

From the President

The Curse and Corporate Cult of Certification in America

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This year, I will have spent four decades as a physician and one decade actively exposing and opposing Board Certification (BC) and especially Maintenance of Certification (MOC®) programs as antiquated extortion schemes that erect practice barriers to non-members.¹⁻³

I have decided to slow down, smell the flowers, and reassess my professional goals and realities working part time.

As a foreign medical graduate (FMG) of a German medical school founded in 1457, I received extensive medical training and practice, producing clinical competency completely extrinsic to any certification industry or product. I exposed American certification as the regulatory capture of medicine.⁴

Not long ago, Americans frequently sought medical education excellence in these premier institutions of Europe, where American Board of Medical Specialties (ABMS) certification still plays no significant role.⁵ The ABMS physician reports in 2020 indicated that there are 300,000 U.S. physicians not participating in recertification (ABMS, personal communication, 2021), and 920,000 certified physicians in 40 specialties with 87 subspecialties, while there are only 860,000 physicians in the U.S. The numbers don't add up.⁶ The complete lack of ABMS impact outside the U.S. indicates that the solely U.S.-based ABMS monopoly is clearly documented in the math alone.

My personal and professional activities on five continents have given me a wide experience of medicine, including many medical services delivery systems. I have also seen many changes in my span of professional activity in the U.S. since 1985. Most concerning are those of the bureaucracy of the medical certification industry. Understanding the impact of these bureaucratic changes requires an understanding of the development and the very nature of certification.^{7,8}

Certification itself is a very widespread American corporate phenomenon, impacting accountants, crane operators, plastics, electronics, organic foods, meat, doctors, licensing, indeed almost any aspect of daily American life. It is generally run by private corporations, with no oversight.

In medicine, the certification and educational industry's acronyms continue to multiply like legislation. Most recent certifications of note are for automatic external defibrillators (AED) operation from the American Heart Association (AHA); the neonatal resuscitation program (NRP) since 2016 via the American Academy of Pediatrics (AAP); and the Pediatric Emergency Assessment, Recognition and Stabilization (PEARS) and Pediatric Advanced Life Support (PALS) from the AHA, which also require Basic Life Support (BLS) to even attend. Also new is a Certified Nursing Assistant (CNA) certification. Apparently no one is to be spared certifications in the contemporary U.S.

Many "unofficial" internet-based courses claim to certify aspects of medical capabilities. While the AAP and AHA

deem any "unofficial" courses "unauthorized," their ease and inexpensiveness provide fast documentation, with questionable "protections"—as if "official" certification provided any in the first place!⁹ The scam is complete, recognizing that even "official" certifications authorize no one to actually provide medical care; that is the prerogative of a state medical license! So, *caveat emptor* applies.

So many choices, acronyms, expenses, and demands come down on a physician, whose abilities exceed such introductory training, but who will still be required to buy certificates every one-to-two years to appease unwitting administrators and their large certification industry incomes.

Many certifications were initially invented to attest basic education of some form (i.e., BLS), but after the AHA noted recertification pays big dividends, recertification was invented and has now been universally adopted by ABMS and others for their "non-profit" organization's financial security. We may "thank" the American Medical Association for creating the first imposition of AMA-Physician Recognition Award (PRA) CME in the 1960s.

Certification is defined as (1) the action or process of providing someone or something with an official document attesting to a status or level of achievement or (2) an official document attesting to a status or level of achievement.

While licensing is a requirement for practicing many professions, delegated to the states under the U.S. Constitution, typically certifications were historically NOT required by state or federal governments in commercial practice. Certification initially documented achievement of a level of training, but this has changed. State medical boards in some ways are now using certification as a *political requirement* for physician licensing, creating a policing function for medicine. Corporations now demand subscription and interval payments to maintain a basic "status," typically found in daily practice alone.

Levels of attestation are most typically required by medical corporate entities themselves, purportedly to provide reassurance to uninformed members of the public or their officers—all those specifically without in-depth knowledge, although no specific guarantee or warranty is *ever* assured. While this has even been admitted by ABMS in print and on their website, the admission has since been removed from their publications and internet sites. In 2012, ABMS on its website recognized that "*regardless of the profession—whether it is health care, law enforcement, education or accounting—there is no certification that guarantees performance or positive outcomes*" (emphasis added).⁸

These certification corporations and time limits exist because corporate America is addicted to the "certification cult," ensuring that corporations are able to demand certifications to reassure a spurious "due diligence" by MBA administrators, who have no significant knowledge of the matters because

it is simply beyond their grasp. These corporations have historically not paid for certifications; they just demand them, forcing physicians to spend time and money to comply.

History

Until the 20th century, formal medicine and education in America was less than scientific, with allopathic, homeopathic, and eclectic (botanical and herbal remedies) therapies practiced and taught at proprietary schools, with practical knowledge acquired then through journeyman experiences. American proprietary schools' unlimited admission rates led to very high numbers of physicians in practice. This return to medical inexperience is now underway with unlimited licensing of non-physicians to practice medicine as "providers."

Early medical licenses were typically mere registration documents, with 28 states and territories by 1890 accepting a recognized diploma to serve as a license to practice in the state.⁵ The Flexner Report of 1910 transformed American medical education, transitioning from a proprietary medical school education to a university one, based in the scientific methods of European, and particularly German, medical education of that period.¹⁰ By 1915, six of 51 jurisdictions still failed to empower their medical board of examiners to define and refuse recognition of diplomas from "sub-standard" medical schools.⁵ Clearly, a need to regulate medicine was evident at that time, and it became the job of state legislatures.

Between the World Wars and during the Great Depression, financial competition became extreme among physicians and paramedical practices. This led to exclusionary guild enforcement mechanisms from the ABMS, thus igniting development of specialty medical certifications under ABMS (founded 1933) under the trademark of "Higher Standards—Better Care." Improvements in education, licensure controls, and research were now already fully underway, fulfilling the role of assuring excellence without guilds.

The first specialty certifying examination was administered in 1926 in otolaryngology, and subsequently a total of 24 subsidiary affiliates were created, most recently in 1991: the American Board of Medical Genetics and Genomics. Initially growing slowly in 1939, ABMS started a simple written registry containing the names of 147 physicians who held board certification from their respective specialty boards.¹¹

The intrusion of Medicare and of large insurance controls preceded the increase of corporatism. Into the 1980s, demand for physician certification became compared to more limited licensing as simply "physician and surgeon," but was not required even within university settings.

The two largest and most general practice specialties of family medicine (founded 1969), with currently 93,000 diplomates, and emergency medicine (founded 1969), currently with 38,500 members, were introduced by ABMS to meet their corporate dictates and provide exclusivity. This carved out medical niches, especially by moving some specialists out of emergency room. ABMS extended its market control with time limits on these two certifications, even from their very inception.^{12,13}

ABMS and multiple other medical organizations/corporations continue to create new specialty and other medical examinations, selling certifications to millions of Americans yearly. Extensive controls over medical and

postgraduate physician education in the 20th century included state, federal, legal, tort, insurance, and hospital oversight, yet ABMS and others continued to expand their fee systems to support the multimillion-dollar physician recertification industry.⁴

Government has delegated controls to corporations as a fourth arm of government. Personal examples: Despite a Bachelor of Science degree from the University of Michigan, and being born and raised in Michigan, I still needed to take English tests (ECFMG and TOEFL) three times to license in the U.S./Ohio, because I studied medicine in Germany! The strange thing is that a colleague from Ghana who studied at a New York medical school and spoke poor English never had to take any language proficiency to license in Ohio. One is simply made to jump through the hoops and click off the boxes, knowing that it does not need to make sense in the corporate state of medicine.

2021 Reality

My recent transition to part-time practice in a *locum tenens* capacity confronted me anew with the stark imposition of certifications. My status as "ABMS Board Certified" is only one of many certifications now required by hospitals for the highly variable credentialing requirements. Reactivating prior Pennsylvania medical licensure took only a week after submission of the following required documentation: 100 continuing medical education (CME) hours including two for narcotics prescription, two for child abuse recognition and reporting (CARR), and 12 in patient safety and risk management; National Practitioner Data Bank verification; and a complete curriculum vitae, none of which are applicable to ABMS certification or its proprietary MOC programs. The narcotics and CARR certifications are particularly concerning because they are clearly politically motivated to promote *policing* by and of physicians.

The exercise of CARR certification was uniquely painful and politically enlightening, with individual minutes spent online measured and the subject matter NOT medically of interest. This requirement was introduced in 2014 and imposed solely upon health-related licensees and funeral directors. Like the narcotics prescribing requirements, they are to be repeated with every re-licensure at two-year intervals.¹⁴ This is clearly not educational, but appears punitive, targeting medical "providers" for the failures of individuals, government, police, and social workers.

While the list of mandatory reporters is extensive, certification requirements are very targeted (see Table 1). Particularly frightening are the implications imposed of felony/misdemeanor conviction for NOT *reporting every mere suspicion* of child abuse.¹⁵ Of note is that solely children are protected, while spouse and elder abuse remain neglected, and policing/social worker professionals—those tasked formally with police functions—were not included in certification/education programs licensing requirements. Legislation that mandated reporting existed long before the Pennsylvania State/Jerry Sandusky affair in 2011. Certification requirements were introduced for initial licensing in 2014, becoming required for every re-licensure effective Jan 1, 2015, ensuring a policing function of medicine, as response to the political need to "do something" in the face of this problem.

Table 1. Pennsylvania Law (§ 6311). Persons required to report suspected child abuse under penalty of law. Bold text indicates “required to undergo CME training at every license renewal.”

The following adults shall make a report of suspected child abuse, subject to subsection (b), if the person has reasonable cause to suspect that a child is a victim of child abuse:

(1) **A person licensed or certified to practice in any health-related field** under the jurisdiction of the Department of State.

(2) A medical examiner, coroner or **funeral director**.

(3) An employee of a health care facility or provider licensed by the Department of Health, who is engaged in the admission, examination, care or treatment of individuals.

(4) A school employee.

(5) An employee of a child-care service who has direct contact with children in the course of employment.

(6) A clergyman, priest, rabbi, minister, Christian Science practitioner, religious healer or spiritual leader of any regularly established church or other religious organization.

(7) An individual paid or unpaid, who, on the basis of the individual’s role as an integral part of a regularly scheduled program, activity or service, is a person responsible for the child’s welfare or has direct contact with children.

(8) An employee of a social services agency who has direct contact with children in the course of employment.

(9) A peace officer or law enforcement official.

(10) An emergency medical services provider certified by the Department of Health.

(11) An employee of a public library who has direct contact with children in the course of employment.

(12) An individual supervised or managed by a person listed under paragraphs (1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11) and (13), who has direct contact with children in the course of employment.

(13) An independent contractor.

(14) An attorney affiliated with an agency, institution, organization or other entity, including a school or regularly established religious organization that is responsible for the care, supervision, guidance or control of children.

(15) A foster parent.

(16) An adult family member who is a person responsible for the child’s welfare and provides services to a child in a family living home, community home for individuals with an intellectual disability or host home for children which are subject to supervision or licensure by the department under Articles IX and X of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

Having recently responded to work part-time at an Ohio hospital, I found that the ever-increasing credentialing demands extend well beyond simple ABMS certification and state medical licensure. Extensive documentation included: NPDB verification, FBI police check, and complete curriculum vitae. The last included a list of all schooling and practice since undergraduate college in 1972 *by month and year (MM/YYYY) including reasons for any interval of unemployment*. Also required: a list of EVERY malpractice carrier from work history back to medical school graduation; names and addresses of prior *locums* contractors, not just the hospitals and dates of practice; driver’s license; tuberculosis test within the last 12

months; current influenza vaccination; copy of all last-two-years’ CME documents; adult cardiac life support, pediatric advanced life support (PALS), and neonatal resuscitation program (NRP) certification; copy of state medical license and ABMS certificate; copies of all educational/residency diplomas. Only the blood, urine, and stool sample and COVID-19 vaccination appeared excluded as “required” in this professional vivisection.

Most importantly, these are all simply corporate hospital requirements, apparently approved by the respective medical executive committee and our colleagues. With all the administrative overlay and employed physicians, this may all well be an administrator’s simple wish list. When I personally refused to acquire PALS (8 CME) and NRP (11 CME) certifications unless paid for my time and registration, (i.e., to spend 19 hours and \$400 registration fees to get a piece of paper about repeating basic information, despite my medical training, 40 years of experience, and ABMS certification of “specialty expertise”), I was offered payment for half the time commitment in a “horse trade” manner.

I simply walked away.

These certified skills are intrinsic knowledge to the highly educated practice of medicine, but not to nursing education. Yet, during such “live” courses, physicians are often lectured to and tested by an emergency medical technician (EMT) or registered nurse! I have numerous times rescued neonates who were dying under the care of apparently PALS/NRP-certified nursery RNs and certified registered nurse anesthetists (CRNAs). I think we are now seeing an increasing plethora of courses designed for “economically preferred” low-level “providers” and now extrapolated to be demanded from expert physicians at significant, unnecessary cost.

Physicians are abandoning leadership in medicine by subordinating their professional integrity to non-physicians and administrators. Unless physicians start taking back medicine with leadership, we will see only continuing decline and subjugation of professionalism to non-physician “providers,” government, insurance, and corporate dictates.

ABMS certification registration **requirements** alone create competence, rather than ABMS’s process identifying competency. One must first complete a full U.S. residency training to even become qualified for certification/testing, along with providing letters of reference.

In 2021 it can be assumed that graduating from a modern U.S. training program and passing the examinations required for licensure is sufficient to assure competence. Yet the increasing “cost effective” licensing of non-physicians to practice algorithmic medicine is without even medical board oversight or ABMS certification! Often certifications do not demand correct answers, just those deemed to be “best” by ABMS. Thus, rather than providing education or ensuring competency, they facilitate corporate marketing of products. When dealing with the certification industry, your knowledge is irrelevant; you just need their piece of paper at their price.

Any ABMS function has devolved to ensure that nothing it demands is of utility or value beyond excluding non-diplomates from practice. The certification industry is antiquated, like slavery, leeches, and bloodletting. Medical costs are now excessive, and antiquated concepts must be addressed, including needless certifications, and especially recertifications (MOC).

While licensure is supposed to protect the public, all these multiple corporate layers of certification are like a cult religion, constituting waste and demanding considerable time and financial impediments to provision of care by highly trained physicians. This has led to widespread and increasing use of non-physician “providers” to deliver mass algorithmic therapy, instead of individualized and tailored professional expertise.

John Adams, our second president, summarized a fundamental problem with government, which applies to medical specialty certification programs governing physicians in 2021:

Virtue cannot exist in a nation without private [virtue], and public virtue is the only foundation of republics. There must be positive Passion for the public interest, honor, power and glory established in the minds of the people or there can be no republican government nor any real liberty. And this public passion must be superior to all private passions.¹⁷

There is no virtue in the ABMS imposing its will—only greed. ABMS MOC no longer serves the profession by providing any methods of assessing, assuring, or advancing entry capabilities. Rather, it imposes arbitrary requirements throughout our professional lives, not with scientific evidence, but with merely the despotic will of an un-elected, self-serving plutocracy.

In the profession of medicine, physicians are not the governed, but are sovereign. Practice must be subject only to the *welfare and needs of the patient*. We must together secure our profession for the public welfare against any corporate, legislative, or material intrusions.

The main reason this industry continues to expand recertification (MOC) is that too many physicians believe they must comply. Physicians continue to allow hospitals, insurance companies, and ABMS to intimidate them, while virtually *no* patient in 2021 cares about anything more than simply being able to acquire affordable, timely, and competent medical care, in that order. Eliminating recertification, and empowering patients to access physicians without corporate/state interference, and without financially justifying lesser-trained “providers,” best serves our patients and our profession.

I refer to ABMS certification as a cult/religion because it is not founded in science. There is no proof that all this testing improves anything; it is all based on beliefs and associations. Night follows day not because one causes the other, but rather by association. The cult nature of certification is one of a scientifically unfounded belief, levying/extorting untold millions of dollars each year from the “believers,” while benefiting only the corporate leadership.

What Must We Do?

There has been progress in many states with legislation opposing MOC requirements.¹⁸ The time has come for individual physicians to “vote with their feet and walk” as I did, whenever possible. The job remains for each individual to refuse to be indoctrinated and extorted by the ever-growing certification industry.

Our profession itself is under attack from multiple sides. Freedom is not free! If you do not resist, you are part of the problem. Change bylaws. Sue for your rights. Physicians are in demand and must fight the demise of professional patient

care actively, including the use of ever more numbers of poorly trained non-physician “providers” who are compliant only with “algorithm medicine.”

AAPS is fighting on this forefront in saving our profession.

Please join us at the annual AAPS meeting in Pittsburgh in September.¹⁹

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