

# DRAFT REPORT

## FEDERATION OF STATE MEDICAL BOARDS SPECIAL COMMITTEE ON MAINTENANCE OF LICENSURE

### Introduction

In the United States, the practice of medicine is a privilege granted by the public through their elected representatives. Medical licensing authorities are charged through state medical practice acts to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine.<sup>1</sup> Every medical practice act is built upon this same premise, and likewise, each state medical board has criteria, such as review of applicant's education and training and assessment of applicant's medical knowledge via a licensing examination, to assess a physician's competence and fitness to practice prior to granting initial licensure.

For a variety of reasons, state medical boards devote few resources to prospectively ensuring the ongoing competence of licensees. In contrast to the rigorous standards for initial licensure, state medical boards have few requirements in place to ensure licensed physicians maintain their competence throughout their professional careers. In virtually all states, it is possible for a physician to practice medicine for a lifetime without having to demonstrate to the state medical board that he or she has maintained an acceptable level of continuing qualifications or competence.

State medical boards recognize that such practices are no longer acceptable. Rapid advances in technology and medical science are revolutionizing medicine, making it increasingly difficult for physicians to meet their professional responsibility to stay current. Some physicians, for example, may take time away from clinical practice for personal reasons such as to raise families or to pursue alternate careers which may cause them to be unable to maintain the requisite competencies to practice medicine.<sup>2</sup> State medical boards have historically functioned in a policing capacity, responding to complaints and devoting their resources to removing from practice the "bad apples." In order to meet increased public demands for greater accountability, state medical boards will need to broaden their responsibilities to include facilitating the continued competence of all licensees.

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35 In 2003, the Federation of State Medical Boards (FSMB) established a special  
36 committee to study the issue of state medical boards' role in ensuring physicians'  
37 continued competence and to develop recommendations for use by state medical  
38 boards. The Special Committee on Maintenance of Licensure was charged to develop a  
39 position statement regarding the responsibility of state medical boards to ensure  
40 licensees are competent over the course of their professional careers; and to develop  
41 strategies for state medical boards to use in implementing programs to carry out that  
42 responsibility.

43

44 The committee sought input from the following organizations regarding their work to  
45 address the continued competence of physicians: Institute of Medicine (IOM), PEW  
46 Health Professions Commission, Accreditation Council for Continuing Medical Education  
47 (ACCME), American Board of Medical Specialties (ABMS), National Board of Medical  
48 Examiners (NBME), The Joint Commission, American Medical Association (AMA),  
49 American Osteopathic Association (AOA) and the North Carolina Medical Board.

50

51 The committee has issued two interim reports, the first of which contained the following  
52 policy recommendation adopted by the FSMB House of Delegates in 2004:

53

54 *State medical boards have a responsibility to the public to ensure the ongoing*  
55 *competence of physicians seeking relicensure.*

56

57 The committee's second report outlined conceptual challenges associated with  
58 implementing maintenance of licensure requirements, including determining the purpose  
59 of the assessment, differentiating between competence and performance, and  
60 assessment of undifferentiated medical practice versus specialty-specific assessment.

61 (The interim reports are provided as Addendum 1.)

62

63 In carrying out its charge, the committee adopted the following principles to guide its  
64 work:

65

66 1. The goal of maintenance of licensure is to support physicians' commitment to  
67 lifelong learning and to facilitate improvement in physician practice while

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- 68 ensuring that physicians identified as having deficiencies are remediated and  
69 truly incompetent physicians are removed from practice.
- 70 2. Collaboration with other stakeholders is critical. State medical boards should set  
71 standards for maintenance of licensure and rely on external parties to develop  
72 tools and resources for use by physicians in meeting those requirements.
- 73 3. Requirements are not to be punitive, redundant or overly burdensome for  
74 physicians; and should be structured to allow consistent implementation across  
75 jurisdictions.
- 76 4. If problems or deficiencies are identified, the system should include mechanisms  
77 to ensure that appropriate training or intervention is prescribed.
- 78 5. Participation in intervention and training programs should be confidential and  
79 non-punitive, enabling physicians to obtain help without fear of recrimination or  
80 action from the state medical board.

81

82 This report provides guidance to state medical boards regarding how to implement  
83 maintenance of licensure requirements. The report is divided into three sections. The  
84 first section addresses maintenance of licensure, beginning with a discussion of  
85 environmental trends that the committee believes create a climate that will support state  
86 medical boards' efforts to implement maintenance of licensure requirements. This  
87 section also provides an overview of the status of discussions within the state medical  
88 board community regarding maintenance of licensure as well as recommendations that  
89 boards could use in implementing requirements for maintenance of licensure. The  
90 second section provides guidelines regarding reentry to practice. The third section  
91 includes suggestions regarding the kinds of assistance the Federation of State Medical  
92 Boards can provide to state medical boards in implementing maintenance of licensure  
93 standards.

94

### 95 **SECTION I: MAINTENANCE OF LICENSURE**

96

#### 97 ***Environmental Trends***

98

99 While the question of how to assure ongoing physician competence has a long history of  
100 debate with little agreement, a number of developments over the past 15 years appear  
101 to be providing impetus for action by the health professions regulatory community.

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102

103 *Public Expectations regarding Physician Competence*

104

105 In the mid-to late 1990s, the Institute of Medicine and the Pew Health Professions  
106 Commission's Taskforce on Health Care Workforce Regulation released a series of  
107 reports addressing the quality and safety of the existing health care system. The IOM's  
108 *To Err is Human* report, which addresses medical error rates in the United States,  
109 challenges the health professions to make the overall health care system safer for  
110 patients by periodically re-examining and re-licensing providers "based on both  
111 competence and knowledge of safety practices."<sup>3</sup> Subsequent IOM reports also  
112 recommend that health regulatory boards take a more proactive and involved approach  
113 to practitioner competence.<sup>4,5</sup>

114

115 The Pew Health Professions Commission Taskforce on Health Care Workforce  
116 Regulation's initial report, *Reforming Healthcare Workforce Regulation*, also is cited as a  
117 turning point for discussions within the health professions about addressing the issue of  
118 ongoing practitioner competence. Released as part of a series of reports focusing on the  
119 regulation of health care providers as a means of ensuring high-quality health care  
120 services, the report recommends that states "require each licensing board to develop,  
121 implement and evaluate continuing competency requirements to assure the continuing  
122 competence of regulated health care professionals."<sup>6</sup>

123

124 In 1997, the FSMB commissioned a study of public awareness and attitudes about state  
125 medical boards. The periodic retesting of physicians was the second most-cited  
126 responsibility for state medical boards.<sup>7</sup>

127

128 In 2007, the AARP, in collaboration with the Citizens Advocacy Center, conducted a  
129 study of Virginians 50 years of age and older to assess their understanding and  
130 knowledge of Virginia's existing licensure requirements for health professionals to  
131 maintain competence. More than 95 percent of respondents believe that healthcare  
132 professionals should be required to show they have the up-to-date knowledge and skills  
133 needed to provide quality care as a condition of retaining their license. Ninety percent of  
134 the respondents indicated that it is at the least very important for health care

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135 professionals to periodically be re-evaluated to show they are currently competent to  
136 practice safely.<sup>8</sup>

137

### 138 *International Initiatives to Ensure Physician Competence*

139

140 Since 1998, the General Medical Council (GMC) in the United Kingdom has been in the  
141 process of implementing a "revalidation" program that will require all licensed physicians  
142 to undergo review of their practice every five years in order to maintain their licenses.

143 The program, and the areas in which physicians' performance are reviewed, are based  
144 on the principles set forth by the GMC in its *Good Medical Practice* guidelines, which  
145 include good clinical care; maintaining good medical practice; teaching and training,  
146 apprising and assessing; relationships with patients; working with colleagues; probity;  
147 and health.<sup>9</sup>

148

149 The College of Physicians and Surgeons of Ontario has evaluated the continuing  
150 competence of its licensees since 1981, when it initiated the Peer Assessment Program.  
151 As part of the program, physicians undergo an office-based evaluation of their facilities,  
152 medical records and quality of care once every 10 years. Physicians found to have  
153 practice deficiencies participate in remediation programs developed by the College. The  
154 College has also initiated Mini-Peer Assessments, in which physicians complete and  
155 submit a questionnaire and medical records to an assessor for determination of whether  
156 an on-site visit is necessary.<sup>10</sup> A December 2006 survey of Ontario physicians regarding  
157 the Peer Assessment Program shows that 73% of respondents rate the program as  
158 excellent (42%) or good (31%).<sup>11</sup>

159

160 In 2007, the Council of the College of Physicians and Surgeons of Ontario approved an  
161 amendment to its Bylaws requiring all physicians to participate in continuing professional  
162 development, which consists of educational programs designed to assist physicians in  
163 upgrading their knowledge and skills and addressing practice-specific needs in order to  
164 assure their ongoing competence. Following legislative approval of the change, the  
165 College will focus on developing standards and ways in which physicians can meet the  
166 requirements.<sup>12</sup> The Council is also considering requiring physicians to notify the College  
167 of any change in their scope of practice or of their intent to return to practice; this  
168 information is currently provided on a voluntary basis. The change would allow the

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169 College to ensure that physicians who are practicing a particular medical specialty have  
170 the necessary skills, training and experience.<sup>13</sup>

171

### 172 ***Increased emphasis on continuous improvement in medicine***

173

174 Recent years have seen a number of medical regulatory organizations implement  
175 initiatives that seek to instill principles of quality and performance improvement within the  
176 medical profession. Such initiatives could provide resources for use by physicians in  
177 meeting state medical boards' continuing competence requirements for purposes of  
178 licensure renewal/re-registration. The following paragraphs describe some of these  
179 initiatives.

180

#### 181 *American Board of Medical Specialties: Maintenance of Certification*

182

183 The American Board of Medical Specialties is an organization of 24 member boards  
184 responsible for specialty certification and recertification of physicians. In 1998, in  
185 response to concerns about the inadequacy of the existing recertification process to  
186 document physicians' ongoing competence, the ABMS proposed a Maintenance of  
187 Certification (MOC) program that requires physicians to provide evidence of meeting the  
188 following criteria on a continual basis in order to maintain specialty board certification:

189

- Part I: professional standing
- Part II: commitment to lifelong learning and involvement in periodic self-  
191 assessment
- Part III: cognitive expertise
- Part IV: evaluation of performance in practice

194

195 Maintenance of Certification has since been adopted by all ABMS member boards as  
196 the model for recertification. Each specialty board is responsible for developing and  
197 implementing its own program to assure the ongoing competence of its members, while  
198 adhering to the standards and guidelines set forth by the ABMS.

199

200 Physicians participating in the MOC program are expected to demonstrate competence  
201 in the following six general competencies: medical knowledge, patient care, practice-  
202 based learning and improvement, interpersonal and communication skills,

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203 professionalism, and systems-based practice. Physicians who have certificates without  
204 time limit are exempt from participation in MOC. However, such physicians will not lose  
205 their permanent certification if they choose to voluntarily participate in MOC but fail to  
206 meet the MOC requirements. Implementation of maintenance of licensure requirements  
207 could motivate this group of physicians to comply with MOC requirements in order to  
208 meet licensure requirements.

209

### 210 *Accreditation Council for Continuing Medical Education*

211

212 In 2005, in an effort to strengthen the role of CME in physician performance  
213 improvement and lifelong learning, the ACCME proposed a model for CME based on  
214 practice-based, self-directed physician learning and change.<sup>14</sup> Subsequently, in  
215 September 2006, the ACCME released new standards for the accreditation of CME  
216 providers that focus on learning and change for both CME providers and learners. The  
217 new standards aim to improve physician practice and, thus, the quality of patient care by  
218 requiring CME providers to develop and implement CME programs that focus on  
219 improving physician competence, physician performance and/or patient outcomes. CME  
220 providers will be asked to evaluate their success in meeting this goal. The new  
221 standards represent a shift in CME in that providers will move through levels of  
222 accreditation that require them to take on greater responsibility for changing and  
223 improving CME, ultimately moving beyond simply providing CME opportunities to  
224 becoming a strategic asset to quality and safety initiatives.<sup>15</sup>

225

### 226 *Accreditation Council for Graduate Medical Education*

227

228 As part of its mission to ensure and improve the quality of graduate medical education,  
229 in 2001 the Accreditation Council for Graduate Medical Education (ACGME) began  
230 implementation of the Outcome Project. While the accreditation process traditionally  
231 focused on the potential of a program to educate residents, the Outcome Project focuses  
232 on the actual accomplishments of a program through an assessment of its outcomes. As  
233 part of the Outcome Project, residency programs are required to provide educational  
234 experiences that enable their residents to obtain competencies in six general areas:  
235 medical knowledge, patient care, practice-based learning and improvement,  
236 interpersonal and communication skills, professionalism, and systems-based practice.

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237

238 Residency programs also must demonstrate a plan to assess residents' performance  
239 and to utilize the results to improve performance. Consequently, the Outcome Project is  
240 also involved in the identification and development of measurement tools. The ACGME,  
241 in collaboration with the ABMS, developed a "toolbox" of instruments that programs can  
242 use for educational outcomes assessment, including 360-degree evaluation, chart  
243 stimulated recall oral examinations, checklist evaluation of live or recorded performance,  
244 patient surveys and written examinations.<sup>16</sup>

245

### 246 *Bureau of Osteopathic Specialists*

247

248 The Bureau of Osteopathic Specialists (BOS) is an organization of 18 member boards  
249 responsible for the specialty certification and recertification of osteopathic physicians. All  
250 member boards currently issue time-limited certificates, and the BOS has begun  
251 incorporating seven core competencies (medical knowledge, osteopathic philosophy and  
252 osteopathic manipulative medicine, patient care, professionalism, interpersonal and  
253 communication skills, practice-based learning, and improvement and systems based  
254 practice) into the recertification process. In addition, there is ongoing dialogue between  
255 the BOS and its member boards about moving to continuous, rather than periodic,  
256 evaluation of physicians' competence.<sup>17</sup> The American Osteopathic Board of Emergency  
257 Medicine (AOBEM) has already implemented a continuous certification program to  
258 replace traditional recertification. As part of this process, diplomats are required to  
259 provide evidence of meeting criteria in four components on a continual basis:  
260 Professional Status, Continuous Osteopathic Learning Assessment, Formal Re-  
261 Certification Examination, and Practice Status.<sup>18</sup>

262

### 263 *The Joint Commission*

264

265 The Joint Commission is responsible for the accreditation of health care organizations  
266 and programs in the United States. As part of the accreditation process, the Joint  
267 Commission evaluates health care organizations' compliance with Joint Commission  
268 standards, including those for credentialing and privileging of physicians. Prompted by  
269 deficiencies in the existing system, in 2003 the commission began revising its  
270 credentialing and privileging standards to focus on the proactive evaluation of

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271 physicians' competence and to move beyond privileging decisions based primarily on an  
272 evaluation of physicians' technical skills.

273

274 The new standards, which were implemented in January 2007 and January 2008, are  
275 intended to make the credentialing and privileging process more objective and evidence-  
276 based by facilitating continuous monitoring of physicians' performance and by providing  
277 a basis for intervening when quality of care concerns are identified.<sup>19</sup> Under the new  
278 standards, organizations are required to implement a Focused Professional Practice  
279 Evaluation as well as an Ongoing Professional Practice Evaluation as part of the  
280 credentialing and privileging process. The Focused Professional Practice Evaluation  
281 standards apply to 1) the evaluation of currently privileged practitioners who are seeking  
282 new privileges they have never performed before in the organization and 2) situations in  
283 which the competence of a practitioner with existing privileges comes into question. The  
284 Ongoing Professional Practice Evaluation standards enable the continuous, rather than  
285 periodic, review of practitioners' performance.<sup>20,21</sup>

286

287 The new standards also require organizations to evaluate physicians on multiple  
288 competencies, such as the six core competencies developed by the Accreditation  
289 Council for Graduate Medical Education (i.e., medical knowledge, patient care, practice-  
290 based learning and improvement, interpersonal and communication skills,  
291 professionalism, and systems-based practice), rather than just technical competency.  
292 Finally, the new standards address hospital-based education and require that such  
293 activities relate, at least in part, to the type of services offered by the organization and be  
294 based on the findings of performance improvement activities.

295

296 *American Medical Association*

297

298 The American Medical Association is a national physician advocacy body in the United  
299 States and works to develop programs and policies that address physician practice. As  
300 part of this effort, the AMA, through its Initiative to Transform Medical Education (ITME),  
301 is collaborating with a broad array of stakeholders within the medical profession to  
302 address the need to reform the medical education system, including the need for  
303 educational opportunities to support physicians' continuing professional development  
304 and to assist physicians seeking to reenter practice.<sup>22,23</sup>

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305

306 Recognizing the increasing and varied ways in which physicians learn, in recent years  
307 the AMA has also expanded the credit for the AMA Physician Recognition Award (PRA)  
308 Category 1 Credit to include test item writing, manuscript review, performance  
309 improvement activities and internet learning and point of care.<sup>24</sup>

310

### 311 ***Ensuring Competence as a Condition of License Renewal/ Re-registration***

312

313 All medical licensing authorities require physicians to renew or re-register their licenses  
314 every one to three years.<sup>25</sup> This process requires licensees to complete a renewal/re-  
315 registration form and pay a fee. State medical boards may also review hospital privilege  
316 reports, malpractice reports, specialty board certification status, disciplinary data banks,  
317 hospital audits/inspections, patient complaints and other information in an effort to  
318 assess licensees' competence and fitness to practice at the time of license renewal/re-  
319 registration.

320

321 In addition to assessing a licensee's qualifications for relicensure, 60 out of 69 medical  
322 licensing boards require physicians to obtain a specified number of CME credits.<sup>26</sup> While  
323 some states mandate that a certain number of required CME hours be content-specific,  
324 such as HIV/AIDS, palliative care, pain management and medical ethics, no jurisdiction  
325 requires physicians to obtain CME that has a direct relation to their actual practice. State  
326 medical boards require physicians to attest on the license renewal/re-registration form to  
327 having met CME requirements and subsequently conduct random audits of a certain  
328 percentage of license renewal/re-registration applicants to ensure CME requirements  
329 have been met.

330

331 Concerns about the utility of CME in assuring physicians' ongoing competence have  
332 been raised since the late 1970s, when state medical boards first began mandating CME  
333 for license renewal/re-registration. Concerns have centered around whether such  
334 programs truly impact physician performance, especially if the CME is not related to the  
335 physician's day-to-day practice or deficiencies.<sup>27,28</sup> There is now empiric evidence from  
336 meta syntheses that supports the use of CME as a tool for physician learning and  
337 change.<sup>29,30,31,32</sup> In addition, the CME community has made great strides in addressing

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338 concerns about CME's impact on physician practice and in developing CME programs  
339 and criteria that address physician performance and lifelong learning.<sup>33</sup>

340

341 *State medical boards and maintenance of licensure*

342

343 In the last 10 years, medical licensing authorities in California, Texas, and Nevada have  
344 attempted to or studied the feasibility of implementing requirements for periodic  
345 demonstration of competence for license renewal/re-registration. In all three cases, the  
346 boards abandoned their initiatives due to the political climate, concerns about the  
347 negative impact on workforce, or resistance from the profession based on lack of  
348 evidence that such requirements would make a difference in the quality of care provided  
349 to patients.

350

351 According to a 2007 survey conducted by the Federation of State Medical Boards,  
352 continuing competence of physicians is a matter of concern. Sixty-three of 69 FSMB  
353 member boards responded to the survey, and 36 (57.2%) indicated that they had  
354 discussed the issue one or more times within the past 12 months. Three boards (4.8%)  
355 had formed a committee to study the issue, while only nine (14.3%) had never discussed  
356 the issue. While many boards (29 or 47.5%) indicated that they were undecided on the  
357 issue, 22 (36.1%) said they are supportive. Eight (13.1%) responded that they are  
358 uninformed and only two (3.3%) responded that they are not supportive.

359

360 The vast majority of boards (55 or 87.3%) have not implemented or previously attempted  
361 to implement rules and regulations, policies or statutes regarding maintenance of  
362 competence, but eight (12.7%) indicated that they have. Finally, most boards (25 or  
363 42.4%) said that their existing statutes do not give board the authority to implement  
364 maintenance of competence requirements. Twenty-one (35.6%) said existing statutes do  
365 give them authority, while 13 (22.0%) were not sure.<sup>34</sup>

366

367 These results are similar to the results of a 2002 Citizen Advocacy Center (CAC) survey  
368 of 323 health professions licensing boards (45 of which were state medical boards)  
369 regarding continuing competence. Seventy boards (21%) stated that they were  
370 "considering introducing continuing competency requirements in the future," and 60  
371 (19%) had already formed committees to study the issue. Responses from 16 boards

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372 (22%) indicated that their state's legislature was considering new initiatives to require  
373 licensees to periodically demonstrate their continuing competence. Program models  
374 being considered ranged from requiring all licensees to demonstrate current competence  
375 upon license renewal to requiring demonstration of current competence by only those  
376 licensees that meet specified "triggers", such as change in practice setting, disciplinary  
377 action and failure to recertify with a credentialing agency.<sup>35</sup>

378

### 379 ***Guidelines for Implementing Maintenance of Licensure Requirements***

380

#### 381 *Establishing standards for demonstrating competence*

382

383 State medical boards should require physicians seeking relicensure to demonstrate  
384 competence in the area of practice in which they engage on a daily basis. Such  
385 requirements should include the following elements or expectations:

386

387 1. Participation in an ongoing process of reflective self-evaluation, self-assessment  
388 and practice assessment, with subsequent successful completion of educational  
389 activities tailored to meet the needs or deficiencies identified by the assessment.

390

391 Evidence of self-evaluation, self-assessment and practice assessment could  
392 include participation in self-evaluation exercises or modules, such as self-review  
393 tests, home study courses and web-based materials, or passage of a state  
394 medical board approved examination in the physician's current practice area.  
395 Remediation and educational activities could include review of literature in the  
396 physician's current practice area; CME in the physician's current practice area  
397 that enhances patient care, performance in practice and and/or patient  
398 outcomes; or participation in other educational programs.

399

400 2. Demonstration of continued competence in the following areas: medical  
401 knowledge, patient care, practice-based learning and improvement, interpersonal  
402 and communication skills, professionalism, systems-based practice and, if  
403 applicable, osteopathic philosophy and osteopathic manipulative medicine;  
404 including the knowledge, skills and abilities to provide safe, effective patient care  
405 within the scope of their professional medical practice.

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406

407 This criterion should be met, in part, by passage of a valid, secure, proctored  
408 examination in the physician's current practice area not more than every 10  
409 years.

410

411 3. Demonstration of accountability for performance in practice.

412

413 This could be met by peer assessment, such as 360 evaluations, letters of  
414 recommendation and letters of attestation of clinical activities, or by patient  
415 reviews, such as satisfaction surveys. Participation in recognized quality  
416 improvement activities as well as collection and analysis of practice data, such as  
417 thorough review of office records, chart review, case review and submission of a  
418 case log, could also be utilized.

419

420 Licensees should be expected to provide documented evidence of compliance with the  
421 state medical board's maintenance of licensure requirements. State medical boards  
422 should provide guidance to licensees as to the types of evidence the board deems  
423 acceptable for purposes of meeting maintenance of licensure requirements. Such  
424 evidence could include documentation of continuous participation in Maintenance of  
425 Certification processes or participation in recognized quality improvement activities such  
426 as those required by Joint Commission, If a licensee's clinical practice is outside the  
427 scope of his or her board certification or training, the licensee's documentation should  
428 include evidence of competence in that practice.

429

430 *Physicians not in active clinical practice*

431

432 All physicians with active licenses should be expected to meet requirements for  
433 maintenance of licensure. Physicians not in active clinical practice who wish to maintain  
434 an active license should be expected to comply with all maintenance of licensure  
435 requirements. Evidence of demonstration of accountability for performance in clinical  
436 practice could be met by evaluation of a physician's competence relevant to that  
437 practice. Assessment methods should address the knowledge, skills and behaviors  
438 necessary to deliver safe and effective care for the types of patients that would typically  
439 be encountered in their practice. Physicians whose licenses are inactive or have lapsed

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440 should be expected to meet these requirements when they reenter active clinical  
441 practice.

442

### 443 *Disclosure*

444

445 Physicians who do not comply with maintenance of licensure requirements or who are  
446 identified through the program as incompetent should be subject to normal adjudication  
447 processes and to public disclosure as required by state law. When an education or  
448 remediation plan is required by the state medical board for these practitioners, the state  
449 medical board should approve the elements and scope of the plan prior to its initiation.  
450 All other maintenance of licensure activities should not be subject to public disclosure.

451

### 452 *Reporting requirements*

453

454 In order to assure that physicians are demonstrating competence within their scope of  
455 practice, state medical boards should require licensees to report information about their  
456 practice as part of the license renewal or re-registration process. Such information  
457 should include: scope of practice, type of practice (to include location, supervisory  
458 responsibilities), status (e.g., full-time, part-time, number of hours worked per week),  
459 whether they are actively seeing patients, specialty board certification or recertification  
460 status, and what activities they are engaged in if they are not engaged in clinical practice  
461 (e.g., research, administration, non-medical work, retired, etc.). Practitioners, as part of  
462 their personal and professional responsibility, should keep the board apprised of their  
463 practice status at all times by reporting any subsequent changes in practice status or  
464 scope of practice to the board within a specified timeframe as determined by the board.

465

### 466 *Research*

467

468 Developing evidence regarding the impact of maintenance of licensure programs on  
469 physician practice and patient care is a priority. State medical boards should work with  
470 relevant organizations to develop a research agenda aimed at gathering data to improve  
471 maintenance of licensure processes.

472

## 473 **Section II: Reentry to Practice**

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475 Many practitioners who take voluntary leaves of absence from clinical practice choose to  
476 maintain full and unrestricted licensure status while on leave. Currently, because states  
477 do not have maintenance of licensure requirements in place, such practice poses a  
478 significant dilemma for state medical boards. Most state medical boards currently do not  
479 gather data about their licensees' practice status, thus they have no means of identifying  
480 licensees who are clinically inactive or validating that these individuals are adequately  
481 prepared to reengage in patient care duties.

482

483 The policy questions pertaining to reentry to practice are challenging. For example, how  
484 many hours a week of patient care duties constitute active clinical practice? Do all areas  
485 of specialized medical practice require the same level of active patient care in order to  
486 maintain competence in that specialty? Should reentering physicians be required to  
487 demonstrate competence for the general undifferentiated practice of medicine or  
488 competence in those areas in which they will be providing patient care?

489

490 Limited information is available to inform discussions about these policy issues.

491 However, the growing number of physicians facing reentry to practice challenges, along  
492 with a growing workforce shortage, has led to the recognition of the critical importance of  
493 facilitating the successful return to practice of qualified practitioners.<sup>36,37</sup>

494

495 The following guidelines are intended to help state medical boards facilitate a physician's  
496 reentry to practice while simultaneously ensuring the public is protected. While some of  
497 the recommendations contained herein may be appropriate for physicians whose  
498 absence is due to disciplinary or impairment reasons, the guidelines are primarily  
499 intended to address situations where a physician has taken a voluntary leave of  
500 absence. For purposes of this report, the recommendations apply to both physicians and  
501 physician assistants.

502

503 *Determining when a practitioner should demonstrate readiness to reenter practice*

504

505 One of the initial questions a state medical board grapples with when faced with a  
506 practitioner who has been clinically inactive is whether he or she has the knowledge and  
507 clinical skills needed to provide safe patient care. Currently, most state boards use a two

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508 year timeframe when considering practitioners who are seeking to return to clinical  
509 practice, although requirements nationwide range from 1 to 5 years. Current FSMB  
510 policy recommends that applicants for licensure by endorsement who have not been in  
511 active practice for the previous 24-month period be required to demonstrate their  
512 continued competence.<sup>38</sup>

513

514 Little research is available to inform discussions about how time away from clinical  
515 practice impacts competence. Because competence is maintained in part through  
516 continuous engagement in patient care activities, practitioners seeking to return to  
517 clinical work following an extended leave should be considered on a case-by-case basis.  
518 Decisions about whether the practitioner should demonstrate readiness to reenter  
519 practice should be based on a global review of the physician, including length of time out  
520 of practice, the physician's area of specialization, malpractice history, prior disciplinary  
521 history, hospital privilege reports, patient complaints and whether the practitioner  
522 participated in continuing medical education activities during the time out of clinical  
523 practice.

524

525 Practitioners who wish to take some time away from clinical practice should be  
526 encouraged to remain clinically active in some capacity, even if on a limited basis, and to  
527 participate in ABMS Maintenance of Certification or AOA equivalent activities if available.

528

529 *Standards for demonstration of readiness to reenter practice*

530

531 All practitioners returning to clinical practice after a period of inactivity should be required  
532 to provide documented evidence of competence in the scope of practice in which he or  
533 she plans to engage. Because the practitioner's intended scope of practice may not be  
534 the same as the specialty in which he or she is trained or board certified, the reentering  
535 practitioner should also be required to provide information regarding the environment  
536 within which they will be practicing, the types of patients they anticipate seeing, and the  
537 types of clinical activities in which they will be engaged. The degree of evidence required  
538 may vary depending on the length of time away from clinical practice and whether the  
539 practitioner's scope of practice is consistent with his or her medical education and  
540 training.

541

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542 Reentry documentation should reflect the practitioner's participation in assessment  
543 and/or self-reflection activities with subsequent successful completion of educational  
544 activities tailored to address weaknesses or deficiencies identified through the  
545 assessment. Formal documentation of such activities should be required. Continuing  
546 medical education activities presented by the practitioner in support of his or her  
547 competence should be relevant to the area of practice in which the practitioner intends to  
548 engage and should be accredited by an accrediting agency acceptable to the state  
549 medical board.

550

551 If available, practitioners also should be required to provide documentation showing their  
552 satisfactory performance in practice. Examples of such documentation could include  
553 reports from practice monitors, preceptors, peer evaluations, *locum tenens*, etc.

554

555 *Requirements for reentry and education plans*

556

557 Practitioners who have been clinically inactive or who plan to move into a new area of  
558 clinical practice should participate in a reentry plan developed and/or approved by the  
559 state medical board. Potential resources that could be used as part of a reentry plan  
560 include practice monitors; chart audits; "mini-residencies"; individualized, tailored  
561 continuing medical education; and evaluation by a formal assessment program.

562

563 State medical boards should use an individualized, diagnostic approach to identify the  
564 educational and clinical needs of the returning practitioner and identify remedial  
565 educational services to address identified weaknesses or deficiencies. State medical  
566 boards should approve the elements and scope of the educational program prior to its  
567 initiation. Subsequently, the practitioner should be required to present the evaluation  
568 results and evidence of successful completion of the subsequent educational plan to the  
569 state medical board. All costs associated with the reentry and educational programs  
570 should be borne by the practitioner.

571

572 State medical boards should foster collaborative relationships with academic institutions  
573 and specialty societies within their jurisdictions to develop educational and remediation  
574 interventions and resources for the various types of practices.

575

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576 *Monitoring practitioners who reenter the workforce*

577

578 Practice monitors may be selected by either the state medical board or the practitioner,  
579 but in all cases should be approved by the state medical board. The practice monitor  
580 should be board certified and practicing in the same clinical area as the practitioner  
581 seeking reentry.

582

583 The state medical board should set forth in writing its expectations of the practice  
584 monitor, including what aspects of the reentering practitioner's practice are to be  
585 monitored, frequency and content of reports by the monitor to the state medical board  
586 and how long the practice is to be monitored. The timeframe stipulated for monitoring the  
587 practice will vary depending on the practitioner's circumstances. The board's  
588 expectations should be communicated both to the monitor and the practitioner being  
589 monitored.

590

591 The practice monitor should be required to demonstrate to the board's satisfaction that  
592 he or she has the capacity to serve as a practice monitor, including sufficient time for  
593 mentoring; lack of disciplinary history; proof of an active, unrestricted medical license;  
594 letters of recommendation; and/or demonstration of a prescribed number of years in  
595 clinical practice.

596

597 The practice monitor should be permitted to receive financial compensation or incentives  
598 for work associated with practice monitoring. Any costs associated with the practice  
599 monitoring should be borne by the reentering practitioner, unless alternate financial  
600 arrangements or funding is available.

601

602 The state medical board should work with the state medical society and the medical  
603 education community to identify and increase the pool of potential practice monitors. The  
604 state medical board should also explore ways in which legal protection could be offered  
605 to practice monitors, such as through the state or through malpractice carriers. Such  
606 protection could encourage and increase the willingness of practitioners to act as  
607 practice monitors.

608

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609 As an alternative to practice monitors, state medical boards could require chart audits to  
610 be performed by independent practitioner reviewers assigned by the state medical  
611 board.

612

613 A system of checks and balances should be in place to ensure that practitioners who  
614 have returned to clinical practice after an extended leave are being monitored. The state  
615 medical board should expect all practitioners reentering clinical practice to inform the  
616 board of what quality assurance and quality control processes and mechanisms will be  
617 used in their practices; such processes and mechanisms should be approved by the  
618 board.

619

620 While state medical boards are responsible for ensuring that practitioners are safe to  
621 reenter clinical practice, hospital credentialing committees and peer review organizations  
622 provide a subsequent check of practitioners' competence to practice. State medical  
623 boards should coordinate with the practitioner's employer or privileging body as a safety  
624 measure to ensure the practitioner is practicing within the scope of practice in which he  
625 or she has demonstrated competence. For practitioners who are in solo or office-based  
626 practices, state medical boards should require chart audits to be performed by  
627 independent reviewers assigned by the state medical board.

628

629 *Improving regulation of licensed practitioners who are clinically inactive*

630

631 Until such time that maintenance of licensure requirements are in effect, state medical  
632 boards should implement the following mechanisms to improve regulation of licensed  
633 practitioners who are clinically inactive but may return to clinical practice in the future.

634

635 Identifying inactive licensees: State medical boards should require licensees to report  
636 information about their practice as part of the license renewal or registration process, to  
637 include: type of practice, status (e.g., full-time, part-time, number of hours worked per  
638 week), whether they are actively seeing patients, specialty board certification or  
639 recertification status, and what activities they are engaged in if they are not engaged in  
640 clinical practice (e.g., research, administration, non-medical work, retired, etc.). Such  
641 information will enable state medical boards to identify licensees who are not clinically  
642 active and to intervene as needed if and when a licensee chooses to return to patient

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643 care duties. State medical boards should advise licensed practitioners who are clinically  
644 inactive of their personal obligation to participate in an individualized, diagnostic reentry  
645 program that assures their readiness to resume patient care duties.

646

647 Licensure status: Licensed practitioners who are clinically inactive should be allowed to  
648 maintain their licensure status as long as they pay the required fees and complete any  
649 required continuing medical education or other requirements as set forth by the board.

650 Upon a practitioner's decision to return to clinical practice, he or she should be required  
651 to participate in a reentry plan approved by the board.

652

653 Consent orders as a licensing mechanism: Medical boards should be authorized to use  
654 non-punitive, time-limited consent orders to return a practitioner's license to active,  
655 unrestricted status. Such a mechanism permits the practitioner to participate in activities  
656 necessary to regain the knowledge and skills needed to practice medicine safely, such  
657 as participation in a mini-residency. The consent order should be a public document  
658 about the physician's participation in a reentry program. The consent order should  
659 specify the case-specific details of the reentry program and should be lifted once the  
660 specified requirements have been met. For liability coverage and specialty board  
661 certification purposes, the license should be reported as active and unrestricted.

662

663 When used in this fashion, the consent order should be viewed as a licensing action, not  
664 a disciplinary action. The licensing committee of the state medical board should have  
665 sole discretion as to the content of the order and should have the authority to remove the  
666 order once the requirements have been met. While the intent of the consent order is to  
667 provide the board with a non-punitive means of assessing an applicant's readiness to  
668 reenter practice, the board should have the authority to discipline the practitioner for  
669 unprofessional conduct should he or she fail to meet the terms of the order.

670

671 *Reducing barriers to reentry*

672

673 Financial: Practitioners returning to clinical practice after an extended leave often face  
674 financial challenges that hinder their ability to update their knowledge and clinical skills.  
675 While a number of practitioner assessment programs exist across the United States and  
676 Canada, they are often cost-prohibitive. State medical boards and practitioners should

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677 work with assessment programs, as well as specialty societies and private  
678 organizations, to determine alternative financial arrangements or sources of funding. Any  
679 costs for participating in the program should be borne by the practitioner, unless  
680 alternate financial arrangements or funding is available.

681

682 Insufficient educational resources: Preceptors and residency programs often are hesitant  
683 to assume responsibility for monitoring or reeducating practitioners who have been out  
684 of clinical practice for some period of time because of financial and liability concerns.

685 State medical boards should work with preceptors and residency programs to address  
686 these concerns.

687

688 Insurance coverage: According to information from the Physician Insurers Association of  
689 America (PIAA), insurers typically require physicians to have a license to practice prior to  
690 providing coverage, as documentation of a license to practice serves as basic  
691 competency criteria for insurers when accepting new physicians.<sup>39</sup> In situations involving  
692 a licensed physician reentering the workforce, state medical boards should utilize the  
693 mechanisms recommended in these guidelines to facilitate reporting of the physician's  
694 license as unrestricted in order to meet insurers' requirements. State medical boards  
695 should work with insurers to address concerns associated with insurance coverage for  
696 physicians returning to clinical practice.

697

698 *Relationship between licensure and specialty certification*

699

700 A physician's ability to maintain specialty board certification during a leave of absence  
701 will depend on whether the physician has voluntarily allowed his or her license to lapse.  
702 The 24 boards of the American Board of Medical Specialties are progressing with  
703 implementing maintenance of certification programs, which require, in part, the  
704 physician's ability to demonstrate good professional standing by virtue of having a full  
705 and unrestricted license. In situations where a licensed, board certified physician is  
706 returning to clinical practice after a substantial period of inactivity (two or more years),  
707 state medical boards should make every effort to ensure that any conditions for the  
708 physician's reentry to practice do not hinder the physician's ability to maintain specialty  
709 certification.

710

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711 *Outreach measures*

712

713 To help prepare practitioners who either are thinking about taking a leave of absence or  
714 are considering returning to the clinical practice, state medical boards should proactively  
715 educate licensees about the issues associated with reentering clinical practice. For  
716 example, state medical boards could develop a white paper providing guidance on  
717 issues like the importance of engaging in clinical practice, if even on a limited, part time  
718 basis, or seeking counsel from their insurance carriers prior to withdrawal from practice  
719 and when they are ready to reenter practice. State medical boards could include such  
720 information with the initial license, in the board's newsletter and on the board's website.

721

722 In doing so, the medical community will have to determine how to make the system  
723 flexible enough to accommodate practitioners whose personal lives impact their ability to  
724 provide patient care even in a part-time capacity. Medical education programs, hospitals  
725 and residencies will need to be encouraged to accommodate individuals who are  
726 interested in engaging in clinical practice and education on a limited basis in order to  
727 remain engaged in medicine.

728

### 729 **Section III: FSMB Assistance in Implementing Standards**

730

731 To assist state medical boards in implementing maintenance of licensure and reentry to  
732 practice standards, the Federation of State Medical Boards should make appropriate  
733 revisions to its policy document *Essentials of a Modern Medical Practice Act*, which will  
734 provide sample language that boards can use, if needed, in revising their medical  
735 practice acts to implement the standards. (Proposed revisions are provided as  
736 Addendum 2.)

737

738 The FSMB should also assist states in developing campaigns to support implementation  
739 of the standards. The FSMB should provide resource materials to assist state medical  
740 boards when speaking to their legislatures about the standards, including testimony and  
741 letters of support. Furthermore, the FSMB should assist state medical boards with  
742 developing key messages and public relations tools to assist in reaching and educating  
743 legislatures, practicing physicians, the public and other relevant and interested entities  
744 about the standards and rationale for implementation.

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745

### 746 **Conclusion**

747

748 State medical boards are charged to protect the public by ensuring that licensed  
749 physicians are safe to practice. As the sole entity with the authority to regulate  
750 physicians, state medical boards are also obligated under the laws of their states to  
751 ensure that unfit physicians are removed from practice. Increased calls for the health  
752 professions to be more accountable are putting the onus on state medical boards to take  
753 a more proactive approach to evaluating and ensuring physicians' ongoing competence.  
754 As state medical boards proceed with implementing maintenance of licensure  
755 requirements, they should find a balance between their duty to remove unsafe  
756 practitioners and facilitating practice improvement and enabling remediation and  
757 education where appropriate.

758

759 Physicians, in turn, have a professional obligation to their patients to maintain their  
760 competence in order to provide safe and effective care. Participation in maintenance of  
761 licensure activities will assist physicians in fulfilling that responsibility.

762

763 Physicians who have been out of practice for an extended period of time and want to  
764 reenter active clinical practice pose a unique challenge to state medical boards. State  
765 medical boards should mandate reentry plans for all physicians who have been out of  
766 clinical practice. However, given the complexity and uniqueness of the circumstances  
767 surrounding physicians' withdrawal from medical practice, state medical boards should  
768 have a multi-faceted plan to address the unique situation presented by each physician at  
769 the time of reentry. Since no one single plan for reentry will work for all physicians, state  
770 medical boards should have available a variety of mechanisms that can be utilized and  
771 implemented depending on what is most appropriate in any given situation. State  
772 medical boards should take proactive steps to encourage physicians to remain "primed"  
773 during the time they are out of practice, such as participating in continuing medical  
774 education activities or a maintenance of certification program of a certifying board.

775

776 Whether assessing the competence of physicians who are currently in practice or who  
777 are seeking to reenter practice, state medical boards should take advantage of the  
778 changing environment to encourage the development of new, additional assessment

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779 programs. State medical boards should also encourage the cooperation of medical  
780 schools and residency programs in providing educational opportunities for updating  
781 existing skills or learning the necessary skills to move into a new clinical area for  
782 physicians identified through the maintenance of licensure process or seeking to reenter  
783 practice.

784

785

### 786 **Definitions**

787

788 For the purposes of this report, the following terms are defined as follows:

789

790 **Accredited** – having complied with the standards of a public or private organization  
791 approved to issue certificates of accreditation based on an examination of quality of  
792 services provided compared to established standards.

793

794 **Assessment** – a formal system to evaluate a practitioner’s competence and ability to  
795 perform safely and effectively within the practitioner’s scope of practice.

796

797 **Clinical practice** – the active involvement in providing direct patient care and/or  
798 consultative care.

799

800 **Competence** – A competent physician is one who demonstrates the requisite  
801 knowledge, technical skills, judgment, and interpersonal and communication skills to  
802 provide safe, effective patient care within the scope of professional medical practice  
803 while engaging in ongoing, practice-based learning and improvement.

804

805 **Continuing Medical Education** – educational activities that maintain, develop or  
806 increase the knowledge, skills, professional performance and relationships that a  
807 physician uses to provide services for patients, the public or the profession.

808

809 **Credentialing** – the process of obtaining, verifying, and assessing the qualifications of a  
810 health care practitioner to provide patient care services in or for a health care  
811 organization. (JCAHO Hospital Accreditation Standards, 2003)

812

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813 **License** – authorization by law to practice medicine.

814

815 **License renewal/re-registration** – the process whereby a licensee demonstrates  
816 qualification for continued licensure.

817

818 **Licensure** – the process by which a state medical board grants a license pursuant to  
819 applicable statutes.

820

821 **Maintenance of competence** – the dynamic process of assessing and updating the  
822 knowledge, skills and attitudes required to meet the needs of the physician’s current  
823 practice. (From Aylmer I)

824

825 **Maintenance of licensure** – the process by which a licensee demonstrates that he/she  
826 has maintained his or her competence and qualifications for purposes of continued  
827 licensure.

828

829 **Performance** – the translation of competence into action when managing patient care.  
830 (From Aylmer I)

831

832 **Privileging** – the process whereby a specific scope and content of patient care services  
833 (that is, clinical privileges) are authorized for a health care practitioner by a health care  
834 organization based on evaluation of the individual’s credentials and performance.  
835 (JCAHO Hospital Accreditation Standards, 2003)

836

837 **Reentry to practice** – a return to clinical practice following a period of inactivity as  
838 defined by the licensing authority.

839

840 **Remediation** – The process whereby deficiencies in physician performance identified  
841 through an assessment system are corrected.

842

843 **Retraining** – updating one’s skills or learning the necessary skills to move into a new  
844 clinical area.

845

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846 **Self-assessment** – the evaluation process a professional uses to define any gaps, or  
847 differences, between their own knowledge or competence (ability) or performance-in-  
848 practice and that of a pre-determined self-, norm- or criterion- referenced standard.

849

850 **Specialty certification** – recognition granted by the American Board of Medical  
851 Specialties (ABMS), Bureau of Osteopathic Specialists (BOS) or other equivalent  
852 organization as determined by the state medical board that a practitioner has met certain  
853 published standards; provides evidence to the public that a practitioner has successfully  
854 demonstrated advanced training and experience in a given specialty.

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## ADDENDUM 1

BRD RPT 04-1

### REPORT OF THE BOARD OF DIRECTORS

**Subject : Report on: Special Committee on Maintenance of Licensure**

**Referred to : Reference Committee**

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In the United States, medical licensing authorities are charged through state medical practice acts to ensure that physicians granted the privilege of licensure are competent to practice medicine safely. According to Federation of State Medical Board policy as set forth in *A Guide to the Essentials of a Modern Medical Practice Act*, the primary responsibility and obligation of the state medical board is to “protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine.” All medical practice acts are built upon this same premise, and likewise, all state medical boards have some set of criteria (e.g., review of applicant’s education and training, assessment of applicant’s medical knowledge via a licensing examination, etc.) to assess a physician’s competence and fitness to practice prior to granting initial licensure.

In the interest of public protection, state medical boards also have the implied responsibility of assuring the ongoing competence of licensed physicians. For a variety of reasons state medical boards have been passive in this arena. In fact, state medical boards currently devote few resources to prospectively assuring the ongoing competence of a licensee. A physician who pays a re-registration fee, fulfills any re-registration requirements set by the board, and who has not had a complaint filed with the medical board may practice medicine for a lifetime without having to demonstrate that he or she has maintained an acceptable level of continuing qualifications.

According to a study commissioned by the Federation of State Medical Boards in 1997 regarding public awareness and attitudes about state medical boards, the periodic

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964 retesting of physicians was the second most-cited responsibility for state medical  
965 boards, with 9.3% of the public mentioning it “top-of-mind.” (10% top-of-mind mention  
966 signals a national issue.) Clearly, the public thinks state medical boards have a  
967 responsibility to monitor and deal with the competence of individual physicians and,  
968 arguably, probably believes this is already occurring. Furthermore, in September 2000,  
969 the Federation hosted a symposium to discuss the role of medical licensure in the next  
970 century and the priorities facing state medical boards. Assuring the ongoing  
971 competence of physicians was identified as one of three main challenges facing state  
972 medical boards in the next decade.

973

974 Recently, national health care policy tracking organizations such as the Pew Health  
975 Professions Commission Taskforce on Health Care Workforce Regulation and the  
976 Institute of Medicine (IOM) have recommended that state medical boards develop and  
977 implement continuing competence requirements and that they periodically re-examine  
978 and re-license physicians based, in part, on demonstration of competence. Likewise,  
979 consumer advocacy groups such as the Citizen Advocacy Center (CAC) have asserted  
980 that medical licensing authorities need to demonstrate to the public that licensees are  
981 competent throughout their careers.

982

983 In 2002, the CAC released the results of a survey of 323 health professions licensing  
984 boards (45 of which were medical boards) regarding continuing competence. Seventy  
985 boards (21%) stated that they are "considering introducing continuing competency  
986 requirements in the future," and 60 (19%) have already formed committees to study the  
987 issue. Responses from 16 boards (22%) indicate that their state’s legislature is  
988 considering new initiatives to require licensees to periodically demonstrate their  
989 continuing competence.

990

991 Medical licensing authorities in Nevada, Texas and California have formed committees  
992 to study how best to assure licensees’ ongoing competence, and Nevada is poised to  
993 become the first board to require physicians to demonstrate their ongoing proficiency for  
994 license re-registration. Additionally, the American Board of Medical Specialties (ABMS)  
995 is implementing a system that will require board-certified physicians to continually  
996 demonstrate their ongoing competence in order to maintain certification.

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## DRAFT REPORT

998 As an organization dedicated to serving the public interest and promoting high standards  
999 for physician licensure and practice, the Federation has periodically discussed the  
1000 responsibility of state medical boards to ensure the ongoing competence of physicians  
1001 since the late 1970s. Through a series of Ad Hoc Committees in the late 1970s and  
1002 early 1980s, the Federation evaluated the concept of physician re-licensure and the role  
1003 that continuing education and other measures could play in assuring ongoing physician  
1004 competence at the time of re-registration and/or re-licensure. In 1996, the Federation's  
1005 Special Committee on Evaluation of Quality of Care and Maintenance of Competence  
1006 assessed the role of state medical boards in assuring quality care and physician  
1007 competence and recommended, in part, that states develop proactive methods of  
1008 identifying physicians whose competence may be in question.

1009

1010 In May 2003, Federation Chair Thomas D. Kirksey, MD, established the Special  
1011 Committee on Maintenance of Licensure. The committee charge is to:

1012

1013 1. Evaluate the responsibility state medical boards have to ensure physician  
1014 competence through the course of one's professional career and the efficacy of  
1015 methods historically used to carry out those responsibilities;

1016

1017 2. Research, review and evaluate systems currently used or under development by  
1018 healthcare providers and national medical organizations to facilitate maintenance  
1019 of physician competence, and determine to what extent these systems could  
1020 assist state medical board efforts to ensure physician competence;

1021

1022 3. Identify pertinent stakeholders, their positions regarding the role of state medical  
1023 boards in ensuring physician competence for purposes of relicensure, and where  
1024 appropriate, their willingness to collaborate with medical regulators to achieve  
1025 improvement in physician practice.

1026

1027 4. Research, review and evaluate tools/resources available to state medical boards  
1028 and others for use in measuring competence and remediating deficiencies;

1029

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1030 5. Develop a position statement regarding the responsibility of state medical boards  
1031 in ensuring physician competence over the course of his/her career;

1032

1033 6. Develop strategies for state medical boards to use in implementing programs to  
1034 ensure physicians maintain an appropriate level of competence to practice  
1035 medicine safely throughout their professional careers.

1036

1037 The Special Committee on Maintenance of Licensure has met twice since May 2003. At  
1038 these meetings, the committee reviewed current legislative and medical board initiatives  
1039 regarding maintenance of competence, as well as similar initiatives being undertaken by  
1040 other healthcare professions and medical regulatory agencies in the United States and  
1041 internationally. The committee has begun to discuss tools and systems or partnerships,  
1042 that boards could utilize or implement to proactively assess the continued competence of  
1043 their licensees. The committee also discussed the need for a cohesive remediation  
1044 system within the United States to provide remedial education programs to physicians  
1045 who would be identified through maintenance of competence initiatives.

1046

1047 Representatives from the Pew Health Professions Commission Taskforce on Health  
1048 Care Workforce Regulation and from the Institute of Medicine met with the committee to  
1049 discuss their organizations' recommendations that regulatory boards implement  
1050 mechanisms to periodically assess licensee competence. A representative from the  
1051 ABMS presented information regarding the ABMS' Maintenance of Certification program,  
1052 and a representative from the Accreditation Council for Continuing Medical Education  
1053 discussed initiatives to develop valid, appropriate, and meaningful continuing medical  
1054 education that is relevant to the physician's practice.

1055

1056 Throughout these discussions, the committee has been cognizant of the need to balance  
1057 public interest against professional autonomy. In making a determination about the  
1058 responsibility of state medical boards to ensure ongoing physician competence, the  
1059 committee acknowledged that the majority of physicians embrace lifelong learning as an  
1060 integral part of professionalism in medicine. However, the committee also  
1061 acknowledged that the permission to practice medicine is granted by the public, and that  
1062 it is reasonable to assume the public expects the re-granting of that permission to be  
1063 based on a fair and reasonable assessment of a physician's continued competence.

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1064

1065 Of equal import was a recognition that non-physician healthcare professions, such as  
1066 nurses, physician assistants and emergency medical technicians, have made significant  
1067 progress in developing maintenance of competence programs, while the physician  
1068 community has moved slowly to embrace a more formal, regulated approach to  
1069 evaluating ongoing competence. There is some concern that continued progress made  
1070 by other healthcare professions will lag unless medicine takes an active role.

1071

1072 At its December 2003 meeting, the Special Committee on Maintenance of Licensure  
1073 determined that state medical boards do have a responsibility to ensure the ongoing  
1074 competence of licensees and has recommended the following public policy statement to  
1075 the Board of Directors for consideration:

1076

1077         State medical boards have a responsibility to the public to ensure the ongoing  
1078         competence of physicians seeking relicensure.

1079

1080 The committee believes such a responsibility should be carried out prospectively, should  
1081 be non-punitive in nature, and should be structured so if problems or deficiencies are  
1082 identified, appropriate training or intervention is prescribed. The committee will continue  
1083 meeting over the next year to develop strategies that may be used by state medical  
1084 boards to ensure ongoing physician competence.

1085

1086 ***Conclusion and Recommendation:***

1087 Events within both the public and the regulatory arena are converging to shape the  
1088 debate regarding how best to ensure ongoing physician competence. While state  
1089 medical boards are just one component of a complex healthcare system, as policy  
1090 makers and regulators they play a critical role in influencing the behavior of the medical  
1091 profession and the environment within which physicians practice.

1092

1093 State medical boards serve the public interest and as such, are responsible for ensuring  
1094 that licensees are competent and fit for the practice of medicine. While applicants for  
1095 initial licensure must meet a variety of prerequisites that ensure their competence and  
1096 fitness to enter practice, regulatory boards have no requirements in place to assure

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1097 those same individuals maintain an acceptable level of qualifications throughout their  
1098 professional careers. However, continuing focus on patient safety initiatives and public  
1099 pressure for physician accountability demands that medical licensing authorities take  
1100 action to proactively ensure the competence of physicians to practice medicine safely –  
1101 not just at the point of initial licensure but throughout their careers.

1102

1103 Accordingly, the Board of Directors recommends that the House of Delegates of the  
1104 Federation of State Medical Boards adopt the following policy statement:

1105

1106 ***State medical boards have a responsibility to the public to ensure the ongoing***  
1107 ***competence of physicians seeking relicensure.***

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**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC.**

**SPECIAL COMMITTEE ON MAINTENANCE OF LICENSURE**

**INTERIM REPORT TO THE BOARD OF DIRECTORS  
FEBRUARY 2005**

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**Section I: Introduction**

The Special Committee on Maintenance of Licensure was established in May 2003 by Thomas Kirksey, MD, Chair of the Federation of State Medical Boards (FSMB), and charged with the following:

- Evaluate the responsibility of state medical boards to ensure physician competence through the course of one’s professional career and the efficacy of methods historically used to carry out those responsibilities;
- Research, review and evaluate systems currently used or under development by national organizations to facilitate physician competence and determine to what extent these systems could assist states efforts to ensure physician competence;
- Identify pertinent stakeholders and their positions regarding the role of state medical boards in ensuring physician competence for purposes of relicensure and where appropriate, their willingness to collaborate with medical regulators to achieve improvement in physician practice;
- Research, review, and evaluate tools and resources available to state medical boards and others for use in measuring competence and remediating deficiencies;
- Develop a position statement regarding the responsibilities of state medical boards in ensuring physician competence over the course of his/her career;

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- 1143       • Develop strategies for state medical boards to use in implementing programs to  
1144       ensure physicians maintain an appropriate level of competence to practice  
1145       medicine safely throughout their professional careers.

1146

1147   The committee has met three times, during which it has reviewed the factors  
1148   precipitating the FSMB's interest in the continuing competence of physicians; information  
1149   about recent initiatives undertaken by state medical boards and other health professions  
1150   regulatory bodies to implement continuing competence requirements for their licensees;  
1151   initiatives being pursued by international medical regulatory bodies to implement license  
1152   revalidation requirements; FSMB policies that contain language regarding physician  
1153   competence; and initiatives being implemented by medical professional organizations to  
1154   increase the profession's accountability to the public.

1155

1156   The committee has also received presentations from the following organizations:

- 1157       • The Institute of Medicine (IOM);  
1158       • The PEW Health Professions Commission;  
1159       • The Accreditation Council for Continuing Medical Education (ACCME);  
1160       • The American Board of Medical Specialties (ABMS);  
1161       • The National Board of Medical Examiners (NBME); and  
1162       • The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

1163

1164   Early in its deliberations, the committee concluded that the profession must implement  
1165   some form of mandated assessment of competence beyond that required for entry to  
1166   practice if it is to demonstrate to the public that it is committed to maintaining high  
1167   standards for practice. The committee further concluded that state medical boards are  
1168   the sole entities with the authority to require all licensed physicians to periodically  
1169   demonstrate their ongoing competence.

1170

1171   The committee identified a number of guiding principles for use in developing  
1172   recommendations for how states should approach implementing maintenance of  
1173   licensure requirements. In developing these principles, the committee acknowledged it  
1174   will be important to develop a system that respects the profession's commitment to  
1175   lifelong learning and improvement while concurrently responding to public calls for  
1176   increased accountability:

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- 1177 1. The goal of maintenance of licensure should be to facilitate improvement in  
1178 physician practice while ensuring that dyscompetent physicians are identified and  
1179 remediated and incompetent physicians are removed from practice.
- 1180 2. If problems or deficiencies are identified, the system should include mechanisms  
1181 to ensure that appropriate training or intervention is prescribed.
- 1182 3. Requirements must not be redundant or overly burdensome.
- 1183 4. Requirements should be consistent across jurisdictions.
- 1184 5. State medical boards should set standards for maintenance of licensure and rely  
1185 on external parties to develop tools and resources for use by physicians in  
1186 meeting those requirements.

1187

1188 In 2004, the FSMB's House of Delegates adopted the following policy position  
1189 developed by the Special Committee on Maintenance of Licensure:

1190

1191 State medical boards have a responsibility to the public to ensure the ongoing  
1192 competence of physicians seeking relicensure.

1193

1194 Through the remainder of 2005 and 2006, the committee's focus will be on developing a  
1195 framework for implementing this policy. Because many physicians work in healthcare  
1196 systems that influence a physician's provision of care to patients, the committee  
1197 recognizes that professional accountability for ongoing competence must take into  
1198 account the impact of the practice environment on a physician's performance.

1199

1200 The following document outlines some of the conceptual challenges associated with  
1201 implementing maintenance of licensure requirements, discusses issues that the  
1202 committee has considered and summarizes the committee's thinking to date. The  
1203 committee will continue to solicit input from other national organizations that will help  
1204 shape the committee's final recommendations to FSMB's House of Delegates.

1205

### 1206 **Section II: Committee Deliberations to Date**

1207

1208 A. State medical board Responsibility to Ensure Physician Competence

1209

## DRAFT REPORT

1210 In the United States, medical licensing authorities are charged through state medical  
1211 practice acts to ensure that physicians granted the privilege of medical licensure are  
1212 competent to practice medicine safely. According to FSMB policy as set forth in *A Guide*  
1213 *to the Essentials of a Modern Medical Practice Act*, the primary responsibility and  
1214 obligation of the state medical board is to “protect the public from the unprofessional,  
1215 improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine”<sup>1</sup>

1216

1217 Recent developments, some of which are listed below, are prompting state medical  
1218 boards to evaluate whether this charge should include a responsibility to ensure  
1219 physicians remain competent throughout their careers:

- 1220 • Rapid advances in technology and medical science that make it increasingly  
1221 difficult for physicians to stay current;
- 1222 • Opportunities to improve practice and provide better medical care afforded by  
1223 advances in technology and medical science;
- 1224 • Increased public focus on improving the safety of the US healthcare system and  
1225 the quality of care received by patients who interact with that system;
- 1226 • Reports issued by national healthcare policy bodies such as the IOM and the  
1227 PEW Commission, which recommend that the health professions regulatory  
1228 bodies develop and implement continuing competence requirements and that  
1229 they periodically re-examine and re-license healthcare professionals based, in  
1230 part, on competence<sup>2,3</sup>;
- 1231 • Data from a study commissioned by FSMB in 1997 regarding public awareness  
1232 and attitudes about state medical boards which indicated that the periodic  
1233 retesting of physicians was the second most-cited responsibility for state medical  
1234 boards (FSMB, unpublished data, 1997); and
- 1235 • Initiatives being implemented by oversight bodies such as the Accreditation  
1236 Council for Graduate Medical Education (ACGME) and the ABMS to establish  
1237 competency-based programs for their physician constituents.

1238

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<sup>1</sup> Federation of State Medical Boards. *A Guide to the Essentials of a Modern Medical Practice Act, Tenth Edition*. 2003.

<sup>2</sup> Finocchio L J, Dower C M, McMahon T, Gagnola C M and the Taskforce on Health Care Workforce Regulation. *Reforming Health Care Workforce Regulation: Policy Considerations for the 21<sup>st</sup> Century*. San Francisco, CA: Pew Health Professions Commission; December 1995.

<sup>3</sup> Institute of Medicine. *To Err is Human: building a safer health system*. Washington, DC: National Academy Press; 1999.

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1239 State medical boards use rigorous standards to ensure individuals seeking to enter  
1240 medical practice are competent. Applicants for initial licensure must provide evidence  
1241 that they have graduated from an accredited medical school, passed a three-part  
1242 standardized, national medical licensing examination of cognitive knowledge and clinical  
1243 and communication skills, and completed a certain amount of post-graduate training.  
1244 When presented with an applicant for initial licensure who has successfully navigated  
1245 such hurdles, state medical boards have a high degree of confidence that the physician  
1246 has the requisite knowledge and skills to practice medicine safely. Likewise, the public  
1247 can be assured that the newly licensed physician is competent to practice medicine.

1248  
1249 In contrast, state medical boards historically have utilized much less stringent  
1250 mechanisms to determine a physician's qualifications for relicensure. As discussed later  
1251 in this report, most state medical boards use continuing medical education as a means  
1252 of encouraging licensees to maintain competence. In addition, information such as  
1253 licensing board disciplinary actions, hospital privileging reports and malpractice history  
1254 are used to prompt reviews of physician competence as part of the license renewal  
1255 process. Currently, however, unless an indicator prompts review, physicians enjoy the  
1256 privilege of licensure for a lifetime without having to demonstrate to the public that they  
1257 have maintained a level of competence to merit that privilege.

1258  
1259 The mechanisms employed by state medical boards to determine physicians'  
1260 qualifications for relicensure are predicated upon an assumption that licensees are  
1261 competent unless a reported event or other problem indicates otherwise. This  
1262 assumption may not be valid and, more importantly, is not consistent with public  
1263 expectations that physicians uphold the highest standards of professionalism and  
1264 medical practice.

1265

### 1266 B. The Role of CME in Ensuring the Ongoing Competence of Physicians

1267

1268 State medical boards have used Continuing Medical Education (CME) requirements  
1269 since 1971 as a means of encouraging physicians to maintain competence. Currently, of  
1270 the 69<sup>4</sup> state medical boards that license physicians, 56 require physicians to participate  
1271 in some amount of CME in order to maintain licensure. Licensees are required to attest

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<sup>4</sup>There are 70 state medical boards in the U.S., 69 of which license physicians.

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1272 on their license renewal form that they completed the requisite number of hours of CME,  
1273 and most states monitor compliance through random audits of a sample of the licensee  
1274 population each year. Some jurisdictions require physicians to obtain a certain number  
1275 of CME hours related to a particular topic, such as pain management or ethics, but no  
1276 jurisdiction requires that the CME be associated with or related to the physician's actual  
1277 practice.

1278

1279 The committee reviewed data provided by the ACCME pointing to the efficacy of  
1280 continuing medical education in changing knowledge and practice when it is obtained as  
1281 a part of a system of continuous professional development involving self-  
1282 assessment/self-reflection, remediation, and reassessment. Groups like the ACCME, the  
1283 Council on Medical Specialties and the American Academy of Family Practitioners are  
1284 implementing standards and systems they believe will transform traditional CME into an  
1285 enterprise that measures the effectiveness of an educational experience by its impact on  
1286 physician performance and patient care outcomes.

1287

1288 CME has the potential to be a viable tool for use in ensuring ongoing physician  
1289 competence if it is part of a system of continuous professional development that includes  
1290 self-assessment, remediation, and reassessment. The committee believes CME, as  
1291 currently mandated by state medical boards, is necessary to facilitate continued  
1292 competence but, alone, is not sufficient to verify or ensure continued competence.

1293

### 1294 C. Efforts by Non-Governmental Oversight Agencies to Ensure Physician Competence

1295

1296 A variety of non-governmental oversight organizations contribute to the system of  
1297 professional self-regulation in which physicians participate. Several of these  
1298 organizations are responding to increased demands for accountability by implementing  
1299 initiatives aimed at measuring the ongoing competence of their physician constituents.

1300

1301 *Specialty board certification.* The ABMS is pursuing one of the most significant  
1302 undertakings – one that could have greatest utility to state medical boards as they  
1303 consider maintenance of licensure requirements.

1304

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1305 In 2000, the 24 member boards of the ABMS endorsed the principles behind  
1306 Maintenance of Certification (MOC), a program designed to continuously and  
1307 comprehensively assess the ongoing competence of physicians certified by each of the  
1308 24 ABMS specialty boards. This initiative will replace the recertification requirements  
1309 that ABMS boards began utilizing in the late 1970s.

1310

1311 The MOC program will require specialists to demonstrate evidence of the following:  
1312 professional standing; a commitment to lifelong learning and involvement in a periodic  
1313 self-assessment process; cognitive expertise; and evaluation of performance in practice.  
1314 Each of the four areas has associated standards in place specifying what is considered  
1315 acceptable evidence for meeting that requirement, including recommended timelines for  
1316 reassessment. As of December 31, 2004, each ABMS board had submitted initial plans  
1317 for implementing MOC requirements.

1318

1319 Physicians who are certified through the ABMS MOC program will be expected to  
1320 demonstrate competence in six core areas: patient care, medical knowledge,  
1321 interpersonal and communication skills, professionalism, practice-based learning, and  
1322 systems based practice. The ABMS is using these competencies, which were developed  
1323 by the ACGME for use with physicians in training, because it believes they have  
1324 relevance to physician practice regardless of area of specialty.

1325

1326 Approximately 90 percent of all licensed and practicing physicians are certified by at  
1327 least one ABMS specialty board. Physicians who have certificates without time limit are  
1328 not required to participate in MOC. Permanent certificate holders who elect to voluntarily  
1329 participate in MOC activities will not lose their permanent certification should they fail to  
1330 meet the MOC requirements. Implementation of maintenance of licensure requirements  
1331 could motivate this subgroup of certified physicians to comply with the MOC  
1332 requirements in order to meet licensure requirements.

1333

1334 ABMS is discussing the possibility of allowing physicians who are not eligible for  
1335 certification by an ABMS board (approximately 10 to 12 percent of all licensed  
1336 physicians) access to some of the tools and resources being developed through the  
1337 MOC program for their use in meeting maintenance of licensure requirements.

1338

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1339 *Physician Credentialing and Privileging in Hospitals.* The JCAHO is responsible for  
1340 accrediting health care organizations, such as hospitals, through an evaluation of the  
1341 quality and safety of care provided by the organizations. While hospitals are responsible  
1342 for credentialing and granting privileges to physicians who want to practice in their  
1343 settings, under the current system, they face several challenges in determining which  
1344 physicians should be granted initial privileges or renewal of privileges. Furthermore,  
1345 hospitals do not have processes in place to proactively ensure the ongoing competence  
1346 of physicians once they are privileged.

1347

1348 In response to these concerns, the JCAHO established a Credentialing and Privileging  
1349 Task Force, which is reviewing ways to implement proactive methods of assessing  
1350 physicians in the hospital setting and to improve the validity of the credentialing and  
1351 privileging processes. The Task Force is also expanding the criteria upon which  
1352 privileges are granted so that hospitals will have to assess physicians in areas such as  
1353 interaction within the team environment, rather than granting privileges solely on  
1354 technical skill and ability.

1355

1356 The Task Force is currently developing new standards for hospital credentialing and  
1357 privileging that are scheduled for implementation in early 2006. As part of the new  
1358 standards, hospitals will be expected to engage in the continuous collection of  
1359 performance data for physicians, provide simulated training experiences, provide  
1360 proctoring as appropriate for physicians and high-risk procedures and implement 360-  
1361 degree reviews for physicians.

1362

1363 State medical boards rely on hospital credentialing and privileging to ensure that  
1364 physicians have the proper training and education to perform procedures safely and  
1365 effectively. While the committee agreed that the current system for hospital  
1366 credentialing is not adequate, it believes that once the new processes are implemented,  
1367 hospital credentialing could serve as a tool for physicians to demonstrate their ongoing  
1368 competence as a condition of relicensure.

1369

1370 The committee will continue to track efforts by non-governmental oversight agencies to  
1371 ensure ongoing physician competence. While the committee felt that the standards  
1372 being implemented by the ABMS and the JCAHO could be utilized by state medical

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1373 boards as part of the maintenance of licensure process, it will continue to discuss,  
1374 evaluate and recommend alternatives for physicians who are not eligible for ABMS  
1375 Maintenance of Certification or who do not practice in JCAHO-accredited health care  
1376 settings. The committee also plans to review information from the American Osteopathic  
1377 Association (AOA) regarding its efforts to ensure the ongoing competence of osteopathic  
1378 physicians.

1379

### 1380 D. Assessing the Competence of Practicing Physicians

1381

1382 Multiple conceptual and methodological challenges come into play when developing  
1383 tools to assess the competence of practicing physicians. The following paragraphs  
1384 discuss three of those challenges: determining the purpose of the assessment,  
1385 differentiating between competence and performance, and assessment of  
1386 undifferentiated medical practice versus specialty-specific assessment.

1387

1388 *Purpose.* The first and perhaps most fundamental conceptual challenge to developing  
1389 an assessment process for practicing physicians is defining its purpose. When thinking  
1390 about how assessment could support maintenance of licensure, it must be decided  
1391 whether the assessment is intended to 1) exclude from practice physicians who are no  
1392 longer able to practice safely and competently, 2) identify areas for improvement in  
1393 otherwise competent physicians or 3) accomplish both.

1394

1395 If the assessment is intended to identify opportunities for improvement in practice, then it  
1396 must be relevant to what the physician does in his or her practice. Because the majority  
1397 of physicians embrace lifelong learning as an integral part of professionalism, an  
1398 assessment process that seeks to improve physician practice would be perceived more  
1399 positively by physicians and would likely have the greatest impact on quality of patient  
1400 care. Since the outcome of such a process would be improved practice, such an  
1401 assessment requirement could reasonably be applied to all licensees.

1402

1403 A number of organizations in the US and internationally are using physician assessment  
1404 and remediation programs as the basis of their recertification or relicensure  
1405 requirements. These programs fall into three broad categories: periodic comprehensive  
1406 assessment of all physicians, performance-focused tiered approach (such as Canada's

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1407 Monitoring and Enhancement of Physician Performance model), and cyclical delivery of  
1408 assessments over time (such as the American Board of Internal Medicine’s Continuing  
1409 Professional Development program). In general, the defined purpose of each is the  
1410 continuous professional development of practicing physicians. While this model is the  
1411 most politically acceptable, has potential for significant quality improvement and focuses  
1412 on the majority of physicians who are competent, it leaves unanswered how to identify  
1413 and respond to the remaining small percentage of physicians who are not competent.

1414

1415 *Competence vs. Performance.* A second conceptual challenge to consider is the blurred  
1416 distinction between competence and performance. While there is no single agreed upon  
1417 definition for these terms, there is some consensus that competence points to the *ability*  
1418 to do (or *can do*), whereas performance refers to *does do*.<sup>5</sup>

1419

1420 Standardized tests are associated with competence assessments, whereas workplace  
1421 assessments are associated with performance assessments. While there are valid,  
1422 reliable standardized tests such as multiple-choice examinations that may be used to  
1423 measure competence, there are few such tools available for use in measuring  
1424 performance. Ideally, a physician should be expected to demonstrate accountability for  
1425 both general competencies, including the knowledge, skills and abilities to provide safe,  
1426 effective patient care within the scope of their professional medical practice, as well as  
1427 performance in practice.

1428

1429 *GUMP vs. practice-specific assessment.* The third conceptual design challenge pertains  
1430 to whether practicing physicians should demonstrate competence in the general  
1431 undifferentiated practice of medicine or in the area of practice in which they engage on a  
1432 daily basis.

1433

1434 Because initial licensure is based on the general, undifferentiated practice of medicine  
1435 (or the “GUMP” model), one could argue that assessment for relicensure should focus  
1436 on the same general domains measured through examinations for initial licensure.

1437 However, because physician practice narrows over time, the deficiencies identified by a

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<sup>5</sup> Rethans JJ, Norcini JJ, Baron-Maldonado M, Blackmore D, Jolly BC, LaDuca T, Lew S, Page GG, Southgate LH. The relationship between competence and performance: implications for assessing practice performance. *Med Educ.* 2002;36:901-909.

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1438 GUMP level assessment may have a low level of relevance to patient care;  
1439 consequently, remediation may not result in improved practice.

1440

1441 An assessment that is tailored to reflect at least in part what the physician does in his or  
1442 her practice will also be perceived by the physician as more relevant and credible than a  
1443 GUMP-level assessment. One challenge to this construct is that the infrastructure  
1444 needed to efficiently gather data about physician practice so that assessments could be  
1445 tailored is not sufficiently developed.<sup>6,7</sup> In the interim, state medical boards could require  
1446 physicians to self-report and to select assessment methods that appear to be relevant to  
1447 their practice.

1448

1449 Physicians who change their scope of practice must also be considered. As part of the  
1450 maintenance of licensure process, physicians could be required to notify their state  
1451 medical board of any change in the scope of their practice and provide evidence of  
1452 having undertaken appropriate education and training to perform safely and effectively  
1453 within the new practice area. Such physicians would then be expected to demonstrate  
1454 accountability for competence and performance in the new practice area.

1455

1456 Also germane to this discussion is whether core competencies exist that all doctors  
1457 granted the privilege of licensure, regardless of specialty, should be presumed to know.  
1458 Both the ACGME and ABMS have identified six core competencies that their physician  
1459 constituents will need to demonstrate. It must be determined whether state medical  
1460 boards could or should utilize these same core competencies for purposes of  
1461 maintenance of licensure. The committee will continue to evaluate this issue, focusing  
1462 specifically on what comprises core competence and what role it should play in  
1463 programs to assess the ongoing competence of practicing physicians.

1464

1465 The committee agreed that, ideally, maintenance of licensure should support and  
1466 facilitate physicians' commitment to continuous professional development while  
1467 balancing the state's responsibility to remove incompetent physicians from practice. The

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<sup>6</sup> Melnick DE, Asch DA, Blackmore DE, Klass DJ, Norcini JJ. Conceptual challenges in tailoring physician performance assessment to individual practice. *Med Educ.* 2002;36:931-935.

<sup>7</sup> Landon BE, Normand ST, Blumenthal D, Daley J. Physician Clinical Performance Assessment: Prospects and Barriers. *JAMA.* 2003;290:1183-1189.

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1468 committee agreed that tools or programs used by physicians to document their ongoing  
1469 competence should be valid, reliable, feasible, have credibility with the profession and  
1470 should provide adequate feedback so that the physician participating in the program may  
1471 improve his or her practice.

1472

1473 Finally, the committee also agreed that remediation must be included in any program  
1474 developed to ensure physicians' ongoing competence. Currently, physicians who seek  
1475 educational interventions to address deficiencies have few resources available. In order  
1476 for maintenance of licensure initiatives to succeed, additional remedial education  
1477 programs will need to be developed and existing programs will need to be improved and  
1478 expanded to assist physicians who are identified through these processes. Data  
1479 regarding the effectiveness of the educational programs will need to be gathered and  
1480 disseminated. Such issues will continue to be a part of the committee's discussions as it  
1481 continues its work over the coming year.

1482

1483 E. Balancing Confidentiality Against the Public's Right to Information

1484

1485 As public agencies, state medical boards are required to conduct much, if not all, of their  
1486 business in a transparent fashion. This raises questions about whether information  
1487 resulting from maintenance of licensure initiatives should be available to the public.

1488 Other professions that are pursuing such initiatives have chosen to use the professional  
1489 development model, whereby the practitioner engages in self-assessment and  
1490 remediation, both of which are completed in a confidential manner. The system is  
1491 similar to the impaired physician model, in that participation is confidential until such time  
1492 as it is determined a practitioner has deficits that are so severe that he/she is a danger  
1493 to the public or until the practitioner fails to comply with the program. Only those  
1494 physicians who are referred to the disciplinary system are subject to public disclosure.

1495

1496 It is the committee's opinion that the process used by physicians to maintain licensure  
1497 should be transparent, but information regarding physicians' participation in maintenance  
1498 of licensure programs should remain confidential. This is based on the premise that  
1499 physicians should not be penalized for engaging in a process that allows them to identify  
1500 and correct their deficiencies, ultimately resulting in improved practice performance and  
1501 patient care. Physicians who do not comply with maintenance of licensure requirements

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1502 or who are identified through the program as incompetent should be subject to normal  
1503 adjudication processes and to public disclosure as required by state law.

1504

### 1505 **III. Conclusion**

1506

1507 There is increasing public pressure on the medical profession to take steps to ensure the  
1508 ongoing competence of physicians as part of its professional responsibility. However, no  
1509 single entity has the resources or capability to accomplish this on its own. Every public  
1510 and private institution that contributes to the system of medical professional self-  
1511 regulation has a responsibility and role to play. To be successful in implementing  
1512 maintenance of licensure requirements, state medical boards will need to collaborate  
1513 with credentialing agencies, certifying bodies, employers, professional associations, and  
1514 others in developing a coordinated system of oversight that supports physicians' efforts  
1515 to be lifelong learners.

1516

1517 Recognizing that state medical boards will need to rely on external organizations to  
1518 develop and provide tools for use by physicians to demonstrate competence, it will be  
1519 important for boards to have methods in place by which they can evaluate the validity  
1520 and acceptability of such tools. Over the next year, the committee will seek to develop  
1521 guidelines for use by state medical boards in evaluating whether the activities in which a  
1522 physician engages are sufficient to meet requirements for ongoing competence.

1523

1524 State medical boards are one component of a complex healthcare system. As policy  
1525 makers and regulators, they play a critical role in influencing standards for physicians  
1526 and the environment within which physicians practice. State medical boards have  
1527 historically devoted the majority of their resources to identifying and removing from  
1528 practice physicians who are unable to practice safely and competently. In order for  
1529 maintenance of licensure initiatives to succeed, that orientation must include facilitating  
1530 practice improvement for all physicians.

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## ADDENDUM 2

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### Revising *A Guide to the Essentials of a Modern Medical Practice Act*

#### Section XVI: Periodic Renewal

The medical practice act should provide for the periodic renewal of medical licenses to permit the Board to review the qualifications of licensees on a regular basis. At the time of periodic renewal, the Board should require the licensee to demonstrate to its satisfaction his or her continuing qualification for medical licensure. These provisions of the act should implement or be consistent with the following:

A. The Board should require the following for license renewal and require documentation thereof:

1. Participation in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent successful completion of educational activities tailored to meet the needs or deficiencies identified by the assessment.
2. Demonstration of continued competence in the following areas: medical knowledge, patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice and, if applicable, osteopathic philosophy and osteopathic manipulative medicine; including the knowledge, skills and abilities to provide safe, effective patient care within the scope of their professional medical practice. This criterion must be met, in part, by passage of a valid, secure, proctored examination in the physician's current practice area.
3. Demonstration of accountability for performance in practice.

~~AB. At the time of periodic renewal, the Board should require the licensee to demonstrate to its satisfaction his or her continuing qualification for medical licensure.~~ The application form for license renewal should be designed to require

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1566 the licensee to update and/or add to the information in the Board's file relating to  
1567 the licensee and his or her professional activity. It should also require the  
1568 licensee to report to the Board the following information:

1569

1570 1. The licensee's completion of activities related to maintenance of licensure,  
1571 specialty board certification or maintenance of certification within the  
1572 registration period.

1573

1574 ~~4~~2. Any action taken against the licensee by:

- 1575 • any jurisdiction or authority (United States or foreign) that licenses or
- 1576 authorizes the practice of medicine;
- 1577 • any peer review body;
- 1578 • any specialty certification board;
- 1579 • any health care organization;
- 1580 • any professional medical society or association;
- 1581 • any law enforcement agency;
- 1582 • any court; and
- 1583 • any governmental agency for acts or conduct similar to acts or conduct
- 1584 described in the medical practice act as grounds for disciplinary action.

1585

1586 ~~2~~3. Any adverse judgment, settlement or award against the licensee arising from  
1587 a professional liability claim.

1588

1589 ~~3~~4. The licensee's voluntary surrender of or voluntary limitation on any license or  
1590 authorization to practice medicine in any jurisdiction, including military, public  
1591 health and foreign.

1592

1593 ~~4~~5. Any denial to the licensee of a license or authorization to practice medicine  
1594 By any jurisdiction, including military, public health and foreign.

1595

1596 ~~5~~6. The licensee's voluntary resignation from the medical staff of any health care  
1597 organization or voluntary limitation of his or her staff privileges at such an  
1598 organization if that action occurred while the licensee was under formal or  
1599 informal investigation by the organization or a committee thereof for any

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1600 reason related to possible medical incompetence, unprofessional conduct or  
1601 mental or physical impairment.

1602

1603 ~~67.~~ The licensee's voluntary resignation or withdrawal from a national, state or  
1604 county medical society, association or organization if that action occurred  
1605 while the licensee was under formal or informal investigation or review by that  
1606 body for any reason related to possible medical incompetence,  
1607 unprofessional conduct or mental or physical impairment.

1608

1609 ~~78.~~ Whether the licensee has abused or has been addicted to or treated for  
1610 addiction to alcohol or any chemical substance during the registration period.

1611

1612 ~~89.~~ Whether the licensee has had any physical injury or disease or mental illness  
1613 within the registration period that affected or interrupted his or her practice of  
1614 medicine.

1615

1616 ~~9.~~ ~~The licensee's completion of continuing medical education or other forms of~~  
1617 ~~professional maintenance and/or evaluation, including specialty board~~  
1618 ~~certification or recertification, within the registration period.~~

1619

1620 ~~B. The Board should be authorized, at its discretion, to require continuing medical~~  
1621 ~~education for license renewal and to require documentation of that education.~~

1622

1623 C. The licensee should be required to provide information about his or her practice.

1624 Such information should include: scope of practice, type of practice (to include  
1625 location, supervisory responsibilities), status (e.g., full-time, part-time, number of  
1626 hours worked per week), whether they are actively seeing patients, specialty  
1627 board certification or recertification status, and what activities they are engaged  
1628 in if they are not engaged in clinical practice (e.g., research, administration, non-  
1629 medical work, retired, etc.). Licensees should keep the board apprised of their  
1630 practice status at all times by reporting any subsequent changes in practice  
1631 status or scope of practice to the board within a specified timeframe as  
1632 determined by the board.

1633

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1634 ~~C~~D. The licensee should be required to attest to the accuracy of the information  
1635 provided on the license renewal form. ~~sign the application form for license~~  
1636 ~~renewal and have it witnessed.~~ Failure to report fully and correctly should be  
1637 grounds for disciplinary action by the Board.

1638  
1639 ~~D~~E. The Board should be directed to establish an effective system for reviewing  
1640 renewal forms. It should also be authorized to initiate investigations and/or  
1641 disciplinary proceedings based on information submitted by licensees for license  
1642 renewal.

1643  
1644 F. Licensees not in active clinical practice who wish to maintain an active license  
1645 should be expected to comply with all maintenance of licensure requirements.  
1646 Physicians whose licenses are inactive or have lapsed should provide evidence  
1647 of meeting maintenance of licensure requirements when they reenter active  
1648 clinical practice.