

**Institute of Medicine of the National Academies
Committee on Identifying and Preventing Medication Errors
July 6, 2005**

**Submitted by:
James N. Thompson, M.D.
President and Chief Executive Officer
Federation of State Medical Boards**

And

**Lisa Robin
Vice President
Leadership & Legislative Services
Federation of State Medical Boards**

FEDERATION OF STATE MEDICAL BOARDS

The Federation of State Medical Boards (FSMB) is a national non-profit organization comprised of 70 medical licensing and disciplinary boards of the United States and its territories. Founded in 1912, the Federation is positioned as a leader in medical regulation and an authoritative source of research, policy development, education, and information. The Federation's primary mission is to improve the quality, safety, and integrity of health care by promoting high standards for physician licensure and practice and by assisting state medical boards in protecting the public.

I. The Role of State Medical Boards In Regulating Practicing Physicians

Authority

Under the 10th Amendment to the U.S. Constitution, states have the authority to regulate activities that affect the health, safety and welfare of their citizens. To protect the public from the unprofessional, improper, unlawful, fraudulent and/or incompetent practice of medicine, each state promulgates laws and regulations that define the practice of medicine and outline the responsibility and authority of the state medical board to regulate that practice.

Responsibility

The primary function of state medical boards is to protect consumers of health care through the proper licensing and regulation of physicians. Their accountability extends to the public, the profession, and individual physicians.

Public protection begins with a licensure process which is designed to ensure that practicing physicians (1) have appropriate education and training (2) have passed an examination of cognitive and clinical skills and (3) adhere to recognized standards of professional conduct. Licensed physicians must periodically reregister with their respective state medical board(s). During the reregistration process, physicians are required to demonstrate that they have maintained acceptable standards of ethics and medical practice by a variety of means, such as, compliance with continuing medical education (CME) requirements and by reporting certain events to the board. These events typically include criminal convictions, loss or restriction of hospital privileges, disciplinary actions, debilitating illnesses, and impairments. State medical boards also protect the public as well as the integrity of the profession by taking away the privilege of practicing medicine from those licensees who have violated professional and ethical standards of conduct and practice. Finally, state medical boards have a responsibility to educate their licensees regarding standards of care, changes in state statutes, new or revised rules and regulations, and issues affecting the quality of care rendered to patients. Boards communicate such information to licensees through newsletters, Web sites, and presentations to medical students and physician groups. Boards may also sponsor or co-sponsor CME activities.

On their own initiative or upon receipt of information reported by others, state medical boards investigate evidence which indicates that a physician is or may be incompetent,

guilty of unprofessional conduct, mentally or physically unable to engage safely in the practice of medicine, or otherwise in violation of the medical practice act or the rules and regulations of the board. Boards receive complaints from a variety of sources such as patients, hospitals, health care providers, etc.

Structure

State medical boards are typically comprised of physician and public members who are appointed by the governor. Some boards are autonomous in structure, exercising all licensing and disciplinary powers independent of other governmental officials or agencies, while others are part of a larger state agency, such as the state health department, which exercises varied levels of responsibility or functions in an advisory capacity. State medical boards employ an administrative staff that may generally include an executive officer, attorneys and investigators. Legal services are often provided by the state's attorney general.

The structure and responsibilities of each state medical board are set out by the state legislature in statute referred to as the medical practice act. While these statutes have many similarities, each is unique in its specific language which means there is variety in how boards are structured and how their responsibilities are described.

Funding

In general terms, state medical boards are primarily funded by physician licensing and registration fees; however, it is important to note that while the most autonomous boards are authorized to collect funds directly, many others are tied closely to the state appropriations process. Some specific mandates, such as physician profiling, may receive a special appropriation of state funds. Federation policy recommends that state medical boards be fully supported by the revenues generated from board activities, i.e. fees, charges and reimbursed costs. Section XIX of the Federation's *Guide to the Essentials of a Modern Medical Practice Act* provides "All such revenues, with the exception of fines, should be deposited in the State Treasury to the credit of a State Medical Board Account, which should also receive all interest earned on the deposit of such revenues. Such funds should be appropriated continuously and should be used by the Board only for administration and enforcement of the medical practice act. All fines levied by the Board should be deposited in the State General Fund."

Medical Practice Act

A state medical practice act is created by legislative authorization. Since each state practice act is unique, there are significant variations among states in how they address the privilege of practicing medicine. However, medical practice acts generally include:

- A definition of the practice of medicine
- A prohibition against the unlawful practice of medicine
- The structure of the state medical board
- Provisions for medical licensing examinations
- Requirements for licensure and reregistration
- The range of disciplinary actions that may be taken against physicians

- Procedures for enforcement of disciplinary actions
- A program for appropriate monitoring of impaired physicians
- Compulsory reporting requirements
- Authority to conduct investigations
- Legal protection and immunity for board members
- Authority for the board to promulgate rules and regulations to facilitate enforcement of the Act.
- A description of the board's source of funding

(The Federation of State Medical Boards publishes a guide for states in reviewing and revising Medical Practice Acts: *A Guide to the Essentials of a Modern Medical Practice Act.*)

Enforcement Procedures and Disciplinary Actions

The medical practice act sets out the procedures and standards by which the board may take enforcement and disciplinary action against those licensees who violate the act, while still assuring fairness and due process to respondent physicians. Common board actions include:

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

The Public Record

All final disciplinary actions and license denials, including the related findings of fact and conclusions of law, are matters of public record. Surrenders of licensure and voluntary limitations on medical licenses are also public record. State medical boards routinely release information on final disciplinary actions to the public upon request, and a number of boards have initiated physician profile systems whereby information on physician licensure, medical education and training, specialty board certification, criminal convictions, medical malpractice experience and disciplinary actions by state medical boards and hospitals may be accessed by the public through the Internet. Currently, at least 50 state medical boards provide physician licensure and disciplinary information via the Internet.

II. Primary Challenges Facing State Boards

Efforts to Change Board Structure

The Federation strongly supports independent status for state medical boards, meaning having authority for their own operations. It is the Federation's position that any restructuring which would diminish a board's independent authority to regulate the practice of medicine would not be in the public's best interest. Unfortunately, a number of states have introduced legislation or initiatives which tend to encumber, rather than streamline, their medical boards' structure and organization.

Fiscal policy is often cited as a major justification for the reorganization of various state boards and agencies. As state budgets become tighter, some state legislators view consolidation of agencies and/or services as a means to reallocate scarce funds. A prime example is the reorganization plan released by California Governor Arnold Schwarzenegger earlier this year. That plan would have eliminated 88 boards and commissions, including the Medical Board of California. Under his proposal, most of the activities and functions of the existing boards and commissions would have been transferred to another agency or department. The governor's stated rationale for the proposed reorganization was to improve the productivity, accessibility and accountability of state government. However, as the proposal was debated, it was concluded that such a proposal was adverse to the board's mandate of public protection as it would have diminished the board's accountability by limiting public access and transparency. Acknowledging the scarcity of and competition for available fiscal resources, medical boards will continue to be challenged to "do more with less."

The Federation's experience in gathering and maintaining performance data on all state medical boards over time indicates that autonomous boards are the most effective in regulating the practice of medicine. Of the seventy (70) composite, allopathic, and osteopathic licensing and disciplining jurisdictions in the United States, its districts and territories, forty-five (45) boards are classified as autonomous and eighteen (18) are classified as semi-autonomous, which means that the Board exercises most key powers with a central agency such as the Department of Health, providing most clerical/administrative functions.

The Federation defines an autonomous or independent board as one having statutory authority to exercise all licensing and disciplinary powers. Key operational characteristics of an autonomous board include:

- Authority to establish fees.
- Access to 100% of funds generated by board activities.
- Authority to develop and retain a reserve fund for board specific uses.
- Authority to hire, dismiss, set compensation, direct activities and evaluate the performance of medical board staff.

Inability to Oversee Investigations of Complaints

An additional challenge facing several state medical boards is their inability to oversee the investigations of complaints. This presents an immediate risk to public safety. When a Board has to share investigative staff with other agencies, it is placed in the position of having to compete with other state programs or services for resources. The importance of having the ability to hire and train investigators who are focused only on the work of the medical board is perhaps best illustrated by the “quality of care” cases. The investigation of complaints based on quality of care issues is highly specialized. These types of cases are complex, difficult, time-consuming, and expensive. Accordingly, it is imperative that state medical boards have the authority to hire investigators with the particular expertise and experience these cases demand.

Medical Malpractice and State Board Actions

State medical boards face an additional challenge in trying to educate legislators, the media, and the public on the differences between medical malpractice actions and state medical board actions. As tort reform and medical malpractice continue to dominate the legislative agendas in many states, this issue is continually addressed in the media.

Medical malpractice judgments or settlements are often not an accurate measure of an individual physician’s competence. While one act of ordinary negligence may give rise to a successful and justified malpractice action, medical boards must generally find a pattern of inappropriate practice before taking a disciplinary action based on the quality of care delivered. Consequently, the circumstances which result in a single malpractice action will seldom sustain a disciplinary action.

It is also important to consider that many times malpractice insurance carriers opt to settle out of court rather than incur the expense of a protracted contest. Medical boards review malpractice reports to detect patterns of inappropriate practice so as to identify physicians who may pose a danger to the public. Board actions are taken against a physician following a formal process of complaint, investigation, and hearing. A sanction taken by a medical board against a physician indicates that a violation of the medical practice act has occurred.

The nexus between medical malpractice and state board action is an area warranting further research. Federal support for medical malpractice reform should include a national research agenda, the results of which could be used by state medical boards to further their ability to better identify physicians whose competence is deficient.

III. Participation in Patient Safety Programs/Health IT/Quality Improvement Programs as Requirements for Licensure

Patient Safety Programs

The Federation is taking an active role in encouraging state medical boards' efforts to improve patient safety and reduce medical errors. As a result of a mandate from the Federation's member state medical boards, the Federation's Patient Safety Workgroup was established to evaluate the role of state medical boards in improving patient safety. The workgroup, consisting of broad representation from the regulatory, professional, consumer, and health care delivery communities, is focused on discovering what strategic, incremental steps state medical boards can take to improve patient safety and assure competent performance by physicians. The workgroup is charged to:

- (1) Evaluate and identify the role(s) of state medical boards in reducing systems errors balanced against medical boards' primary responsibility to protect the public from unqualified and incompetent physicians (i.e. evaluating competence over time, ability to receive reports from hospitals, managed care organizations, other health care providers, early identification of unsafe providers, and value and use of complaint data);
- (2) Identify "models" whereby information received by state medical boards that involves systems problems could be shared with licensees, state patient safety organizations, other regulatory entities, and/or healthcare facilities, as appropriate; and
- (3) Distribute information to state medical boards on appropriate "models" and "best practices" regarding the role of state medical boards in reducing medical errors.

The goals developed by the workgroup include: (1) proactively promoting the role of state medical boards in improving patient safety and reducing medical errors (2) assuring a commitment to foster the role of state medical boards in collaboration with other stakeholders in keeping patient safety a priority (3) asserting the position that state medical boards have an active role in hospital credentialing and assessing providers (4) conducting an analysis of current legislation and regulations to develop model legislation and tools to improve patient safety (5) identifying constraints on state medical boards in achieving patient safety, (6) forming partnerships with other health regulatory boards, and (7) developing a statement of principles regarding the role of state medical boards in improving patient safety.

In addition, one of the focal points of the Federation's 2005 Annual Meeting, the highlight of FSMB's annual educational activities, was improving patient safety and reducing medical errors. State medical board efforts to improve patient safety also include conducting criminal background checks on license applicants, providing license and disciplinary information to the public, and developing and enforcing practice standards in areas such as pain management, office-based surgery, and the use of the Internet in medical practice.

Health IT

State medical boards are responsible for assuring the quality, safety, and integrity of health care through physician licensure and discipline. These regulatory bodies face new challenges in their mission to protect the public as new technologies emerge in the practice of medicine and the delivery of health care. Specifically, state medical boards must balance their responsibility to ensure that only qualified physicians are providing medical services to the residents of their states with the rapid development and acceptance of new technologies that allow medical services to be provided by physicians located in other jurisdictions. While some progress has been made to reduce regulatory barriers affecting the use and promotion of telehealth practices across state lines, there is currently no widely accepted model for telehealth licensure that satisfies the concerns of state medical boards while allowing patients to benefit from rapid advances in interstate delivery of medical care.

Recognizing the potential benefits of new technologies, the Federation has been working with two regional groups of states to design demonstration projects to be used as models for state medical boards seeking to facilitate license portability by simplifying multi-state licensure. These projects are designed to significantly reduce the redundancies which currently complicate the process of obtaining medical licensure in multiple jurisdictions. If implemented, these projects will provide state medical boards with the resources to adapt state regulatory processes to facilitate new modalities in health care delivery without compromising public protection. These projects will require sufficient funding in order to develop the technical architecture necessary for state medical boards to access and share physician-specific information and facilitate (1) the availability of telehealth services (2) mobilizing physicians in the event of a national disaster and (3) the early sharing of complaint, investigative and other information in the interest of patient safety.

The Federation is also closely monitoring Federal initiatives to advance efforts toward the transition to electronic health records and increased use of e-prescribing to determine what implications a national health IT infrastructure will have on measuring physician competence and performance.

Continued Competence of Licensed Physicians

The Federation has long considered whether physicians should be required to demonstrate ongoing competence as a condition of relicensure. In 2002, the Federation Board of Directors incorporated into its strategic action plan a goal pertaining to the continued competence of licensed physicians. A key strategy for this action goal was the creation of the Special Committee on Maintenance of Licensure in May 2003, which was charged with developing a policy position regarding state medical boards' role in ensuring the ongoing competence of licensed physicians, together with recommendations as to how state medical boards should proceed in this arena.

Responding in part to demands from the public that the health care community in general and physicians in particular must improve both the quality of medical care provided and the health care delivery system, the Federation adopted an official policy statement in

May 2004 specifying that state medical boards are responsible to the public for ensuring the ongoing competence of physicians as a condition of relicensure.

In March 2005, the Federation, with support from the Robert Wood Johnson Foundation, hosted an invitational summit to explore how the medical regulatory community should respond to the forces and trends influencing medicine. Individuals representing the medical and academic communities, state licensing authorities, accrediting agencies, employers, providers, hospitals and the public participated in the first of what will be a series of forums aimed at developing a coordinated approach to ensuring physician competence.

The methodology used during the summit in developing a shared vision for medicine's system of self-regulation was scenario-based planning, creating plausible scenarios to understand what is currently happening and what might happen in the future, and also to discuss interventions that might influence and improve the outcome. The key premise behind this approach is recognition that more than one future is possible and that the actions taken by stakeholders will determine which future unfolds. Ultimately, this approach will provide a roadmap that the participating organizations may use in determining what their role should be in creating a preferred future that is in the best interest of both the profession and patients.

Additionally, because CME is used by state medical boards as an indicator of currency, the Federation supports the future direction of the CME industry to make CME more meaningful, relevant and measurably impact physician practice and patient outcomes. In May 2005, the Federation adopted an official position that CME credits be given for point of care learning that is practice-based, supporting specific patient care.

IV. Conclusion

The primary function of a state medical board is to protect consumers of health care through proper licensing and regulation of physicians, yet at a time of increased accountability for physicians, many state medical boards are forced to compete with other agencies for funding, thereby, jeopardizing the quality of health care received by the public. It is imperative state medical boards receive sufficient funding to carry out their mission of public protection and move forward, in collaboration with the profession, payers, and other health regulatory agencies, with initiatives to support and improve patient safety and improved access to care. Legislators should understand that any restructuring or other efforts which diminish the board's authority to regulate medical practice compromises public safety.

The effectiveness of state medical boards will continue to be challenged due to misconceptions regarding the nexus between medical malpractice liability and state medical board actions. Research is needed to determine how malpractice information can be used by state medical boards in establishing performance standards to identify physicians whose competence is deficient.

The current state-based regulatory system should be enhanced by creating technical interconnectivity and the use of common standards, definitions and tools. The state-based system is preferable in that patients are best served at the local level and therefore local regulation is both necessary and efficient, although the system should be strengthened and enhanced. In the interest of patient safety, improved access to care through technology, and homeland security, it is critical that sufficient resources be allocated to develop and implement programs that will enhance the portability of medical licensure and the ability of state medical boards to share complaint, investigative, and other pertinent information among jurisdictions.

Finally, it is critical that the medical profession move forward to ensure the ongoing competence of physicians by developing and implementing systems to assess competence beyond the threshold established for entry to practice. State medical boards will have an important role in this arena as they are the sole entities with the authority to require all licensed physicians to periodically demonstrate their ongoing competence. In order to be successful in implementing such systems, state medical boards will need to collaborate with credentialing agencies, certifying bodies, employers, professional organizations, and others to develop a coordinated system of oversight which supports physicians' commitment to maintaining competence over time.