

The Use of Board Certification to Credential Internists

Recommendations of
the American Society
of Internal Medicine

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Note:

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Contents

Executive Summary	4
Introduction	6
What Is Board Certification?	6
Demographics of Board Certification.....	7
Why Is Board Certification Becoming Such an Issue?	8
What Is the Impact of Managed Care's Emphasis on Board Certification?	10
Why Certification Should Not Be Used by Health Plans as the Sole Criterion for Physician Selection.....	11
Alternatives to Board Certification.....	14
Recommendations	15
Conclusion	19
Appendix A	20
Endnotes	22

Executive Summary

As burgeoning health care costs have driven employers and public health programs to turn increasingly to managed care as a health care delivery method for their employees and beneficiaries, managed care's use of board certification to credential physicians has become an issue. The questions surrounding board certification affect all specialties. However, this paper presents the perspective of internal medicine, the nation's largest medical specialty and the specialty that delivers the majority of the medical care provided to Medicare patients. The American Society of Internal Medicine (ASIM), an advocacy organization representing the interests of internists and their patients on matters of socioeconomic health policy, has been charged by its members with examining the many facets of the board certification debate.

This paper addresses some of the key questions of the debate, including:

- What is board certification?
- Why is board certification becoming such a contentious subject in the context of managed care?
- What is the impact of the emphasis placed on board certification by managed care plans?
- Why should board certification not be used as the sole criterion for credentialing physicians?
- Are there alternatives to board certification that will satisfy the public's desire for guarantees of health plan physician quality, without adversely affecting high-quality, noncertified physicians?

Two-thirds of all physicians in the United States are certified by one of the 24 members of the American Board of Medical Specialties (ABMS). Among ASIM's members—who are both generalists and subspecialists—approximately 80 percent are board certified. However, some 200,000 physicians nationwide are not board certified. Many of those physicians without a board certificate are older physicians who entered medicine when board certification was not considered necessary for practice. The insistence by managed care plans that their network doctors must be board certified not only falls heaviest on physicians such as these but on the patients who have established relationships with them.

A health plan that focuses solely on board certification as the test for whether it contracts with a physician may be overlooking a highly qualified, caring doctor who participates in ongoing medical education, holds a teaching position at a medical school, or is an exceptionally empathetic yet cost-effective practitioner. Some health plans have begun to recognize the need for alternatives to board certification in selecting high-quality physicians for their panels. In a recent survey of 62 managed care plans, ASIM found 70 percent of those plans willing to accept other standards that would demonstrate solid performance by a physician in the field of internal medicine.

To assist health plans, policymakers and the public in identifying alternatives to board certification, this paper outlines several measures that health plans should consider to obtain a more accurate assessment of an internist's clinical judgment and competence.

These measures include:

- Meeting the training requirements necessary to sit for the certification examination of the American Board of Internal Medicine (ABIM);
- Completion of an approved internal medicine residency;
- Faculty appointment in a medical school or participation in teaching residents and medical students;
- Evidence of extensive continuing medical education (CME);
- Appointments to peer review or quality assurance committees;
- Evidence of a large, busy practice of satisfied patients;
- Documentation of good standing in the medical community;
- Clinical privileges granted by a hospital medical staff; and
- Outcomes measures.

It is not ASIM's intent to dismiss board certification as an appropriate measure of a physician's competence. However, board certification as the sole measure for a physician's selection by—and retention in—a health plan will become more problematic as greater numbers of people receive their health care through managed care. There are too many experienced, high-quality, but noncertified physicians in the U. S. and too many patients with long-standing attachments to those physicians to continue reliance on board certification alone.

This document is one of four policy papers on "Reinventing Managed Care" published simultaneously by ASIM. The other papers, which are available on request, address methods for assessing physician performance, assuring appropriate patient care under capitation arrangements, and access to subspecialty care.

The Use of Board Certification To Credential Internists

Introduction

In the last 20 years, managed care has established a firm foothold in the United States as more businesses and public agencies have chosen this method of health care delivery for their employees and beneficiaries. This managed care "revolution" has brought with it a host of issues and dilemmas for patients, physicians, policymakers, purchasers and health plans.

Some issues of debate are the managed care plans' use of board certification as a surrogate for quality medical care, and the plans' insistence that their physicians be board certified. Although the board certification issue affects many medical specialties, this paper generally reflects the perspective of internal medicine, the largest medical specialty in the United States. The American Society of Internal Medicine (ASIM), an advocacy organization representing the interests of internists and their patients on matters of socioeconomic health policy, has been charged by its members to examine the many facets of the board certification debate. Some of the questions this paper addresses are:

- What is board certification?
- How many physicians are board certified?
- Why is board certification such a contentious issue in the context of managed care?

This white paper also discusses several alternatives to board certification that would satisfy the public's desire for guarantees of quality medical care from health

plan physicians. These alternatives would have no adverse effect on noncertified physicians who provide high-quality care.

What Is Board Certification?

There are 24 medical specialty boards in the U. S. representing certain core disciplines of medicine such as internal medicine, family practice, ophthalmology, psychiatry, surgery and radiology. Most of the 24 boards—which are all members of the American Board of Medical Specialties (ABMS)—also award certificates in their subspecialties. The ABMS is made up of representatives from the American Medical Association (AMA), the American Hospital Association (AHA), the Association of American Medical Colleges (AAMC), and the Federation of State Medical Boards. Today, over 60 percent of all physicians are certified by one of the ABMS boards.¹ While board certification is voluntary on the part of a physician, it is becoming increasingly difficult for doctors to practice without this designation.

The American Board of Internal Medicine (ABIM) was established 60 years ago with the aim of enhancing the knowledge, skills and quality of care provided by doctors of internal medicine. Not a part of—or affiliated with—any organization other than ABMS, the ABIM neither confers privileges to practice medicine, nor is certification by ABIM required to practice medicine. As stated in its *Policies and Procedures for Certification*: "The Board does not intend either to interfere with or to restrict the professional activities of a licensed physician because the physician is not certified."²

ABIM certification includes several com-

ponents, of which the board examination is the most well-known. This written exam is intended to "provide evidence that a diplomate's fund of medical knowledge is both comprehensive and up-to-date."³ Physicians certified prior to 1990 hold certificates that are valid indefinitely, but those who took the examination after 1990 must take it again every 10 years to retain their board-certified status. Diplomates with certificates issued before 1990 also will be given the same opportunity to recertify, by taking an at-home, open-book self-test; undergoing an evaluation of credentials; and taking a proctored final exam. The ABIM sets training requirements for candidates for the board exam, evaluates their credentials, substantiates their "clinical competence and professional standing," and develops and conducts the examination for certification and recertification.⁴

To sit for the ABIM exam, which is given annually throughout the U.S., Puerto Rico and Canada, physicians must have graduated from an approved medical school, completed three years of accredited training after earning their MD (medical doctor) or DO (doctor of osteopathy) degree, and must substantiate to the ABIM competence in "clinical judgment, medical knowledge, clinical skills (medical interviewing, physical examination, and procedural skills), humanistic qualities, professionalism, and provision of medical care."⁵ The ABIM has set guidelines for a minimum number of times a candidate must perform certain diagnostic and therapeutic procedures to be eligible for certification. In addition, physicians must pay ABIM an exam fee of \$790.⁶

When a candidate for internal medicine board certification receives notice of admission to an exam, he or she achieves a

status known as "board eligible." Essentially, this means that the candidate has finished the necessary training, demonstrated appropriate clinical competence, and has met other credentialing requirements, except for passing the exam.

In the past, physicians had up to six years or four attempts to take the exam before their board eligibility expired. They could renew their board eligibility by meeting a complicated set of requirements set out by the ABIM—such as demonstration of satisfactory clinical competence and completion of 100 hours of continuing medical education (CME) in two years, and passing a "qualifying" exam. However, in July 1995, ABIM officials informed ASIM that they had begun a complete review of policies concerning the board-eligible status. ABIM plans to announce these revised policies by Dec. 31, 1996. In the meantime, all currently board-eligible candidates will remain eligible and able to sit for the certifying exam in internal medicine, the subspecialties or areas of added qualifications.

Demographics of Board Certification

Two-thirds of all physicians nationwide are board certified. However, another 200,000 are not.⁷ A report on the makeup of the U. S. physician population from 1980 to 1986 found that, while the total number of physicians increased, the percentage of those who were board certified did not increase proportionately. Calling this a "major finding," the authors noted this meant that a "progressively growing number of physicians are therefore in practice without this criterion of post-graduate educational achievement."⁸

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According to figures compiled by the AMA, 55 percent of all practicing primary care physicians in the U. S. are board certified.

Many physicians who are not board certified entered medicine when certification was used more by academic consultants than by physicians in private practice.⁹ Thirty years ago, board certification was viewed as a fulfillment of a personal goal, not as a necessary professional credential. Before 1972, the certification process included an oral exam as well as a written test. This oral exam was considered by many physicians to be subjective, with the results depending "more on what the examiner had for breakfast than the examinee's competency."¹⁰ Although ABIM discontinued the oral part of the certification program in 1972, quite a few physicians who went through the process vowed never to repeat the experience.

According to figures compiled by the AMA, 55 percent of all practicing primary care physicians in the U. S. are board certified.¹¹ The total number of U.S. physicians qualified by training to call themselves internists is 113,970. Of those, 58,576 designate themselves as general internists. Of these self-designated general internists, 42,240—slightly over 72 percent—are board certified.

In 1989, ABIM granted board-eligible status to some noncertified internists who had taken the exam at least once, affecting approximately 15,000 internists.¹² If these individuals do not pass the board exam, their eligibility will expire in 1996.

Why Is Board Certification Becoming Such An Issue?

The importance of board certification for physicians has risen in tandem with the growth of managed care. In the last decade, employers looking to restrain costs

in their employee health benefits plans increasingly turned to managed care, and as more people found themselves limited by those plans to network providers, the clamor grew for "proof" that those providers delivered "high quality care." Outcomes measures and other scientifically based standards of what constitutes "quality" care were too new and untested, as well as too difficult for many purchasers to understand. So health plans began emphasizing the credentials of their network physicians and their accreditation by organizations such as the National Committee for Quality Assurance (NCQA). NCQA accredits managed care plans throughout the U.S., and has approved about half the health maintenance organizations (HMOs) in this country. As Lee Newcomer, MD, national medical director for United Healthcare Corporation, said at a managed care conference sponsored by ASIM in 1994, "I will tell you there is no objective evidence that board-certified physicians are better, but the bottom line is that the people who buy our coverage want board-certified physicians and, therefore, so do we."¹³

In a 1993 article advising its readers "How To Size Up a Doctor Network," *Money* magazine outlined five questions prospective enrollees should ask about a managed care plan, including: "What percent of the plan's doctors are board certified?" The magazine then went on to suggest that a 70 percent board certification rate, "about average for [HMOs] and preferred provider organizations (PPOs)—is acceptable. Also make sure the board that certifies your doctor is one of the 24 recognized by [ABMS]."¹⁴

According to a 1994 survey of managed care plans conducted by the Group Health Association of America (GHAA), 85 percent of physicians who provided services

under an arrangement with a managed care plan were board certified. In 1992, a GHAA survey of managed care plans found 70 percent considered board certification "very important" in their selection of physicians (medical liability history and hospital privileges did, however, score higher) while only 1 percent said this credential was not a factor.¹⁵

The Physician Payment Review Commission (PPRC) also conducted an extensive survey of managed care plans in 1994. The PPRC found that 57 percent of the 108 responding plans required physicians to be board certified or board eligible. Most of the group or staff model HMOs questioned in the survey required board certification, while "a smaller proportion of other types of plans" did so.¹⁶

That same year, ASIM surveyed over 60 HMOs around the country and learned that only 10 percent required certification by one of the ABMS boards as a minimum acceptance standard. However, 74 percent said certification was "strongly preferred," although they made exceptions in rare cases. Asked their reasons for emphasizing board certification, almost 60 percent of the plans cited employers' and patients' desires for board-certified physicians and also noted that NCQA looks at the percentage of board-certified physicians in a plan as one of its evaluation criteria. Among plans that required or strongly preferred board certification, 27 percent mentioned marketing advantages, 30 percent said employers and patients wanted board-certified physicians, and 28 percent said that NCQA and other regulators were looking at the percentage of board-certified physicians.

As these survey responses show, NCQA and its rating system have figured prominently in the board certification debate.

NCQA requires plans to have "rigorous" credentialing and recredentialing procedures. Although hospital privileges and work and malpractice history are factors NCQA requires plans to investigate, it does not prohibit plans from using board certification as a prerequisite for selection.¹⁷ NCQA creates report cards on health plans using a system called the Healthplan Employer Data and Information Set (HEDIS). Among the elements HEDIS uses to measure plans is the percentage of board-certified physicians in the plan. The higher the percentage, the greater the likelihood that the plan will be viewed as delivering "high quality" care, which, in turn, will aid in its marketing strategy.

In addition, many states are considering proposals to link board certification to licensure, and a number of HMOs have begun to use certification as "a quick, clean cut when they need to reduce their physician panels," according to Peter Kongstvedt, MD, a former HMO president who is now a consultant with the accounting firm Ernst and Young.¹⁸ Kaiser Permanente, the largest HMO in the country, requires physicians to become board certified within three years of being hired by the company.

Beyond the managed care world, even some hospitals are using board certification as a requirement for privileges. The American Hospital Association surveyed its members in 1992 and found that 95 percent were requiring new doctors seeking privileges to be certified. A number of other hospitals were requiring board certification for physicians to renew their privileges.¹⁹ This last development could pose a problem for the hospitals themselves, however, if they receive any Medicare funding, since the program's regulations specifically prohibit hospitals from

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using certification as the sole criterion for granting staff membership or professional privileges.

What Is the Impact of Managed Care's Emphasis on Board Certification?

What has been, and what will be, the effect of managed care plans' use of board certification for entrance into their provider networks? In a 1993 letter to the *New England Journal of Medicine*, the current speaker of the Massachusetts Medical Society's House of Delegates cited statistics compiled by the state medical society showing that nearly 1,200 Massachusetts doctors were not board certified. In some cases, these physicians started practice before their specialty adopted board certification. In other cases, "many physicians did not become certified, because doing so was not considered important for private practice. As that correspondent correctly noted, exclusion of over 1,000 physicians providing primary care "will exacerbate problems of access for patients, and at the same time deprive many competent, experienced physicians of their livelihoods. What is needed is a change in credentialing criteria that reflects the value of the same or similar training followed by multiple years of practice experience and recognized competency in clinical practice."²⁰

Some leaders of medicine have warned that the medical community could "play the economic game" and give all physicians board certification upon graduation. This would devalue board certification without providing any useful alternative to identify high-quality physicians.²¹

In order to claim that they are "board certified," some physicians are using designations given by groups other than the ABMS boards. This only confuses patients and employers trying to ascertain the caliber of providers associated with their health plan. Only three states—California, Florida and Colorado—bar physicians who have become "certified" by self-designated boards from calling themselves "board certified." Challenges to such laws are arising from those who contend that the ABMS does not reflect the emerging multidisciplinary approach to health care and medicine. The executive director of the American Academy of Pain Management, a self-designed board in California, has said: "It's an economic guild issue....The public should be allowed to make its own informed decisions about specialists....ABMS has no acupuncture board, no herbalist board.... When \$1 out of every \$3 is spent on alternative medicine, it would indicate that the ABMS is missing the boat."²²

Contributing to this confusion are the "certificates of added qualification" in various subdisciplines, offered by several ABMS members. For example, ABIM and the American Board of Family Practice have established a certificate of added qualification in geriatric medicine. These certificates do not represent full-fledged board certification, but they are nonetheless legitimate credentials issued by those specialty boards.

The current alternatives for physicians without a board certificate are limited. Some physicians could base their practices solely on Medicare since that program does not require board certification to participate. However, as changes are made in Medicare program reimbursement, this will be increasingly untenable for most physicians. Noncertified physi-

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cians could always join a group practice comprising mostly board-certified physicians. Yet, if the proportion of nonboarded physicians in such a group becomes too great, managed care plans could become reluctant to contract with the group for fear that it would affect their NCQA rating. Physicians also could try to get their patients who are enrolled in a managed care plan to lobby for their inclusion in that plan. Another option would be for physicians to arm themselves with data about the cost-effectiveness of their services despite a lack of board certification. Dr. Newcomer cautions that, in compiling profiling data, a physician's "perception of 'best' may be different from that of the plan."²³ Finally, physicians can become board certified. However, this may be more feasible for physicians who have completed a residency and are still within their specialty's time limit for taking the test.

Physicians personally feel the burden of the heavy emphasis placed on board certification by managed care plans. A letter to ASIM from one of its members illustrates this. After graduating from a highly rated medical school in the early 1960s, completing his residency, serving as president of his local medical society and state society of internal medicine, teaching as a clinical instructor, and building and maintaining a thriving practice for almost 30 years, this member did not pass the board certification exam. He wrote that his colleagues told him, "Don't worry, look around, it's just a club...to add status to [those who passed the exam] as consultants." Although by all other measures this physician had enjoyed a successful career, the growing emphasis placed on board certification made him feel "second class." Eventually, he closed his practice and moved to a rural area "where I'm closer to the patient and fur-

ther from that oppressive potential restriction—not board certified."²⁴

In sum, there are many reasons why fully qualified physicians may not have taken the board exam. The burden of proof for board certification requirements should fall on those who insist that well-qualified physicians must take and pass the exam in order to provide patient care.

Why Certification Should Not Be Used by Health Plans as the Sole Criterion for Physician Selection

Reducing the emphasis health plans place on board certification as the minimum acceptance requirement will be difficult because the plans continue to sense that patients and employer-purchasers want some concrete assurance that their physicians meet a certain level of quality. However, the use of board certification as the sole criterion for selection to a plan is being challenged more and more.

Even NCQA officials caution against using the percentage of board-certified physicians as a deciding factor for whether an employer or patient should choose a plan. Last year, in an issue of *Managed Care*, Janet Corrigan, executive director of NCQA, said of the HEDIS measurement of the percentage of board-certified physicians in a plan, "It's one of many, many indicators in the HEDIS process, and it's intended to be used in that context. We wouldn't expect any one indicator to be a deciding factor for any of the outside organizations that might be reviewing HEDIS information."²⁵

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As noted earlier, board certification requirements may fall heaviest on older, experienced physicians. But managed care guidelines calling for board-certified doctors can work a hardship not only on older physicians but also on younger ones. Eight of the 24 medical specialty boards require a young physician to satisfy certain practice qualifications before gaining eligibility for the exam. If health plans exclude these young physicians, not only is this an unjust prejudice against young, well-qualified, competent doctors, but it also could affect Medicare beneficiaries' access to physicians. A recent PPRC report noted that, although the number of doctors who began seeing Medicare patients from 1991 to 1993 outnumbered those who stopped seeing such patients, these new physicians were "younger and were less likely to be board certified than were those who stopped seeing Medicare patients."²⁶ As more Medicare beneficiaries receive care under managed care, this becomes a problem.

While health plans contend that purchasers and patients want board-certified physicians because these doctors offer higher quality care, there are few studies validating this. One study that attempted to answer the question, "Does board certification mean high quality?" looked at 259 internists, of whom 185 were ABIM-certified. It found a "clinically modest trend suggesting that board-certified physicians provided more comprehensive preventive care compared to noncertified internists."²⁷ Even so, the study also found "more similarities than differences" between ABIM-certified and noncertified internists on questions of practice patterns, patient satisfaction, and patient outcomes.²⁸ Given the inconclusive and minimal objective data, further study on the relationship between board certification and quality might be

desirable before health plans use board certification as a definition for quality.

Board certification does not guarantee physician characteristics that may be extremely important to patients, such as listening ability, time spent with a patient, availability when a patient is sick or facing an emergency, and the length of the physician-patient relationship. Neither does it measure "the ethical nature of a physician's practice; the value of life experience; the ability of a physician to participate as part of a health care team; practice performance through a peer review process; or the devotion and satisfaction of patients." Nor can the exam measure "motivation, adaptability, work habits, response to criticism, and handling of stressful situations."²⁹ Board certification only reveals what "a doctor knew at a particular point in time, and cannot measure what has been learned or forgotten in the interim," according to witnesses at a 1994 PPRC hearing.³⁰

Many areas of the country are currently experiencing severe shortages of physicians. In these regions, board certification acts as an impediment to a community's ability to find qualified doctors. Because of this, some health plans have loosened their physician selection requirements in underserved areas. For example, United HealthCare will accept three years of postgraduate residency training in lieu of certification in areas with few boarded physicians.³¹

Health plans that insist on board certification may be turning away nonboarded physicians who have participated in ongoing medical education, have held teaching appointments at medical schools, and have taken other steps to keep their medical knowledge current. There is a great deal of debate within internal medicine

over the equity of the present policy that permanently certifies physicians who passed the exam before 1990. Physicians who passed the board years ago may, in fact, be less knowledgeable than newer, noncertified practitioners. Indeed, a 1991 study found that internists' knowledge-base declined significantly after 15 years had elapsed since passing the board certification exam.³²

Some health plans, recognizing the limitations of board certification, have begun to broaden their criteria for selecting physicians. United Health Plans of New England instituted a policy five years ago that all physicians at the time of application would have to be board certified or obtain certification within five years. Nonboarded physicians in the plan were "grandfathered" in. After the five years had elapsed, the health plan revisited its policy because some of its physicians had not become certified. In a letter to ASIM, the medical director of United Health Plans stated, "We recognized that some, if not all, of the physicians who had not obtained board certification within the five-year period appeared to be, by any other *available* subjective or objective measure, excellent physicians. Thus, we amended our credentialing plan to allow more flexibility in granting exceptions to the board certification requirement for physicians who are board eligible on entry, but who do not receive certification within the allowed time period." That plan identified measures they believe to be "fair and objective" in credentialing and recredentialing, including "utilization scores, patient-satisfaction survey results, member complaints, and quality data."³³ The medical director acknowledged, however, that such information may not always be available. But the changes made by United Health Plans are a step in the right direction and they point

to actions other plans could take when evaluating noncertified physicians in the selection process.

Most health plans engage in ongoing assessments of physicians' performances—using profiling and feedback to evaluate whether the physician demonstrates the level of clinical competence, patient satisfaction and outcomes needed to *remain* in the plan. In this fashion, health plans are able to weed out physicians whose performance falls below accepted levels, while retaining the services of physicians—board certified or not—who meet the plan's standards. Furthermore, health plans that can demonstrate a comprehensive, continuing quality assessment of their physicians may be in a better position to market themselves to purchasers than plans that rely only on requiring board certification.

As noted earlier, Medicare's conditions of participation forbid hospitals from restricting staff privileges based solely on board certification. Medicare requires that hospitals, "Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship or membership in a specialty body or society."³⁴ A letter published in *American Medical News* quoted Thomas Ault, director of the Bureau of Policy Development for the Health Care Financing Administration: "A hospital would be in violation of the regulatory requirement...if it adopted policies or followed practices under which individual physicians could be denied medical staff membership or professional privileges solely because they are not certified by, or eligible for certification by, a specialty board or society."³⁵ It is apparent that, as more and more hospitals become affiliated with or are purchased by man-

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aged care health plans, and as Medicare moves increasingly into managed care, this federal regulation may compel re-evaluation of board certification as the minimum selection criterion.

Board certification may become less of an issue in coming years as more and more physicians become certified as a matter of course. However, if the nation is to avoid losing the talents and experience of the 200,000 physicians who are not board certified—almost half of whom are primary care doctors, including 50,000 internists—it must identify alternative measures for quality of care.

Finally, consideration also must be given to the millions of patients now receiving care from those noncertified physicians. If their employers enroll in health plans that require board certification, these patients will be denied access to physicians with whom they may have long-standing relationships. If patients have confidence in their own physician's skills, they should be able to continue with that physician. To do otherwise would not enhance patient care.

Recently, other alternatives to board certification have been suggested by an assortment of policymakers, organizations and health care analysts.

Alternatives to Board Certification

In its survey of 62 managed care plans, ASIM found that some plans might consider accepting alternatives to board certification as a condition for a physician's participation. Over 70 percent of the plans surveyed said they would "consider accepting other standards (as an alternative to board certification) that would demonstrate competence in internal medicine as a minimum qualification for

participation." Over 65 percent of the plans said they would accept the completion of the training requirements necessary to qualify for the board exam. Sixty-two percent said they would accept successful completion of a residency program in internal medicine. Few other alternatives, however, received approval by any margin close to 50 percent.

Recently, other alternatives to board certification have been suggested by an assortment of policymakers, organizations and health care analysts, including: teaching privileges at a hospital; appointments to peer review or quality assurance committees; evidence of continuing medical education; and participation in preceptorships with medical students. Some medical societies, such as the American Academy of Pediatrics, have begun programs to measure the quality of care in physicians' offices and hospital practices.³⁶

A recent position paper jointly issued by the Colorado Medical Society and the Colorado HMO Association proposed standards that could be used by other HMOs when contracting with physicians. The standards identified were medical education; postgraduate medical training; board certification and eligibility; geographic location; office hours; hospital staff privileges; needs of HMO members for accessible and available medical care; number of members receiving care from the physician; results of patient satisfaction surveys; medical utilization factors based—as much as possible—on objective data collection and interpretation; and the HMO's perception of a physician's ability to work collaboratively in a managed care environment.³⁷

Recommendations

ASIM believes that there are viable alternatives that provide a more complete assessment of the quality of a physician's clinical judgment and practice than board certification alone. The focus of the credentialing process should be on the quality of clinical care provided to patients by the physician. To assist in that process, a sample credentialing form using these alternatives can be found in Appendix A, page 20. Board certification should be considered one measure of competence, but other measures may provide an additional, and often a more accurate, assessment of the physician's clinical judgment and current practice.

Health plans, in consultation with physicians, may wish to decide on the appropriate weight to give each measurement with selection more likely for physicians who meet multiple measures.

ASIM therefore recommends that health plans use the following additional measures of clinical competency as alternatives to requiring that a physician be board certified in internal medicine:

1. Meeting the training requirements necessary to sit for the certification examination of the American Board of Internal Medicine.

Meeting these requirements means that an individual is a graduate of an accredited medical school; has completed three years of postgraduate training in internal medicine; and has been able to substantiate competence in clinical judgment, including performance of a minimum number of diagnostic and therapeutic procedures. The three years of training must include a minimum of 24 months of "meaningful patient responsibility, at least 20 of which must occur in the following settings: (1) inpatient services in

which disorders of general internal medicine or its subspecialties are managed; (2) emergency medicine, general medical or subspecialty ambulatory settings; and (3) dermatology or neurology services."³⁸

2. Completion of an approved internal medicine residency.

Completion of an internal medicine residency approved by the Accreditation Council of Graduate Medical Education (ACGME) which approves all U.S. medical training programs. This means that the individual has undergone training through a program that meets the criteria and follows the guidelines set out by ACGME for matriculating physicians.

3. Faculty appointment in a medical school, or participation in teaching residents and medical students.

The Liaison Committee on Medical Education—which counts the AMA and the AAMC among its members—has stated in its *Functions and Structure of a Medical School* that individuals "appointed to a faculty position must have demonstrated achievements within their discipline commensurate with their faculty rank...will have a commitment to continuing scholarly productivity, thereby contributing to the educational environment of the medical school....Practicing physicians appointed to the faculty, either on a part-time basis or as volunteers, should be effective teachers, serve as role models for students, and provide insight into contemporary methods of providing patient care."³⁹

Obtaining such an appointment requires a review by the teaching program of the physician-applicant's record of performance and ability. Clearly, those appointed to medical school faculty have

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been judged by their professional peers and academic faculty as having met current medical practice criteria for teaching medical students at all levels. Even if physicians are not full faculty members, they must constantly reeducate themselves and keep current with modern medical practice, to convey that knowledge to their students.

4. Evidence of extensive continuing medical education (CME).

Physicians who pursue significant ongoing medical education demonstrate a willingness to continue learning and a commitment to improved patient care by constantly upgrading their skills. It is reasonable to expect, however, that the CME should reflect participation in clinically pertinent programs run by sponsors accredited by the Accrediting Council for Continuing Medical Education.

5. Appointments to peer review or quality assurance committees.

To fulfill Joint Commission on Accreditation of Health Organizations (JCAHO) standards, hospitals and other health care facilities are expected to involve medical staff in improving quality and performance. Although the standards do not "require adoption of any management style, subscription to any specified 'school' of continuous quality improvement or total quality management, use of specific quality improvement tools...or adherence to any specific process for improvement," they do call for those individuals involved in quality-improvement activities to acquire the knowledge necessary to participate effectively in the process.⁴⁰ Those who assume leadership roles in improving the performance and quality of care delivered in an organization are expected to establish a process of improvement; to

set priorities for improvement; to assess performance; to implement improvement actions based on that assessment; and to maintain that level of improvement.⁴¹ The revised standards for 1996 call for medical staff to take a "leadership role" in evaluating and improving medical assessment and treatment of patients, use of medications, efficiency of clinical practice patterns, patient education and coordination of care.⁴²

Depending on the level of skill and knowledge required by the individual health care organization to sit on a quality assurance or improvement committee, a physician's participation in these activities demonstrates dedication to a high standard of care for his or her community. These committees evaluate the quality of care provided by other physicians and, therefore, those who serve on these committees have been deemed by their peers as qualified to judge the performance of others.

6. Evidence of a large, busy practice of satisfied patients.

Patient satisfaction is a major part of any process by which plans select physicians and market their product. It would not make sense to exclude from a plan physicians who enjoy a reputation for providing excellent care. One way to measure patient satisfaction is through a patient survey. Obviously, this would be most applicable to physicians already in a plan, but physicians seeking entry into a health plan could obtain the plan's patient survey and conduct their own evaluation. There are two caveats, however, concerning patient satisfaction surveys. These surveys should capture the elements of patient satisfaction directly linked to a physician's care and not factors over which a physician exercises no direct con-

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trol—such as the amount of parking provided by a health plan's facilities or the efficiency with which the plan's administrative office schedules appointments. In addition, sample sizes should be sufficient to draw definitive conclusions.

7. Documentation of good standing in the medical community.

Some will argue that "good standing in the medical community," like "patient satisfaction," is difficult to measure objectively. However, references from hospital medical-staff supervisors or other medical colleagues may provide some insight into measuring this alternative.

To document a physician's good standing in the medical community, ABIM seeks references from the chief of medical service at the institution that holds the physician's main staff appointment. Particular "red flags" ABIM looks for are evidence of substance abuse; convictions and felonies related to medical practice; or substantial disciplinary action by the hospital staff. Health plans could request similar references from physicians seeking to participate in their network. ABIM also checks with the Federation of State Medical Boards to ascertain if there have been any state licensure actions against a physician.

In 1993, ABIM began examining the feasibility and utility of a professional associate rating (PAR) to evaluate the standing of a physician in the medical community by posing questions to the physician's colleagues. Although there have been drawbacks—such as the amount of paperwork involved and concern about the use of the results in malpractice actions—elements of the survey identify some of the measures health plans could use to document a physician's standing in the medi-

cal community. These include a physician's humanistic qualities; communications skills; use of laboratory tests and diagnostic procedures; and inpatient and outpatient clinical management skills. The PAR used a "nine-point Likert scale" to rate various categories "including verbal communications, management prior to referral, medical knowledge, integrity, psychological aspects of illness, management of multiple complex problems, responsibility and overall clinical skills."⁴³

8. Clinical privileges granted by a hospital medical staff.

JCAHO—which accredits most hospitals and other health care networks and organizations in the U. S.—sets out requirements for hospital medical staffs in granting clinical privileges. Medical staff membership and clinical privileges are based on the recommendations of medical staff in accordance with the hospital's bylaws, rules, and regulations. Hospital appointment and reappointment mechanisms must include criteria pertaining to current licensure, specific training, experience, and demonstration of "current competence provided by the applicant, with information from the primary source(s) whenever feasible." Reappointment is granted based on a review of a physician's performance and clinical and/or technical skills and must be conducted every two years. Hospitals also are encouraged to consider additional information from other sources such as the AMA Physician Masterfile and the Federation of State Medical Boards Physician Disciplinary Data Bank.⁴⁴ Although the JCAHO manual recognizes board certification as one benchmark to be considered in granting privileges, it states that when "privilege delineation is based primarily on experience, the individual's credentials record reflects the specific experience and

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successful results that form the basis for granting privileges.”⁴⁵

Obviously, physicians must go through an extensive and thorough approval process to receive hospital clinical privileges. In particular, physicians who are not board certified must have a proven record of “successful results” to receive privileges.

9. Outcomes measures.

The best tests of a physician’s competence are outcomes measures, which assess the result of the medical care given. However,

development of these measures is still in its infancy. An accurate system of measurement should include methods for adjusting for severity of illness and for complexity of diseases; it should develop data collection systems to gather information from appropriate sources. Two outcomes indicating a physician’s competence are patient outcomes in terms of process of care, and clinical outcomes in terms of morbidity and mortality. As noted in the April 1995 issue of *The Internist: Health Policy in Practice*, “until these elements can be collected routinely, outcomes measurement remains crude.”⁴⁶

Conclusion

ASIM recognizes that board certification is one of many appropriate measures of a physician's competence. However, as the population increasingly receives its health care from managed care organizations, board certification as the sole criterion for a physician's selection and retention by a health plan becomes increasingly problematic. There are too many experienced, high-quality physi-

cians in the U. S. who are not board certified—and too many patients with long-standing attachments to those physicians—to continue to rely on board certification alone. ASIM believes that the measures outlined in this paper serve as appropriate alternatives to board certification as indicators of a physician's quality of care.

APPENDIX A

Sample Credentialing Form for Contracting with a Managed Care Plan

Name: _____

Address: _____

Telephone: _____

1. Medical school graduated from: _____

Year: _____ Address: _____

2. Postgraduate Training

Dates: _____ to _____ Hospital: _____

City: _____ State: _____

Specialty areas: _____

3. Evidence of current valid license to practice medicine:

4. Employment History: List employment pertinent to your specialty since graduation from medical school. Do not include postgraduate training. Include dates and addresses. A CV will be satisfactory.

5. Valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate:

6. Hospitals in which you hold privileges. Attach additional sheets as required.

Hospital name: _____

Location: _____

Department chief: _____

Type of privileges (active, courtesy, etc.): _____

Year from which privileges date: _____

Reinventing Managed Care

7. Board eligible? _____ yes _____ no
8. Evidence of current malpractice insurance coverage:
9. Professional liability claims history:
10. Hours of continuing medical education (CME) in last two years: _____
Attach list of courses.
11. Faculty appointments: _____
School: _____ Number of years: _____
Courses taught: _____
12. Quality assurance/peer review activities (*list committees, dates of service, and positions*):
13. Evidence of patient satisfaction (*attach survey results or other ratings*):
14. Documentation of good standing in medical community (*attach references from chief of medical service of the hospital at which you hold your major staff appointment and other relevant references*):
15. Membership in local medical organizations:
Organization: _____
Position(s) held: _____

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