Recommendations of the North Carolina Medical Board Task Force on Physician Advertising of Board Certification

The Task Force met at 6 PM on Tuesday, May 18, 2010 in the Board Room of the North Carolina Medical Board, 1203 Front Street, Raleigh, North Carolina. The “Minutes of the Meeting of the North Carolina Medical Board Task Force on Physician Advertising of Board Certification” are incorporated as Attachment 1. The Task Force was charged with discussing and identifying standards for the state’s physicians advertising to the public that they are “board certified.”

Defining “Board Certified”

“Board certified” has a special meaning within the health care industry and to the general public. Board Certification requires completion of a residency, licensure by a state medical board, and passing additional examinations in the specialty field. Board certification further assures the public that a physician remains dedicated to lifelong learning and mastery of the specialty field. Board certification connotes that a physician has advanced knowledge and expertise.

The general public relies on the term “board certified” as a means of assessing a physician’s clinical ability. Patients who select a board certified physician as their health care professional historically have been safe in assuming that the physician had met rigorous educational, training and testing requirements. (ABMS letter to NCMB Task Force, May 10, 2010.) A physician’s board certification may be used to determine eligibility to contract with managed care entities, for credentialing to serve on hospital staffs, to obtain other clinical privileges, to ascertain competence to practice medicine or for other purposes. (AMA Policy H-275.944 Board Certification and Discrimination (Sub. Res. 701, I-95, Reaffirmed: CME Rep. 7, A-07)) However, the Task Force is focused only on the issue of physician advertising of board certification to the public.

History of Board Certification

In the early 1900’s advances in medical science vastly improved the delivery of health care. Unfortunately this era of rapid medical advancement also allowed less well trained or less well qualified physicians to make claims concerning the extent of their knowledge and training that could not be substantiated. With no formal system in place to validate these claims, neither the public nor the medical profession could trust that a self-designated specialist had the appropriate qualifications. This uncertainty prompted the rise of the specialty board movement.

In 1908 the American Academy of Ophthalmology and Otolaryngology first proposed the notion of specialized training followed by an examination in order to determine a physician’s competence in a particular field. The National Board of Medical Examiners and the American Medical Association, among others, worked together to implement standards for graduate medical school education and the recognition of physician specialists which was largely accomplished during the 1920s and 1930s. National specialty boards designated certain clinical and practical experiences as well as graduate course requirements as prerequisites to sit for the examinations. Eventually specialty boards established a uniform system to administer examinations conducted by a group of peers selected by the boards. The rapid and widespread acceptance of specialty boards by the profession began to restrain physicians with little or no formal education in the specialty from designating themselves as specialists. (www.ABMS.org)
There are currently approximately 100 to 200 organizations claiming to certify physicians as specialists. (ABMS letter to NCMB Task Force, May 10, 2010) These certifying boards have a broad spectrum of intellectual, clinical, and academic requirements to achieve certification status. Some boards have been criticized for lacking intellectual rigor and designating physicians as “board certified” without meeting any real standards other than paying the certifying board’s fees. These “bogus boards” have degraded the term “board certified” as a measure of reliability. A significant conflict exists between the well established certifying organizations (ABMS and AOA) and newer organizations wishing to become certifying boards. The conflict revolves around a perception of prejudice on the part of the established organizations against newcomers on the grounds of economic issues and differences regarding the quality of the programs and the appropriateness of subdivisions of medical training. There may be varying degrees of truth in the claims made on all sides of the debate. Regardless, the public can no longer safely assume that “board certified” means what it once did. The North Carolina Medical Board wishes to establish guidelines for its physician licensees to avoid misleading the public when advertising “board certification.”

**NCMB and Standards for Physician Advertising of Board Certification**

The Board has broad general authority under N.C.G.S. 90-14(a)(1) to discipline its licensees for conduct such as false or misleading advertising. In November 1999 the Board first adopted a Position Statement entitled “Advertising and Publicity” generally cautioning licensees against false advertising and providing guidelines to assess the propriety of certain kinds of ads. (Position Statement adopted November 1999; amended March 2001; revised September 2005). The Board revisited physician board certification advertising standards three years ago when the Board disciplined a physician for publicly advertising his board certification by a patently “bogus” board and failing to disclose in advertising that his post graduate training was done in another specialty field. The NCMB felt that its licensees would benefit from more robust advertising guidelines. Accordingly, the NCMB issued proposed rule 21 NCAC 32Y .0101 “Advertising of Specialty and Board Certification” which set criteria that a board must meet before a physician could advertise board-certified status. The Medical Board received 77 letters of public comment at the November 2009 rule hearing, prompting the Board to delay the rulemaking process to create this Task Force to allow for additional public input and discussion among stakeholders.

**Background**

The issue of defining the parameters of appropriate advertising of board certification by physician licensees began when the California Board studied the issue in 1990 at the request of the California state legislature. Since then the Texas, Florida and Oklahoma boards have each labored to adopt criteria for distinguishing “bogus” or “sham” certifying boards from their legitimate counterparts. These efforts have given rise to expensive and protracted litigation as well as aggressive lobbying efforts by specialty boards which do not meet the criteria of the various state licensing Boards. At its 2010 Annual Meeting, the Federation of State Medical Boards declined to adopt a resolution asking the FSMB to study advertising standards regarding board certification. The North Carolina Medical Board and the Task Force have endeavored to find a solution that will adequately protect the public.

**Task Force Recommendations**

The issue of advertising board certification is complex and contentious. To fully understand board certification requires a working knowledge of physician residency and fellowship training,
the taxonomy of physician specialty designations, and specialty certification boards. Constitutional law concerning commercial free speech, state physician regulatory law and physician specialty politics all relate to the issue of advertising. Consequently the Task Force recommends that the Medical Board adopt a strategy to regulate and educate its physician licensees and educate the general public. First, the Task Force recommends amendments to proposed Rule 21 NCAC 32Y .0101 “Advertising of Specialty and Board Certification.” The Board should also amend its current Position Statement, “Advertising and Publicity” (adopted Nov. 1, 1999) to better inform both licensees and the general public in specific terms what the Boards expectations are for specialty and board certification advertising by physicians. Finally, the Board should provide consumer education regarding “board certification” on the Board website with links to appropriate resources.

Changes to Proposed NCMB Rule 21 NCAC 32Y .0101

The proposed rule, Attachment 2, precludes advertisement of board certification unless the board in question has been approved by the American Board of Medical Specialties; the Bureau of Osteopathic Specialists of the American Osteopathic Association; the Royal College of Physicians and Surgeons of Canada; or a board or association fulfilling the characteristics listed in the rule. The proposed rule further requires that a physician advertising board certification disclose the name of the specialty board granting certification. Finally, the proposed rule requires that if a physician is board-certified in a specialty different than the one in which he or she is residency- or fellowship-trained, the physician must note that with equal prominence in the advertising materials.

The Task Force recommends against the Medical Board’s implementation of any rule, policy or procedure that would require the Medical Board to individually assess the legitimacy of specialty boards that grant board certification status to physicians. The leadership, management, board certification requirements and membership requirements in such organizations are in a state of flux. Assessing specialty boards is a data-intensive, time-intensive and resource-intensive undertaking and requires special expertise. Other state medical boards with such review mechanisms report substantial litigation by certifying boards which do not meet the various state licensing boards’ criteria. While litigation risk should not prevent the adoption of policies, the cost in time and resources must be considered.

Amendments to the NCMB Position Statement “Advertising and Publicity”

The Task Force recommends amendments to the Position Statement. The Task Force believes that the statement in its present form lacks the specific detail that licensees may rely on when crafting their advertisements to comport with the Board’s expectations. The Task Force believes specific guidance serves the licensees and the public better. The statement should reflect NCMB’s opinions concerning consumer advertising. The statement should reflect the reality that physicians often cannot control information on the internet in physician listings, consumer rating services and other media. The statement should also encourage physicians to provide accurate current information on the North Carolina Medical Board’s Licensee Information Pages. Consideration should be given to the Constitutional protections afforded commercial speech in crafting the Position Statement.

Consumer Education on the NCMB Website

The Task Force recommends that the North Carolina Medical Board expand the use of the North Carolina Medical Board website as a consumer resource center. The Board should direct
its staff to provide educational materials in laymen’s terms that explain the significance of the term “board certified.” The materials should explain how certifying boards differ from state licensing agencies and give a brief explanation of the history of the development of certifying boards. It should be noted that board certification is used for assessment purposes by a variety of organizations, including insurance panels, hospital privileging committees, and Medicare and Medicaid, among others. The information should include recognition that ABMS- and AOA-recognized board certifications are acknowledged by industry experts to represent the “gold standard” for physicians but that other legitimate and credible boards exist. Likewise, the public should be informed that Boards requiring completion of a specialty-specific ACGME-approved postgraduate training program represent the highest standard of physician training and certification. The public should also be informed that there are viable reasons why such board certification is not open to everyone, for example, emergency physicians who graduated from medical school prior to the formal recognition of emergency medicine as an independent specialty. The public should also be afforded a list of criteria the NCMB feels are essential components of a legitimate certifying board. NCMB should also provide a list of “red flags” that identify “bogus” or “sham” boards.

The consumer education page should make clear that the Board’s rules governing physician advertising of board certification apply to the limited instance of consumer advertising and do not serve as a referendum on the legitimacy of various certifying boards. The standards should not be used as a benchmark or controlling authority for credentialing organizations or for privileging purposes. Likewise, the Board’s approval of advertising of board certification by boards other than those traditional ABMS- or AOA-approved boards should not be misconstrued as tacit approval of diminution of standards for certifying boards.

**Conclusion**

The North Carolina Medical Board Task Force on Physician Advertising of Specialty Board Certification hereby presents this report for consideration by the Policy Committee of the North Carolina Medical Board at the Board’s September, 2010 meeting.

Respectfully submitted,

William Walker, MD
Task Force Chair

Christina Apperson, JD
Medical Board Staff