

Editorial:

# MOB: Maintenance of Bureaucracy

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On the 1-to-10 bureaucracy scale, where 1 represents little if any regulation/bureaucracy, and 10 represents such a high level of regulation/bureaucracy that there may be little time left to engage in the regulated activity, bureaucracy affecting medicine in our country today is currently about 9.8.

The list of bureaucracies that regulate and control medicine has become so expansive, and the attack on medicine so unrelenting, that most physicians have had to hire additional employees just to cope with bureaucracy. Bureaucracies grow and thrive, maintaining their individual kingdoms, while physicians endure a withering assault at the hands of a growing army of bureaucrats.

The burden imposed by some bureaucratic requirements is irrelevant to those, who, lacking any medical training themselves or evidence that the requirements improve quality care or patient safety, decide that it would be a good idea to make physicians jump through yet another hoop.

Earlier this year, for example, I was forced to attend the New York State mandatory hand-washing course (infection control) for the fifth time! Physicians and other licensed healthcare workers in New York State have to take this same hand-washing course every 4 years as a condition of licensure. Each mandatory hand-washing course lasts about 4 hours. So to date, New York State has confiscated 20 hours of my time, approximately \$175 in course fees (no CME credit offered), and has forced me to listen to the same material presented over and over again. Those who provide the state-mandated courses are happy, as they get paid for teaching the same material over and over again. Yet, there is no evidence that forcing physicians to listen to the same material repeatedly is any more effective in reducing iatrogenic infection than forcing physicians to write 100 times on an official state blackboard every 4 years, "I will wash my hands between patients."

## Federal and State Bureaucracies Thrive

The Medicare bureaucracy continues to grow with Provider Enrollment Chain and Ownership System (PECOS) requirements, revalidation of enrollment, coding changes and restrictions, and private bounty hunters constantly lurking in the shadows ready to pounce on any unsuspecting physician. Is it mere coincidence that the "c" in PECOS stands for "chain" and the "o" stands for "ownership"? Physicians who have not yet opted out of Medicare are even required to give Medicare bureaucrats complete access to their checking accounts. As Medicare bureaucrats have a proven history of incompetence, that ought to give many physicians pause for concern.

The litany of bureaucracies/laws/regulations/policies that regulate medicine, Medicare, Medicaid, TriCare, HIPAA, ADA, EMTALA, OSHA, DEA, Translator Requirements, Workers' Comp,

No Fault, Medical Boards, Department of Health, American Board of Medical Specialties, specialty boards, pay for performance standards, and EHR meaningful use standards is overwhelming, and it is doubtful that any practicing physician would ever have time to read all of the regulations and requirements that apply to his practice. Physicians have thus become dependent on others to interpret the requirements as they apply to their specific practice, although if the interpretation is wrong, the physician will nonetheless be held accountable.

## Maintenance-of-Certification Requirements Staggering

In the very near future, those physicians who have time-limited certification in their specialty will have to submit to onerous new maintenance-of-certification (MOC) requirements. Physicians who have a subspecialty will have to meet additional subspecialty MOC requirements. These MOC requirements often entail a self-assessment program (SE), which specifies completion of a certain number of CME credits over specific time intervals within a typical 10-year MOC cycle. The self-assessment activity typically requires a written examination after completion of educational modules, and typically must include comparative performance to peers. Additionally, specialty boards will audit a certain percentage of physician MOC applicants and require that they send complete written documentation of SE completion to the specialty board. The "approved" self-assessment programs are typically limited to those offered by the specialty society. Thus, both the certifying boards and the specialty societies benefit by an increased revenue stream provided by these new MOC requirements. In addition, an average number of specialty-specific CME credits typically must be obtained per year over a 10-year MOC cycle.

After meeting self-assessment CME requirements and additional specialty specific CME requirements, the physician is eligible to take the cognitive examination. In order to take the examination, physicians must travel to one of the approved examination centers. Practice guidelines, often promulgated by specialty societies, will likely be a focus of cognitive exams. Physicians will also typically be required to meet performance-in-practice (PIP) standards, whereby several PIP modules will need to be completed over specific time periods during a 10-year MOC cycle. Chart reviews typically will compare the physician's data to best practices and practice guidelines, and must include a written plan to improve compliance and efficiency in the physician's practice. And, within a period of about 2 years, the physician must repeat the entire process to demonstrate that the written plan for compliance and efficiency was actually met.

Each PIP module will also typically require a chart review of the physician's practice, an additional external review of the physician's charts, and a feedback module. The feedback module typically involves soliciting personal performance feedback from at least five

peers and at least five patients. Special standardized feedback forms, supplied by the certifying board, must be filled out by the evaluators. Physicians typically will be required to develop a written plan to implement suggested improvements by peers and patients, and within 2 years repeat the entire process to demonstrate that improvements have actually been implemented.

Although the specialty boards claim that the goal of MOC is to promote the highest evidence-based guidelines and standards so as to ensure excellence in care, the specialty boards exempt themselves from the same evidence-based standard, and have no evidence that MOC improves quality care or patient safety. Moreover, no specialty board provides a guarantee of physician competence by virtue of being board-certified or completing MOC requirements. Given the extremely time-intensive requirements imposed, which will take time away from actually practicing medicine, new MOC requirements may even have a detrimental effect on access to care. In any event, there is no evidence that the American Board of Medical Specialties or the specialty boards ever did any cost-benefit analysis of these new requirements.

### Conclusion

How ironic that at a time when physicians are increasingly being weighed down by the heavy chains of bureaucracy, forced to continuously prove and re-prove their specialty knowledge and performance, nurse practitioners and physician assistants, who are not even eligible for physician certification, and who lack the training, knowledge and experience of physicians, are proliferating and their roles are expanding. Could it be that cost containment, not quality care, is the goal government is promoting?

The maintenance and growth of bureaucracy, aside from being beneficial only to bureaucrats, may also have the adverse effect of driving solo physicians and small physician groups out of business. As bureaucratic requirements expand, a larger administrative component will be required to meet the increasing demands. At a time when government is actively promoting Accountable Care Organizations (ACOs)—i.e. bundled payments sent to hospitals for hospital and physician care) as the preferred model of care, it is likely that MOC requirements will dovetail with an ACO structure so as to bend the physician fee curve downward.

Hospital-controlled quality improvement programs will likely serve the MOC requirement of chart reviews, peer and patient feedback reviews, and comparative performance tracking. Those physicians who fail to follow cost-containment-oriented practice guidelines promulgated by a hospital, so as to maximize the hospital's revenues, or who complain about the amount of the bundled payment provided to the physician, may not fare well on evaluations if they seek to do what is best for their patients, as opposed to what is best for the hospital's bottom line.

When the chains of bureaucracy obstruct the physician's ability to care for patients appropriately, the physician has an ethical duty to discard the chains and escape, to be free to practice according to the physician's best clinical judgment, as opposed to the substituted judgment and whims of arrogant bureaucrats.

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