a path of least resistance, even when recognizing the folly, waste, and indignity of the exercise. These physicians have apparently accepted the idea that an official certificate, rather than lifelong learning, is important. The fear of exclusion from insurance panels, practice opportunities, and hospital affiliations—and even licensure if MOL should be enacted—is a significant concern.

A Strategy for Opposition

The basic steps are to gather information, inform your colleagues, and engage the political machine.

The first and most important step is to begin to audit your state medical board directly, as well as any relationships involving FSMB or ABMS. There will be many! In Ohio, the SMBO executive director and one prior president/longstanding member of 13 years were also board members of FSMB during the FSMB MOL "pilot" initiative in Ohio. They both were clearly the principal zealots pressing for the introduction of this initiative. This is readily seen as a conflict of interest by most informed individuals, yet SMBO disregarded it.

Look at your board's finances, member payments, lecture materials, travel logs, and year-end reports. Use their data to define the issues. Review the materials from Ohio, which serves as a representative American state and will not differ significantly from other states.[5] Make it clear that lack of competency is not a significant issue. Indeed, in Ohio competency does not even appear as a listed entity in actionable complaints (see Figure 2, which includes physician assistants, anesthesia assistants, massage therapists, and physicians). Compare the budget with another state agency, such as the nursing board, which does essentially the same job for a much larger number of licensees. In Ohio, the nursing board is eight times larger and does much more work for only 80 percent of the budget of the SMBO. Such over-prosecution of physicians appears to be motivated by a desire to achieve recognition as a "good board" based solely on the number of prosecutions per 1,000 physicians as determined by Citizen.org—another private nonprofit corporation! In the certification industry, multiple corporations certify each other to maintain the confidence game.

Join the large state medical associations and pass resolutions to oppose MOL or MOC requirements at the state, hospital, and insurance board levels. Do it now and do not wait for the proposals to arise to be fought, but be pro-active. Define and defend the status quo. It is easier to maintain a situation or legal state than to turn back a new law or legal precedent. Do not rely upon, or expect national specialty organizations to even show interest or provide a forum for discussion of MOL/MOC matters. They are in on the profits, providing the educational components of the ABMS MOC program. The leaders here will be university academics with significant personal interests in producing educational programs and enjoying participation in the ABMS testing machine. State organizations are also likely to have academics in their political hierarchy, who will actively support the MOL/MOC. Colleagues who treat patients, however, will greatly outnumber the academics and will also be available to attend these local meetings to vote, especially if they are informed. Network with other state and national non-specialty based societies like AAPS and Docs4-PatientCare, who do not have a vested interest in MOC/MOL profits.

Expose the lies. The public is not "clamoring" for testing of physicians or MOC. This propaganda originates at ABMS and FSMB simply to justify their corporate programs and earnings. These two agencies are the leaders in polls and publications, printed often in their own journals by their own authors with less than credible scientific methods.[12] Expose the propaganda and myth of MOC/MOL with the truth that board certification and MOL serve to limit physician numbers and entry into the marketplace. We clearly need more rural general practitioners, those able to practice general medicine—not subspecialists. Rural physicians will be especially impacted by MOL, due to travel and locums coverage costs.

Cost being the leading factor in the national debate, point out that it is nonsense to impose more costly and time-consuming activities upon small private physician offices, when increasingly physician assistants, nurse practitioners, nurse anesthetists, and other less educated "providers" are being given a license to practice medicine because they are considered cheaper. While federal funding of physicians is being cut, the Affordable Care Act Expansion of Physician Assistants Training (EPAT) has recently allocated $32 million in funding for federal fiscal years 2010 through 2014 for physician assistants alone.[18] The concept of MOL, which requires physicians to maintain specialty certification to maintain a basic medical license when physician educational programs are being gutted and less-educated "providers" are being offered full practice of medicine, is illogical.[19]

If you find evidence of abuse of power, ethics violations, and financial waste in your state medical board, seek to engage other state regulatory agencies, who can only get involved if confronted with specific problems. These would include the Office of Inspector General, the Federal Trade Commission, and the attorney general or district attorney.

Network with colleagues and those in other states, and use news media when possible.

If MOL becomes law, legal redress may be possible through antitrust or potentially anti-racketeering laws.[20]

Success Is Possible

It may take as few as two to 10 individual physicians in each state to coordinate and educate colleagues in the defense of medicine against MOC/MOL, as the recent victory in Ohio demonstrated.

A resolution passed by the Ohio State Medical Association led to the unified opposition of 11 state medical societies and ultimate rejection of MOL in Ohio. These documents serve as the single most important template of coordinated physician anti-MOL activity and should be referenced by all as examples.[21, 22] AAPS has been the first national society to formulate a strategy for state opposition to implementation of MOL.[23] Many believe the rejection of MOL in Ohio resulted in ousting the SMBO executive director, who also served as an FSMB board member.[24]

A key element in a successful strategy is exposing the lies on which the certification industry bases its case, and the perils in allowing private corporations to use governmental power to achieve private ends without the checks and balances that could restrain public agencies.

If the independent practice of private medicine is to survive, it is essential to win this battle.

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About Exposing Big Lies

" . . **in the big lie there is always a certain force of credibility**; because the broad masses of a nation are always more easily corrupted in the deeper strata of their emotional nature than consciously or voluntarily; and thus in the primitive simplicity of their minds they more readily fall victims to the big lie than the small lie, since they themselves often tell small lies in little matters but would be ashamed to resort to large-scale falsehoods. **It would never come into their heads to fabricate colossal untruths, and they would not believe that others could have the impudence to distort the truth so infamously.**

Adolf Hitler: In *Mein Kampf*