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**FEDERATION OF STATE MEDICAL BOARDS
SPECIAL COMMITTEE ON MAINTENANCE OF LICENSURE
DRAFT REPORT ON MAINTENANCE OF LICENSURE
FEBRUARY 2008**

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.¹ Every medical practice act is built upon this same premise, and likewise, each state medical board uses criteria to assess a physician's competence and fitness to practice prior to granting initial licensure.

In 2003, the Federation of State Medical Boards (FSMB) established a special committee to develop a position statement regarding the responsibility of state medical boards to ensure licensees are competent over the course of their professional careers; and to develop strategies for state medical boards to use in implementing programs to carry out that responsibility.

The Special Committee on Maintenance of Licensure has met eight times. In carrying out its charge, the committee reviewed the factors precipitating the FSMB's interest in the continuing competence of physicians; information about recent initiatives undertaken by state medical boards and other health professions regulatory bodies to implement continuing competence requirements for their licensees; initiatives being pursued by international medical regulatory bodies to implement license revalidation requirements; FSMB policies that contain language regarding physician competence; and initiatives being implemented by medical professional organizations to increase the profession's accountability to the public.

The committee also sought input directly from the following organizations: Institute of Medicine (IOM), PEW Health Professions Commission, Accreditation Council for Continuing Medical Education (ACCME), American Board of Medical Specialties (ABMS), American Medical Association (AMA), American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS), The Joint Commission, the National Board of Medical Examiners (NBME), and the North Carolina Medical Board.

Early in its deliberations, the committee concluded that if the profession is to demonstrate to the public that it is committed to maintaining high standards for practice, all licensed physicians should be expected to periodically demonstrate competence beyond that required for entry to practice. The committee further concluded that state medical boards are the sole entities with the authority to require all licensed physicians to periodically demonstrate their ongoing competence.

In 2004, at the special committee's urging, the FSMB House of Delegates adopted the following statement as official FSMB public policy:

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

52 In developing recommendations for use by state medical boards to implement
53 maintenance of licensure programs, the committee identified a set of guiding principles
54 for use in developing a framework for how state medical boards should approach
55 maintenance of licensure. In adopting these principles, the committee acknowledges the
56 importance of responding to public calls for increased accountability while concurrently
57 respecting the profession's commitment to lifelong learning and improvement:
58

- 59 1. The goal of maintenance of licensure is to support physicians' commitment to
60 lifelong learning and to facilitate improvement in physician practice while
61 ensuring that physicians identified as having deficiencies are remediated.
- 62 2. Collaboration with other stakeholders is critical. State medical boards should set
63 requirements for maintenance of licensure and may rely on external parties to
64 develop tools and resources for use by physicians in meeting those
65 requirements.
- 66 3. Requirements should not be punitive, redundant or overly burdensome for
67 physicians; and should be structured to allow consistent implementation across
68 jurisdictions.
- 69 4. If problems or deficiencies are identified, the system should include mechanisms
70 to ensure that appropriate training or intervention is prescribed.
- 71 5. Participation in intervention and training programs should be confidential and
72 non-punitive, enabling physicians to obtain help without fear of recrimination or
73 action from the state medical board.
74

75 This report provides guidance to state medical boards regarding how to implement
76 maintenance of licensure requirements. The report is divided into the following sections:
77

- 78 Section 1: Licensure Practices Today
- 79 Section 2: Environmental Assessment
- 80 Section 3: State Medical Boards and Maintenance of Licensure.
- 81 Section 4: Conceptual and Methodological Challenges to Assessing Competence.
- 82 Section 5: A Proposed Framework for Maintenance of Licensure Requirements.
- 83 Section 6: Moving Forward
84
85

86 **SECTION I. LICENSURE PRACTICES TODAY**

87
88 State medical boards have rigorous requirements in place to ensure individuals seeking
89 to enter medical practice are competent. Applicants for initial licensure must provide
90 evidence that they have graduated from an accredited medical school, passed a
91 standardized, national medical licensing examination of cognitive knowledge and clinical
92 and communication skills, and completed a certain amount of post-graduate training.
93 When an applicant for initial licensure provides evidence of successfully meeting such
94 conditions, state medical boards – and by extension, the public – can be confident that
95 the physician has the requisite knowledge and skills to practice medicine competently
96 and safely.

97
98 In contrast, license renewal is largely an administrative function that assumes licensees
99 are competent unless a reported event or other development indicates otherwise. In all
100 jurisdictions, licensees are required to complete a renewal form and pay a fee. As a part
101 of the renewal process, many state medical boards ask licensees to provide information
102 about hospital privilege reports, malpractice reports, specialty board certification status,
103 and disciplinary actions taken by other jurisdictions to assess licensees’ qualifications to
104 practice at the time of license renewal.

105
106 In addition to providing evidence of qualifications, 60 out of 69 medical licensing boards
107 require physicians to obtain a specified number of CME credits.² Physicians are required
108 to attest on the license renewal form to having met CME requirements, and state
109 medical boards conduct random audits of a certain percentage of license renewal
110 applicants to ensure they have met CME requirements. While some states mandate that
111 a certain number of required CME hours be content-specific, such as HIV/AIDS,
112 palliative care, pain management and medical ethics, few jurisdictions require licensees
113 to take CME that is directly related to his or her scope of practice. As currently mandated
114 by state medical boards, CME is not sufficient to verify or ensure continued competence.
115

116 **SECTION II: ENVIRONMENTAL ASSESSMENT**

117
118 While the question of how to assure ongoing physician competence has a long history of
119 debate with little agreement, a number of developments over the past 15 years appear
120 to be providing impetus for action by the health professions regulatory community.

121
122 ***Public Expectations Regarding Physician Competence***

123
124 In the mid-to late 1990s, the Institute of Medicine and the Pew Health Professions
125 Commission's Taskforce on Health Care Workforce Regulation released a series of
126 reports addressing the quality and safety of the existing health care system. The IOM's
127 *To Err is Human* report, which addresses medical error rates in the United States,
128 challenges the health professions regulatory boards to do their part in making the overall
129 health care system safer for patients by periodically re-examining and re-licensing
130 providers "based on both competence and knowledge of safety practices."³ Subsequent
131 IOM reports also recommend that health regulatory boards take a more proactive and
132 involved approach to practitioner competence.^{4,5}

133
134 The Pew Health Professions Commission Taskforce on Health Care Workforce
135 Regulation's initial report, *Reforming Health Care Workforce Regulation*, also is cited as
136 a turning point for discussions within the health professions about addressing the issue
137 of ongoing practitioner competence. Released as part of a series of reports focusing on
138 the regulation of health care providers as a means of ensuring high-quality health care
139 services, the report recommends that states "require each licensing board to develop,
140 implement and evaluate continuing competency requirements to assure the continuing
141 competence of regulated health care professionals."⁶

142
143 In 1997, the FSMB commissioned a study of public awareness and attitudes about state
144 medical boards. The periodic retesting of physicians was the second most-cited
145 responsibility for state medical boards.⁷

146
147 In 2007, the AARP, in collaboration with the Citizens Advocacy Center, conducted a
148 study of Virginians 50 years of age and older to assess their understanding and
149 knowledge of Virginia's existing licensure requirements for health professionals to
150 maintain competence. More than 95 percent of respondents believe that health care
151 professionals should be required to show they have the up-to-date knowledge and skills
152 needed to provide quality care as a condition of retaining their license. Ninety percent of
153 the respondents indicated that it is at the least very important for health care
154 professionals to periodically be re-evaluated to show they are currently competent to
155 practice safely.⁸

156
157 An unpublished Harris Poll conducted by FSMB in October 2007 produced results
158 similar to the AARP study. While a majority of respondents to the poll were unsure how
159 licensing boards currently assess licensees to ensure they remain competent, an
160 overwhelming majority believe physicians *should* be evaluated at least once every five to
161 10 years to ensure they are maintaining their competence.⁹

162
163 ***Increased Emphasis on Continuous Improvement in Medicine***

164
165 Recent years have seen a number of national medical organizations implement
166 initiatives that seek to instill principles of quality and performance improvement within the

167 medical profession. Such initiatives could provide resources for use by physicians in
168 meeting maintenance of licensure requirements. The following paragraphs describe
169 some of these initiatives.

170

171 *American Board of Medical Specialties: Maintenance of Certification*

172

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

179

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

184

185 Maintenance of Certification has since been adopted by all ABMS member boards as
186 the model for recertification. While each specialty board is developing tools and
187 resources for use by their diplomats to meet MOC requirements, the systems being
188 developed must adhere to the standards and guidelines set forth by the ABMS.
189 Physicians participating in the MOC program are expected to demonstrate competence
190 in the following six general competencies: medical knowledge, patient care, practice-
191 based learning and improvement, interpersonal and communication skills,
192 professionalism, and systems-based practice.

193

194 Physicians who have certificates without time limit are exempt from participation in MOC.
195 However, a recent systematic review suggests that physician performance, among
196 multiple specialties, declines over time in both medical knowledge and skills.¹⁰
197 Therefore, certifying boards recommend that physicians who have certificates without
198 time limit voluntarily participate in MOC. Physicians will not lose their permanent
199 certification if they choose to voluntarily participate in MOC but fail to meet the MOC
200 requirements. Implementation of maintenance of licensure requirements could motivate
201 this group of physicians to comply with MOC requirements in order to meet maintenance
202 of licensure requirements.

203

204 *Continuing Medical Education*

205

206 Historically, concerns about the utility of CME have centered on whether such activities
207 truly impact physician performance, especially if the CME is not related to the
208 physician's day-to-day practice or deficiencies.^{11,12} There is now empiric evidence from
209 meta syntheses that supports the use of CME as a tool for physician learning and
210 change if it is part of a system of continuous professional development that includes self-
211 assessment, remediation, and reassessment.^{13,14,15,16} The CME community has made
212 great strides in addressing concerns about CME's impact on physician practice and in
213 developing CME programs and criteria that address physician performance and lifelong
214 learning.¹⁷ In 2005, in an effort to strengthen the role of CME in physician performance
215 improvement and lifelong learning, the ACCME proposed a model for CME based on
216 practice-based, self-directed physician learning and change.¹⁸ Subsequently, in

217 September 2006, the ACCME released new standards for the accreditation of CME
218 providers that focus on learning and change for both CME providers and learners. The
219 new standards aim to improve physician practice and, thus, the quality of patient care by
220 requiring CME providers to develop and implement CME programs that focus on
221 improving physician competence, physician performance and/or patient outcomes.¹⁹

222

223 *Graduate Medical Education*

224

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

234

235 Residency programs also must demonstrate a plan to assess residents' performance
236 and to utilize the results to improve performance. Consequently, the Outcome Project is
237 also involved in the identification and development of measurement tools. The ACGME,
238 in collaboration with the ABMS, developed a "toolbox" of instruments that programs can
239 use for educational outcomes assessment, including 360-degree evaluations, chart
240 stimulated recall oral examinations, checklist evaluation of live or recorded performance,
241 patient surveys and written examinations.²⁰

242

243 In 2006 all osteopathic training programs began to use seven core competencies in
244 osteopathic graduate medical education curriculum. The seven Core Competencies
245 include Osteopathic Philosophy and Osteopathic Manipulative Medicine in addition to
246 medical knowledge, patient care, professionalism, interpersonal/communication skills,
247 practice-based learning, and systems based practice.

248

249 *American Osteopathic Association Clinical Assessment Program (CAP)*

250

251 The AOA Clinical Assessment Program (CAP) is a quality improvement tool for
252 osteopathic physician to evaluate the effectiveness and safety of patient care in their
253 clinical practice during residency programs and physician practices. CAP's goal is to
254 improve patient outcomes by providing valid and reliable assessments of current clinical
255 practices. Using evidence-based guidelines to evaluate clinical practices and track
256 patient outcomes, the data in CAP is compared to national benchmarks and the
257 performance of other participants to determine whether their treatment protocols are
258 consistent with the best standards of practice. CAP provides evidence-based
259 measurement sets on eight clinical conditions including diabetes, coronary artery
260 disease, hypertension, women's health screening, asthma, COPD, childhood
261 immunizations, and low back pain.²¹ CAP measurements of quality can be used as a
262 component of board certification and osteopathic continuous certification to meet the
263 requirement of practice performance assessment.

264

265 *American Osteopathic Association Bureau of Osteopathic Specialists*

266

267 The American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS) is
268 an organization of 18 member boards responsible for the specialty certification and
269 recertification of osteopathic physicians. All member boards currently issue time-limited
270 certificates, and the AOA BOS has begun incorporating seven core competencies
271 (medical knowledge, osteopathic philosophy and osteopathic manipulative medicine,
272 patient care, professionalism, interpersonal and communication skills, practice-based
273 learning and improvement, and systems based practice) into the recertification process.
274 In addition, there has been ongoing dialogue between the AOA BOS and its member
275 boards about moving to continuous, rather than periodic, evaluation of physicians'
276 competence.²² A schedule for implementation for continuous certification was approved
277 by the AOA BOS in 2007, and all osteopathic certifying boards are required to submit a
278 plan for continuous certification to the AOA BOS by November 2008. Plans will be
279 implemented by 2012.²³ The American Osteopathic Board of Emergency Medicine
280 (AOBEM) already has implemented a continuous certification program to replace
281 traditional recertification. As part of this process, diplomats are required to provide
282 evidence of meeting criteria in four components on a continual basis: Professional
283 Status, Continuous Osteopathic Learning Assessment, Formal Re-Certification
284 Examination, and Practice Status.²⁴

285

286 *The Joint Commission*

287

288 The Joint Commission is responsible for the accreditation of health care organizations
289 and programs in the United States. As part of the accreditation process, the Joint
290 Commission evaluates health care organizations' compliance with Joint Commission
291 standards, including those for credentialing and privileging of physicians. Prompted by
292 deficiencies in the existing system, in 2003 the commission began revising its
293 credentialing and privileging standards to focus on the proactive evaluation of
294 physicians' competence and to move beyond privileging decisions based primarily on an
295 evaluation of physicians' technical skills.

296

297 The new standards, which were implemented in January 2007 and January 2008, are
298 intended to make the credentialing and privileging process more objective and evidence-
299 based by facilitating continuous monitoring of physicians' performance and by providing
300 a basis for intervening when quality of care concerns are identified.²⁵ Under the new
301 standards, organizations are required to implement a Focused Professional Practice
302 Evaluation as well as an Ongoing Professional Practice Evaluation as part of the
303 credentialing and privileging process. The Focused Professional Practice Evaluation
304 standards apply to 1) the evaluation of currently privileged practitioners who are seeking
305 new privileges they have never performed before in the organization and 2) situations in
306 which the competence of a practitioner with existing privileges comes into question. The
307 Ongoing Professional Practice Evaluation standards enable the continuous, rather than
308 periodic, review of practitioners' performance.^{26,27}

309

310 The new standards also require organizations to evaluate physicians on multiple
311 competencies, such as the six core competencies developed by the Accreditation
312 Council for Graduate Medical Education (i.e., medical knowledge, patient care, practice-
313 based learning and improvement, interpersonal and communication skills,
314 professionalism, and systems-based practice). Finally, the new standards address
315 hospital-based education and require that such activities relate, at least in part, to the

316 type of services offered by the organization and be based on the findings of performance
317 improvement activities.

318

319 *American Medical Association*

320

321 The American Medical Association is a national physician advocacy body in the United
322 States and works to develop programs and policies that address physician practice. As
323 part of this effort, the AMA, through its Initiative to Transform Medical Education (ITME),
324 is collaborating with a broad array of stakeholders within the medical profession to
325 address reformation of the medical education system, including the need for educational
326 opportunities to support physicians' continuing professional development and to assist
327 physicians seeking to reenter practice.^{28,29}

328

329 Recognizing the increasing and varied ways in which physicians learn, in recent years
330 the AMA has also expanded the credit for the AMA Physician Recognition Award (PRA)
331 Category 1 Credit to include performance improvement activities and internet learning
332 and point of care.³⁰

333

334 ***International Initiatives to Ensure Physician Competence***

335

336 Since 1998, the General Medical Council (GMC) in the United Kingdom has been in the
337 process of implementing a "revalidation" program that will require all licensed physicians
338 to undergo review of their practice every five years in order to maintain their licenses.
339 The program, and the areas in which physicians' performance are reviewed, are based
340 on the principles set forth by the GMC in its *Good Medical Practice* guidelines, which
341 include good clinical care; maintaining good medical practice; teaching and training;
342 appraising and assessing; relationships with patients; working with colleagues; probity;
343 and health.³¹

344

345 The College of Physicians and Surgeons of Ontario evaluates the continuing
346 competence of its licensees through its Peer Assessment Program, which it initiated in
347 1981. As part of the program, physicians undergo an office-based evaluation of their
348 facilities, medical records and quality of care once every 10 years. Physicians found to
349 have practice deficiencies participate in remediation programs developed by the College.
350 The College also conducts Mini-Peer Assessments, in which physicians complete and
351 submit a questionnaire and medical records to an assessor for determination of whether
352 an on-site visit is necessary.³² A December 2006 survey of Ontario physicians regarding
353 the Peer Assessment Program shows that 73% of respondents rate the program as
354 excellent (42%) or good (31%).³³

355

356 In 2007, the Council of the College of Physicians and Surgeons of Ontario amended its
357 Bylaws to require all physicians to participate in continuing professional development,
358 which consists of educational programs designed to assist physicians in upgrading their
359 knowledge and skills and addressing practice-specific needs in order to assure their
360 ongoing competence. Following legislative approval of the change, the College will
361 focus on developing standards and ways in which physicians can meet the
362 requirements.³⁴ The Council is also considering requiring physicians to notify the College
363 of any change in their scope of practice or of their intent to return to practice; this
364 information is currently provided on a voluntary basis. The change would allow the
365 College to ensure that physicians who are practicing a particular medical specialty have
366 the necessary skills, training and experience.³⁵

367 **SECTION III: STATE MEDICAL BOARDS AND MAINTENANCE OF LICENSURE**
368

369 In the last 10 years, medical licensing authorities in California, Texas, and Nevada have
370 attempted to or studied the feasibility of implementing requirements for periodic
371 demonstration of competence for license renewal. In all three cases, the boards
372 abandoned their initiatives due to the political climate, concerns about the negative
373 impact on workforce, or resistance from the profession based on lack of evidence that
374 such requirements would make a difference in the quality of care provided to patients.
375

376 According to a 2007 survey conducted by the Federation of State Medical Boards,
377 continuing competence of physicians is a matter of concern to state medical boards.
378 Sixty-three of 69 FSMB member boards responded to the survey, and 36 (57.2%)
379 indicated that they had discussed the issue one or more times within the past 12
380 months. Three boards (4.8%) had formed a committee to study the issue. Nine (14.3%)
381 had never discussed the issue. While many boards (29 or 47.5%) indicated that they
382 were undecided on the issue, 22 (36.1%) said they are supportive. Eight (13.1%)
383 responded that they are uninformed and only two (3.3%) responded that they are not
384 supportive.
385

386 The vast majority of boards (55 or 87.3%) have not implemented or previously attempted
387 to implement rules and regulations, policies or statutes regarding maintenance of
388 licensure, but eight (12.7%) indicated that they have. Finally, most boards (25 or 42.4%)
389 said that their existing statutes do not give the board the authority to implement
390 maintenance of licensure requirements. Twenty-one (35.6%) said existing statutes do
391 give them authority, while 13 (22.0%) were not sure.³⁶
392

393 These results are similar to the results of a 2002 Citizen Advocacy Center (CAC) survey
394 of 323 health professions licensing boards (45 of which were state medical boards)
395 regarding continuing competence. Seventy boards (21%) stated that they were
396 "considering introducing continuing competency requirements in the future," and 60
397 (19%) had already formed committees to study the issue. Responses from 16 boards
398 (22%) indicated that their state's legislature was considering new initiatives to require
399 licensees to periodically demonstrate their continuing competence. Program models
400 being considered ranged from requiring all licensees to demonstrate current competence
401 upon license renewal to requiring demonstration of current competence by only those
402 licensees that meet specified "triggers", such as change in practice setting, disciplinary
403 action and failure to recertify with a credentialing agency.³⁷
404

405 In addition to questions about statutory authority, another impediment to establishing
406 continuing competence requirements is the lack of resources available to assess
407 licensees' ongoing competence. For physicians, only those who are board certified by an
408 ABMS or AOA BOS certifying board are eligible to participate in the maintenance of
409 certification programs developed by those boards. That leaves the cohort of physicians
410 who are not board certified or otherwise not participating in the maintenance of
411 certification process left without a mechanism to objectively establish their having
412 maintained ongoing competence in their respective area of medical practice.
413

414 **SECTION IV: CONCEPTUAL AND METHODOLOGICAL CHALLENGES TO**
415 **DETERMINING COMPETENCE**

416
417 The following paragraphs provide a discussion of three challenges to assessing the
418 competence of practicing physicians: determining the purpose of the assessment,
419 differentiating between competence and performance, and assessment of
420 undifferentiated medical practice versus specialty-specific assessment.

421
422 ***Purpose***

423
424 The first and perhaps most fundamental conceptual challenge to developing an
425 assessment process for practicing physicians is defining its purpose. When thinking
426 about how assessment could support maintenance of licensure, it must be decided
427 whether the assessment is intended to 1) exclude from practice physicians who are no
428 longer able to practice safely and competently, 2) identify areas for improvement in
429 otherwise competent physicians or 3) accomplish both.

430
431 If the assessment is intended to identify opportunities for improvement in practice, then it
432 must be relevant to what the physician does in his or her practice. Because the majority
433 of physicians embrace lifelong learning as an integral part of professionalism, an
434 assessment process that seeks to improve physician practice would be perceived more
435 positively by physicians and would likely have the greatest impact on quality of patient
436 care. Since the outcome of such a process would be improved practice, such an
437 assessment requirement could reasonably be applied to all licensees.

438
439 A number of medical organizations in the US and internationally are using assessment
440 and remediation programs as the basis of their recertification or relicensure
441 requirements. These programs fall into three broad categories: periodic comprehensive
442 assessment of all physicians, performance-focused tiered approach (such as Canada's
443 Monitoring and Enhancement of Physician Performance model³⁸), and cyclical delivery
444 of assessments over time (such as the American Board of Internal Medicine's
445 Continuing Professional Development program³⁹). In general, the defined purpose of
446 each is the continuous professional development of practicing physicians. While this
447 model has potential for significant quality improvement and focuses on the majority of
448 physicians who are competent, it leaves unanswered how to identify and respond to the
449 remaining small percentage of physicians who are not competent.

450
451 ***Competence vs. Performance***

452
453 A second conceptual challenge to consider is the blurred distinction between
454 competence and performance. While there is no single agreed upon definition for these
455 terms, there is some consensus that competence points to the *ability* to do (or *can* do),
456 whereas performance refers to *does* do⁴⁰.

457
458 Standardized tests are associated with competence assessments, whereas workplace
459 assessments are associated with performance assessments. There are valid, reliable
460 standardized tests such as multiple-choice examinations that may be used to measure
461 competence, and more tools are becoming available for use in measuring performance.
462 Ideally, a physician should be expected to demonstrate accountability for both general
463 competencies, including the knowledge, skills and abilities to provide safe, effective

464 patient care within the scope of their professional medical practice, as well as
465 performance in practice.

466

467 ***GUMP vs. Practice-Specific Assessment***

468

469 The third conceptual design challenge pertains to whether practicing physicians should
470 be held accountable for maintaining competence in the general undifferentiated practice
471 of medicine or in the area of practice in which they engage on a daily basis.

472

473 Because initial licensure is based on the general, undifferentiated practice of medicine
474 (or the “GUMP” model), one could argue that assessment for relicensure should focus
475 on the same general domains measured by examinations for initial licensure. However,
476 because physician practice narrows over time, the deficiencies identified by a GUMP
477 level assessment may have a low level of relevance to patient care; consequently,
478 remediation may not result in improved practice. An assessment tailored to reflect at
479 least in part what the physician does in his or her practice will be perceived by the
480 physician as more relevant and credible than a GUMP-level assessment.

481 **SECTION V: A FRAMEWORK FOR MAINTENANCE OF LICENSURE**

482
483 ***Establishing Requirements for Demonstrating Competence***

484
485 State medical boards should require physicians seeking relicensure to periodically
486 demonstrate competence within the scope of their professional practice. Such
487 requirements should include the following elements or expectations:

- 488
489 1. Participation in an ongoing process of reflective self-evaluation, self-assessment
490 and practice assessment, with subsequent successful completion of educational
491 activities tailored to meet the needs or deficiencies identified by the assessment.

492
493 Evidence of self-evaluation, self-assessment and practice assessment could
494 include participation in self-evaluation exercises or modules, such as self-review
495 tests, home study courses and web-based materials, or passage of a state
496 medical board approved examination in the physician's current practice area.
497 Remediation and educational activities could include review of literature in the
498 physician's current practice area; CME in the physician's current practice area
499 that enhances patient care, performance in practice and and/or patient
500 outcomes; or participation in other educational programs targeting areas of
501 weakness or deficiency identified through the self-assessment.

- 502
503 2. Demonstration of continued competence in the following areas: medical
504 knowledge, patient care, practice-based learning and improvement, interpersonal
505 and communication skills, professionalism, systems-based practice and, if
506 applicable, osteopathic philosophy and osteopathic manipulative medicine;
507 including the knowledge, skills and abilities to provide safe, effective patient care
508 within the scope of their professional medical practice.

509
510 While a variety of tools may be used by physicians to document evidence of
511 compliance with this criteria, state medical boards should mandate that it be met,
512 at least in part, by passage of a valid, secure, proctored examination in the
513 physician's current practice area at least once every 10 years.

- 514
515 3. Demonstration of accountability for performance in practice.

516
517 This could be met by peer assessment, such as 360-degree evaluations, letters
518 of attestation of clinical activities, or by patient reviews, such as satisfaction
519 surveys. Participation in recognized quality improvement activities as well as
520 collection and analysis of practice data, such as thorough review of office
521 records, chart review, case review and submission of a case log, could also be
522 utilized.

523
524 Licensees should be expected to provide documented evidence of compliance with the
525 state medical board's maintenance of licensure requirements. State medical boards
526 should provide guidance to licensees as to the types of evidence deemed acceptable for
527 purposes of meeting maintenance of licensure requirements. For example,
528 documentation of active participation in Maintenance of Certification processes could be
529 deemed acceptable by state medical boards as meeting all maintenance of licensure
530 requirements. Participation in recognized quality improvement activities such as those
531 required by The Joint Commission or the AOA Clinical Assessment Program could be

532 deemed as meeting requirements for self-assessment and accountability for
533 performance in practice. If a licensee's clinical practice is outside the scope of his or her
534 board certification or training, the licensee's documentation should include evidence of
535 competence in that practice.

536

537 ***Physicians not in Active Clinical Practice***

538

539 Physicians not in active clinical practice who wish to maintain an active license should
540 be expected to comply with all maintenance of licensure requirements. Evidence of
541 demonstration of accountability for performance in clinical practice could be met by
542 evaluation of a physician's competence relevant to that practice. Assessment methods
543 should address the knowledge, skills and behaviors necessary to deliver safe and
544 effective care for the types of patients that would typically be encountered in their
545 practice. Physicians whose licenses are inactive or have lapsed should be expected to
546 meet these requirements prior to reentering active clinical practice.

547

548 ***Disclosure***

549

550 Physicians who do not comply with maintenance of licensure requirements or who are
551 identified through the program as deficient such that the deficiency rises to a level that
552 would subject the licensee to a disciplinary action for violation of the practice act should
553 be subject to normal adjudication processes and to public disclosure as required by state
554 law. When an education or remediation plan is required by the state medical board for
555 these practitioners, the state medical board should approve the elements and scope of
556 the plan prior to its initiation. All other maintenance of licensure activities should not be
557 subject to public disclosure.

558

559 ***Reporting Requirements***

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561 In order to assure that physicians are demonstrating competence within their scope of
562 practice, state medical boards should require licensees to report information about their
563 practice as part of the license renewal process. Such information should include: scope
564 of practice, type of practice (to include location, supervisory responsibilities), status (e.g.,
565 full-time, part-time, number of hours worked per week), whether they are actively seeing
566 patients, specialty board certification or recertification status, and what activities they are
567 engaged in if they are not engaged in clinical practice (e.g., research, administration,
568 non-medical work, retired, etc.). Licensees should keep the board apprised of their
569 practice status at all times by reporting any subsequent changes in practice status or
570 scope of practice to the board within a specified timeframe as determined by the board.

571

572 ***Research***

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

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579 ***Assessment Resources***

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581 Assessment tools used to document compliance with maintenance of licensure
582 requirements should be valid, reliable, feasible, have credibility with the profession and

583 should provide adequate feedback to facilitate practice improvement. FSMB and state
584 medical boards should encourage development of programs and services for use by the
585 cohort of physicians who are not board certified or otherwise not participating in the
586 maintenance of certification/continuous certification processes in order that they have
587 access to resources necessary to comply with maintenance of licensure requirements.
588

589 **SECTION VI: MOVING FORWARD**

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591 Maintenance of licensure represents a social and cultural change both for state medical
592 boards and the physicians they license. State medical boards are being asked to take
593 the first step in that process of change. Given that Maintenance of Licensure will have
594 significant implications for multiple stakeholder groups, it will be important to move
595 forward in a thoughtful and studied fashion that allows for course correction as
596 necessary. With that in mind, the following steps could be taken to develop information
597 to inform future dialogue and decisions.

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1. Design implementation models that take into account the different regulatory configurations within which state medical boards operate.
2. Conduct pilot projects to evaluate the financial and operational implications of maintenance of licensure on medical regulatory systems and relevant stakeholders.
3. Encourage development of valid, reliable tools and resources for use by physicians in meeting maintenance of licensure and reentry to practice requirements.
4. Gather and disseminate studies documenting the validity and reliability of assessment instruments for use in measuring competence.
5. Engage appropriate organizations in developing evidence regarding the impact of maintenance of licensure on physician practice and patient care.
6. Encourage state medical boards to require that a certain amount of CME obtained for purposes of license renewal be practice-relevant.

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FSMB could play a major role in facilitating this work. In addition to pursuing the activities noted above, the Federation of State Medical Boards should make appropriate revisions to its policy document *Essentials of a Modern Medical Practice Act*, which will provide sample language that state medical boards can use, if needed, in revising their medical practice acts to implement the requirements. (Proposed revisions are provided as Addendum 1.)

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The FSMB could also assist states in developing campaigns to support implementation of the requirements. The FSMB should provide resource materials to assist state medical boards when speaking to their legislatures about the need to establish maintenance of licensure requirements, including testimony and letters of support. Furthermore, the FSMB should assist state medical boards with developing key messages and public relations tools to assist in reaching and educating legislatures, practicing physicians, the public and other relevant and interested entities about maintenance of licensure and reentry to practice requirements and rationale for their implementation.

631 **SECTION VII: CONCLUSION**

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633 As policy makers and regulators, state medical boards play a critical role in influencing
634 standards for physicians and the environment within which physicians practice. Public
635 expectations that the health professions' regulatory boards do their part in making the
636 health care environment safer for patients are putting the responsibility on state medical
637 boards to take a more proactive approach to evaluating and ensuring physicians'
638 ongoing competence.

639

640 State medical boards are charged to ensure that licensed physicians are qualified to
641 practice medicine safely. Currently, physicians who meet conditions for initial licensure
642 effectively are granted the privilege of licensure for a lifetime without having to
643 demonstrate to the public on a regular basis that they have maintained the level of
644 competence their patients expect and deserve. By requiring licensees to periodically
645 demonstrate competence as a condition of relicensure, state medical boards have an
646 opportunity both to make the health care environment safer and to improve the quality of
647 medical care that patients receive.

648

649 Physicians, in turn, have an ethical and professional obligation to their patients to
650 maintain their competence in order to provide safe and effective care. Participation in
651 maintenance of licensure activities will assist physicians in fulfilling that responsibility
652 and in improving the quality of health care.

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Definitions

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

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

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

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

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

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

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

License – authorization by law to practice medicine.

License renewal – the process whereby a licensee demonstrates qualification for continued licensure.

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

Maintenance of competence – the dynamic process of assessing and updating the knowledge, skills and attitudes required to meet the needs of the physician’s current practice. (From Aylmer I⁴¹)

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

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

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

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

707

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

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

713

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

717

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

724 **SPECIAL COMMITTEE ON MAINTENANCE OF LICENSURE**

725

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730

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ADDENDUM 1

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

1. The licensee's completion of activities related to maintenance of licensure, specialty board certification or maintenance of certification within the registration period.
42. Any action taken against the licensee by:
 - any jurisdiction or authority (United States or foreign) that licenses or authorizes the practice of medicine;
 - any peer review body;
 - any specialty certification board;
 - any health care organization;
 - any professional medical society or association;
 - any law enforcement agency;
 - any court; and
 - any governmental agency for acts or conduct similar to acts or conduct described in the medical practice act as grounds for disciplinary action.
23. Any adverse judgment, settlement or award against the licensee arising from a professional liability claim.
34. The licensee's voluntary surrender of or voluntary limitation on any license or authorization to practice medicine in any jurisdiction, including military, public health and foreign.
45. Any denial to the licensee of a license or authorization to practice medicine By any jurisdiction, including military, public health and foreign.

~~56.~~ The licensee's voluntary resignation from the medical staff of any health care organization or voluntary limitation of his or her staff privileges at such an organization if that action occurred while the licensee was under formal or informal investigation by the organization or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct or mental or physical impairment.

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

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

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

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

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

C. The licensee should be required to provide information about his or her practice. Such information should include: scope of practice, type of practice (to include location, supervisory responsibilities), status (e.g., full-time, part-time, number of hours worked per week), whether they are actively seeing patients, specialty board certification or recertification status, and what activities they are engaged in if they are not engaged in clinical practice (e.g., research, administration, non-

medical work, retired, etc.). Licensees should keep the board apprised of their practice status at all times by reporting any subsequent changes in practice status or scope of practice to the board within a specified timeframe as determined by the board.

- Ⓓ. The licensee should be required to attest to the accuracy of the information provided on the license renewal form. ~~sign the application form for license renewal and have it witnessed.~~ Failure to report fully and correctly should be grounds for disciplinary action by the Board.
- Ⓔ. The Board should be directed to establish an effective system for reviewing renewal forms. It should also be authorized to initiate investigations and/or disciplinary proceedings based on information submitted by licensees for license renewal.
- F. Licensees not in active clinical practice who wish to maintain an active license should be expected to comply with all maintenance of licensure requirements. Physicians whose licenses are inactive or have lapsed should provide evidence of meeting maintenance of licensure requirements when they reenter active clinical practice.