

The Certification-Industrial Complex: Time to Include Medical Journals

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No evidence exists that certification or re-certification improves quality of medical care, despite repeated and generously funded research attempts by the American Board of Medical Specialties (ABMS) to provide proof.^{1,2}

Medical journals are the latest front in battling the certification-industrial complex, and it requires immediate, direct physician ethical oversight. We must require an open declaration of conflicts of interests of all involved in the regulatory capture of certification and re-certification.

From Voluntary to Mandatory: from Providing Education to Amassing Profit

Two decades have passed since ABMS changed its proprietary certifications from the one-time, lifelong product to forcibly impose Maintenance of Certification® (MOC) upon American physicians. The 24 board affiliates have long been allowed and invited by medical journal editors to repeatedly publish their comments and “attestations,” and to promote their products, perspectives, apologies, and programs as unpaid advertising.^{3,4} Overwhelmingly, views opposed to publishing that content, and to MOC itself, received limited attention from and publication in medical journals. Opposition mounted to imposition of certification programs, because of their lack of utility or value, while the ABMS industry’s egregious abuse was exposed and then rejected, mainly in popular press sites.⁵

The “non-profit” medical certification industry used regulatory capture to amass net assets approaching \$1 billion, according to an independent forensic audit in 2016.⁶ The national specialty societies and their journals have a long history of providing the educational materials and venues for continuing medical education (CME) credits. Now, under the market pressures of the certification industry, including MOC, pressure to promote ABMS educational materials as proprietary “MOC points” thrives beyond simple CME.

For example, the American Society of Anesthesiologists (ASA) lists on their homepage two anesthesia-specific MOC (MOCA®) pages for proprietary educational programs, including simulation sessions providing MOC® points.^{7,8} The 2018 ASA annual report further identifies significant income resulting from educational endeavors supporting certification: \$6.6 million for continuing education products, \$2.9 million for publications and journals, and \$9.1 million from the annual meeting, totaling \$18.6 million (36 percent) of \$51.7 million total revenue.⁹

Notably, professional national societies’ journal publications have routinely rejected numerous submissions critical of the MOC program, and recently international journals are doing the same

The Objective Structured Clinical Exam (OSCE)

For example, a January 2020 “Special Article—Medical Education” describing the American Board of Anesthesiology’s

(ABA) unilateral introduction of the Objective Structured Clinical Exam (OSCE) raises serious ethical questions, as testing is not educational, and no significant/scientific information is presented.¹⁰ ABA says it is a proprietary “non-profit” certification corporation that is leading the “innovation” of certification programs. Its annual gross receipts income was \$37.4 million in 2018, significantly up from \$13.6 million in 2011. Journal publication of any pharmaceutical or medical device company would never achieve such widespread publication with such lack of scientific evidence and structure.^{11,12} ABA pioneered the expensive, high-tech Simulation programs as a certification requirement, only to now introduce human actors with the OSCE process. These changes are complex and obfuscating, aimed at fooling people into believing that these methods have value and are necessary for certification, while creating opportunity to publish spurious advertising as “research” in medical journals.

OSCE was first introduced in British medical education in 1975 and has remained controversial.¹³ In 1998, the Federation of State Medical Boards (FSMB) and its affiliated Educational Commission for Foreign Medical Graduates (ECFMG)—both proprietary testing corporations—incorporated the OSCE to further encumber foreign medical graduate (FMG) entry into U.S. training programs. OSCE was additionally “needed” to assess bedside information-gathering, clinical reasoning, interpersonal skills, and English communication skills in FMGs. OSCE became firmly embedded in 2004, when the test was pushed onto all U.S. Medical Licensing Examination (USMLE) applicants, including U.S. medical school graduates, in addition to the existing two-step test.

OSCE use then became widespread in more than 100 U.S. medical schools to prepare for the required USMLE test.¹⁴ To perform well, students appeared to need to learn the testing system itself. Proprietary educational programs also arose to “teach the test.” In this method of regulatory capture, FSMB created a specific, expensive testing industry to further complicate medical education, while “incidentally” increasing financial burdens on already cash-strapped medical students.

The OSCE system is expensive, time-consuming, and requires much planning to achieve uniformity.¹⁵⁻¹⁷ This limits “national” testing to very few locales, and imposes significantly higher travel costs.

Longstanding criticism of the objectivity of oral vs. standardized written exams persisted, but the controversial oral testing is now being expanded by the ABA, without evidence and at great expense, by incorporation of the OSCE component into certification testing. Indeed, the “Special Article—Medical Education” indicated plans (providing no results) to evaluate OSCE’s “validity and impact,” while excluding institutional review board (IRB) approval, violating journal research ethics and the Nuremberg Code.¹⁸

Hidden Rights Violations, Hypocrisy, and Conflicts

Most disturbing is that application for certification requires relinquishing significant legal, personal, and data rights, compelling applicants to become ABMS research subjects, as well as commercially lucrative data sources without opportunity to protect personal data or provide for informed consent. Biased standard (“boiler plate”) legal contracts that are required for submitting to the certification process ensure that ABMS prerogatives are dominant over diplomates’ rights.¹⁹

Medical journals do not typically even list certification credentials of their editorial staffs or authors, thereby negating all of certification’s importance. Many members of editorial staffs found in all journals, international and domestic, are unknown in the U.S. and are typically not ABMS diplomates. ABMS certification is impossible without complete U.S. residency training, which is really the defining criterion for ABMS specialty certification. Looking at any U.S. society journal’s editor list will underscore the irrelevance of ABMS certification on the world stage due to significant numbers of foreign (and thus ABMS uncertified) editorial experts. It is time, in 2021, to demand that specialty journals’ editorial staffs disclose their certifications, so that readers may evaluate journals’ and authors’ potential for conflicts of interest in this area. Those who publish ABMS advertising as “scientific” articles, with no opportunity for dissenting opinion, would be targeted. Given the extensive conflicts of interests of the high-ranking and employed ABA’s 12 authors (Warner et al.) in the January 2020 article,¹⁰ these following questions were submitted to the chief editor and authors, yet remained “respectfully unanswered”:

(1) Were any of the Journal reviewers non-ABA diplomates? Why not? (Multiple international editors and reviewers unrelated to the ABA participate in this international journal.) Should they have been specifically selected to avoid conflicts leading to this inappropriate publication?

(2) What prompted the editorial staff to accept this article for publication, given the extensive conflicts of interest, ethics violations, and apparent commercial function to advertise and promote for the ABA product? (The ABA has its own commercial websites for this purpose.)

(3) Where is the data to suggest that this OSCE measures anything, is needed, or is predictive in any way? Why are no results available at publication after 2 years since implementation? (This was apparently the goal of the article, which it did not deliver—why not?)

(4) How does proprietary testing from a private corporation that produces no educational materials rate a special article in the “medical education” section?

(5) Is it ever appropriate to publish such commercial, clearly unscientific advertisements from corporate sources in any journal?

The editors rejected publication of my letter posing these questions now, saying, “The journal has already allowed you to present your contrary opinion.” That prior opinion was published in 2014,¹² predating all consideration of OSCE as first detailed by Warner et al. now.¹⁰ A Pubmed search of this *one journal* identified five proprietary publications from paid ABA authors in 2019, and always without opposing viewpoints. OSCE had also been repeatedly described elsewhere, and

with significant controversy. These facts undermine claims that it is a “novelty” needing scientific exposure.^{13-17,20,21} This controversy over OSCE was afforded no mention in the article—it might have undermined the advertising effect.

The only place in the January 2020 issue where certification credentials of any kind are found is in an editor-in-chief’s editorial, proudly displaying a fledgling European certification (DEAA).²² Personal attempts to contact this European certification board directly have been difficult, raising additional questions. Oddly, the lack of ABA certification has not impaired this specific editor’s ability to practice as a vice-chairman at a renowned U.S. state university. The text of his editorial, as well as basic research ethics, suggest that such ABMS-paid authored articles do not belong in this or any medical journal.^{18,22}

It is time for specialty journals to stop publishing such unpaid advertisements of ABMS product lines, given certification’s significant and growing controversy, especially without excluding reviewers who could benefit from sales of the products. ABMS programs limit quality patient care, and allow patient access only to those physicians within the ABMS’s protected “guild.” The persistence of the “re-certification” industry is deleterious to patient access and quality of care, and to the medical profession itself, while medical care is dumbed down to profit large corporate entities.

Adverse Effects of Maintenance of Certification®

Continued imposition of proprietary ABMS certification programs directly undermines the physician’s ability to advocate for individual patient care because of its demand on time and financial resources. These programs also encumber physician ability to compete financially in today’s “provider” market, where “termination of certification” for subscription “non-payment,” even immediately after completion of “high-level testing,” may lead to loss of employment or insurance coverage of independent services.

Government, insurance companies, and hospital administrators use certification to limit patients’ physician access, as well as physician payments, employment, and professional advocacy. ABMS, in order to deflect legal liability, admits the reality that certification does not assure competence. Re-certification demands contribute to physician burnout and loss to the profession, as through early retirement.²³

These adverse realities of MOC have mobilized physicians to initiate eight lawsuits²⁴ and multiple legislative efforts²⁵ (passed in 14 states) opposing mandatory certification, including the effort by Meg Edison, M.D., in Michigan.²⁶

Conclusions

Board certification, like earning a medical degree, should once again be for life. It needs to be de-coupled from proprietary Maintenance of Certification programs. MOC® should be truly voluntary for those who find it helpful, with full disclosure of all relevant conflicts of interest. Medical journals must not permit advertising for lucrative re-certification products to be disguised as scientific articles.

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REFERENCES

1. Grosch EN. Does specialty board certification influence clinical outcomes? *J Eval Clin Pract* 2006;12:473-481.
2. Hayes J, Jackson JL, McNutt GM, et al. Association between physician time-unlimited vs time-limited internal medicine board certification and ambulatory patient care quality. *JAMA* 2014;312:2358-2363.
3. Johnson DH. Maintenance of certification: confession of a grandfather. *J Oncol Pract* 2012;8:203-204.
4. Brennan TA. Recertification for internists—one 'grandfather's' experience. *N Engl J Med* 2005;353:1989-1992.
5. Sullivan T. MOC controversy continues, as *Newsweek* unveils ABIM's troubled financials. *Policy & Medicine*, May 5, 2018. Available at: <https://www.policymed.com/2015/04/moc-controversy-continues-as-newsweek-unveils-abims-troubled-financials.html>. Accessed Feb 18, 2020.
6. Kroll C, Tremblay E. ABMS and 24 Member Boards 2016 Full Report. wikimoc; Aug 26, 2018. Available at: <http://www.wikimoc.org/2016/abms/report/pdf/color.pdf>. Accessed Nov 23, 2020.
7. American Society of Anesthesiologists. Track MOCA 2.0® Part 2. Education Center. Available at: <https://education.asahq.org/totara/mod/page/view.php?id=17451>. Accessed Nov 23, 2020.
8. American Society of Anesthesiologists. Track MOCA 2.0® Part 4. Education Center. Available at: <https://education.asahq.org/totara/mod/page/view.php?id=17452>. Accessed Nov 23, 2020.
9. American Society of Anesthesiologists. 2018 Annual Report. Available at: https://www.asahq.org/-/media/sites/asahq/files/public/resources/Publications/ASA_AnnualReport_2018.pdf. Accessed Feb 18, 2020.
10. Warner DO, Isaak RS, Peterson-Layne C, et al. Development of an objective structured clinical examination as a component of assessment for initial board certification in anesthesiology. *Anesth Analg* 2020;130:258-264.
11. American Board of Anesthesiologists. IRS Form 990; 2018. Available at: https://projects.propublica.org/nonprofits/display_990/60646523/12_2019_prefixes_01-06%2F060646523_201812_990_2019122616977503. Accessed Feb 18, 2020.
12. Kempen PM. Maintenance of Certification and Licensure: regulatory capture of medicine. *Anesth Analg* 2014;118:1378-1386.
13. Harden RM, Stevenson M, Downie WW, Wilson GM. Assessment of clinical competence using objective structured examination. *BMJ* 1975;1(5955):447-451.
14. Swanwick T, Forrest K, O'Brien BC, eds. *Understanding Medical Education: Evidence, Theory, and Practice*. 3rd ed. Hoboken, N.J.: John Wiley & Sons; 2018.
15. Barman A. Critiques on the Objective Structured Clinical Examination. *Ann Acad Med Singapore* 2005;34:478-482.
16. Dong T, Saguil A, Artino AR Jr, et al. Relationship between OSCE scores and other typical medical school performance indicators: a 5-year cohort study. *Mil Med* 2012;177(9 Suppl):44-46.
17. Turner JL, Dankoski ME. Objective structured clinical exams: a critical review. *Fam Med* 2008;40:574-578.
18. Kempen PM. Maintenance of Certification: ethics and conflicts of interest. *J Am Phys Surg* 2014;19:85-89. Available at: <http://www.jpands.org/vol19no3/kempen.pdf>. Accessed Nov 24, 2020.
19. Kempen PM. MOC®kery and MOLEstimation update 2015: the regulatory capture continues. Keynote Lecture to the St. Louis Medical Society Annual Hippocrates Lecture; Sep 30, 2015. Available at: <https://www.youtube.com/watch?v=enG7QzbWmWE&app=desktop>. Accessed Feb 18, 2020.
20. Lehman EP IV, Guercio JR. The Step 2 Clinical Skills exam—a poor value proposition. *N Engl J Med* 2013;368:889-891.
21. Flier LA, Henderson CR, Treasure CL. Time to eliminate the Step 2 Clinical Skills Examination for US medical graduates. *JAMA Intern Med*. 2016;176:1245-1246.
22. Pittet JF, Suresh S. Anesthesia & Analgesia: a journal for the practicing anesthesiologist globally. *Anesth Analg* 2020;130:3.
23. Kempen PM. Maintenance of Certification—important and to whom? *J Community Hosp Internal Med Perspect* 2013;3:1. Available at: <https://www.tandfonline.com/doi/full/10.3402/jchimp.v3i1.20326>. Accessed Nov 25, 2020.
24. AAPS. Overview of MOC Lawsuits. Available at: <http://bit.ly/mocsuits>. Accessed Nov 25, 2020.
25. AAPS. Overview of MOC Legislation. Available at: <https://bit.ly/mocbills>. Accessed Nov 25, 2020.
26. Edison M. The inspiring story of how a physician fought MOC against all odds. Kevin MD.com; May 16, 2019. Available at: <https://www.kevinmd.com/blog/2019/05/the-inspiring-story-of-how-a-physician-fought-moc-against-all-odds.html>. Accessed Nov 25, 2020.

Interview: Firsthand Experience in a Required 'Professionalism' Course

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Physicians subjected to medical licensure board discipline may be required to enroll in a medical "professionalism" course. They dare not speak openly about these courses because of fear of board retaliation. This physician spoke to me about this experience on condition of anonymity. It may be useful for physicians being referred to such courses to know what to expect.

Q: Why were you referred to this course?

A: I was cited for "unprofessional behavior" by the medical board. This behavior had nothing to do with any patient-doctor relationship. I posted a warning video on a website for a pain clinic that simply wanted to ward off anyone who intended to come to the clinic solely in order to obtain pain medications and divert them. The clinic did its utmost to avoid such individuals. Efforts included required referrals and background checks. The posted video was obtained from YouTube and displayed a warning that required acknowledgment before proceeding. I was not involved in making this video and knew none of the persons involved in it. It was determined that this video may have offended someone. Of all the examples

of "unprofessional behavior" that are presented on medical board websites, none resembled what I was cited for.

Q: How was the "professionalism" course selected?

A: I searched for such courses and found one, approved by the AMA, which cost several hundred dollars. But this far less expensive AMA course was deemed "not acceptable" by the medical board that sanctioned me. Instead, I had to go far away to a very expensive course. It was difficult for me since I did not have much money, especially after not being able to find work when my license was sanctioned. (To this day, I have not been able to find any medical paying job.) My distant family had to help me out, as my own family had been financially devastated by this action.

Q: How was the course structured?

A: I have been to many continuing medical education conferences in the past, but I soon learned that this "CME" course was very different. The course took place over several days. The first day was an introduction. Daily attendance was