

MAINTENANCE OF LICENSURE FREQUENTLY ASKED QUESTIONS

The following subjects are addressed in these FAQs:

- The basics: who, what, how, why, and when
- Proposed framework
- Process to date
- Learning from others
- Impact on physicians
- Reactions to date

The basics

What is maintenance of licensure?

Maintenance of licensure (MOL) is the process by which a licensee demonstrates that he or she has maintained the competence and qualifications necessary for continued licensure. Right now, most physicians demonstrate their competence to their licensing boards only once – when they first apply for a license to practice medicine. If MOL requirements are implemented by state medical boards, physicians will be expected to demonstrate their competence periodically in order to maintain active medical licenses.

What do physicians do now to maintain their licenses?

Medical boards' current requirements for license renewal vary in detail, but generally ask physicians to update information such as board certifications, additional training, malpractice claims and so forth, and to pay a fee. In most states, physicians also must show that they have obtained a certain amount of continuing medical education. However, they are not required to get education credits in areas related to their practices nor are they required to demonstrate to their licensing boards what they have learned from continuing medical education activities. The MOL programs outlined in the proposed model policy would require physicians to demonstrate skills and knowledge in their areas of practice.

How does a model policy differ from actual regulations?

The Federation of State Medical Boards develops model policies at the requests of its members; it does not have the authority to license physicians to practice medicine. That authority rests with the individual states and U.S. territories, which carry out this responsibility through their medical licensing boards. There are 69 such boards: some boards license allopaths (physicians holding M.D.s); some, osteopaths (physicians holding D.O.s); and some, both. All belong to FSMB.

Through their participation in the House of Delegates, the medical boards may direct FSMB to develop a model policy. Once the House has reviewed the model policy, the delegates will then vote to adopt or not. The states and territories are free to adapt model policies to meet their jurisdictional needs.

In sum, a model policy is just that – a model – unless and until a state or territory translates it into statute or regulations.

How has the translation of FSMB policy into practice worked before?

FSMB's policy guidelines on pain management provide one excellent example. In 2004, FSMB revised its guidelines for pain management to reflect advances in knowledge about pain and its treatment. Some three dozen states now reflect FSMB's current guidelines for appropriate pain management in their regulations, but each state enacted its regulations in their own time and with some variations. FSMB also developed programs and resources that states could use to educate physicians about their updated regulations.

What was the original directive that set FSMB on the path to develop a model policy?

In 2004, FSMB House of Delegates adopted this policy directive, which remains in effect:

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

What will be the next steps in finalizing the model policy on maintenance of licensure?

In May 2008, the FSMB House of Delegates approved a recommendation by the FSMB Board of Directors to endorse plans to study how the MOL requirements outlined in the model policy would impact state medical boards and other stakeholder groups. Next steps are for the FSMB to invite member boards, specialty boards, physicians' organizations and practicing physicians, consumer groups, IT organizations, and others to collaborate with FSMB on developing implementation models and pilot projects.

Why did the FSMB Board of Directors recommend further research as a precursor to finalizing the policy framework?

In part, the concerns of member boards led the Board to seek additional information on how new MOL regulations would play out on the ground. For instance, state medical boards have different administrative structures, legal requirements, and staff and budget resources. Different implementation models would explore the implications for state medical boards of moving forward with MOL programs under different circumstances. Pilot projects would then test the strongest of the models. Developing and testing

models will also help other stakeholders, certifying boards and hospitals understand how their organizations could collaborate to assist physicians in meeting MOL requirements.

What is the goal of proposed MOL programs?

The ultimate goal of any maintenance of licensure program would be to improve patient care. To achieve that goal, MOL programs would support continuous learning as a touchstone of physicians' lifelong practice.

Why is this change necessary?

The accelerating pace of change in medicine increases the urgency of integrating continuous learning into the requirements for licensure. Research demonstrates the importance of this shift: As physicians' time away from medical school and training increases, they risk developing deficits in important skills and knowledge unless they are in an environment that encourages continuous professional development.

When will FSMB begin developing implementation models?

Immediately. The House of Delegates has directed FSMB to report back on the results of the research in May 2009. Over the next 12 months FSMB will invite state medical boards and other collaborators to join in this work.

Once the policy framework is approved, how long will it take for states to translate the framework into regulations?

The time frame will vary from state to state.

Proposed Model Policy

What are the major components of the proposed model policy for maintenance of licensure?

The model policy suggests that state medical boards require physicians to:

- Participate in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent successful completion of educational activities tailored to meet the gaps in knowledge and skills identified by the assessment.
- Demonstrate continued competence in the areas of medical knowledge, patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism, systems-based practice and, if applicable, osteopathic philosophy and osteopathic manipulative medicine. The demonstration of competence should include the knowledge, skills and abilities to provide safe, effective patient care within the scope of their professional medical practice.
- Demonstrate accountability for performance in practice.

How might physicians fulfill these requirements?

A guiding principle of the model policy is the provision of flexible options for physicians to meet MOL requirements. One very likely option would be for state medical boards to accept physicians' active participation in maintenance of certification processes. Similarly, state medical boards might accept participation in activities required by The Joint Commission or the Clinical Assessment Program of the American Osteopathic Association.

Many of these programs already require physicians to participate in self-evaluation exercises or modules, such as self-review tests, home study courses and web-based materials. Activities to address identified needs can include a review of literature and/or continuing medical education in a current area of practice. Acceptable demonstrations of performance in practice may include peer assessments, such as evaluations from colleagues and co-workers and/or letters attesting to clinical activities, and patient reviews, such as satisfaction surveys. Other tools might include collection and analysis of practice data, such as office records, chart review, case review, and submission of a case log.

The requirements in the model policy also call for physicians to demonstrate their competence by passing a valid, secure, proctored examination in their current practice areas at least once every 10 years. This is consistent with maintenance of certification programs, which require physicians to periodically pass an examination in their areas of specialization.

What would happen to physicians who do not fulfill their state boards' MOL requirements?

If a state adopts MOL requirements, then MOL is likely to become a requirement that a state medical board would require for license renewal, just as CME is required today. A physician would be unable to renew his or her license until presenting evidence of satisfactory completion of MOL. How this will actually work will be studied as part of the next steps undertaken by the FSMB to determine how MOL requirements would impact state medical boards.

Would the public know how physicians perform on maintenance of licensure requirements?

The model policy calls for balance between the public's need to know how their physicians perform and the public benefit in supporting physicians' continuing education. Physicians are more likely to embrace new learning if they can complete assessments and have a reasonable period to close gaps in skills and knowledge.

The states and medical boards will find that point of balance individually.

Process

When did FSMB actively begin the work of developing a policy framework for maintenance of licensure?

An FSMB committee began studying the complex issues involved in maintenance of licensure in 2004, after the House of Delegates adopted a policy directive affirming state boards' responsibility for ensuring physicians' ongoing competence. The committee included physician and public members of state medical boards, representatives from their staffs, and consultants from the education and testing communities. The committee reviewed the experience of other countries as well as research on the relationship between continuous learning and improvement in practices. They surveyed the extensive requirements for quality improvement activities at other junctures in a physician's education, training and practice. The committee members examined how to determine what skills and knowledge physicians would need to demonstrate and what assessment tools to use. Out of all this work, the committee developed recommendations to the Board of Directors for a model policy. In May 2008, the House of Delegates approved a recommendation by the Board of Directors to study the impact of implementing MOL regulations before finalizing the model policy.

Why is the process taking so long?

The issues are extremely complex. With physicians practicing in so many settings and specialties, which skills do you assess and how do you assess them? How do you know your assessment tools are reliable? How do boards make sure skills and knowledge are actually being applied in a physicians' practice to improve patient care? How do state boards carry out these new duties at a time when many of them operate with budgetary constraints? How can a framework be structured to accommodate the varied legal and administrative structures that affect member boards? How do boards do all this in a way that poses the least additional burden on physicians?

Also, it has been clear from the beginning that implementing MOL requirements will require a great deal of collaboration between state medical boards and national organizations establishing competency requirements at other points in physicians' education, training and practice. Collaboration will be the only way to reduce redundancies that would otherwise burden physicians and to promote rational continuity in what physicians are expected to know and be able to do.

The work of the special committee has taken us a long way in focusing on fundamental principles and in framing proposed requirements. Pilot projects would test these principles and requirements against environmental realities and look at the impact on physicians.

Learning from others

What does research tell us about the relationship between continuous professional development and practice improvement?

Meta-analyses support the use of continuing medical education as a tool for physician learning if it is part of a system of professional development that includes self-assessment, remediation and re-assessment. These findings support the shifts in requirements for re-licensure embodied in the proposed model policy – from a counting of CME hours to a demonstration of improvement in a physician’s practice. References to relevant research are provided in the special committee’s draft report on maintenance of licensure.

Are other healthcare organizations doing similar work to assure that physicians are competent?

By 2012, all 24 boards that belong to the American Board of Medical Specialties will have programs in place that require physicians to demonstrate continuing competence in order to maintain their board certification. The American Osteopathic Association Bureau of Osteopathic Specialists will also have continuous certification requirements in place for its 18 specialty boards. The Joint Commission, which is the accreditation body for U.S. health care organizations and programs, has enacted new standards that include quality improvement activities and performance-monitoring for physicians among its requirements for granting hospital privileges. The Accreditation Council for Continuing Medical Education, the Accreditation Council for Graduate Medical Education, and the American Medical Association are other organizations that have placed continuous learning and practice improvement at the center of their principles for lifelong practice.

Licensing boards seek to learn from these organizations and, where appropriate, to collaborate with them. However, as their 2004 policy directive makes clear, state medical boards also believe they have a unique role in ensuring the ongoing competence of licensed physicians. As the sole entities that regulate *all* physicians and that operate with a direct mandate to protect the public’s safety, the U.S. medical licensing boards have a unique responsibility to assure physicians’ ongoing competence and continuous improvement.

What do the experiences of other countries tell us?

Both Canada and the United Kingdom have programs for assuring the continuous improvement of their physicians, but none has a long enough history to provide solid information about outcomes. The College of Physicians and Surgeons of Ontario has had a program in place since 1981 to conduct office-based evaluations of facilities, medical records and quality of care in its licensees’ practices at least every ten years. In 2006, 73 percent of Ontario physicians rated the program as excellent or good in

response to a College survey. In 2007, the College amended its bylaws to require all physicians to take part in continuing physician development.

In 1998, the General Medical Council of the United Kingdom began implementing requirements for all licensed physicians to undergo review of their practices every five years. However, the program is too new for evaluations to measure impacts on physicians' practices

The policy framework for MOL programs in the U.S. will support the standards and realities of medical practice in this country. However, FSMB will continue dialogue with our colleagues in other countries for mutual learning.

Haven't several of the states begun work on maintenance of licensure programs in the past?

In the last 10 years, California, Nevada and Texas have begun work at various points to assess the feasibility of such programs. In all three states, the medical boards abandoned these efforts due to the broader political climate, concerns about the impact on the supply of physicians in the state, or physicians' concerns.

What makes you think this time will be different?

The body of research supporting a correlation between improvements in medical practice overall and continuous learning among physicians has grown in recent years. Furthermore, the breadth of commitment among certifying boards and other organizations to such requirements has raised physicians' awareness about the value and variety of programs that support continuous learning. Finally, the level of national dialogue calling for physicians' greater accountability to the public has grown so that physicians are more aware of public demand.

Impact on Physicians

How would MOL requirements impact physicians?

The vast majority of physicians are already pursuing continuing education and training to keep their knowledge and skills current, and many do so through the maintenance of certification programs required by their specialty boards or other quality improvement activities. If state boards were to find these activities acceptable as evidence that their licensees have met MOL requirements, the impact on these physicians would be minimal. As FSMB develops and test implementation models, one of the criteria for success will be models that minimize redundancies and the burden on physicians.

Do all physicians take part in maintenance of certification programs now?

According to data from the American Board of Medical Specialties (ABMS), over 80 percent of the approximately 700,000 practicing physicians are board-certified in a particular area of specialization. At different dates, specialty certification boards began establishing time limits on certificates. Some specialty boards “grandfathered in” physicians who received their certificates before the time limits were established. These physicians are exempt from participating in maintenance of certification programs, although some have voluntarily done so. More physicians are likely to do so if that step will satisfy requirements of licensure as well.

How would MOL requirements impact physicians financially?

That will be one of the questions FSMB will be evaluating as it develops and pilot tests various implementation models.

How would new MOL requirements impact physicians who wish to re-enter practice?

They would need to demonstrate compliance with MOL requirements as a condition of reentering practice.

How might MOL requirements impact other developments affecting medical practice, such as e-health and telemedicine or the pay-for-performance movement?

Patients today benefit from the availability of services from physicians who may not be present in their state when the services are provided but who are licensed in their state, as is often the case with telemedicine. State medical boards realize that policies they impose must not interfere with physicians’ ability to secure licensure in other states. Consistency will be necessary among states when adopting MOL requirements to avoid interstate mobility issues. A model FSMB policy will guide states to adopt policy with uniform elements so that license portability problems are avoided.

How would state medical boards keep new requirements from being yet another infringement on physicians' time with patients?

Our commitment is to work with certifying boards, physicians' organizations, practicing physicians, and others to create a system that involves the least redundancy and least burden possible within medical boards' mandate to protect patients' safety.

Reactions to Date

How does FSMB know the public cares about this issue?

In a 2007 Harris poll, as yet unpublished, FSMB found the overwhelming majority of respondents said physicians should be evaluated at least once every five to ten years to maintain their licenses.

In 2007, the American Association of Retired Persons, in collaboration with the Citizens Advisory Council, conducted a survey of Virginia citizens, 50 years and older. Ninety-five percent of respondents said they believe physicians should demonstrate their skills and knowledge periodically as a condition of re-licensure.

What about physicians' current attitudes toward maintenance of licensure requirements?

A recent survey conducted by the Institute on Medicine as a Profession found that 77 percent of physicians believe they should undergo recertification exams periodically. Nearly all respondents believed they should take part in peer evaluations of the quality of care provided by colleagues.

How did medical boards react to the draft model policy?

Their concerns have been on the specifics of implementation. Will they need additional statutory authority in order to mount such programs? How will they manage the additional work load when their staffs and budgets are already overtaxed? How will they incorporate the requirements into the medical practice acts, which are the source of their regulatory power but that differ from state to state? These concerns are what set FSMB on the course of testing various models through pilot projects so that it could augment the model policy with implementation guidelines.

What sort of comments is FSMB getting from physicians?

The vast majority of physicians recognize how important it is that their system of self-regulation provides assurance to the public that members of their profession are competent. Concerns have centered on whether MOL requirements would duplicate those already in place or being implemented by other national organizations. FSMB's work seeks to minimize the burden and duplication as much as possible.

For instance, FSMB has been spearheading work with other organizations to align standards of medical practice across the continuum of medical school, residency programs, state medical boards, certifying organizations, and other organizations whose requirements affect practice. This collaborative work has engaged board members and administrative leaders who realize the importance of clarifying expectations for physicians both within the medical community and for the public. The work has also involved an array of stakeholders, even beyond those representing physicians and

regulators to engage consumer groups, hospitals, insurance representatives, state legislators, and foundations. The level of collaboration bodes well for outcomes that will help the public know what they can expect from their physicians and physicians what they will be expected to do.

The special committee's report states that current licensure requirements are no longer enough to assure physicians' continuous competence. Should patients worry about the safety of medical care while the development of a model policy and MOL requirements goes on?

The worry is probably smaller than it ever has been, given the focus of the medical community as a whole on continuous improvement and the number of programs in place to engage physicians in continuous learning. The vast majority of physicians are doing the right things to keep their skills and knowledge current. MOL requirements will constitute an additional safeguard and a shift in the regulatory process to place greater emphasis on continuing improvement.