

Maintenance of Certification (MOC): the Elite's Agenda for Medicine

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The elite medical establishment correctly foresaw that there was a huge treasure in the medical certification business. After all, who could argue against “standards” to “protect” the public? This gold mine was discovered several decades ago, as the Maintenance of Certification (MOC) business was in its infancy. The necessary ingredients were: 1) the strong arm of government to enforce the “new and improved standards”; 2) naive physicians; 3. a gullible public. Following gold mine development, captive physicians could be channeled into circuitous pathways that would siphon ever increasing amounts from their struggling practices in a continuous interminable cycle until the poor doctors retired in exhaustion.

The American Board of Medical Specialties (ABMS) became the umbrella organization for the 24 subsidiary medical specialties. Its 2011 Form 990 lists \$13,065,364 in grant income and \$7,019,998 in dues income. Is this coming from the dues/fees of doctors who contributed to their individual medical societies/boards? Additionally, ABMS reported license fee income of \$3,174,831 and even International Certificate income of \$2,864,835. Clearly, this has become a successful enterprise. Its president and chief executive officer (CEO) at the time, Kevin B. Weiss, M.D., enjoyed a compensation package of \$562,456. ABMS expansion is further evident in its related organizations, which include ABMS International, ABMS Singapore, ABMS Solutions, and ABMS Research and Educational Foundation.¹

Thus, the ABMS has become the agent for change in lobbying for increased mandates by hospitals and payers to discriminate against physicians who are not board certified, which increasingly means Maintenance of Licensure (MOL). The ABMS, of course, uses different language, claiming that “medical specialty certification in the United States is a voluntary process” (see www.abim.org). This is comparable to a Mafioso don demanding payment for protection, but then claiming that the payment was voluntary! Actually, it is worse, as the U.S. government generally protects the public from organized crime, while the ABMS establishment functions in conjunction with government. So, young physicians who have completed training, have young families, and are indebted \$200,000 or \$300,000 are supposed to “voluntarily” submit to board certification and re-certification. They know full well that the alternative is that they will not be able to work, as these “voluntary” requirements are being implemented.

Although many believe that medical specialty board certification is something every physician should strive to obtain, it should truly be voluntary, and physicians who fail or refuse should not be prevented from practicing medicine. Furthermore, MOC should never be a weapon to terminate a physician's career if he chooses not to pay for the process.

Current fees for the MOC Examination for the American Board of Allergy and Immunology are \$2,800 (see www.abai.org). While some medical specialty boards also charge high fees, others extract amounts on a yearly basis in order to retain MOC. By maintaining high failure rates, the boards can further enhance revenue. The American Board of Plastic Surgery requires passing both written and oral examinations prior to certification. Failure rates for the written examination ranged from 13.4% to 23.1% between 2002 and 2012. Oral examination failure rates ranged between 13.5% and 22.2% between 2002 and 2012. MOC plastic surgery examinations in 2009 carried a 9.2% failure rate, while recertification for hand subspecialty had a failure rate as high as 40.9% in 2005.² Thus, highly qualified physicians are driven into oblivion simply because they did not know what the elite wanted them to know.

Who replaces these highly qualified physicians? Non-physician paramedical personnel step in to fill the void. Does it matter that they did not attend medical school and residency training? Does it matter that they are not board certified? Does it even matter that they are doing procedures they have not been trained to perform? Walgreens recently announced that its Take Care Clinics are expanding the scope of health care services “to help meet the need for greater access to affordable health services and bridge gaps in patient care.” These nurse practitioners and physician assistants “can evaluate, recommend and order preventive health services, such as screenings or lab tests, based on a patient's age, gender and family history.” Were not these the traditional functions of physicians? Walgreens and Take Care Health “strongly encourage all patients to have a designated primary care physician and medical home for ongoing medical needs and routine exams, and under this new service expansion will continue to work collaboratively...”³ What a duplication of effort! What a waste! And, this is labeled “affordable”? Is the public so gullible as to trade highly qualified non-MOC physicians for this?

Meanwhile, the 24 specialty medical boards are flourishing under the protection and guidance of ABMS, and their combined revenue in 2011 was \$320 million.⁴ Much of this obviously came from ever increasing MOC profits. The elite favor this expansion, as it affords them a level of prestige and financial rewards that the ordinary physician can only dream about. Naturally, these elite will continue preaching that “the public must be protected,” when, in fact, the public is being tricked into accepting substandard care from non-physicians. Have you also seen patients being channeled into non-physician care who subsequently find their way to your offices? Are you also forced to listen as they vent their complaints?

Interlocking Directorates

One of the most ardent proponents of MOC is Christine Cassel, M.D. This is not surprising in view of her 2011 compensation package of \$786,131 as president of the American Board of Internal Medicine. She was even able to obtain paid travel expenses for her husband.⁵ ABIM's annual revenue, almost entirely derived from examination fees and MOC, was listed as \$49,304,645. Cassel, a founding director of the Robert Wood Johnson Clinical Scholars Program, was listed on the ABIM website as being certified in internal medicine in 1979, a time when certification was valid indefinitely. She is not listed as re-certifying in internal medicine, even though the ABIM "encourages all diplomates voluntarily to renew certificates relevant to their practice." One would expect that as president of ABIM, Cassel might have chosen to endure the rigors and expense she is demanding of her fellow internists. She is listed, however, as re-certifying in geriatrics.

Cassel left the ABIM in the hands of Richard J. Baron, M.D., who was architect of the Best Clinical and Administrative Practices program, partly funded by the Robert Wood Johnson Foundation. Another ABIM director, Harlan Krumholz, M.D., is also the director of the Robert Wood Johnson Clinical Scholars Program (see www.abim.org). Is the Robert Wood Johnson Foundation a germination center for MOC?

Baron also served on the Board of the National Quality Forum (NQF). Yes, this is the same NQF where Cassel now serves as president/CEO. Judging from her predecessor's compensation, it is likely that Cassel endured a slight compensation decrease. It seems more lucrative to invade internists' wallets via mandated MOC. The NQF is funded by both private and public funds, including the Centers for Medicare and Medicaid Services (CMS), as well as the Robert Wood Johnson Foundation. Other supporters include various pharmaceutical companies.

A perusal of the NQF website is about as time-consuming as MOC examinations, but far more frightening, as one sees the extensive interlocking committees and mechanisms all devoted to control in the name of "quality." Particularly disconcerting is the realization that here we see the interface between the private sector and the public sector. Indeed, this is where anything and everything labeled as "quality" can find itself registered into the laws and regulations—yet it must not be called mandatory. Though effectively required, one must still label it "voluntary." The 29-page NQF "Plain Language Guide to NQF Jargon" is replete with phrases such as "structural measures assess healthcare infrastructure," "process measures assess steps that should be followed to provide good care," "outcome measures," "measure harmonization," "measure of affordability," and perhaps the most alarming, "health information technology," which is the means by which NQF intends to control the entire healthcare arena.

A subsection of NQF is the HHS Performance Measurement, along with formulation of national strategy, implementation, maintenance of consensus-endorsed measures, and promotion of electronic health records. Along with focused measurement

development, harmonization, and endorsement efforts to fill critical gaps in performance measurements is the annual report to Congress and the Secretary of the U.S. Department of Health and Human Services (HHS).

Another NQF subsection is the Health Information Technology Advisory Committee (HITAC), which provides "guidance to support the transition to electronic performance measurement." The Leadership Network, the National Priorities Partnership, and the Measure Applications Partnership are other subsections (see www.qualityforum.org).

Why do the elite even need to lobby, when there is direct access to the government via NQF?

At the American Board of Pediatrics, David G. Nichols, M.D., recently replaced James A. Stockman, III, M.D., as president/CEO. While under Stockman's bold leadership, this board became the first to institute continuous MOC, an interminable process that continually extracts large sums from fellow pediatricians' modest salaries in order to fund Stockman's compensation package of \$1.24 million, as listed by the American Board of Pediatrics 2009 Form 990.⁶ Other pediatricians were apparently considered to be mere rodents, and ceremoniously cast onto a lifelong treadmill, but Stockman declined. He is listed as not meeting the requirements of MOC in general pediatrics; he was certified in 1974, and his certification has no expiration. He was, however, listed as current in the pediatric hematology/oncology MOC, according to the Board's website (see www.abp.org).

Stockman now moves on to be board chairman of Data Commons, a new information-sharing company that is expected to ease the electronic exchange of physician profile information. Founding members of this new venture include the American Board of Family Medicine, the American Board of Pediatrics, the Association of American Colleges, the Educational Commission for Foreign Medical Graduates, the Federation of State Medical Boards (FSMB), and the National Board of Medical Examiners.⁷

The AMA is an associate member of the ABMS, along with the Accreditation Council for Continuing Medical Education (ACCME), Accreditation Council for Graduate Medical Education (ACGME), American Hospital Association, Association of Medical Colleges, Council of Medical Specialty Societies, Educational Commission for Foreign Medical Graduates, the Federation of State Medical Boards (FSMB), and the National Board of Medical Examiners. This perhaps explains why the AMA steadfastly refuses to do anything of substance to rescue physicians from the stranglehold of MOC.

Elite Refuse Their Own MOC/MOL Prescription

Component specialty medical board directors do not all share an enthusiasm for the MOC process that they advocate for their comrades. The American Board of Neurological Surgery (AANS) lists only eight out of 14 board directors as being current in MOC. The American Association of Neurological Surgeons has even fewer directors participating in MOC. The participating directors are generally those with more recent initial board

certifications, where MOC is required. The president of the AANS is not current on MOC, and only six out of 16 directors are listed as participating (see www.abns.org).

The American Board of Preventive Medicine lists 11 board members, with all except three being certified indefinitely. Two have re-certified, and one is current only because certification was granted in 2004 (see www.theabpm.org).

Humayun Chaudhry, D.O., serves as president/CEO of the FSMB. Not content with MOC requirements, FSMB targeted state medical boards to add yet another layer of LLL (lifelong learning), by mandating Maintenance of Licensure (MOL) requirements. Fortunately, some alert physicians prompted passage of anti-MOL resolutions in numerous state medical societies. Chaudhry, however, is listed as being certified by the American Board of Internal Medicine with a certificate valid through 2006, and is currently not certified, according to the Board's website, www.abim.org.

Lois Margaret Nora, M.D., J.D., MBA, currently serves as president/CEO of ABMS. A recent listing showed her as certified in neurology in 1987, with the certificate valid indefinitely. Her MOC status is listed as "not meeting MOC requirements and not required to do so as of 1/13/2013." A more recent search, however, at the ABMS website lists Nora as meeting MOC requirements! (See www.certificationmatters.org.) I was perplexed. I was certified by the American Board of Plastic Surgery in 1982 and was also listed as meeting MOC requirements, while I most assuredly did nothing to participate in MOC activity of any kind! The ABMS does indeed include a disclaimer questioning the accuracy of the data. But, if such is the case, why post anything at all?

Nora's predecessor at the ABMS, Kevin B. Weiss, M.D., claimed that member boards would build physicians' knowledge base and improve their skills, and that "the intent is to derive a higher-quality workforce. We're finding that physicians aren't concerned about the time re-certification takes if it adds value to their experience."⁸ Quite obviously, Weiss did not listen to himself, as he is found listed as certified by the American Board of Internal Medicine in 1984 and certified indefinitely. The adjacent comment states: "Certificates awarded in Internal Medicine prior to 1990 do not require renewal. However, ABIM encourages all diplomates voluntarily to renew certificates relevant to their practice" (see www.abim.org). Meanwhile, Weiss proudly announces: "There is language in the new law (Obama Care) that formally recognizes that physicians who will be taking a maintenance-of-certification approved activity prior to participating in the Physician Quality Reporting Initiative (PQRI) will get payments above and beyond the basic Medicare PQRI program."⁹

Why do the elite bypass MOC? Could it be that they truly realize that MOC is irrelevant to quality care? Could it be that they fear adverse results? Could it be that they have better ways to spend their money? Perhaps they are too busy mining that \$320 million mother lode? Perhaps, by virtue of being elite, they are excused from MOC.

Controlling Knowledge; Defining "Quality"

As the money fills their coffers, the elite get to control

the content of these perpetual examinations. They even provide exam preparation materials to the hapless "voluntary participants" for substantial fees. Not only do they copyright these materials, but they even copyright the examinations themselves! For some reason, their syndicated materials are able to yield considerable CME credits, while competing educational activities struggle to obtain CME. Remember, the Accreditation Council for Continuing Medical Education (ACCME) is an associate member of ABMS. Who confers upon these elite the control of the educational process? Are these protected commercial activities congruent with the nonprofit status of the entities that benefit from them? The elite certainly benefit handsomely. Furthermore, are these medical educational activities congruent with the Oath of Hippocrates, which states "...and to teach them this art if they desire to learn it—*without fee and covenant*, to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken the oath according to medical law, but to no one else" [emphasis added]?

The elite, by constructing a nearly seamless, amorphous network of semi-private agencies (including the AMA), have been able to exercise control over the proletariat, all in the name of "quality." In reality, however, their actions have drastically diminished quality by replacing highly qualified practicing physicians with paramedical personnel.

The elite have infiltrated virtually all levels of government, influencing legislation and rule-making that confiscate substantial portions of their fellow physicians' incomes, while enhancing their own. This activity is accurately termed "fascism," which the *American Heritage Dictionary* defines as "a system of government that exercises a dictatorship of the extreme right, typically through the merging of state and business leadership." In other words, this is a system of government giving preferential treatment to a select group.

Increasing numbers of authors are bringing board certification and MOC to the public's attention. Donna Fuscaldo admonishes: "The first thing consumers need to check is whether a doctor is board certified, this is the only way to ensure the doctor has achieved a certain level of experience and competence in his or her specialty [*sic*]."¹⁰ Worse, she quotes Archelle Georgiou, strategic advisor to Healthgrades, who states: "If a doctor isn't board certified...they likely failed that test [*sic*]."¹⁰ Then, she directs them to the website (www.abms.org) to check physician certification status. By this website's own admission, this is questionable data. Of course, failure to maintain MOC can lead to an ABMS listing as non-certified, thus inflicting great harm on such a physician.

Katheryne Lawrence, a third-year law student, weighs in by admitting that "there are many studies that show some link between board certification and improved patient outcomes. However, hard evidence is still hard to find. In theory, requiring physicians to maintain current certification sounds like a great idea. However, in practice, the benefits are not fully known." In spite of this, she claims that "regular assessment of physician

competence in some form is an idea whose time has come. Recertification may not remain an expectation, but stricter quality oversight is here to stay.”¹¹

Reaction from Physicians

Physicians are awakening. Sam Unterricht, M.D., President of the Medical Society of the State of New York (MSSNY), makes this observation about MOC: “It seems that the villagers are gathering torches and pitchforks.”¹² Indeed, the “villagers” have endured enough. They’re not going to tolerate the elite’s implication that they resist “lifelong learning.” Instead, they are beginning to re-define LLL as lifelong larceny and have started educating their patients and the public. They will begin to question the wisdom of endless support of the various organizations that are tormenting them.

The Association of American Physicians and Surgeons has instituted litigation against ABMS over its monopolistic activities and anti-trust law violations.¹³ It would seem that ABMS might start listening to the villagers. But no, ABMS is signaling a brave defense, in spite of what some predict will be a mass revolution.

Even if the villagers win, I am concerned that somehow this public-private partnership between ABMS, FSMB, AMA, and all the other entangling alliances, will be allowed to survive.

Fascism must be stamped out. Furthermore, the federal government is not constitutionally allowed to interfere in medical or healthcare issues. It is vastly overstepping its authority in these matters via the Department of HHS, Medicare/Medicaid, and the Joint Commission, and must also be challenged.

What Is at Stake?

The ABIM Foundation is launching its new initiative Choosing Wisely, which encourages “physicians, patients, and other health care stakeholders to think and talk about medical tests and procedures that may be unnecessary, and in some instances can cause harm.” While we are all in favor of eliminating waste in health care, who are the stakeholders, and what do the stakeholders consider to be waste? There are many partners in this new venture, and a prominent one is the Robert Wood Johnson Foundation. This “stakeholder” is also listed as a grantee, funding projects across the country. One of these “collaboratives” is the Iowa Healthcare Collaborative, which will be endorsed by the governor’s office at a kick-off event, and will collaborate with the state Medicaid office and Iowa’s Business Council, as well as Wellmark Blue Cross Blue Shield of Iowa. These will address “over-utilization in the Iowa market.” The Michigan Health Information Alliance, Inc., will also promote Choosing Wisely and will partner with large health systems, as well as Hospital Boards to “support and encourage physician use of the specialty society recommendations.” This alliance will work with Aetna and Blue Cross Blue Shield to “communicate to their members and also with the Federally Qualified Health Care Centers System.” The Wisconsin Collaborative for Healthcare

Quality will partner with Epic to support specialty society recommendations, which will be integrated into the electronic medical record so that “data can be analyzed on how often an alert was accepted or overridden and why.”¹⁴

Thus, instead of doctors and patients making joint decisions on care, the “stakeholders” will be in control. Who are they? Virtually everybody except doctors and patients. Thanks to the ABIM Foundation and the Robert Wood Johnson Foundation, we see an effort that brings Medicaid offices, business councils, legislators, insurers, hospital boards, and other “stakeholders” to coerce doctors to follow specialty society recommendations via the electronic medical record, driving a stake through the patient-physician relationship. If physicians ignore the demands, their certification, and eventually their ability to work, is at risk. Even worse, what will happen to the patients?

Conclusion

MOC is a key part of the elite’s agenda to seize control of medical decision-making, for their own financial self-interest, under a false flag of “quality.” Physicians and patients must thwart the intrusion of these “stakeholders” into the sacred patient-physician relationship.

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