

Maintenance of Certification (MOC), Maintenance of Licensure (MOL), and Continuing Medical Education (CME): How the Regulators Prosper

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Maintenance of Certification (MOC)

In the dim and distant past, physicians completed medical school, internship, and National Board examination or FLEX (Federal Licensure Examination), and were then eligible to obtain a state license to practice medicine. Specialization led to the creation of specialty boards, and specialty board certification was considered an important milestone in a physician's career. It was not, however, a requirement to practice medicine. Some of these boards consisted of both written and oral examinations, with failure rates set as high as 25-30%. Successful completion of some boards was so difficult that many qualified physicians were never able to pass them in spite of repeated attempts. I have encountered numerous highly qualified non-board certified physicians over the years, even medical school professors! Although successful completion of specialty board requirements is a very worthwhile goal for each physician, failure to become board certified does not equate to lack of competence and skill, and should not terminate a medical career.

Protecting Monopoly and Revenue Stream

The various specialty boards discovered that certification examinations were quite profitable, and two or three decades ago decided to offer specialty certification for limited periods. Those physicians certified prior to the inception of time-limited certificates were considered "grandfathered," but subsequent younger physicians would be required to recertify periodically for the remainder of their careers. One wonders how CPAs, attorneys, and other professionals would have responded to demands to repeatedly recertify.

The specialty medical boards are united under a parent umbrella, the American Board of Medical Specialties (ABMS), which largely subsists on contributions from the component specialty boards. The ABMS uses some of those funds for lobbying various entities (hospitals) to require physician certification and recertification. This has led to greater recertification revenue to the specialty medical boards, and by 2009, the American Board of Internal Medicine (ABIM) listed its income at nearly \$40 million for certification and maintenance-of-certification fees on its publicly available IRS form 990. It also reported the 2009 compensation package for its executive director Christine K. Cassel, M.D., as \$861,691 for what was described as a 35-hour work week. Cassel was a founding director of the Robert Wood Johnson Clinical Scholars Program, a founding director of the Center for Health Policy Research, and one of 20 scientists chosen by President Barack Obama to serve on the President's Council of Advisors on Science and Technology. She naturally is an ardent advocate for board certification and recertification.

Interestingly, even though the ABIM is a nonprofit organization, it also considers itself to be a trade, considering its certification and recertification materials to be copyrighted, and representing them as "trade secrets." Sarah von Muller, M.D., sat for the gastroenterology board certification examination in November, 2008. She allegedly promised the Arora Board Review to provide examination questions, while also paying Arora \$480 for board exam material. She was sued by the American Board of Internal Medicine and Dr. Cassel, resulting in a verdict in favor of ABIM of \$91,114.¹ Even this was not enough, as Dr. Cassel and others sought and obtained a verdict for payment of their attorney fees as well! This was necessary in order to protect the ABIM revenue stream.

Board review courses have a long history of utilizing similar material, if not actual questions from previous boards. I specifically recall my medical school arranging board review courses prior to the Part 1 National Board Exam, and a prominent biochemistry professor was chosen to conduct the review. He had written National Board questions for years, and not only told us the questions and answers, but even listed the probabilities of certain questions appearing on the Board exam. Did Dr. von Muller's "crime" consist of her board review course's providing actual questions, or was the problem that this activity was not sanctioned by the ABIM and Dr. Cassel? Was this board review course competing with ABIM and its income stream?

Indeed, there are many advertisements for materials to prepare for recertification, as at www.medstudy.com. For example, I received a promotional flyer that stated: "PASS THE ABIM RECERT EXAM WITH MedStudy. Recert Core Curriculum material can be obtained for \$465, which includes free shipping and 150 hours CME!" Additionally, for \$175, one can receive Internal Medicine Board-Style Questions & Answers, which are advertised as being "like a sneak preview of your recert exam." For \$1,125 you can take the Internal Medicine Recertification Board Review Course, sponsored, of course, by ABIM.

Who Owns the Law?

Who owns the law? If ABIM and ABMS lobby to require hospitals and other entities to mandate physician certification/recertification through their monopolistic nonprofit certification agency, how can copyrights apply? In 1997, Peter Veeck posted building codes on a website so that people could know what the regulations were prior to building. He was sued by the Southern Building Code Congress International (SBCCI) because its revenue stream was threatened. The case, which was decided by the U.S. Court of Appeals for the Fifth Circuit,² held that no one can own the law and one cannot "copyright" a legal requirement.

The U.S. Supreme Court denied the petition for writ of certiorari. Interestingly, the American Medical Association (AMA) filed amicus briefs on behalf of Southern Building Code Congress, likely in an attempt to protect its ownership of the “law” as it pertains to CPT codes. AAPS filed amicus briefs supporting Veck.³

How can nonprofits like ABIM use the ABMS to lobby to mandate physician certification/recertification, while simultaneously claiming “trade secrets” and “copyrighted material”? Is ABIM an altruistic nonprofit agency simply acting to protect the public from incompetent physicians? Or, is it a well-lubricated money-making machine? Are the ABMS and its component specialty medical boards a monopoly, since they attempt to invalidate any board that is not a part of the ABMS system? Is the ABIM a nonprofit, or is it a business enterprise with trade secrets, as the litigants claimed?

Medical Education and the Oath of Hippocrates

Perhaps the ABIM leadership should be reminded of the Oath of Hippocrates: “...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].”

Maintenance of Certification— Does the Process Provide Any Value?

Is there any educational value to MOC? An AAPS survey of Ohio physicians yielded 85 responses: 55% of recertified respondents said it was irrelevant to their practice, while 50% indicated the process was onerous. Only 3% claimed it was a valuable protection for patients. An amazing 68% indicated they will quit before going through MOC again. I spoke with one surgeon who had to educate the examiner, who was not at all familiar with his area of expertise.

I know a fine physician on the staff of a hospital within a network. She applied for privileges at a second hospital within the same network since her patients were being admitted by hospitalists, and, upon discharge, were being referred elsewhere. She was denied privileges at the second hospital because she chose not to engage in the recertification experience. She is indeed board certified, but by a board outside ABMS. How does ABMS come to decide who practices medicine within a hospital? Apparently it engages in heavy lobbying. Is ABMS a monopoly? Does it engage in restraint of trade?

Can the MOC Cycle Be Stopped?

How can this cycle be interrupted? Suggestions include:

1. By physicians refusing to be recertified. Specialty board certification is a laudable goal, but once is enough, and physicians should be no different from other professionals concerning recertification requirements.

2. By cutting the funding to the ABMS. Each physician should demand that his specialty medical board refuse to fund and participate in ABMS activities.
3. By insisting on full transparency by the specialty medical boards. Furthermore, they should be required to produce evidence that specialty board recertification improves the quality of medical care. There is at present no such evidence.

Maintenance of Licensure (MOL)

State medical boards issue medical licenses to physicians practicing in their respective states. Each state medical board also belongs to the Federation of State Medical Boards (FSMB), which also represents itself to the public as a nonprofit organization. However, the FSMB’s lucrative adventures with testing organizations lead it to desire more and more examinations for physicians. It is unclear whether or not state medical boards send a portion of medical licensure fees to FSMB, which has a significant lobbying budget. According to its IRS form 990 for 2010, its president received a compensation package of more than \$500,000.

Federation of State Medical Board Launches MOL Assault on Physicians

In February 2011, the FSMB held a meeting entitled Maintenance of Licensure Implementation Group. Maintenance of Licensure (MOL) refers to additional requirements above and beyond continuing medical education (CME) in order to renew a medical license. In order to justify this additional burden upon physicians, FSMB cites the need for public protection. Others claim that legislators demand it and the public wants it. FSMB advances “lifelong learning,” a concept to which all good physicians adhere. Lifelong learning to FSMB, however, means an additional lucrative lifelong revenue stream. For physicians, already struggling with decreased compensation, it will siphon both time and resources.

The MOL implementation group included an attorney, a physician assistant, and a former senior program officer from the Robert Wood Johnson Foundation.⁴ It would seem odd that lawyers and physician assistants would sit on committees that determine the maintenance of licensure requirements for physicians. The lawyer was Richard Whitehouse, executive director of the State Medical Board of Ohio. In a March/April 2011 article in the newsletter of the Academy of Medicine of Cleveland & Northern Ohio,⁵ he writes:

Currently, Ohio and other medical boards rely upon continuing medical education as a mechanism to insure some semblance of continued competency. But, this alone is not enough, as there may be no relationship between the CME taken and the actual nature of the physician’s practice. Beyond this, the best that medical boards have offered in augmenting their regulatory efforts are complaint-driven programs limited to quality intervention, remediation, or rehabilitation....

[Ohio needs more regulation in order to] do even more to provide the public with meaningful assurance

that licensure renewal does indeed connote continued competence. Ohio and state medical boards across the country are currently embracing a new approach to ensure that physicians can better fulfill this profession's obligation in a matter transparent to the public.

Whitehouse's closure is chilling:

If the best outcome in battle is achieved with unsheathing the sword, so too should medical boards strive to achieve their goal of public protection in such a manner as to avoid disciplinary battle whenever possible. Among other things, this means doing more to ensure the ongoing competency of physicians to avoid human and systems-based errors. MOL accomplishes this, thereby saving the sword of discipline for cases of reckless behavior. It is a better approach to protecting the public and preserving the integrity of the medical profession.

From attorney Whitehouse's description, it would sound as if medical incompetency in Ohio is rampant. However, Paul Kempen, M.D., Ph.D., did exhaustive Freedom of Information Act research of 2011 State Medical Board of Ohio documentation of all actions against physicians in Ohio and confirmed only one who was disciplined for medical incompetency issues after leaving the state, while continuing to practice in N.Y. That's right, only one out of 42,000 physicians licensed by the State of Ohio. (P.M. Kempen, personal communication, 2012).

The MOL implementation group selected Ohio as one of the pilot states for implementing MOL (perhaps *the* pilot state). Surprisingly, even though FSMB is intent on implementing the program, MOL is not clearly defined. One description⁶ is: "The MOL framework helps address these concerns by envisioning 3 components (reflective self-assessment, assessment of knowledge and skills, and performance in practice) that would be periodically required of actively licensed physicians in their area of practice in order for them to renew their license." The only thing that is clear is that it will be expensive, time consuming, and something above and beyond current CME requirements.

Ohio State Medical Association Strongly Opposes MOL

In March 2012, the Ohio State Medical Association (OSMA) House of Delegates passed a resolution which called for OSMA to actively oppose any efforts by the State Medical Board of Ohio to implement licensure renewal requirements different from than those currently in place for physicians in Ohio. In spite of this, the FSMB continued its efforts to implement MOL, claiming that any MOL requirements in Ohio would not take effect for 5-10 years. According to the official publication of the OSMA, "it has become clear that maintenance of certification (MOC) will not be mandated by the Medical Board to meet the guidelines for MOL."⁷ Even though this is slightly reassuring, it is not at all clear that FSMB has abandoned MOL. On the contrary, they may very well move on to other pilot states. These include Colorado, California, Delaware, Massachusetts, Mississippi, Ohio, Oklahoma, Oregon, Virginia, and Wisconsin.

Why was the FSMB pursuing a requirement for MOC as part of its MOL program? There seems to be a connection between the

ABMS and the FSMB. Barbara Schneidman, M.D., M.P.H., was interim president and CEO of the FSMB in 2009. She served as the Associate Vice President of ABMS from 1993-1998 and as vice president for Medical Education at the AMA from 2002 to 2008.⁸

Proposed Model Legislation

If MOL develops roots in any state, it will quickly spread to other states, subjecting all physicians to the "unsheathed sword." This is why the AAPS presented model legislation to state legislators across the country at the July 2012 meeting of the American Legislative Exchange Council (ALEC). That model legislation is as follows:

Patient Access Expansion Act (Draft, July 26, 2012)

Summary

This Act prohibits maintenance of licensure, maintenance of certification, and specialty certification as requirements to practice medicine. It also prohibits the state medical board from funding the Federation of State Medical boards.

Definitions:

Maintenance of Licensure (MOL) is defined as state medical board requirements for physician re-licensure above and beyond current continuing medical education (CME) requirements.

Maintenance of Certification (MOC) is defined as periodic recertification requirements as specified by various specialty medical boards in order for a physician to represent himself/herself as being board certified.

Provisions

Section 1. Short Title. This act shall be known as the "Patient Access Expansion Act."

Section 2. Prohibition of Maintenance of Licensure, Maintenance of Certification, Specialty Certification to Practice Medicine.

The state of {insert state} is prohibited from requiring any form of maintenance of licensure, maintenance of certification, or original certification by a specialty medical board, in order to practice medicine within the state. This Act shall apply to hospitals, insurers, other third-party payers, and the {insert state medical board}.

Section 3. Prohibition of State Funding of Federation of State Medical Boards.

The {insert state medical board} is prohibited from funding the Federation of State Medical Boards (FSMB). Funds from physician licensures shall not be sent to FSMB and the state of {insert state} shall not permit any money to be forwarded to FSMB from this state.

Section 3. {Severability Clause}

Section 4. {Repealer Clause}

Section 5. {Effective Date}

Continuing Medical Education (CME)

Most physicians engage in continuing medical education courses in order to advance their knowledge and improve quality of care, and few object to required CME participation. Some state medical boards require no CME for renewal of medical licenses, while some require as many as 50 CME credits yearly for renewal. Additionally, some of these CME credits are specified to be in Category 1 AMA PRA (Physicians Recognition Award). Why is category 1 CME more valuable than category 2 CME? Nobody knows for sure, except perhaps the regulators. In some states, if a doctor falls short of CME requirements by even one hour, heavy fines are imposed.

The accreditation agency for CME is the Accreditation Council for Continuing Medical Education (ACCME), another “nonprofit” entity whose board consists of individuals nominated by several other “nonprofit” organizations, including the AMA, the ABMS, the FSMB, and the American Hospital Association. According to the AACME’s IRS form 990 for 2010, its executive director enjoyed a compensation package of about \$600,000 per year.

ACCME licenses other entities to provide Category 1 AMA PRA CME credits, which are required for physician relicensing by many states. Those licenses are expensive, but entitle the licensees to charge substantial sums to those organizations that actually offer the CME events. The CME providers not only pay large fees, but also are encumbered by reams of paperwork, financial data, conflict-of-interest forms, evaluations, etc. The expense and the bureaucracy have become so difficult to navigate that many legitimate CME activities are not able to offer Category 1.

Wright State University’s Plastic Surgery Residency program in Dayton, Ohio, has discontinued offering Category 1 CME for community plastic surgeons who attend periodic functions where guest speakers discuss pertinent advances in the specialty. Why? It is too expensive, and the secretaries simply do not have time to provide the voluminous and irrelevant data to the ACCME licensing agent. I fully understand, as I have spent countless hours with those treacherous forms in order to obtain CME for AAPS events. Furthermore, the physicians, in order to qualify for credit, must also respond to increasingly incomprehensible queries about what type of “learning” took place. In some cases, the evaluations take almost as long to complete as the actual CME event. If one is particularly unlucky, an e-mail will follow several weeks later, requesting yet another meaningless evaluation.

Ironically, FSMB is concerned that physicians are not engaged in enough CME “relevant to their practice,” yet such CME is increasingly not being offered as Category 1 because of over-regulation. Ironically, it is the FSMB and ACCME regulators that are impeding “life-long learning.”

It is my understanding that some board-review courses that are not sponsored by the specialty board are unable to obtain CME from that specialty, in spite of the fact that some of these courses are deemed superior.

CME Monopoly

Nobody should be allowed to have a monopoly on medical education—not the AMA, ABMS, FSMB, nor ACCME. Physicians

should be free to seek their own relevant CME and certification. These nonprofits have huge reserves, yet continue to extract valuable time and resources from physicians, forcing some into early retirement, only to be replaced by physician assistants and nurse practitioners who are not required to repeatedly face the re-examination hurdles. So, although they claim to be “protecting the public” from bad doctors, the public needs to be aware that doctors would become far more knowledgeable *without* these powerful regulators.

Should mandated CME be abolished? Absolutely. But, in the event that it is preserved, no single entity should have monopolistic control. State medical boards that require CME Category 1 AMA PRA should recognize that other entities are more qualified to certify CME. AAPS can certify CME in a less costly and intrusive fashion, thereby creating more relevant CME opportunities for physicians.

Conclusion

In conclusion, let us advance the idea of life-long learning, unrestricted CME, improved quality of care without MOL, and specialty board certification sans the ABMS and FSMB.

Physicians can stop doctor MOLEstation. Physicians, acting in the interest of patients and the profession, must do everything possible to prevent FSMB and MOL from invading their state. Physicians should take model legislation to state legislators and ask them to introduce this legislation as soon as possible. The proposed legislation calls for a prohibition of maintenance of licensure along with prohibition of state funding to the FSMB.

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REFERENCES

- 1 *American Board of Internal Medicine v Sarah von Muller, M.D.*, No. 10-CV-2680 (E.D. Pa. 07/09/12).
- 2 *Veck v Southern Building Code Congress Intl, Inc.* 293 F.3d 791 (5th Cir. 2002) (*en banc*).
- 3 AAPS and Eagle Forum Legal Defense Fund. Brief of amici curiae in *Southern Building Code Congress Intl, Inc. v Veck* on Petition for Writ of Certiorari. Available at: <http://www.aapsonline.org/judicial/veeckcert.pdf>. Accessed Aug 13, 2012.
- 4 Federation of State Medical Boards. Report from the Maintenance of Licensure Implementation Group; Feb 14, 2011. Available at: <http://www.fsmb.org/pdf/molimplementation.pdf>. Accessed Aug 14, 2012.
- 5 Whitehouse RA. Maintenance of licensure: medical regulation with a sheathed sword. *Northern Ohio Physician* 2011;96(2):17-18. Available at: www.amcno.org/pdf/2011_maraprfinal.pdf. Accessed Aug 13, 2012.
- 6 Chaudhry HJ, Talmage LA, Alquire PC, et al. Maintenance of licensure: supporting a physician’s commitment to lifelong learning. *Ann Intern Med* 2012 Jun 26. doi: 10.7326/0003-4819-157-4201208210-00478. [Epub ahead of print].
- 7 OSMA. OSMA responds to maintenance of licensure (MOL) push. *Ohio Medicine* 2012(4):22-23. Available at: http://www.nxtbook.com/nxtbooks/osma/om_20120708/#/0. Accessed Aug 13, 2012.
- 8 Medscape. Medscape Continuing Medical Education Advisory Board. Available at: <http://www.medscape.org/pjsp/cme/public/cmeboard.html>. Accessed Aug 13, 2012.