

Why Patients Should Avoid Physicians Who Submit to Specialty Board Re-Certification

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I am a strong advocate of specialty board certification. I was certified by the American Board of Plastic Surgery in 1982 and am very proud of that certificate. The idea that physicians should spend several years in residency programs without undergoing some sort of testing is preposterous.

On the other hand, some specialty medical boards have extremely rigorous standards, often requiring both written and oral examinations (which must be passed separately). There are also requirements based upon practice experience as well as time restrictions following the completion of residency. Failure rates can be high. For instance, the failure rate for hand subspecialty re-certification for 2005 was 40.9%.¹ Furthermore, boards can impose a limit to the number of attempts, thus permanently excluding many physicians from being board-certified, or even board-eligible.

In a census taken 3 years ago by the Federation of State Medical Boards (FSMB), "74.5 percent of the nation's 850,085 physicians were certified by at least one American Board of Medical Specialties (ABMS) specialty board."² There are some very highly qualified physicians who have never achieved specialty medical board certification, including some of my medical school professors. These should never be cast into early retirement solely on the basis of lack of board certification, even if the FSMB and ABMS say otherwise.

Specialty board exam questions may have nothing to do with the delivery of competent care. I still vividly recollect my specialty board oral examiner asking the position of the X-ray cassette and the beam angle for Water's facial images! I'm still uncertain about the accuracy of my response, but this would have been a suitable question for radiology technologists, not plastic surgeons.

Today however, specialty board certification is not enough for the ABMS and FSMB. They want every doctor in America not only to be board-certified, but also to be re-certified. While labeling this as voluntary, they lobby hard to make it mandatory. They label these efforts with a seemingly worthy nomenclature such as "protecting the public," "quality improvement," "lifelong learning," etc. However, increasing numbers of physicians are beginning to recognize that the very expensive re-certification exams and investment of time in ineffective processes are doing nothing to improve the quality of patient care. Rather, they are enriching the FSMB, ABMS and their 24 specialty medical boards, and other constituents of this private nongovernmental regulatory industry, which is not subjected to any oversight or regulation itself.

Why should patients care? Isn't this simply a problem that doctors need to deal with? No, there are numerous reasons

why patients are being harmed and their healthcare put at serious risk.

Specialty Board Regulators Should Not Be Allowed to Define Quality

Whenever I see that word "quality," my instinct is to run away from such "quality." For instance, how often do we hear that this phone call will be recorded and/or monitored for "quality purposes"? Don't you wonder how recording a conversation will improve its quality? What about PPACA, or the Patient Protection and Affordable Care Act? How does this act protect patients? Please be aware that it does the exact opposite, as it constructs a formidable bureaucracy, which will serve as a barrier to patient care. How is it affordable? Recent media reports indicate that there is a huge sticker shock to this act and few are enrolling, precisely contrary to "affordability."

As a patient I insist on defining "quality" healthcare for myself. I refuse to let a regulatory entity define it for me. My definition is this: appropriate care tailored to my needs and wishes, with my understanding and consent, given in a timely manner by a physician whose allegiance is entirely toward me and my health, in a location of my doctor's and my choosing, and at a price that is mutually agreed upon. In that scenario, the doctor and I are the only stakeholders. There is no interfering governmental authority (state or federal), no insurance company, no hospital, no Joint Commission, no specialty board, no ABMS, no FSMB, and no other regulatory agency. Period.

As a pawn on the ACA healthcare chessboard, I am soon to be considered an expense item, along with virtually all other citizens and non-citizens. The potential for rapidly escalating costs is so alarming that systems must be built to curtail expenditures while simultaneously using the label of "quality."

The American Board of Internal Medicine (ABIM), the largest of all specialty boards, aims to have a dominant role in defining quality and reducing costs. Through its efforts, it is enjoying ever-increasing revenues from the doctor certification and re-certification business. In 2011 it grossed \$49,304,645, while its then-CEO, Christine Cassel, M.D., reaped \$786,131 for her 35-hour work week.³ The ABIM Foundation is launching a program called "Choosing Wisely," which encourages "physicians, patients, and other health care stakeholders to think and talk about medical tests that may be unnecessary, and in some instances can cause harm."

Under my definition of quality, there are only two

stakeholders: 1) myself as patient, 2) my doctor. You should know who these “other Choosing Wisely stakeholders” are. The biggest is the Robert Wood Johnson Foundation, which funds numerous projects, or “collaboratives”, across the country. One of these, the Iowa Healthcare Collaborative, will be endorsed by the governor’s office at a kick-off event. In conjunction with the state Medicaid office, the Iowa Business Council, and Wellmark Blue Cross Blue Shield of Iowa, it will address the problem of “over-utilization” in the Iowa market.

“Over-utilization” occurs when the “other stakeholders” (other than the patient and the doctor) determine that a medical treatment is too expensive. So, here you see the Foundation of the largest specialty medical board (ABIM) announcing a new project that will include “stakeholders” from the state Medicaid office, the business community, and even the governor! Choosing Wisely’s blueprint is to “choose” local physician leaders to present these programs, which are designed to deliver less care. I attended one of these conferences and was impressed with the number of physicians who questioned the wisdom of recommending such curtailment in care. Some comments were pointed and blunt. After all, these are the same doctors who are at risk of being questioned and sued if they fail to deliver “appropriate” care!

The Michigan Health Information Alliance, Inc., will partner with Choosing Wisely as well as with large health systems and hospital boards to “support and encourage physician use of the specialty society recommendations.” “Support and encourage” is code for “require.”

This Choosing Wisely campaign is spreading to other specialty medical boards, and they are coming up with recommendations that are often blurred and ill-defined, if not misguided. Nevertheless, if the specialty medical board’s recommendations are required, doctors who stand up against both the hospital and the specialty medical board will risk losing their board certification status. Patients need to ask themselves whether their doctor will really take such a risk, potentially leading to premature career termination.

How will these decisions be implemented? The Wisconsin Collaborative for Healthcare Quality will partner with Epic, a leading electronic medical records system, to support specialty society recommendations, which will be integrated into the electronic medical record (EMR) so that “data can be analyzed on how often an alert was accepted or overridden and why.”⁴

While it is clear that there is inexcusable waste in U.S. healthcare delivery, and that some Choosing Wisely initiatives make sense, I am deeply concerned about others.

The American Academy of Family Physicians (AAFP) released its third Choosing Wisely list on Sept 24, 2013, and advised not prescribing antibiotics for otitis media in children aged 2-12 years with non-severe symptoms where the observation option is reasonable. I wonder how many conscientious physicians will really follow this? Another dictum was to avoid cancer screening: “Do not routinely screen

for prostate cancer using a prostate-specific antigen (PSA) test or digital rectal exam.” A previous admonition was: “Don’t do imaging for low back pain within the first six weeks, unless red flags are present.” Really? What is a red flag? According to Reid Blackwelder, M.D., AAFP president, “The goal of Choosing Wisely is to start a national conversation about the right [care], at the right time, for the right patient, and avoiding unnecessary care.”⁵ Patients have no way to engage in such a national conversation; they need to be able to have a private conversation with their non-board re-certified physicians, who need not be subservient to the specialty board.

Implications of this are crystal-clear. The EMR will be used to monitor patients and doctors (yes, your conversations will be monitored and recorded for “quality assurance”), and doctors will risk losing their ability to work if they deviate from the plan laid out by their specialty medical boards and enforced by hospitals, insurers, business councils, state governments, federal governments, and just about any other regulatory “stakeholder” you can imagine. This should prompt all patients to immediately contact their state and federal legislators, their state medical boards, ABMS, FSMB, and hospitals, and demand that they do not want any of their doctors to be re-certified.

Some boards are placing improper limitations upon their certified physicians. The American Board of Obstetrics and Gynecology insisted, before an outpouring of protest forced it to rethink its position, that to remain ABOG-certified, physicians could not care for male patients except in very limited circumstances. How would gynecologists’ treatment of men in any way diminish their capability to treat women? Why would this bar them from even taking re-certification examinations?

Healthcare rationing is coming, and the interface between EMRs and specialty board certification will be the method used to do it. According to Paul Hsieh, M.D., “Rationing is inevitable whenever the government controls medical spending. He who pays the piper calls the tune. Under ObamaCare, government control of health spending will quickly expand to affect most Americans, not only the elderly.” He laments the chilling proposition by Ezekiel Emanuel, M.D., of “rationing based on a combination of factors, including patient age, expected ‘quality adjusted life years,’ and the patient’s ‘instrumental value’ to ‘society.’ Given that government would be making (and paying for) these rationing decisions, value to ‘society’ will become ‘value as determined by the government.’”⁶ Amazingly, Emanuel is a physician specializing in oncology, and also a founding chairman of the National Institutes of Health Department of Bioethics. He is also influential at the White House, where he helped frame ACA.

Emanuel, in his efforts to expand hospice and palliative care, proclaims that changes are to be made in two ways: 1) The Joint Commission “could make training physicians and nurses to talk about end-of-life care and having palliative care available a requirement for hospital accreditation.” 2) Medicare, private insurers, and state exchanges “could require

hospitals to provide communication training and palliative services as a condition of payment.”⁷

Does the Public Demand Specialty Board Re-Certification?

In 2003, the Gallup Organization submitted a survey to the American Board of Internal Medicine (ABIM) regarding board certification and re-certification. Those who profit from this re-certification industry are more than happy to claim that this survey of 1,001 adults “proves” that the public demands that doctors be constantly re-certified. It is evident, however, that respondents had a very rudimentary understanding of the re-certification process. According to the report, “Eight in every 10 adults report that their doctor is state-licensed.” In fact, every doctor must be state-licensed. The report also admitted, “Eleven percent said they didn’t know what board-certified means and 15% said they didn’t know if their doctor was board-certified.”⁸

It was obvious that the questions led people to respond in a predetermined fashion, as the report said, “When read a definition of board-certification, overwhelmingly, adults feel that physicians should go through a formal certification.” However, 79% of respondents admitted that they had never visited a website to verify a physician’s credentials. As for re-certification, “79% once informed of what certification involves, feel that re-certification of physicians is very important. An additional 16% say this is somewhat important.”⁸

This survey indicates that the public doesn’t understand the re-certification process, yet claims it is important or very important, even though few bother to verify such board certification. Patients simply want to know that their doctors are competent to care for them, in the same way I would want to know that my plumber or electrician is competent. However, I certainly do not want them subjected to continuous and needless re-certification processes, as I know that those needless costs will be passed on to me as higher charges. Patients also need to know that physician re-certification most definitely leads to increased healthcare costs, whether they are seen directly or indirectly, via higher premiums, taxes, or other fees.

In sharp contrast to the Gallup survey, Paul Martin Kempen, M.D., Ph.D., conducted a survey of 101 adults in which “every attempt was made to prohibit all suggestion of terms or ideas” other than to answer a simple question: “When you go to a physician for medical care, what factors, considerations, or decisions, in the order of importance to you, lead you to go to or stay in the care of this physician versus getting care from any other physician?” The responses included personality, competency, referral, insurance factors, and availability. Notably, “none of the respondents mentioned board-certification status or specific educational background.”⁹ These respondents simply were not concerned about board certification or re-certification status without being prompted.

Has Board Re-Certification Improved Quality of Medical Care?

While there have been some studies that have demonstrated a slight improvement in certain “quality” indicators among re-certified physicians, some have actually measured a decrease in “quality.” There are no valid studies proving that specialty board re-certification leads to improved quality of care. Rather, physicians who have participated in these re-certification activities overwhelmingly claim that they are of little, if any value.

ABMS President Lois Margaret Nora, M.D., J.D., M.B.A., in an article entitled “Viewpoint: Maintenance of Certification Has Value for Physicians and Their Patients,” writes: “Two criticisms leveled at the MOC program are that the process has not been ‘proved’ to produce better patient outcomes and that it has associated costs. Because of the relative youth of the MOC program, we don’t have evidence that results from decades of study.”¹⁰ Her generous compensation package might influence her opinion as to the value of MOC, as her predecessor as ABMS president was compensated \$582,456 for 2011.¹¹ Her article begins with a note from the editor: “No subject has elicited more reader e-mail to *Medical Economics* in recent years than that of maintenance of certification, and all of the comments received were negative.”¹⁰

Howard C. Mandel, M.D., writes, “We should not give in to potential threats of government mandates. For two centuries, the medical profession has evaluated the proper use of techniques, procedures, and therapies that have proved to be of important benefit. Most practicing physicians find MOC to be clinically irrelevant, and it has not been found to correlate with creating better physicians. Yet with an ever-increasing physician shortage, the self-serving boards are creating systems that potentially will decrease access to healthcare for many Americans.”¹¹

Lawrence Voesack, M.D., complains, “I have yet to discover how MOC is designed to allow me to participate. I have no ongoing care of diabetic or hypertensive patients that can be followed over time, nor for that matter am I able to submit patient charts for review of the same.... Now the cost is well over \$4,000. Why? How is this process truly adding to the quality of patient outcomes?”¹³

Marc S. Frager, M.D., asks, “Can Dr. Nora answer why a secure test is needed when physicians have immediate access to clinical support on smartphones or computers? Does the secure test exist only as a source of revenue to the member boards? Why is certification now time-limited? Is it to coerce diplomates into incessantly studying for tests and paying outlandish fees for member boards?”¹⁴

AAPS conducted an Internet survey in 2012, receiving responses from 167 physicians, of whom 44% had undergone re-certification. Of those, 61% found the process to be onerous and 61% declared it irrelevant to their practice; 58% said they would quit before going through the process again.¹⁵ Who will replace them? Undoubtedly, physician assistants and nurse

practitioners. As for me, I would much prefer that my care be rendered by an honest, competent, non-re-certified physician.

Can the Care Pathways, Guidelines, and Scientific Literature Be Trusted?

I will never forget the day when, as a resident researcher, I was operating on a dog with a senior researcher who suddenly asked me, "If the chairman asks how we did this, you'll tell him we used this technique, won't you?" He didn't like my response, which was, "I am not going to lie to him."

As it turned out, the chairman never asked me, but I was certainly enlightened as I witnessed the production of scientific papers that I knew full well were not performed with the claimed numbers. Furthermore, this particular researcher did not even possess the technical skills to perform what was claimed. The chairman was able to publish ever more papers with his name attached, and I will never know whether he knew, or even cared about any integrity lapses.

Over time, I have seen scientific literature that simply didn't make sense to me, and have skeptically demanded hard evidence. If MOC is such a wonderful protection for patients, where is the evidence? Why are the elite physicians, such as ABMS president Nora, listed on the ABMS website (www.certificationmatters.org) as not meeting MOC requirements? Why is her predecessor, Kevin B. Weiss, M.D., found listed as certified by the American Board of Internal Medicine in 1984 and certified indefinitely?

When it was revealed that Humayun Chaudhry, M.D., president/CEO of FSMB, was listed on the American Board of Internal Medicine's website (www.abim.org) as currently not certified, Lance Talmage, M.D., also connected with the FSMB, posted on Ohio State Medical Society's Forum: "FMSB has developed a policy for nonclinically active physicians to allow them to document appropriate Continuing Professional Development [*sic*] as an alternative." Yes, these are the same Dr. Chaudhry and Dr. Talmage who published an article, "Maintenance of Licensure: Evolving from Framework to Implementation," in which the authors provide a report summarizing progress to date in the Federation of State Medical Boards' long-term Maintenance of Licensure (MOL) initiative.² This was published in the *Journal of Medical Regulation*. Yes, FSMB owns, finances, and publishes its own journal! Obviously, medical regulation is a thriving business, and very lucrative for those who can engineer re-certification schemes for everybody else.

The elite who foist MOC on physicians and patients have opted out of these requirements for themselves, and just do continuing medical education (CME), which is what physicians already do. Why not just allow physicians to choose their own CME rather than to force them into activities that are not germane to their practices? Do patients really want to trust these people to determine clinical guidelines, Choosing Wisely schemes, etc.?

As for the re-certification processes, some boards require "secure examinations." Others might require irrelevant patient surveys. Others might require intrusive production of patient charts and records. One highly specialized physician chuckled as he explained how the examiner himself did not understand his practice and had to be educated by the examinee!

Is the Public Awakening to the Lifelong Larceny, Rather Than Lifelong Learning, of the Regulators?

Economist Byron Schlomach, Ph.D., writes:

During legislative sessions in virtually every state, just as there is someone looking to pass a new traffic law or someone else pushing for more spending on health care, someone is pushing a licensing law. It's always for our own good. Without licensing, it's claimed, charlatans will take advantage of us, providing dangerous, shoddy service.... Professional licensing often has little to do with public safety. Evidence for the economic argument that unlicensed professional markets can break down if charlatans are too prevalent is slim to none.¹⁶

Schlomach refers to a relatively new book, *Why Nations Fail*, and how "professional licensing is an example of what the authors call an exclusive institution, favoring artificially created elites over the general populace."¹⁶

Even Medicare is discovering that too much regulation is harmful. On Sept 25, 2013, Medicare announced its discontinuation of the 7-year-old requirement for accreditation of bariatric surgery facilities, claiming that accreditation has not improved health outcomes. Not surprisingly, however, at least five surgical groups mounted strong opposition to dropping this requirement. Jaime Ponce, M.D., a bariatric surgeon and president of the American Society for Metabolic and Bariatric Surgery (ASMBS), issued a joint statement with David B. Hoyt, M.D., executive director of the American College of Surgeons (ACS): "The standards required for accreditation provide important lifesaving safeguards for patients." It happens that ASMBS and ACS are in the lucrative business of accrediting 750 inpatient and outpatient bariatric centers, and such loss of mandatory accreditation drives a spike into their business models. Undeterred, though, they intend to continue their now-combined accreditation scheme, the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program.¹⁷ There's that "quality improvement" terminology again, but we now identify it with a clever revenue-enhancing scheme designed to pick the pockets of unsuspecting patients.

Medicare should be applauded for its recognition of the utter worthlessness of "quality improvement" in bariatric surgery accreditation. If only Medicare would turn its sights to another quality improvement scheme known as National Quality Forum (NQF). When Christine Cassel, M.D., left her high-paying job as ABIM president, she took the helm of NQF. Meanwhile, Richard J. Baron, M.D., who was listed as a featured speaker at

NQF as well as an NQF director, assumed Dr. Cassel's position as ABIM president. The NQF website is loaded with "quality" terminology, as well as much additional jargon. The NQF website actually devotes 29 pages to "Plain Language Guide to NQF Jargon," using terms such as "structural measures assess healthcare infrastructure," "outcome measures," "measure harmonization," "measure of affordability," "health information technology," and a host of others.

Links between the board re-certification industry and NQF are painfully and glaringly obvious. So is the link to government, as NQF provides an annual report to Congress and the secretary of the U.S. Department of Health and Human Services (HHS). While the ABMS spends considerable sums on lobbying expenses, here they have direct access to government authorities. Furthermore, here one sees the confluence of the public and private sectors, as funding comes from both. Yes, the Centers for Medicare and Medicaid Services (CMS) actually help fund NQF! So, is it conceivable that, with a public outcry, CMS might begin to also recognize the worthlessness of the National Quality Forum and its 29 pages of jargon?

The British Are Coming—or Have They Already Come?

Since 1999, England's National Health Service has used NICE (National Institute for Health and Clinical Excellence). NICE seeks out "low value" activities that could be stopped. Lest patients be lured into believing this is nice, they must realize that the driving goal is to ration healthcare, thereby conserving funds. Pilot studies aim at identifying "low value interventions," which, if stopped, would save over £1 million each. Even wisdom teeth extractions are targeted by NICE. The NHS will not simply allow its citizens to define what is of low value.¹⁸

According to Martin Frost, NICE is officially independent, but that illusion was shattered when in November 2005 the "North Stoke primary care trust refused Herceptin to Elaine Barber, a patient who was in the early stages of an aggressive form of breast cancer." To pinpoint which drugs were "cost effective," NICE had to "decide what a life is worth" and that answer was £30,000. Frost continues, "Ironically, NICE is envied abroad, where it is viewed as a cost-cutting body. Germany and France have just joined Australia, Canada and Sweden in setting up NICE-like bodies to curb their drug bills..., and patients are dying because of delays."¹⁹

Conclusion

AMA authors Donna Jeffe, Ph.D., and Dorothy Andriole, M.D., say, "Although lack of ABMS board certification does not necessarily mean that a physician is not well qualified, its presence is associated with the quality of medical care that physicians deliver to their patients."²⁰ I concur. There are, however, many other factors that outweigh board certification/re-certification that should be considered when choosing a physician.

I have undergone surgery by a surgeon who, I knew, was never board-certified. The results were excellent, as expected. We, as patients, should even go further. We should seek out physicians who resist the re-certification process. We should insist that physicians who care for us are those who possess the courage to "just say no" to the board re-certification cartel. Why should we trust our healthcare to the guidelines and pathways designed by the "quality" people and the "NICE" people?

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