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Revocation of Board Certification for Legally Permitted Activities

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In 1917, the American Board of Ophthalmic Examinations (precursor to the American Board of Ophthalmology) was founded.[1] It was followed by the founding of the American Board of Otolaryngology in 1924 and the America Board of Obstetrics and Gynecology (ABOG) in 1930. The number of medical specialty boards increased rapidly during the 1930s and 1940s, and currently there are 24 boards offering certification in more than 140 specialties and subspecialties.

Medical specialty boards developed in part to justify and define a specialty.[1,2] Boards sought to ensure clinical expertise by certifying that their diplomates had a defined body of knowledge and skill. Board certification also helped make specialty practice economically viable by limiting entry into the specialty and minimizing competition from nonspecialty physicians. To protect the quality and reputation of their imprimatur, their diplomates, and their specialty, boards also developed professionalism requirements for obtaining and maintaining board certification.

The purpose of medical specialty boards is to serve the public. Boards that are now responsible for certifying physicians typically emphasize professional, ethical, and moral standards in reserving the right to revoke board certification. Standard reasons include falsely obtaining board certification, having a medical license limited or revoked, or committing a felony.[3-8] Several of the boards permit revocation for misdemeanor convictions of moral turpitude, convictions that have a "material relationship to the practice of medicine,"[7] or unauthorized disclosure of examination content.[5,7-10]

In 2010, following publicity about the practice of lethal injection,[11-13] the American Board of Anesthesiology (ABA) incorporated the American Medical Association's opinion regarding physician participation in capital punishment[14] into its reasons for revocation of board certification:

> [I]t is the ABA's position that an anesthesiologist should not participate in an execution by lethal injection and that violation of this policy is inconsistent with the Professional Standing criteria required for ABA Certification and Maintenance of Certification in Anesthesiology or any of its subspecialties. As a consequence, ABA certificates may be revoked if the ABA determines that a diplomate participates in an execution by lethal injection.[15]

I am not aware of any other board that now directly prohibits a specific legal activity.

The ABA's statement spurs a larger question. Under what circumstances is it appropriate for medical specialty boards to proscribe legal activities? Boards are obligated to establish professional standards for physicians, and boards have the legal right to establish rules. However, because boards actively seek and have substantial influence on the ability of physicians to practice (consider the American Board of Medical Specialties Certification Matters website, which declares "You want quality care for your family. That's why choosing a Board Certified doctor is so important."[16]), there should be a specialist-community discussion of the process by which boards declare that a specific legal activity can affect board certification.

Implementation of one policy that proscribes a legal activity logically and psychologically opens the door for future policies that proscribe other legal activities. It is important to have this discussion before proscription is accepted as unremarkable. This article centers on proscribing legal activities in general, although I will use examples from the lethal injection policy and from gynecologists performing anoscopy for men.

Proposed Requirements for Proscribing Legal Activities

To declare a legal activity sufficiently unprofessional as to permit revocation of board

certification, I propose that all of the following requirements be met. In the following discussion, these requirements are "teased out" because each step deserves clear recognition.

Evidence That the Activity Is Unprofessional. Sufficient evidence should be provided by both a substantive argument and a concurring literature discussion. An argument that appears substantive but has not gone through the crucible of academic discussion is insufficiently tested.

Relevance to the Profession. The board should have a specific concern about the consequences of its members participating in the activity. For example, participation in lethal injection is relevant to the ABA because lethal injection may appear similar to anesthesia. It would be unwarranted for the American Board of Allergy and Immunology, for example, to implement a similar rule. Gratuitous proscriptions perceived as insignificant (eg, proscribing lethal injection by allergists) help establish the precedent of proscribing legal activities by getting an innocuous "foot in the door."

The Relevant Harm. The board should identify who is being harmed and how they are being harmed. For example, the similarity between lethal injection and anesthesia practice may lead patients to distrust their anesthesiologists, perhaps heightening their concerns about being anesthetized.

The Mechanism by Which the Activity Will Cause Harm. The board should explain the specific mechanism by which the activity will cause harm. For example, if the postulate is that public trust is harmed, the board should be able to explain how the public learns about the activity and why knowledge of it will have a relevant effect on an individual's opinion.

Evidence That the Activity Will Cause Harm. In addition to describing the mechanism, sufficient evidence should support the contention that the proposed mechanism will occur and that the activity will cause relevant effects. For example, if the argument were that public trust is harmed, data would need to support the proposed mechanism of the public finding out and, more importantly, that this knowledge would have a relevant effect.

One has to be careful about the data used. Consider the scenario about loss of public trust because members of the public believe that physicians are involved in lethal injection. One may intuitively jump to looking at the Netherlands because its physicians can legally perform euthanasia. There are 2 broad problems with comparing trust of physicians in the Netherlands and the United States regarding this matter. The first is that the issues, euthanasia in the Netherlands and physician participation in lethal injection in the United States, are wholly unrelated. Among other things, euthanasia is a very public and accepted role of physicians in the Netherlands, and end-of-life care is routinely discussed with patients. Patients may well be involved in decisions about their own euthanasia.

Second, researchers who compare trust across countries chalk up differences to culture.[17] Definitions about trust are highly contextual.[18] There is a high level of trust in physicians in the United States, and it is rooted in the physician attributes of caring, competency, honesty, and confidentiality. One of the most prominent declines of trust in physicians occurred during the 1990s because of concerns about prioritizing cost over health care.[19]

When determining whether an activity will cause harm, the assessment needs to occur in the specific patient population with regard to the specific matter.

Grander arguments about "slippery slopes" and professionalism fail. Claims that the activity may cause a crisis in professional mores must be carefully explained. Burgess,[20] in arguing this claim in the context of *voluntary euthanasia* (ie, the practice of ending a life in a painless manner) being a gateway to Nazi genocide, called this sweeping generalization "the great slippery-slope argument," in which hand-waving or the claim that "it is obvious" leads to sloppy slippery slope arguments. Slippery slope arguments need to be simple, specific, and tightly bound.

Inclusive Process. The board should seek opinions from rank-and-file members and from appropriate medical societies. The board should publicly document the process, including from whom they sought and received comment. I would recommend oral and electronic public

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comment periods, with the responses being public record.

The usefulness of this approach may be considered in light of the ABOG's recent scope of practice concerns. Board-certified gynecologists, because of their related expertise in treating cervical cancer, have been providing care to men who are at high risk of anal cancer. In September 2013, the ABOG declared that, except for defined circumstances, gynecologists may only treat women. They prohibited gynecologists from performing anoscopy for men. This affected not only the patients of these gynecologists, but also the ability to perform clinical research in anal cancer.

The ABOG implemented this change because the mission of the ABOG is the treatment of women. They felt the need to preserve the reputation of the specialty, in part because some gynecologists were performing lucrative care outside their ABOG-sanctioned expertise, such as testosterone therapy for men.[21] However, following an outcry from physicians and their patients, the ABOG changed their position regarding anoscopy in men. A stated reason for the change was that the outcry was distracting from the ABOG's mission.[22]

In regard to other proposed criteria, it does not appear that there were substantive discussions in the literature to support this prohibition. Although the ABOG had general concerns about gynecologists practicing outside of their abilities, it did not appear to have evidence that performing anoscopy was causing harm. A more inclusive process may have prevented this distraction.

The ABA

Because I have used the ABA policy on lethal injection as an example, it is important to explain that for the most part, the ABA fulfilled the criteria I have proposed. The ABA examined the academic literature, established the relevance to the profession, defined who would be harmed and how they would be harmed, and actively sought opinions from others.

Medical Specialty Boards

Medical specialty boards view themselves as private organizations from which physicians may voluntarily seek certification to show that they have reached a defined level of excellence. Although board certification is technically voluntary, pragmatically it is not. Not being board certified is a distinct professional disadvantage. Losing board certification can be life changing.

Medical specialty boards' obligations have always been to the patient. However, they now need to recognize and publicly acknowledge the obligations that come with their increasingly powerful influence over the careers and lives of physicians. They need to develop and publish detailed processes about how they will walk the fine line in managing their overriding obligations to patients and the burgeoning obligations to diplomates.

Conclusion

The development and history of medical specialty boards suggest that proscribing specific legal activities is probably within the concept of their responsibility to define professionalism. Nonetheless, proscribing legal actions has consequences. Stout arguments and thorough community discussion should help determine when it is appropriate for boards to proscribe legal activities. Medical specialty boards should recognize the imperative to consider changes in their policies and procedures now that board certification is functionally required to practice medicine in the United States.

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