

## **Report of the Special Committee on Physician Profiling**

### **The Federation of State Medical Boards of the United States, Inc.**

The recommendations contained herein were adopted as policy by the House of Delegates of the Federation of State Medical Boards of the United States, Inc., April 2000

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#### **Section I. Introduction and Charge**

Federation President Alan E. Shumacher, MD, established the Special Committee on Physician Profiling in April 1999 in response to the increasing demand for public access to physician-specific information and efforts by state medical boards to address consumer education and protection by making physician profiles easily available to the public. The committee was charged to review the breadth and depth of physician profile information available to the public through a variety of sources including web sites sponsored by state medical boards and other health-related organizations. Further, the committee was asked to address whether physician profile information is valuable to the public in choosing a physician and, if so, what information is most helpful. The committee reviewed statutes from states with mandated physician profiles and rules from states voluntarily providing profiles to the public. Additionally, the committee considered recommendations from several consumer advocacy groups regarding the types of information they believed to be useful to consumers in making health care decisions.

The committee assembled a comprehensive list of possible profile components and reviewed each component discussing information sources, reliability and verification, maintenance of accurate information, and contextual information needed to assist the public in understanding the significance of individual profile components. The committee also discussed associated issues, such as funding, which should be considered by state medical boards, legislatures and others, when implementing a physician profile system. Finally, the committee acknowledged that the Federation's integrated database could be a useful resource in the future for state medical boards undertaking profile systems.

The following report provides an overview of the committee's deliberation on the issue of physician profiles and is intended to be a resource for state medical boards and others initiating physician profile systems.

#### **The Special Committee on Physician Profiling was charged with the following:**

1. Review models of physician profiles currently being utilized by state medical boards.
2. Review and evaluate models of physician profiles currently being utilized by state medical boards as to whether differences exist between profiles created by legislative mandates and profiles created as a result of state medical board initiative and the reasons for any differences identified.
3. Review and evaluate the different elements/components utilized in physician profiles and determine the relative importance of each element/component to an evaluation of a physician by the public.
4. Review the effectiveness of the processes utilized by state medical boards to verify the informational elements/components included in physician profiles.
5. Review the effectiveness of the processes utilized by state medical boards to maintain the currency of the information included in physician profiles.
6. Develop recommendations to state medical boards as to what elements/components should be included in a physician profile.
7. Develop recommendations to state medical boards regarding verification and updating of physician profiles.

8. Develop an informational guide to be utilized by the public that interprets the relative importance of the elements included in a physician profile in the evaluation of a physician's practice.
9. Develop a recommendation to the Board of Directors of the Federation as to whether or not FSMB should utilize data from the new All Licensed Physicians Data Bank to develop profiles on physicians for use by state medical boards and the public.

The committee met in the summer and fall of 1999 and during the winter of 2000 at the Federation's national office.

For the purposes of this report, a physician profile is a data record, which may be in hard copy or electronic format, that includes personal, educational, demographic and professional information about an individual physician compiled for the purpose of assisting health care consumers when choosing a physician. In addition, a profile may include information on disciplinary actions taken by state medical boards, hospitals and other entities; medical malpractice experience; and criminal convictions. There is no standard format for a physician profile. The amount and types of information included in a mandated profile may be determined by administrative rule or state statute in the state where a physician is licensed to practice.

Some managed care organizations have used the term "physician profiling" to refer to a system of measuring and reporting patterns of resource use as a means to control health care costs and satisfy accreditation requirements. Additionally, using profile data as a comparative performance measure for individual physicians is gaining support in some arenas. These uses of profile information are not addressed in this report.

## **Section II. Background of Physician Profiling**

### **The Massachusetts Experience**

An interest in better informing consumers set the stage for introduction of a profile initiative in Massachusetts, which eventually became the first physician profile system mandated by statute in the United States.

In 1993, the Massachusetts Teachers Association filed legislation requiring the Massachusetts Rate Setting Commission to collect and publish information on individual physicians. Despite intense lobbying against the measure by organized medicine, it passed both Houses of the Legislature. The Governor ultimately vetoed the bill because of concerns raised by the Massachusetts Medical Society (MMS) and others. The MMS subsequently introduced a bill to require expanded release of physician information by the Board of Registration in Medicine.<sup>1</sup>

At the same time, in an effort to satisfy the interests of all involved, the Governor's Secretary of Consumer Affairs appointed a special three-person committee to examine issues related to physician profiling and return with recommendations regarding what information should be disclosed to the public. In April 1995, the Kramer Commission, as the committee came to be known, issued its report, "Making Informed Choices About Doctors." After release of the Kramer Report, a new physician profile bill was introduced with the support of the MMS and the Board of Registration in Medicine. The bill eventually passed and was signed by the Governor on August 9, 1996, with an effective date 90 days later.<sup>2</sup> One significant and ultimately controversial aspect of the Massachusetts profile statute is that the legislature appropriated no funds to prepare and implement the program leaving the Board to its own resourcefulness in creating an effective profile system while not compromising the Board's regulatory obligations.

Flaws enacted in the Massachusetts system were destined to be duplicated by other states. Since its passage, the Massachusetts profile bill has become a template for states and medical boards undertaking profile initiatives in response to a rapidly changing health care delivery system and consumer demand for reliable information on which to base provider decisions.

## **Profile Legislation in the States 1997 to 1999**

During the 1997 legislative sessions, profile initiatives were enacted in Florida, Rhode Island, and California. During the 1998 sessions, laws were passed in Idaho, Tennessee and Virginia. The Idaho and Tennessee laws require provider profiles on a wide spectrum of health care professionals beyond just physicians.<sup>3</sup>

Brisk activity in profile legislation continued in 1999 as new profile laws were enacted in Arizona, Connecticut, Maryland, and Texas. At the time of this report, Hawaii, Illinois, New Jersey, New York, Ohio, Oklahoma and Pennsylvania have legislation pending with several of the bills slated for carryover to the 2000 session.

In addition to activity at the statehouses, fourteen state medical boards have recognized profiles as a significant resource for health care consumers and elected to address the issue of physician profiles voluntarily. Arizona, Colorado, Iowa, Kansas, Maine, Maryland, Michigan, Minnesota, New York, North Carolina, Ohio, Oklahoma, Oregon and Vermont have independently initiated some form of physician profiling with most available to consumers through a web site.

## **Historical Summary**

At this time, nearly half the states make profile information available to the public through some combination of vehicles, including, telephone, toll-free numbers, mail, e-mail and web sites. What becomes readily apparent when reviewing individual state profiles is that there is no consistency in the types of information included. Some of the more basic profiles give identifying information, details about medical education, licensing and an indication of any board disciplinary actions. More comprehensive profiles include criminal convictions, malpractice history and disciplinary actions taken by other entities. In general, states having profiles created by legislative initiative tend to provide more comprehensive information. States providing profile information voluntarily are more basic in content.

## **Other Sources of Physician Profile Information**

Several health-related organizations have established web sites that provide consumer access to a limited amount of information regarding physicians, including:

American Board of Medical Specialties, [www.certifieddoctor.org.verify](http://www.certifieddoctor.org.verify)

American Medical Association, AMA Physician Select, [www.ama-assn.org](http://www.ama-assn.org)

Administrators in Medicine (AIM), [www.docboard.org](http://www.docboard.org)

HealthGrades.com, [www.healthgrades.com](http://www.healthgrades.com), provides ratings of physicians

Medi-Net, [www.askmedi.com](http://www.askmedi.com), provides profile information for a fee

None of the sources listed above, however, contain information on criminal convictions or medical malpractice actions.

## **Section III. Recommended Profile Components**

The Special Committee on Physician Profiling recognizes that public demand for consumer-oriented information regarding physicians, hospitals, managed care organizations, etc., is increasing. Consumers are becoming more proactive in educating themselves on medical issues. To quote the November 1999

*Connecticut Medicine*, “A revolution is underway among American health-care consumers.”<sup>4</sup> Managed care is imposing significant limitations on consumer choice in health care provider decisions. While individuals historically have relied on the advice of family, neighbors and friends when choosing a physician, they are now often forced to choose from a prescribed list of physicians they do not know and have little means to investigate.

Despite the sense of increasing demand for information by consumers, the Committee found no studies or market research regarding what consumers want to know about physicians. While consumer advocacy groups have lobbied for specific information to be provided in physician and other provider profiles, their recommendations have not been supported by formal consumer research known to the committee. The Committee believes that physician profiles should contain only information which is useful to consumers in making physician decisions. Profile data should be presented in a format that is easy to understand and supported by contextual information, as suggested in the Consumer Guide (Appendix), to aid consumers in understanding its significance. The Committee emphasizes that only high quality, credible information should appear in a profile associated with a medical board. Customer inconvenience or harm from relying on inaccurate information and medical board liability must be considered. In addition, the Committee recognizes that verification and maintenance processes can be very costly and resource intensive.

The Committee assembled a master list of profile components from existing profiles, from related literature and recommendations made by consumer advocacy groups. Each profile component was reviewed and discussed as to medical board access, usefulness to consumers, reliability, and sources for verification and maintenance.

After considerable deliberation, the Committee recommends that state medical boards include the following components in a physician profile:

<b>Profile Component</b>	<b>Source/Verification */Recommendation</b>
<b>Demographic Information</b>	<b>Demographic information is reported by the physician on their initial license application.</b>
Licensee Name	Updated as changes occur or at the time of renewal.
Gender	Changes require a legal document.
Business Address/Practice Site	Business address was preferred to home address because of concerns for a physician’s safety and privacy.
Birth Date	
<b>Medical Education</b>	<b>Medical education information is reported by the physician on their initial license application.</b>
Medical School	
Medical School Location	Should be presented in a profile as City, State/Country.
Year of Graduation	
Degree	Indicates whether physician is an MD or DO.
Approved Postgraduate Training	<p>Only American Osteopathic Association (AOA), Accreditation Council of Graduate Medical Education (ACGME), Royal College of Physicians and Surgeons of Canada (RCPSC) and College of Family Physicians of Canada (CFPC) approved programs should appear in a profile. The Committee felt it would be ideal to include all approved postgraduate training even that obtained after initial licensure. The Committee agreed that the decision to include fellowships should be left to the individual state board. In addition, the profile should include the following, or a similar, explanation of postgraduate training:</p> <p><i>The educational training of a physician includes premedical education in a college or university, four years of medical school, and after receiving an M.D. or D.O. degree, at least one year of postgraduate training under supervision, which is often referred to as a residency. Residency training prepares a physician to practice</i></p>

Profile Component	Source/Verification */Recommendation
	<i>independently. Completion of specialty training can require three to seven years of postgraduate training.</i>
<b>License and Certification Information</b>	<b>All information under License and Certification, except Type of Practice and Board Certification, is taken from the state medical board database. Board Certification comes from the initial license application or a renewal application. Type of Practice is submitted by the physician.</b>
License Status	License status in the profile should be changed concurrently with changes in the database. Consumers should be instructed to call the medical board if they have questions about a physician’s license status.
License Number	
License Type	The type of license, for example, telemedicine, limited/training, etc.
Original License Date	
License Renewal Date	There was some question as to whether this information is useful to the public, although it is useful to anyone using the profile for credentials verification. The Committee recommended that inclusion of license renewal be optional.
Type of Practice	In order to assist consumers in knowing the physician’s usual area of practice, the Committee recommended that physicians be allowed to submit their type of practice. A disclaimer should be included to inform consumers that the information was received from the physician and is not attested to by the board.
Board Certification	<p>Only board certifications from a member board of the American Board of Medical Specialties (ABMS), American Osteopathic Association –Bureau of Osteopathic Specialists, Royal College of Physicians and Surgeons in Canada (RCPSC), or College of Family Physicians of Canada (CFPC) should be included in a profile*. The Committee discussed the inclusion of approved subspecialty certifications from these organizations. There was concern that some medical boards may not have the resources to verify subspecialty information. The Committee concluded that inclusion of subspecialty certifications should be left to the discretion of individual medical boards. Boards may wish to indicate that consumers can get additional information from the certification boards or their web sites.</p> <p>The committee acknowledged that some specialty boards require a waiting period before a licensed physician can take the specialty board exam. Such physicians are sometimes referred to as “board eligible.” The committee recommended that board eligibility not be addressed in a profile.</p> <p>It was noted that there are numerous other boards offering “certification” to physicians in various areas. In order to clarify the significance of board certification by ABMS, AOA-Bureau of Osteopathic Specialists, RCPSC or CFPC specialty boards, the Committee recommended a profile include the following, or a similar, explanation:</p> <p><i>ABMS, AOA-Bureau of Osteopathic Specialists, RCPSC, and CFPC specialty boards certify that physicians have met certain published standards and passed a board exam. Board examinations consist of a written examination and, depending on the specialty, an oral examination. When a physician achieves board certification, he or she is called a diplomate of the respective specialty board. For many specialties, to remain board-certified, physicians must present evidence of licensure and pass an examination every 6 to 10 years. The intent of certification is to provide evidence to the public that a medical specialist has successfully demonstrated advanced training and experience in that specialty.</i></p> <p>*Resolution 02-1, adopted by the Federation's House of Delegates in 2002 expanded</p>

Profile Component	Source/Verification */Recommendation
	the recommendation on specialty certification boards to: <b>State medical boards may also elect to include certifications by specialty boards that (1) provide advanced certification beyond prior ABMS or AOA certification and (2) are permitted by the state medical board for physician disclosure in advertising.”</b>
<b>Criminal Convictions</b>	Criminal convictions are reported to the state medical board from the court having jurisdiction over the case or from the physician.
Criminal Convictions	<p>While courts in most states are required by law to report convictions to state medical boards, compliance is inconsistent in many jurisdictions. When undertaking profile initiatives, state medical boards should review reporting requirements for criminal convictions and, if necessary, request introduction of legislation making such reports mandatory for courts. Provisions should also be made to give the state medical board access to state criminal records electronically.</p> <p>The Committee discussed the issue of setting time limits on the inclusion of criminal convictions. Some states with existing profiles specify time limits on profile components such as board actions, criminal convictions, and medical malpractice. It was recognized that the relevance of some criminal convictions diminishes over time, while convictions, such as crimes involving children, could be significant for a lifetime. In addition, states vary in how crimes are categorized; for instance, in some states practicing medicine without a license is a misdemeanor and in others a felony. The committee reached consensus that time limits not be recommended for criminal convictions. Decisions to impose time limits should be left to the discretion of state medical boards.</p> <p>With regard to criminal offenses the Committee recommends the following be included in a physician profile:</p> <ol style="list-style-type: none"> <li>1. All criminal convictions for felonies. A person shall be deemed convicted of a felony if entering a plea of guilty or found or adjudged guilty by a court of competent jurisdiction, or having been convicted by the entry of a plea of nolo contendere.</li> <li>2. All convictions for misdemeanors involving offenses against the person, offenses of moral turpitude, offenses involving the use of drugs or alcohol and violations of public health and safety codes. A person shall be deemed to be convicted of a misdemeanor if pleading guilty, found guilty by a court of competent jurisdiction or entering a plea of nolo contendere.</li> </ol> <p>The Committee agrees that deferred adjudications should not be included. Finally, the profile should include a notation that specific information about the case is available from court records.</p>
<b>Medical Malpractice</b>	Medical malpractice information is reported to the state medical board by courts and insurance companies or by the physician on a license application.
Medical Malpractice	Health care consumers want access to physicians’ medical malpractice experience because of the perception that knowing about malpractice judgments will allow them to make better decisions when choosing a physician. The Committee agreed that malpractice information is in great demand, but is frequently not a reliable measure of a physician’s competence. Issues such as the physician’s time in practice, the nature of their specialty, the types of patients treated, geographic location, etc., can have a significant influence on the number and amounts of malpractice judgments,

Profile Component	Source/Verification */Recommendation
	<p>awards, and settlements.</p> <p>The committee sought to balance fairness to physicians with a desire to facilitate public disclosure and protection. Judgments and arbitration awards are already public information and available from court records. Settlements are a more difficult issue because these are sometimes handled by insurance companies as business decisions and may not be related to the validity of the claim. Insurance companies often enter into settlement agreements without the consent of the physician or any finding of fault.</p> <p>Regarding the issue of medical malpractice, the Committee recommends reporting the following:</p> <ol style="list-style-type: none"> <li>1. The number of medical malpractice court judgments and arbitration awards against the physician within the past 10 years. This is a numeric field showing the total number of such actions in the designated time period.</li> <li>2. The number of malpractice settlements when that number is equal to or exceeds 3 in the past 10 years. This is a numeric field. The field will be blank or contain a number greater than two.</li> </ol> <p>Dollar amounts of awards, judgments and settlements should not be included for malpractice cases.</p> <p>The committee recommends that a profile include the following or a similar context for the medical malpractice data:</p> <p><i>Consumers should take the following factors into consideration when evaluating a physician's competence from malpractice data.</i></p> <p><i>A number of studies have been conducted to identify indicators of substandard care among physicians. There is no conclusive evidence that malpractice data correlates with professional competence. There are a variety of factors unrelated to professional competence or conduct which affect the likelihood that a physician will be the subject of a malpractice claim, such as, the physician's time in practice, the nature of their specialty, the types of patients treated, geographic location, etc. For example, certain medical specialties have a higher rate of malpractice claims because of a higher risk inherent to their field of practice. Settlements of malpractice cases by insurance companies are sometimes handled as business decisions. In the case of some minor claims, it is less expensive for the insurance company to make a monetary settlement than it is for them to take the case to court. Many times such cases are settled without a finding of fault or admission of guilt on the part of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.</i></p> <p>Additionally, boards that independently investigate malpractice claims may want to include a statement in the profile that the board investigates malpractice cases and takes disciplinary action against a physician when appropriate. These actions will appear under Disciplinary Actions/ State Medical Board Orders.</p>
<b>Disciplinary Actions</b>	<b>Disciplinary actions are taken from the state medical board database or reported to the board from other entities.</b>
State Medical Board Orders	All disciplinary actions taken by the state medical board should be included in a profile. Complaints that do not result in board action should not be included. The

Profile Component	Source/Verification */Recommendation
	profile or a user guide should offer examples and explanations of the most frequent forms of board discipline, for example: license denial, revocation, probation, limitation or suspension; reprimand or censure; voluntary surrender of license; administrative fines, penalties or restitution, or other conditions warranting a board order. An explanation of what it means when a board action is “stayed” should be included. It should be clarified that consumers can call the medical board for additional information.
Orders by Other State Medical Boards	While there are generally no specific reporting requirements, state boards do often share information about licensees especially when it is known that physicians are licensed in multiple jurisdictions. Boards may also learn of disciplinary actions in other states by accessing the FSMB database or through queries of the NPDB or AMA databases. Boards should include disciplinary actions from other states in the profile when they are known.
Disciplinary Actions by Hospitals	Disciplinary actions by hospitals that are required to be reported to the medical board should appear in a profile. In most states, hospitals are required to report disciplinary actions to the state board. If this requirement does not exist, consideration should be given to including it in implementing legislation.

*\* All information included in a profile should be verified, received directly from a primary source, or attested to by the physician under penalty of discipline. Boards should identify information attested to by the physician with an asterisk or other symbol to indicate that the information has not been verified by the board for accuracy.*

In addition to the profile components described above, the Committee suggests the state medical board provide contextual information for consumers seeking to use a physician profile. In the Appendix, the Committee has supplied a Model Consumer Guide based on the Committee’s profile recommendations, which can be adapted by a board to apply to a particular profile system. The Guide is intended to help consumers understand the significance of individual profile components and could be made available as a link from the profile web site and in hard copy form for consumers making requests by mail, telephone, etc.

**Section IV.  
Collection, Release, and Updating of Profile Information**

The accuracy of information provided in a physician profile reflects on the credibility of the entire operation of the state medical board. As one medical board executive put it, “all your errors are out there for the public to see.” Implementation of a successful profile system requires that procedures for collection, release and updating of profile components be outlined specifically in board operational rules. Basically, profile information can be categorized into three groups:

1. Information from applications or renewals.
2. Information that occurs outside the normal record keeping of the board, such as specialty board certification.
3. Information that is received from other entities.

All profile information not received from a primary source must be verified or attested to by the physician under penalty of discipline. State medical boards should consider adding a provision to their rules and revising applications to include a statement that misrepresenting information to the board, including profile information, may be grounds for disciplinary action. Boards should identify information attested to by the physician with an asterisk and an explanation that the information has not been verified by the board. The state board may need to reassess time frames for renewal applications and review requirements for specific changes to be reported by the physician in the interest of ensuring accurate information in the profile.

There are two additional issues relating to release of profile information, which must be addressed by the board. First, board rules or profile legislation should state specifically how the public can request a profile,



for example, via the Internet, toll-free telephone number, in writing, by e-mail, in person, etc. Some state legislation gives state boards the authority to charge individuals and commercial entities for profile information, although state boards have not generally elected to charge individuals. The Committee recommends that profiles provided by medical boards be made available free of charge or at cost to the public, however, appropriate fees may be charged for commercial customers, such as hospitals and HMO's. There should also be statutory standards for how profile information is to be used by the public. Profiles are intended to be a resource for health care consumers in choosing a physician. They are not intended to be a source for harassment of physicians, for commercial uses, for targeting certain groups of physicians, etc. Statutory limits on the use of profile information and punishments for misuse should be considered.

Secondly, provisions should be made to make a copy of the profile available to the subject physician for review with procedures to correct factual inaccuracies. Boards need to be aware that significant costs may be incurred in this effort depending on how often profiles are provided to physicians and the methods adopted for making corrections. There also should be a mechanism for physicians to dispute reported information. Such a provision should address how information in dispute is to appear (or not appear) in a profile.

## **Section V.**

### **Profile Components Considered but Not Recommended Be Included in Physician Profiles**

The Special Committee reviewed an extensive list of possible profile components. The two principle criteria used by the committee in selecting components for inclusion were: 1) the usefulness of the information to the public in making decisions about physicians, and 2) the ability of the state medical board to verify the information in order to assure that accurate and reliable information appears in a profile. Some components not recommended for inclusion were clearly of interest to consumers, such as hospital affiliations and translating services, but posed problems for state medical boards in collecting and maintaining the information. Since the accuracy of information in the profile is a direct reflection on the credibility of the medical board, the Committee agreed that specific components not normally collected by the medical board and those that change frequently should not appear in a profile. Other components not recommended were perceived as not helpful to consumers. There is a growing trend for individual physicians and physician groups to maintain web sites related to their practice. This is perhaps the most efficient way to provide this "soft" information to the public.

The committee thoughtfully considered the following components, but chose not to recommend inclusion in the state medical board profile: Office Phone Number, Practice Setting, Examination Type, Licensure in Other States, Basis of Licensure, Hospital Affiliations, Insurance Plans Accepted, Medicare/Medicaid Accepted, Appointments to Medical School Faculties, Translating Services, Professional Publications, Awards, Professional or Community Service, Peer Review, and Initial Complaints to the State Medical Board.

Peer Review activities have traditionally been confidential. If a hospital or professional society, etc., takes disciplinary action against a physician, such action will be reported under Disciplinary Actions. Initial Complaints to the State Medical Board will appear in the profile if the Board takes an action based on the complaint. Not all complaints received by the board involve violations of the Medical Practice Act. Publications, Awards, and Appointments to Medical School Faculties would be reported by the physician and most boards do not have the resources to verify this information. Items such as Office Phone Number, Insurance Plans Accepted, Practice Setting, Hospital Affiliations, and Medicare/Medicaid Accepted can change quickly in today's dynamic environment and would be costly to keep up-to-date. Knowing Examination Type and Basis for Licensure have no useful value for consumers. Medical illness and substance abuse problems not impacting the public health, safety and welfare are sometimes successfully addressed through non-disciplinary treatment programs. If they affect a physician's competency or conduct, actions taken by the medical board will appear in State Medical Board Orders.

## **Section VI.**

### **Implementing a Profiling System**

Physician profiles can be implemented by administrative rule or legislative enactment. Listed below are basic considerations a board should attend to when implementing a profile system. This list is not intended to be inclusive or a prescription for a model act.

#### **Considerations in Implementing a Profiling System**

1. Clearly articulate an intention to create a physician profile to be made available to the public for the purpose of assisting health care consumers in choosing a physician.
2. Specifically list profile components to be included in each physician profile. Consider including definitions or contextual information, which will assist consumers when interpreting profile information.
3. Identify specific procedures for collecting and updating profile data, including:
  - Collection and verification of information not normally maintained by the board;
  - Timing, deadlines, and format for information submitted by the physician;
  - Penalties for not submitting information or submitting inaccurate information;
  - Procedures and timelines for updating variable profile components;
  - Regular evaluation of profile methodologies, reliability, sources; and
  - Mandatory reporting of profile components not readily available to the board, such as, criminal convictions, hospital and medical society disciplinary actions, medical malpractice actions, etc.
4. Consider procedures for providing a copy of the profile to the subject physician prior to release of the information to the public with provisions for correction of factual errors and a mechanism to resolve disputed information.
5. Designate the means by which profile information will be made available to the public: Internet, mail, phone, fax, walk-ins, etc. Determine what fees will be charged and to whom they will accrue.
6. Establish standards for use of physician data; safeguards and penalties to protect against unauthorized use or disclosure of profile information.
7. Review state disclosure laws as to their implications for the release of physician profile information.
8. Provide for a funding mechanism sufficient to achieve and maintain the profile initiative without compromising the board's regulatory function.
9. Establish authority for the board to adopt rules as necessary to implement the profile system.
10. Provide for a realistic implementation date.

Most importantly, profile systems mandated by legislative enactment should provide for adequate funding and sufficient staff to ensure that the regulatory function of the board is not compromised. Funding from the state general fund should be considered. The Committee felt strongly that profiling should never be imposed on state medical boards as an unfunded mandate. If not properly funded, a profiling system can draw resources away from the regulatory function of the board and consequently jeopardize public safety.

A variety of factors affect the cost of implementing, maintaining, and operating a profile system. The significance of each factor for a particular medical board will vary depending on: the status of physician information already collected; the amount of new information required to be collected; amount of information not previously verified; new staff required; and hardware, software and programming needed to make the profile system functional. No specific cost formula applies across the board to medical boards because each board begins the process from their unique position. Implementation cost estimates from boards with existing profiles range from \$11 to \$36 per licensee. Maintenance costs tend to be less per licensee than the cost of implementation, but there is no consistent differential amount, for example, one state board reported implementation costs of \$26/licensee and maintenance/operation costs of \$22/licensee

while another board reported \$20/licensee for implementation and \$4/licensee for maintenance and operation.

There are significant costs associated with implementing, maintaining and operating any profile system. Accurately estimating costs requires planning and forethought on the part of the state medical board and/or the state legislature to ensure that operating the profile system does not compromise the regulatory function of the board.

## **Section VII. Providing Physician Profile Information to the Public**

The Special Committee on Physician Profiling brought together individuals from across the country to examine the whole spectrum of issues related to providing physician profiles to the public. Although there have been no scientific studies to document that profiles help the public make better health care decisions, the Committee recognizes existing public demand for physician profiles and the public perception that profile information helps consumers make choices. Therefore, the Committee believes there is public benefit in making physician profiles accessible to health care consumers when so doing does not compromise the regulatory function of the board. After a thorough study, the Committee believes that state boards undertaking profile initiatives should incorporate the recommendations and considerations addressed in this report.

The Committee also agrees that other medical professional organizations, individual physicians and physician groups should be encouraged to maintain databases of “soft” information, for example, office phone numbers, translating services provided, insurance plans accepted, hospital affiliations, etc, which are difficult for state medical boards to verify and are not collected in the normal course of board business. State medical boards may consider providing links to web sites, such as those offered by some state medical societies, to facilitate consumer access to information not available in the profile.

## **Section VIII. Assisting Member Medical Boards in Meeting Public Demand for Physician Profile Information**

The Federation has partially completed the **All Licensed Physicians Project**, which will create a national database containing biographical, educational, licensure and disciplinary information on every physician licensed to practice medicine in the United States. This expanded database will dramatically enhance physician regulation and will be unique among health care data banks. Completion of this project also will position the Federation to act as a resource for state boards in providing physician profile information to the public.

## **Section IX. Recommendations of the Special Committee on Physician Profiling**

In summary, the Special Committee on Physician Profiling submits the following recommendations for consideration by FSMB’s Board of Directors and the House of Delegates:

1. The Federation of State Medical Boards encourages all member boards to provide information on physicians to the public in the form of a physician profile (via Internet access, toll-free telephone numbers, etc.) in the interest of public accountability.
2. State medical boards should include profile components as detailed in the Special Committee on Physician Profiling Report when implementing a physician profile system.
3. Physician profiles should be presented in a format that is easy to understand and be supported by contextual information, which aids the public in understanding the significance of profile components in choosing a personal physician.

4. All profile components should be verified, received directly from a primary source, or attested to by the physician under penalty of discipline. Components attested to should be so indicated on a profile.
  5. Physician Profiles provided by state medical boards should be made available to the public free of charge or at cost.
  6. State medical boards should be authorized to charge appropriate fees to commercial entities for accessing physician profiles.
  7. Profile systems mandated by legislative enactment should provide for adequate funding and sufficient staff to ensure that the regulatory function of the board is not compromised. Profile initiatives should never be imposed as unfounded mandates.
  8. The Federation should study the possibility of utilizing data from its databases and other sources to develop profiles on physicians for use by state medical boards and the public.
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## References

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  2. Fleming, *Federation Bulletin*, p.14
  3. Marla Rothhouse and Elizabeth Kaiser, Provider Profiles, Health Policy Tracking Service, National Conference of State Legislatures, Sept. 22, 1999, p. 1
  4. Richard L. Reece, The Internet as an Equalizing, Energizing and Transforming Force in Patient and Physician Relationship, *Connecticut Medicine*, vol. 63, no. 11, November 1999, p. 683
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## Consumer Guide to Using Physician Profiles

What follows is a guide to how you might use the information in a physician profile to help you choose a physician. The Guide also points out areas where information may be misinterpreted and gives you useful directions on how to acquire additional information.

### Using Physician Profile Data:

**Name of Physician:** Indicates the full name of the physician. There may be several physicians with similar names, in which case, their medical license number is an important identifier.

**Gender:** Gender is helpful when consumers have a preference for a male or female physician. Many times names are not gender specific and foreign names may be confusing for those not familiar with a particular language.

**Business Address/Practice Site:** Indicates the location of the physician's office or practice site. A physician's home address is not provided in a profile in order to protect their privacy and security.

**Birth Date:** Some consumers have a preference for physicians in a particular age range. If you have moved your family to a new location, you may want to avoid choosing a physician who is likely to retire soon. Conversely, you may have a preference for a physician who has been in practice for a longer time.

**Medical School:** Physicians must meet certain educational requirements in order to receive a license to practice medicine. If you have questions about where a physician attended medical school, you should feel free to ask him/her during an appointment.

**Medical School Location:** This field allows you to determine if the physician attended medical school in the United States, Canada, or a foreign country. Foreign medical graduates, like U.S. and Canadian graduates, must meet certain standards before they qualify for a medical license.

**Year of Graduation:** All medical graduates must complete four years of medical school before they begin postgraduate training. Graduation date may not be a good measure of how long a physician has been practicing because the number of years of postgraduate training varies.

**Degree:** This tells you whether the physician is a Medical Doctor or Doctor of Osteopathy.

**Approved Postgraduate Training:** The educational training of a physician generally includes premedical education in a college or university, four years of medical school, and after receiving an M.D. or D.O. degree, at least one year of postgraduate training under supervision, which is often referred to as a residency or internship. Postgraduate training prepares a physician to practice independently. Training for specialty board certification can require three to seven years of postgraduate training.

**License Status:** Indicates the status of the physician's medical license, which is issued by the state medical board. The most common status categories are:

- active—full and unrestricted license to practice medicine
- inactive—physician is not practicing, but reserves the right to activate their license in the future
- expired—no longer valid for use
- revoked—disciplinary action prohibits the practice of medicine
- restricted—board imposed limitation on the practice of medicine

Questions about the status of a physician's medical license should be directed to the state medical board, which will be listed in the telephone directory under state agencies. The board is permitted to provide the public with the details of any board action affecting the status of a physician's license.

**License Number:** Physicians are issued a unique license number by each state in which they are licensed. License number is a good identifier when several physicians have similar names.

**License Type:** States may issue more than one type of medical license. Some examples of types of license are:

- telemedicine – issued to out-of-state physicians who are treating patients across state lines, usually by electronic means
- limited/training – issued to physicians in postgraduate training

Call the state medical board if you have questions about the type of license a physician holds.

**Original License Date:** This is the date the state board originally issued the physician's medical license. This may not be the date the physician began medical practice. It is possible that the physician was licensed in another state previously.

**License Renewal Date:** This is the date by which the physician must submit a renewal application to the board.

**Type of Practice:** This information is submitted by the physician and allows the physician to indicate the primary area of his/her practice. The state medical board does not verify this information or attest to its reliability.

**Board Certification:** Although there are numerous boards offering “certification” to physicians in a variety of areas, only certifications by member boards of the American Board of Medical Specialties (ABMS), American Osteopathic Association-Bureau of Osteopathic Specialists, Royal College of Physicians and Surgeons in Canada (RCPSC), or the College of Family Physicians of Canada (CFPC) are listed in the profile. These specialty boards certify that physicians have met certain published standards and passed a board exam. Board examinations consist of a written examination and, depending on the specialty, an oral examination. When a physician achieves board certification, he or she is called a diplomate of the respective specialty board. For many specialties, to remain board-certified, physicians must present evidence of licensure and pass an examination every 6 to 10 years. The intent of certification is to provide evidence to the public that a medical specialist has successfully demonstrated advanced training and experience in that specialty. Some specialty boards require a waiting period before a licensed physician can take the specialty board exam. During this time, physicians sometimes refer to themselves as “board eligible,” however the profile does not acknowledge board eligibility, only board certification. To determine if an individual physician is ABMS board certified and to find more information about the significance of board certification, you can access the ABMS website at [www.certifieddoctor.org.verify](http://www.certifieddoctor.org.verify). The AOA-Bureau of Osteopathic Specialists has plans to have a web site available soon.

**Criminal Convictions:** Criminal convictions are public information in the court having jurisdiction over the case. In most states, courts are required to report criminal convictions to the state medical board. The medical board reports the following information on criminal convictions in the profile:

- All criminal convictions for felonies.
- All convictions for misdemeanors involving offenses against the person, offenses of moral turpitude, offenses involving the use of drugs or alcohol and violations of the public health and safety code.

A person is considered to have been convicted if they plead guilty or are found guilty by the court.

Not all criminal convictions impact on a physician’s ability to practice medicine safely and competently. For example, a violation of the IRS Code can result in a felony conviction, but probably doesn’t reflect on a physician’s fitness to practice. The state medical board routinely reviews criminal convictions, investigates those that may affect a physician’s competency and takes disciplinary action when appropriate.

**Medical Malpractice:** A number of studies have been conducted to identify indicators of substandard care among physicians. There is no conclusive evidence that malpractice data correlates with professional competence. There are many factors unrelated to a physician’s competence, which can have an effect on the likelihood that a physician will be the subject of a malpractice claim. Those factors include the length of time a physician has been in practice, the nature of their specialty, the types of patients treated, geographic location, etc. For example, certain medical specialties have a higher rate of malpractice claims because of a higher level of risk inherent to their field of practice. Consumers should take these factors into consideration when evaluating a physician’s competence from malpractice data.

Medical malpractice judgments and arbitration awards are public information. Details about a case resulting in a judgment or arbitration award can be found in court documents. Settlements of malpractice cases by insurance companies take place outside of court and are often handled as business decisions. In the case of minor claims, it may be less expensive for the insurance company to make a monetary settlement than it is for them to take the case to court. Many times such cases are settled without a finding of fault or admission of guilt on the part of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred. Public release of settlement information may be restricted by the settlement agreement.

Information on medical malpractice is reported in two fields in the profile:

- The number of medical malpractice court judgments and arbitration awards. This is a numeric field and tells the total number of court judgments and arbitration awards throughout a physician's career. If the malpractice case resulted in a disciplinary action by the state medical board, more information about the case may be available from the board. In addition, information may be available from the court having jurisdiction in the case.
- The number of malpractice settlements when the number is equal to or exceeds 3 in the past 5 years. Additional information on settlements may not be available because many settlement agreements restrict public release of information about the specifics of the settlement.

**State Medical Board Orders:** The state medical board issues a physician's license to practice medicine and is charged with the responsibility of evaluating a physician's professional conduct and continued competence to practice medicine. When the board receives a complaint about a physician, the board has the power to investigate, hold hearings, and impose some form of discipline. Although laws vary from state to state, the most common examples of disciplinary actions taken against physicians are:

- Revocation—A permanent loss of license to practice medicine; however, under certain conditions, a physician may petition for reinstatement after a specific time period.
- Probation—Physician's practice is monitored for a specific period of time.
- Suspension—Physician may not practice for a specific period of time.
- Summary Suspension—Immediate suspension of a physician's license when there is evidence that their continued practice presents an immediate danger to the public health and safety.
- Reprimand or Censure—A public admonishment.
- Voluntary Surrender of License—Physician surrenders his/her license to practice in lieu of further disciplinary action.
- Limitation or Restriction—Physician's license to practice is restricted in some way; e.g. prohibited from performing specific procedures.
- Denial—Physician's license is not initially awarded or subsequently renewed.
- Administrative Fine/Monetary Penalty—A civil penalty imposed by the board for certain types of professional misconduct.
- Restitution—Statutory authority to require a physician to reimburse an individual/entity for monies improperly obtained.
- "Stay"—The board withholds enforcement of a board action, usually under some enumerated conditions.

Other board orders may be authorized by state statute or board rules. Call the medical board for more details about any specific board action.

**Orders by Other State Medical Boards:** The state medical board in the state where the physician is currently licensed might not be aware of actions taken by other state boards. This could happen if a physician does not disclose that he/she was previously licensed in another state on their licensure application. The board sometimes learns of actions taken by other states through the Federation of State Medical Boards' Board Action Data Bank, which is a national database of disciplinary actions taken by state medical boards against licensed physicians. When the state medical board is aware of final board actions taken in other states, they will appear in the profile. Call the medical board for more details.

**Disciplinary Actions Taken by Hospitals:** In most states, hospitals are required to report disciplinary actions taken against physicians to the state medical board. Disciplinary actions taken by hospitals and reported to the board appear in the physician's profile. Such actions may include, but are not limited to, revocation of privileges, involuntary restriction of hospital privileges for reasons related to competence or character, non-renewal of privileges, etc. The state medical board may be contacted for additional information about a particular disciplinary action.

If you have questions pertaining to data presented in a profile, you can call your state medical board.

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