

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

SPECIAL COMMITTEE ON MAINTENANCE OF LICENSURE

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

Section I: Introduction

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

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

The committee has met three times, during which it has 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 has also received presentations from the following organizations:

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

Early in its deliberations, the committee concluded that the profession must implement some form of mandated assessment of competence beyond that required for entry to practice if it is to demonstrate to the public that it is committed to maintaining high standards for 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.

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

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

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

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

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

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

Section II: Committee Deliberations to Date

A. Medical Board Responsibility to Ensure Physician Competence

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

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

- Rapid advances in technology and medical science that make it increasingly difficult for physicians to stay current;
- Opportunities to improve practice and provide better medical care afforded by advances in technology and medical science;
- Increased public focus on improving the safety of the US healthcare system and the quality of care received by patients who interact with that system;
- Reports issued by national healthcare policy bodies such as the IOM and the PEW Commission, which recommend that the health professions

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

- regulatory bodies develop and implement continuing competence requirements and that they periodically re-examine and re-license healthcare professionals based, in part, on competence^{2,3};
- Data from a study commissioned by FSMB in 1997 regarding public awareness and attitudes about state medical boards which indicated that the periodic retesting of physicians was the second most-cited responsibility for state medical boards (FSMB, unpublished data, 1997); and
 - Initiatives being implemented by oversight bodies such as the Accreditation Council for Graduate Medical Education (ACGME) and the ABMS to establish competency-based programs for their physician constituents.

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

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

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

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

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

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

State medical boards have used Continuing Medical Education (CME) requirements since 1971 as a means of encouraging physicians to maintain competence. Currently, of the 69⁴ medical boards that license physicians, 56 require physicians to participate in some amount of CME in order to maintain licensure. Licensees are required to attest on their license renewal form that they completed the requisite number of hours of CME, and most states monitor compliance through random audits of a sample of the licensee population each year. Some jurisdictions require physicians to obtain a certain number of CME hours related to a particular topic, such as pain management or ethics, but no jurisdiction requires that the CME be associated with or related to the physician's actual practice.

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

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

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

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

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

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

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

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

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

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

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

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

proactively ensure the ongoing competence of physicians once they are privileged.

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

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

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

The committee will continue to track efforts by non-governmental oversight agencies to ensure ongoing physician competence. While the committee felt that the standards being implemented by the ABMS and the JCAHO could be utilized by state medical boards as part of the maintenance of licensure process, it will continue to discuss, evaluate and recommend alternatives for physicians who are not eligible for ABMS Maintenance of Certification or who do not practice in JCAHO-accredited health care settings. The committee also plans to review information from the American Osteopathic Association (AOA) regarding its efforts to ensure the ongoing competence of osteopathic physicians.

D. Assessing the Competence of Practicing Physicians

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

Purpose. The first and perhaps most fundamental conceptual challenge to developing an assessment process for practicing physicians is defining its

purpose. When thinking about how assessment could support maintenance of licensure, it must be decided whether the assessment is intended to 1) exclude from practice physicians who are no longer able to practice safely and competently, 2) identify areas for improvement in otherwise competent physicians or 3) accomplish both.

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

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

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

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

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

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

Because initial licensure is based on the general, undifferentiated practice of medicine (or the “GUMP” model), one could argue that assessment for relicensure should focus on the same general domains measured through examinations for initial licensure. However, because physician practice narrows over time, the deficiencies identified by a GUMP level assessment may have a low level of relevance to patient care; consequently, remediation may not result in improved practice.

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

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

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

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

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

The committee agreed that, ideally, maintenance of licensure should support and facilitate physicians' commitment to continuous professional development while balancing the state's responsibility to remove incompetent physicians from practice. The committee agreed that tools or programs used by physicians to document their ongoing competence should be valid, reliable, feasible, have credibility with the profession and should provide adequate feedback so that the physician participating in the program may improve his or her practice.

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

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

As public agencies, medical boards are required to conduct much, if not all, of their business in a transparent fashion. This raises questions about whether information resulting from maintenance of licensure initiatives should be available to the public. Other professions that are pursuing such initiatives have chosen to use the professional development model, whereby the practitioner engages in self-assessment and remediation, both of which are completed in a confidential manner. The system is similar to the impaired physician model, in that participation is confidential until such time as it is determined a practitioner has deficits that are so severe that he/she is a danger to the public or until the practitioner fails to comply with the program. Only those physicians who are referred to the disciplinary system are subject to public disclosure.

It is the committee's opinion that the process used by physicians to maintain licensure should be transparent, but information regarding physicians' participation in maintenance of licensure programs should remain confidential. This is based on the premise that physicians should not be penalized for engaging in a process that allows them to identify and correct their deficiencies, ultimately resulting in improved practice performance and patient care. Physicians who do not comply with maintenance of licensure requirements or who are identified through the program as incompetent should be subject to normal adjudication processes and to public disclosure as required by state law.

III. Conclusion

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

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

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