
A sunset over a dark sea with a road leading to the horizon. The sun is on the right, low on the horizon, casting a golden glow across the sky and sea. The sky is filled with soft, golden clouds. The sea is dark, and a road with white lines leads from the bottom center towards the horizon, creating a strong sense of perspective.

Federation of
STATE 
MEDICAL
BOARDS

State of the States

Physician Regulation 2008



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A close-up photograph of a baby's face, looking directly at the camera with large, dark eyes. A hand is visible in the foreground, holding a silver stethoscope against the baby's chest. The background is a soft, out-of-focus white surface.

**Upholding High
Standards for Medical
Practice**

This report, *State of the States: Physician Regulation 2008*, is the third in a series of in-depth looks at the work of state medical boards. As state agencies dedicated to upholding high standards for medical practice, medical boards seek to fulfill their mandate of public protection through collaborative, national efforts and innovative work at the state level. This year's *State of the States* report features the following issues:

Access to Appropriate Pain Care

By working to put up-to-date, practical information on the appropriate management of chronic pain directly into the hands of every licensed physician in the United States, medical boards continue to address the persistent problem of untreated and undertreated pain. At the same time, medical boards are part of a national effort addressing the epidemic of prescription drug abuse through prescription monitoring programs.

Enhancing Physician Mobility

Medical boards are collaborating in an array of innovative ways to develop tools and procedures to streamline the licensure process – reducing the burden for physicians in obtaining a medical license in multiple states and enhancing the practice of telemedicine.

Responding to Public Health Emergencies

With unique databases of physician contact information, state medical boards are positioned to help facilitate the rapid mobilization of physicians in times of severe public health emergencies. Medical boards have several efforts underway to better coordinate the response of the health care community during times of crisis.

Promoting High Standards for Licensure

As the state agencies that grant licensure to physicians, state medical boards are responsible for ensuring that all physicians treating patients are qualified, competent practitioners. To ensure high standards for medical licensure, medical boards collaborate with an array of other organizations, including the medical education community, national testing agencies and others.

We hope you find this latest report on the work of state medical boards helpful and informative. For more information, please visit www.fsmb.org.

State Medical Boards and Public Protection



State Medical Boards: Authorized to Protect the Public

The 10th Amendment of the United States Constitution authorizes states to establish laws and regulations protecting the health, safety and general welfare of their citizens. Medicine is a regulated profession because of the potential harm to the public if an incompetent or impaired physician is licensed to practice. To protect the public from the unprofessional, improper, unlawful, fraudulent or incompetent practice of medicine, each of the 50 states, the District of Columbia and the U.S. territories has a medical practice act that defines the practice of medicine and delegates the authority to enforce the law to a state medical board.

State medical boards license physicians, investigate complaints, discipline those who violate the law, conduct physician evaluations and facilitate rehabilitation of physicians when appropriate. By following up on complaints, medical boards give the public a way to enforce basic standards of competence and ethical behavior in their physicians, and physicians a way to protect the integrity of their profession. State medical boards also adopt policies and guidelines related to the practice of medicine. There are currently 70 state medical boards authorized to regulate allopathic (M.D.) and osteopathic (D.O.) physicians.

Medical Board Structure

The structure and authority of medical boards vary from state to state. Some boards are independent and maintain all licensing and disciplinary powers, while others are part of a larger umbrella agency, such as a state department of health, and share legal and investigative resources with other regulatory boards. State medical boards are typically made up of volunteer physicians and members of the public who are, in most cases, appointed by the governor and paid a nominal stipend for their service. State boards employ an administrative staff including an executive officer, attorneys, investigators and licensing staff. The state legislature determines the financial resources of most boards. Boards are typically funded directly from physician licensing and registration fees.

Physician Licensure

Obtaining a license to practice medicine in the United States is a rigorous process. State medical boards ensure those entering the profession have met predetermined qualifications that include

medical school graduation, postgraduate training and passage of a national medical licensing examination. Applicants also must provide details about their work history and reveal information regarding past medical history that may affect their ability to practice. Only those who meet a state's predetermined qualifications are granted permission to practice medicine in that state.

After physicians are licensed, they must re-register periodically to continue their active status. During this re-registration process, physicians must demonstrate that they have maintained acceptable standards of professional conduct and medical practice. In a majority of states, physicians must also show that they have participated in a program of continuing medical education.

Physician Discipline

State medical boards devote a significant amount of resources monitoring licensed physicians' competence and professional conduct. They review and investigate complaints and/or reports received from patients, health professionals, government agencies, health care organizations and other state medical boards about physicians who may be incompetent or acting unprofessionally, and take appropriate action against a physician's license if the person is found to have violated the law. State laws require that boards ensure fairness and due process to any physician under investigation.

While medical boards sometimes find it necessary to suspend or revoke licenses, regulators have found many problems can be resolved with additional education or training in appropriate areas. In other instances, it may be more appropriate to place physicians on probation or place restrictions on a physician's license to practice. This compromise protects the public while maintaining a valuable community resource in the physician. Probation and restrictions of a medical license can also be in place while a physician receives further training or rehabilitation.

State Medical and Osteopathic Boards

Alabama State Board of Medical Examiners
Alaska State Medical Board
Arizona Medical Board
Arizona Board of Osteopathic Examiners in Medicine and Surgery
Arkansas State Medical Board
Medical Board of California
Osteopathic Medical Board of California
Colorado Board of Medical Examiners
Connecticut Medical Examining Board
Delaware Board of Medical Practice
District of Columbia Board of Medicine
Florida Board of Medicine
Florida Board of Osteopathic Medicine
Georgia Composite State Board of Medical Examiners
Guam Board of Medical Examiners
Hawaii Board of Medical Examiners
Idaho State Board of Medicine
Illinois Department of Financial and Professional Regulation
Medical Licensing Board of Indiana
Iowa Board of Medicine
Kansas Board of Healing Arts
Kentucky Board of Medical Licensure
Louisiana State Board of Medical Examiners
Maine Board of Licensure in Medicine
Maine Board of Osteopathic Licensure
Maryland Board of Physicians
Massachusetts Board of Registration in Medicine
Michigan Board of Medicine
Michigan Board of Osteopathic Medicine and Surgery
Minnesota Board of Medical Practice
Mississippi State Board of Medical Licensure
Missouri State Board of Registration for the Healing Arts
Montana Board of Medical Examiners
Nebraska Board of Medicine and Surgery
Nevada State Board of Medical Examiners
Nevada State Board of Osteopathic Medicine
New Hampshire State Board of Medicine
New Jersey State Board of Medical Examiners
New Mexico Board of Osteopathic Medical Examiners
New Mexico Medical Board
New York State Board for Medicine
New York State Board for Professional Medical Conduct
North Carolina Medical Board
North Dakota State Board of Medical Examiners
Northern Mariana Islands Medical Professional Licensing Board
State Medical Board of Ohio
Oklahoma Board of Osteopathic Examiners
Oklahoma State Board of Medical Licensure and Supervision
Oregon Medical Board
Pennsylvania State Board of Medicine
Pennsylvania State Board of Osteopathic Medicine
Board of Medical Examiners of Puerto Rico
Rhode Island Board of Medical Licensure and Discipline
South Carolina Board of Medical Examiners
South Dakota State Board of Medical and Osteopathic Examiners
Tennessee Board of Medical Examiners
Tennessee Board of Osteopathic Examiners
Texas Medical Board
Utah Osteopathic Physicians and Surgeons Licensing Board
Utah Physicians Licensing Board
Vermont Board of Medical Practice
Vermont Board of Osteopathic Physicians and Surgeons
Virgin Islands Board of Medical Examiners
Virginia Board of Medicine
Washington Medical Quality Assurance Commission
Washington State Board of Osteopathic Medicine and Surgery
West Virginia Board of Medicine
West Virginia Board of Osteopathy
Wisconsin Medical Examining Board
Wyoming Board of Medicine

For state medical board contact information, visit www.fsmb.org.



Pain Management:
Translating Policy
into Practice

Finding Balance: Boards Address Issues of Access, Abuse and Diversion

Living with untreated or undertreated pain is a normal part of life for many Americans. According to estimates, 40 to 80 million Americans live with moderate to severe pain as a result of disease or injuries. The economic and social costs in terms of lost productivity and diminished quality of life are enormous.

According to pain specialists and policy analysts, this suffering and its consequences often are needless:

- 1. Effective pain treatment options exist.** For more than a decade, controlled substances, including opioid pain medications, have proven highly effective in the treatment of pain, particularly severe pain.
- 2. More than ever before, state policies require effective practices for managing pain.** During the last decade, many states have discarded outdated laws hindering appropriate pain care.

Despite these advances, say observers, the problem of untreated or undertreated pain in the United States persists due to 1) a widespread lack of knowledge in the medical community about appropriate pain treatment, including the presence of improved standards and clinical guidelines; 2) a prevalent concern about contributing to addiction, abuse or diversion; and 3) the perception among health care practitioners that prescribing controlled substances, especially those in Schedule II, will result in scrutiny by regulatory authorities or law enforcement agencies.

A 2005 survey by the National Center on Addiction and Substance Abuse (CASA) found less than half of surveyed physicians (47.5 percent) received instruction in pain management while in medical school. Among the physicians who did receive instruction, 94 percent received “more than a few hours but less than an entire course” or “a few hours or less” instruction in pain management.

According to the CASA survey, one-third of physicians said they worried “a great deal” or “somewhat” about regulatory or enforcement agencies reviewing their prescribing practices. “These concerns have profound implications for practitioners’ willingness to consider these medications as a viable treatment option and can, as a result, hinder patient access to adequate pain relief,” stated the University of Wisconsin Pain & Policy Studies Group in its 2007 report, *Achieving Balance in State Pain Policy*.

A Decade of Progress by States

Prior to the mid-1990s, few states had pain management policies to guide licensed physicians. As the science underlying pain management improved, state medical boards saw a growing need to translate this new knowledge into a policy framework that would guide appropriate physician practice and ensure the public of access to adequate treatment for pain.

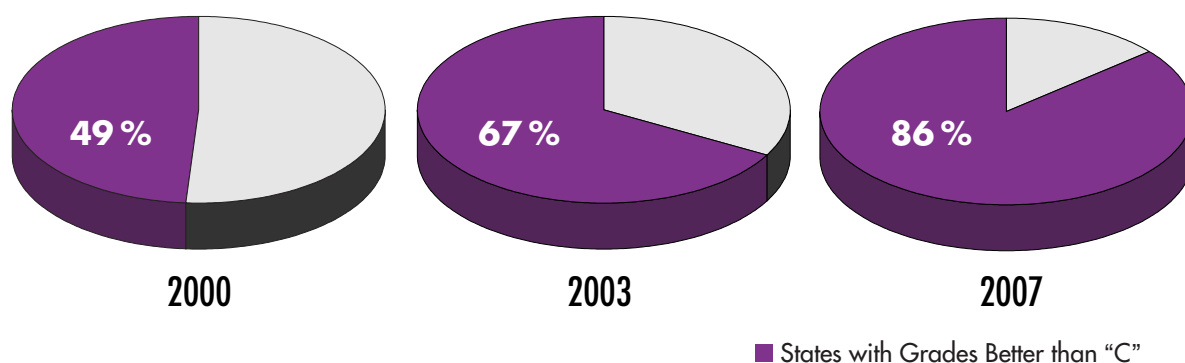
State medical board pain care policies have been particularly influenced by national model guidelines the FSMB developed in 1998, which were revised and expanded in 2004 as the *Model Policy for the Use of Controlled Substances for the Treatment of Pain*. Adopted in whole or part by more than three dozen boards, the FSMB *Model Policy* affirms that:

- State medical boards view pain management to be important and integral to the practice of medicine.
- Opioid analgesics often may be necessary for the relief of pain.
- The use of opioids for other than legitimate medical purposes poses a threat to the individual and society.
- Physicians have a responsibility to minimize the potential for the abuse and diversion of controlled substances.
- Physicians will not be sanctioned solely for prescribing opioid analgesics for legitimate medical purposes.

The *Model Policy* emphasizes the need for “balanced” policies that recognize the dual obligation of government to develop systems preventing abuse and diversion of controlled substances, while ensuring their availability for legitimate medical purposes. States are increasingly achieving this balance. According to a 2007 analysis by the University of Wisconsin Pain & Policy Studies Group, 86 percent of states, nearly double the proportion in 2000, are achieving a grade above a “C,” which results in policy language conducive to a healthy balance between access and the prevention of diversion (Table 1).

Table 1.

Percentage of State Policies Achieving Better than “C” Grade in Balancing Access with Diversion



Source: University of Wisconsin Pain and Policy Studies Group, December 2007

Educating Licensed Physicians

Unfortunately, however carefully worded, policy content does not always influence clinical practice. According to medical board leaders, the complexity of modern pain treatment, with the difficulty in predicting the risks and benefits of opioid therapy for a particular patient, and a lingering anxiety among physicians about the possibility of investigation by medical regulators or law enforcement agencies, continues to limit patient access to appropriate pain care.

In late 2007, state medical boards, under the auspices of the FSMB Research and Education Foundation, launched an initiative to educate all 700,000 licensed physicians in the United States about appropriate pain care. In collaboration with author and pain expert Scott Fishman, M.D., the FSMB Foundation developed a 150-page book based on the FSMB *Model Policy*. Entitled *Responsible Opioid Prescribing: A Physician's Guide*, the book includes pragmatic strategies that physicians can use to appropriately treat chronic pain and reduce the risk of addiction, abuse and diversion. The publication recommends steps to:

- Evaluate pain effectively.
- Create a function-based treatment plan with actionable patient goals.
- Obtain a written patient-physician agreement that includes informed consent from the patient and a commitment to significant patient education from the physician.
- Oversee periodic review of a patient's progress toward functional goals.
- Make referrals to specialists and managing patients with complex pain syndromes.
- Create and maintain clear, consistent, transparent and detailed documentation.
- Remain up-to-date on federal and state policies on controlled substances.

Medical boards can customize the publication to include their state-specific statutes, regulations and guidelines. Boards that can secure funding for distribution are then mailing books to physicians licensed in their state. To date, medical boards in Alabama, the District of Columbia, Maine, New Mexico, North Dakota, Oklahoma, Virginia and West Virginia have distributed the book, while a number of other states are preparing to do so.

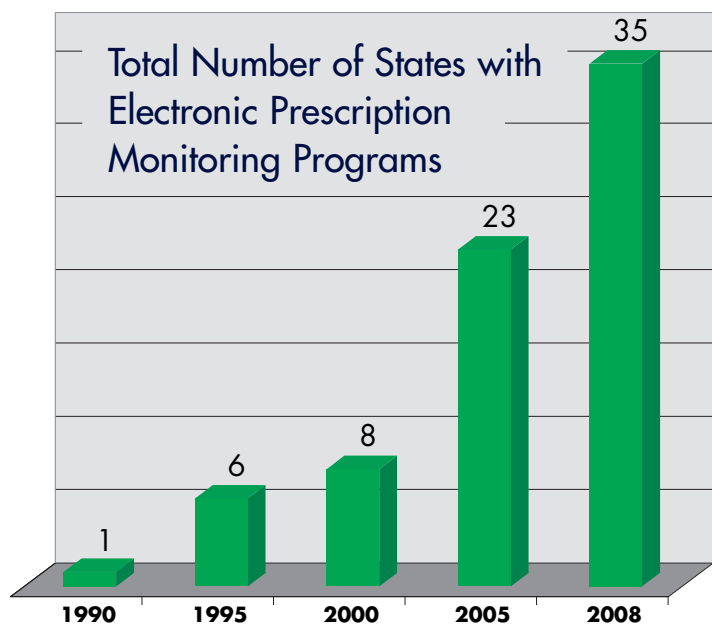
Physicians can find additional pain management resources at www.fsmb.org/pain, including:

- Updated pain policies and regulations for each state.
- Links to updated information from the Drug Enforcement Administration, the Substance Abuse and Mental Health Services Administration, and the Food and Drug Administration.
- Pain assessment tools.

Prescription Monitoring Programs: Addressing Abuse and Diversion

In recent years, abuse of controlled prescription drugs has become epidemic. According to the National Center for Addiction and Substance Abuse, the number of Americans who abuse controlled prescription drugs nearly doubled from 1992 to 2003, from 7.8 million to 15.1 million.

Table 2.



Source: University of Wisconsin Pain and Policy Studies Group, December 2007

A sharp rise in the diversion of controlled prescription drugs from legitimate to illicit uses has accompanied this spike in abuse. Although only a small percentage of health care providers and patients have been involved in diversionary practices, the growing number of adverse incidences from overdoses has caused significant concern in the regulatory, law enforcement and medical communities.

In an effort to address this epidemic, states are increasingly turning to electronic prescription monitoring programs (PMPs). Typically, PMPs

collect prescribing and dispensing data from pharmacies and health care providers, enabling regulators and physicians to review the data to detect illicit prescribing and dispensing patterns. In some states, physicians can access their state's PMP from their office computers and determine, within a few minutes, whether a patient is obtaining prescriptions from multiple practitioners or pharmacies.



"Responsible Opioid Prescribing is short, well-written, well-organized, and easy to read. I am a psychiatrist who specializes in addictions, and I agree with you that the best way to promote responsible, medically appropriate opioid use is to give physicians the confidence to know that they can successfully identify abuse, and that they have tools to minimize the risk of abuse."

Daniel Z. Lieberman, M.D., Director of the Clinical Psychiatric Research Center, George Washington University School of Medicine, Washington, D.C.

In recent years, medical boards across the country have strongly supported the development of PMPs, collaborating with pharmacy boards, law enforcement officials, medical associations and other groups to implement the programs. To date, 35 states have implemented PMPs and an additional 14 states have proposed or are considering one (Table 2).

Without a PMP, medical board investigators must canvass multiple pharmacies, enlist the aid of law enforcement officials and collect paper records of prescriptions to investigate suspicions of abuse or diversion. This

resource-intensive process limited the number of cases boards could investigate. PMPs enable investigators to more readily access prescribing data and more efficiently spot “red flag” cases, for example, an individual patient obtaining prescriptions from multiple practi-

tioners and pharmacies (Table 3). However, “red flag” cases do not necessarily indicate instances of wrongdoing; investigations are essential to determine whether “red flag” cases are indeed valid cases of abuse or whether there is a legitimate clinical reason.

Table 3.

Benefits of Prescription Monitoring Programs for Medical Boards

- Review of more prescribing cases.
- Easy access to centrally located information.
- Greater likelihood of complete and accurate prescribing information for a specific doctor.
- A format that helps investigators spot trends.
- A comprehensive analysis of physician prescribing.

Resources

Responsible Opioid Prescribing: A Physician’s Guide, by Scott Fishman, M.D., FSMB Research and Education Foundation, 2007 (www.fsmb.org)

FSMB Research and Education Foundation Pain Management Resources (www.fsmb.org/pain)

FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain (www.fsmb.org)

Under the Influence: The Diversion and Abuse of Controlled Prescription Drugs in the U.S., National Center on Addiction and Substance Abuse at Columbia University, July 2005 (www.casacolumbia.org)

Achieving Balance in State Pain Policy: A Progress Report Card, University of Wisconsin Pain & Policy Studies Group, 2007 (www.painpolicy.wisc.edu)

Alliance of States with Prescription Monitoring Programs (www.nascsa.org/monitoring)

Medical Boards Enhance License Portability



Medical Boards Work to Enhance Physician Mobility and Expedite Telemedicine Licensure

The practice of medicine increasingly transcends state borders. Nearly one-quarter of the approximately 700,000 licensed physicians in the United States hold licenses in two or more states (Table 1). Today's physicians more frequently practice in health systems with multiple facilities or move from state to state to work for new employers. Technologies continue to advance the role of telemedicine, linking physicians and patients who live thousands of miles apart. And in the post-9/11, post-Katrina era, states are acutely aware of the need to rapidly mobilize health care practitioners across jurisdictional boundaries in case of a major public health emergency.

The state-based system of medical regulation allows each state to tailor its regulatory standards to meet the unique needs of its residents. Nonetheless, state medical boards recognize that duplications and differences in their administrative requirements can be burdensome for physicians and cause delays in obtaining licensure, discouraging physicians from seeking a license in more than one state.

State medical boards have been responding to this challenge through wide-ranging collaborations for more than a decade (Table 2). For example, state medical boards adopted a common licensing examination for U.S. and international medical graduates in the 1990s. Replacing two predecessor examinations, the United States Medical Licensing Examination (USMLE) now provides a common examination for physicians with an M.D. degree or its equivalent. States' rapid adoption of USMLE, coupled with the recognition of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) by all licensing boards for D.O. physicians, has enabled medical boards to replace the exams previously taken annually by tens of thousands of medical students and residents with just two highly regarded examinations.

Medical boards also have collaborated through the adoption of national policy calling for boards to develop tools and procedures to streamline the licensure process. During the last several years, several of these recommendations have gained significant usage across the United States, including widespread use of a centralized system for primary source verification and storage of core physician credentials.

Reducing Barriers to Multi-state Licensure

During 2007, two regional groups of medical boards continued work on an initiative expected to significantly reduce redundancies that slow the process of obtaining medical licensure in multiple

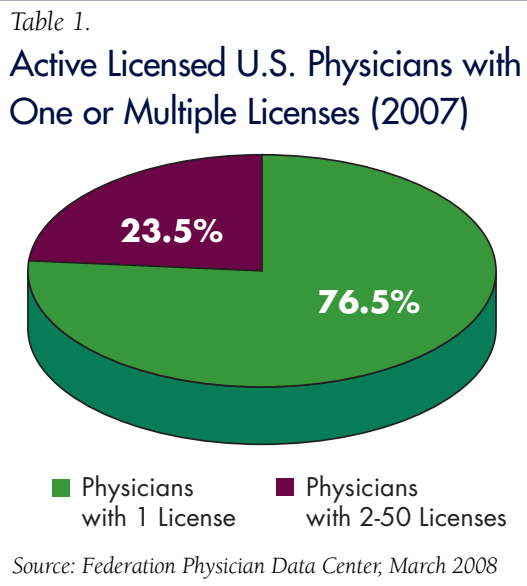


Table 2.

Milestones in Improving License Portability

1994	1995	1995-2002	1996	2006	2007	2008
United States Medical Licensing Examination introduced, creating a single licensure exam for MDs.	Comprehensive Medical Licensing Examination (COMLEX) introduced, creating a single licensure exam for DOs.	State medical boards adopt national policy recommendations calling for greater uniformity in licensure processes, special tele-medicine licensure and creation of a centralized credentials verification system.	Centralized credentials verification system established through FSMB via Federation Credentials Verification Service (FCVS).	Fourteen medical boards initiate projects to reduce licensure barriers to telehealth multi-state licensure.	First states implement standardized common license application.	FCVS surpasses 85,000 applicants.

states (Table 3). The project will allow states to accept key credentials, such as medical education and training, that have already been verified by another participating state.

Funded by a 2006 grant from the federal Office for the Advancement of Telehealth, the initiative taps into new technologies developed during the recent implementation of a Common License Application Form (CLAF) by several states. Developed by a task force of medical board representatives, the CLAF can serve as the core of a state's license application without replacing unique state-level requirements. In 2007, medical boards in Ohio, New Hampshire and Kentucky became the first in the country to implement the form in their online licensure processes and other medical boards are working toward adding CLAF to their processes as well. To date, more than 4,000 physicians have applied for licensure using the CLAF.

Developing a Common Credentials Verification System

State medical boards continue to make significant progress in improving license portability through use of a common credentials verification system. One resource available for the initiative is the Federation Credentials Verification Service (FCVS), established as a result of national policy

adopted by medical boards in 1995. Approximately 10 percent of the nation's nearly 700,000 licensed physicians have now used the service (Table 4) to verify their credentials and maintain a permanent record of their credentials. The overwhelming majority of medical boards accept the service, and some boards require applicants for licensure to use it.

Table 3.

Northeast and West Regional Groups

Northeast regional group: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont boards

West regional group: Colorado, Idaho, Iowa, Kansas, Minnesota, North Dakota, Oregon and Wyoming boards

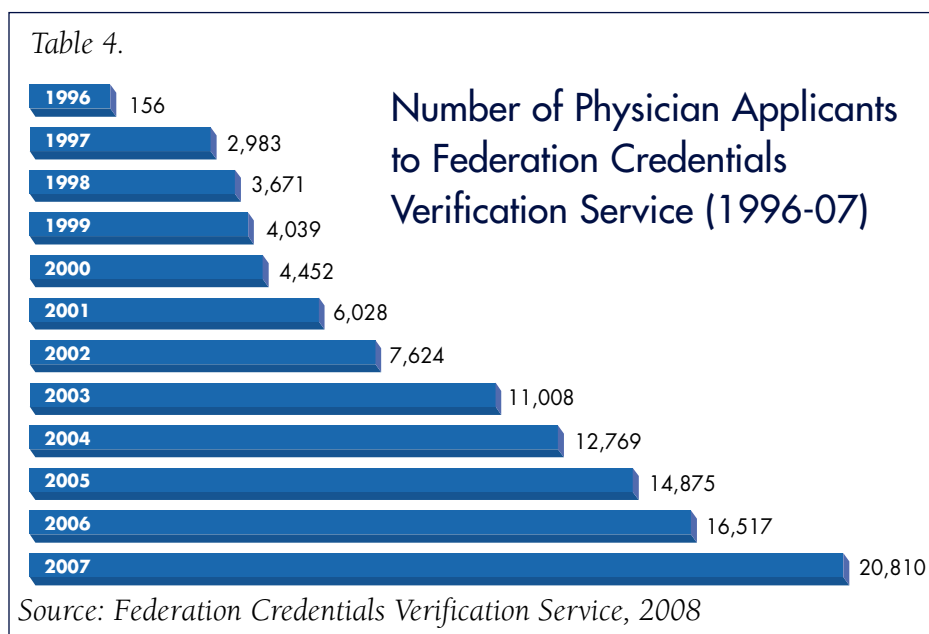
The FCVS repository of medical credentials for a physician or physician assistant includes medical education, postgraduate training, examination history, history of medical board actions, board certification and identifying information. Modeled after the best practices of state medical boards, FCVS's standard credentialing parameters require the FSMB to verify core credentials directly with medical schools and postgraduate training programs. A physician or physician assistant can then ask FCVS to send this record to any medical board, expediting licensure and reducing redundancies. Both the physician and medical board save time and money.

Collaborating to Expedite Telemedicine Licensure

The FSMB has shared what we have learned about improving license portability with key national groups also working to improve access to health care. The State Alliance for e-Health, co-chaired by Tennessee Governor Phil Bredesen and Vermont Governor Jim Douglas, is addressing barriers to the widespread adoption of health information technology. Representatives from the state medical board community played a key role in developing recommendations adopted in 2007 and early 2008 by the Alliance, including:

- State medical, nursing and pharmacy boards work to implement online licensure applications.
- All state nursing and pharmacy boards develop common core licensure application forms, and state medical boards adopt the FSMB's Common Licensure Application Form. Individual states may include state-specific requirements.
- In order to facilitate e-health, states must move toward requiring at least one state license that is recognized by other states in order to enable physicians to practice across jurisdictional lines.
- States must create a licensure system that, in a uniform manner, permits open doctor-to-doctor and doctor-to-patient interactions across jurisdictional boundaries.
- State boards must have the statutory authority to discipline physicians practicing in their respective states, regardless of the state of licensure.

The recommendations also call for a convention of all state medical boards to establish consensus on methods for achieving the recommendations.





Responding to Public Health Emergencies

Medical boards are in a unique position to facilitate fast and effective responses to public health emergencies. With unique databases of contact information, they can get vital information to physicians. They also have the authority to help physicians serve in areas of need. Currently, state medical boards have several efforts underway to better coordinate the response of the health care community to large-scale public health emergencies.

In 2007, the Centers for Disease Control (CDC), the FSMB and state medical boards continued to collaborate on developing a database of emergency contact information of physicians practicing in the United States. When the database is fully operational, the CDC will be able to work through the FSMB to contact physicians immediately with critical information during a severe public health emergency. For example, following an act of bioterrorism, the CDC could provide physicians in the affected area with typical symptoms of afflicted patients and suggested treatments. Physician emergency contact information is being collected and includes such elements as physician phone and fax numbers and e-mail addresses.

The project began in 2004 with a pilot program to assess the feasibility of collecting and maintaining emergency contact information. The pilot project resulted in the successful addition of emergency contact information from physicians in five states to the FSMB Physician Data Center, a repository of licensure and disciplinary information on physicians licensed in the United States. Updates to this information are provided to the Physician Data Center by state medical boards on a regular basis.

With the pilot project completed, the CDC and the FSMB embarked on a three-year project to collect physician emergency contact data and complete the database. In phase one of the project, the CDC asked the FSMB to work with state medical boards in 10 to 15 states identified as having high-risk metropolitan areas and add their physician emergency contact information to the database by February 2008.

Completed on time, phase one of the project added the following states to the database: Arizona, California, Florida, Georgia, Illinois, Massachusetts, New York, North Carolina, Pennsylvania, Texas, Washington and West Virginia, as well as the District of Columbia. These states joined pilot project participants Maine, North Dakota, Oklahoma, Rhode Island and Virginia in the database.

During the next two years, the FSMB will add the remaining states. Prior to completion, simulations will test the reliability and responsiveness of the database with hypothetical queries that might occur in a public health emergency.

Uniform Emergency Healthcare Act

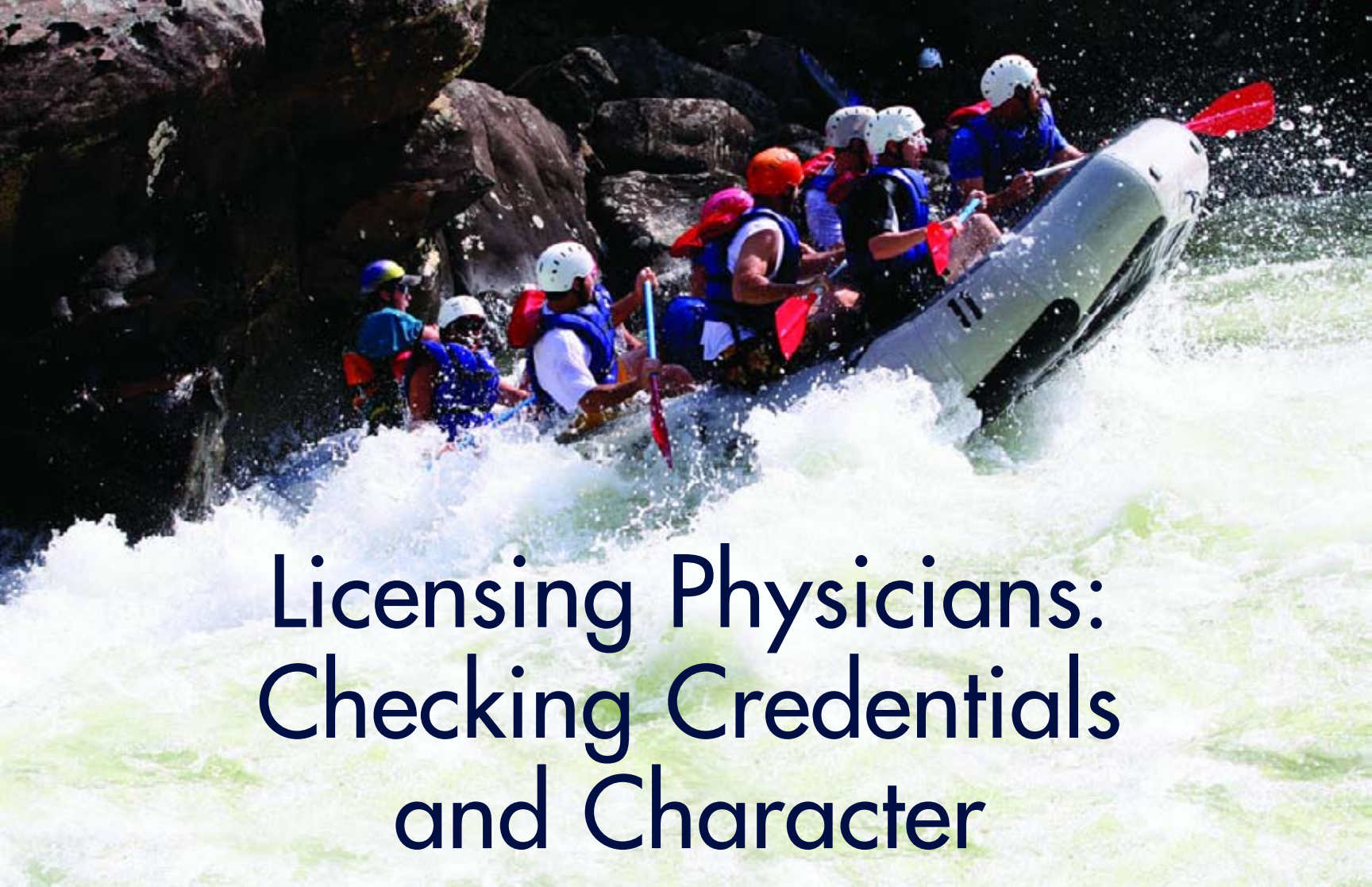
Contacting and informing licensed physicians during public health emergencies is a critical first step in improving emergency preparedness. Mobilizing physicians and other health professionals at the site of a disaster also requires ensuring their authorization to practice in the affected state. In the immediate aftermath of Hurricane Katrina in 2005, medical professionals from other states who volunteered health services were sometimes unable to obtain authorization to practice medicine in the affected areas.

To address this issue, the National Conference of Commissioners on Uniform State Laws (NCCUSL) developed the Uniform Emergency Volunteer Healthcare Practitioners Act. The model act would allow state governments to give reciprocity to other states' licensees during a declared emergency. Physicians would be able to provide health services for which they are licensed in their home state without meeting license requirements in the afflicted state.

The NCCUSL is a nonprofit organization of state-appointed legal professionals who donate their time and expertise to draft uniform state laws and make them available for adoption by all states. FSMB representatives served on the committee of the NCCUSL that developed the model act.

To date, Colorado, Kentucky, New Mexico, Tennessee and Utah have adopted the Uniform Emergency Volunteer Healthcare Practitioners Act and other states are considering the measure.

Through their collaboration with government and non-government organizations, state medical boards are enabling the professional medical community to respond more quickly and effectively to public health emergencies. In this way, boards are working to improve preparedness and protect the public.



Licensing Physicians: Checking Credentials and Character

As the state agencies that grant licensure to physicians, state medical boards are responsible for ensuring that all physicians treating patients are qualified, competent practitioners. To ensure high standards for medical licensure, medical boards collaborate with an array of other organizations, including the medical education community, national testing agencies and others.

Medical boards invest substantial resources each year licensing thousands of physicians to practice medicine in the United States. Ensuring physicians are qualified to receive a license entails a careful process in which medical boards evaluate a physician's credentials and decide whether he or she is qualified to practice medicine. Although specific requirements for obtaining a medical license vary somewhat between states, medical boards typically look closely at a physician's:

- Medical educational background
- Postgraduate (residency) training
- Performance on a national licensing examination
- Mental, moral and physical fitness to safely practice medicine

Medical Education

All state medical boards require candidates for physician licensure to provide evidence that they have graduated from a medical school acceptable to the board. Medical board licensing staff invest a significant amount of time verifying whether a licensure applicant actually attended and graduated from the school cited on their application. This process greatly reduces the chances of an unqualified individual from fraudulently gaining a medical license.

For applicants educated in U.S. medical schools, medical boards rely on the accreditation processes used by the Liaison Committee on Medical Education (LCME) and the American Osteopathic Association (AOA) to judge the quality of their education. U.S. medical graduates receive either an allopathic medical degree (M.D.) from one of 129 LCME-accredited allopathic schools or an osteopathic medical degree (D.O.) from one of 25 AOA-accredited osteopathic medical school programs. (The LCME also accredits 17 medical school programs in Canada.)

Graduates of medical schools located outside the United States and Canada, often called international medical graduates or IMGs, follow a slightly different pathway to licensure in the United States. Before entering a U.S. postgraduate (residency) training program, IMGs must receive certification from the Educational Commission for Foreign Medical Graduates (ECFMG). ECFMG certification requires verification of a physician's medical degree and successful completion of the first two portions of the United States Medical Licensing Examination. Ultimately, IMGs take the same licensing examination as graduates of U.S. allopathic medical schools and obtain postgraduate training in the same accredited residency programs.

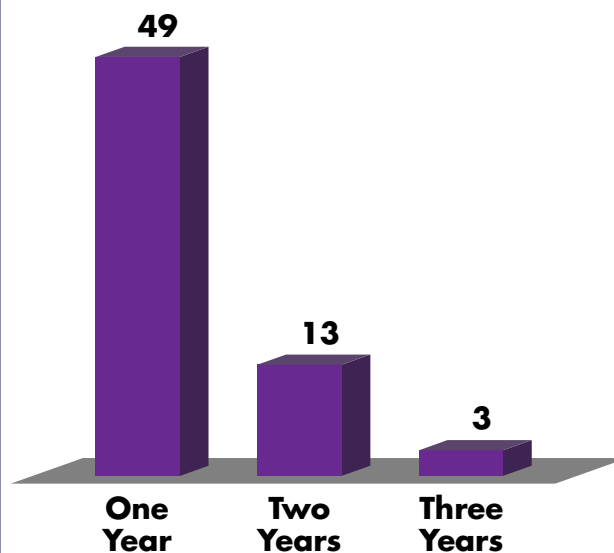
Postgraduate Medical Training

After graduation from medical school, physicians typically enter postgraduate training for specialized instruction in specific areas of clinical and non-clinical practice. Most state medical boards issue resident or training permits for physicians in postgraduate training. Training permits allow resident physicians to practice within the limited, supervised context of their postgraduate program and, for the first time, bring resident physicians under the direct jurisdiction of the medical board. The directors of postgraduate training programs communicate with medical boards about competency or behavioral issues of concern that may arise with a physician during his or her residency. Medical boards will take appropriate action in cases involving egregious behavior by resident physicians.

State medical boards require physician residents to complete at least one year of postgraduate training before they are eligible to apply for a full and unrestricted medical license (Table 1). International medical graduates usually must complete two or three years of postgraduate training before they are eligible to apply for a full and unrestricted medical license. In recent years, medical boards have largely moved towards uniform postgraduate training standards by requiring residents to complete programs approved through the accreditation processes administered by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. Just as they carefully verify an applicant's medical school education credentials, medical board licensing staff also verify the authenticity of an applicant's postgraduate training.

Table 1.

Years of Postgraduate Training Required by Medical Boards for Initial Licensure of U.S. Medical Graduates



Source: Federation of State Medical Boards, 2008

National Licensing Examinations

As with postgraduate training requirements, state medical boards have in recent years moved toward uniform standards with the licensing examinations required of licensure applicants. State medical boards typically require applicants to have successfully completed either the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Licensing Examination-USA (COMLEX). These national, multi-part examinations, taken at various points in prospective physicians' careers, are designed to assess a physician's knowledge and clinical and communication skills.

Students in U.S. medical schools typically take the first two portions of the licensing examination prior to graduation from medical school and the third and final portion of the examination sequence during residency training. Although some international medical graduates begin the USMLE sequence while in medical school, most do not begin the USMLE sequence until after graduation from medical school. Many medical boards impose limits to the number of attempts and the allow-

able time that may be taken by physicians to complete the licensing examination sequence. This ensures that newly licensed physicians have demonstrated the currency of their medical knowledge.

Fitness to Practice

All state medical boards are concerned with the physical, mental and moral fitness of licensure candidates. Many boards explicitly define the practice of medicine in their licensure applications to ensure that candidates for licensure clearly understand the expectations for acceptable performance. Medical board applications typically ask questions about the personal history and background of the applicant, including work history and physical and/or mental conditions that might impact their ability to safely practice medicine. Licensing staff will query the FSMB's data bank of disciplinary actions to determine if an applicant has been previously sanctioned by another medical board or regulatory entity. Staff also closely review the responses to questions on the licensure application for missing or inconsistent information. In some instances, the board may request that the applicant appear for a formal interview before either the full membership or a subcommittee of the board.

In response to evidence of a small, but significant cohort of physicians who have concealed criminal histories, medical boards are increasingly conducting criminal background checks on physicians who apply for licensure to practice medicine. In recent years, more than 30 state medical boards have been authorized to conduct criminal background checks of applicants. Medical boards deny licensure to physician applicants with criminal histories when the nature of the conviction and other circumstances warrant. License denials are reported to the Federation Physician Data Center, managed by the FSMB, which medical boards routinely query when processing licensure applications. This system prevents physicians who have been denied licensure because of unrevealed criminal backgrounds in one state from concealing this past when applying for licensure in another state.

Relicensure

Physicians are required to renew their licenses periodically to maintain their active status, typically every one to two years. During the license renewal process in most states, physicians must document that they have participated in continuing medical education and maintained acceptable standards of medical and professional conduct.

Enhancing Licensure Processes

State medical boards continually work to improve the efficiency of the licensure process while maintaining the rigorous standards associated with granting a license. Examples include:

- Many state medical boards have moved from paper-based license application processes to online processes, significantly reducing processing times. Applicants can often check the status of their application online, eliminating numerous inquiries to board staff.
- Retired physicians and others who have been out of active practice for a significant amount of time are often interested in re-entering practice. State medical boards are increasingly exploring re-entry programs for inactive physicians that include elements such as signed re-entry agreements, monitoring plans and reporting requirements.
- Some states have created special-purpose, limited licenses for physicians, licensed and in good standing in other jurisdictions, who want to come to the state to teach or learn a specific procedure or in other ways practice on a short-term basis.

State medical boards continually seek to improve the efficiency and effectiveness of their licensure functions. A streamlined, yet rigorous licensure function enables state medical boards to fulfill their charge of protecting the public by maintaining and improving the quality of readily available health care.

Clearinghouse of International Medical Education Data in Development

The sheer number of medical schools worldwide – more than 1,800 – poses a significant challenge for medical boards when evaluating the educational background of graduates of medical schools located outside the United States. As no international accrediting body exists, the quality and standards of some international schools can be difficult to determine. In 2006, state medical boards approved an FSMB special committee report on the evaluation of undergraduate medical education calling for the creation of a national clearinghouse of information and data on international medical schools. Members and staff from several state medical boards are currently serving on a workgroup guiding creation of the database. They have begun with the development of a “primer” on international medical education that can serve state medical boards as a Web-based resource containing important information, data and a glossary of key terminology. The primer is scheduled for release in late 2008.

A street scene featuring a large, leafy green tree in the foreground. To the left, a yellow fire hydrant stands on the sidewalk. A black lamppost with a white globe is positioned to the right of the tree. An American flag is attached to the lamppost. In the background, a building with a sign that reads "FRI JUL 2 8 PM" is visible. The scene is set on a city street with other buildings and cars in the distance.

The FSMB: Helping Medical Boards Fulfill Mandate to Protect the Public

The Federation of State Medical Boards: Helping Improve the Quality, Safety and Integrity of Health Care

The Federation of State Medical Boards (FSMB) is a national not-for-profit organization representing the 70 medical boards of the United States and its territories. The FSMB assists state medical boards in protecting the public's health, safety and welfare through the promotion of high standards for physician licensure and practice.

The FSMB provides an array of services, several of which are described below, to assist medical boards in their mission of public protection. To learn more about the FSMB, please visit www.fsmb.org.

Policy Development and Dissemination

In the past few years, the FSMB has played a key role in state and national debates on many prominent issues, including Internet prescribing, telemedicine, alternative medicine, international medical education, physician competence and management of chronic pain. As the national authority on issues regarding medical licensure and discipline, the FSMB is often called upon to offer testimony before Congress, federal agencies and state legislatures. The FSMB identifies legislative trends, develops model medical regulatory policies, facilitates communication between states on legislative issues, drafts statutory language and legislative testimony and assists with legislative strategies.

Physician Data

Established in 1912, the FSMB was the first group to publish and distribute the names of the country's disciplined physicians. That information is now disseminated electronically via the Federation Physician Data Center, a repository of licensure data on U.S. physicians that contains more than 156,000 disciplinary actions against 46,000 physicians dating to the 1960s. The Data Center receives regular updates from medical boards when they take disciplinary actions. An alert service provided by the Data Center helps medical boards quickly identify disciplined physicians who seek to relocate to another jurisdiction without detection. A similar service advises hospitals and managed care organizations when one of their physicians has been disciplined. The public can access nationally consolidated information about a physician from docinfo.org for a nominal fee.

United States Medical Licensing Examination

Medical licensing authorities in the United States require each applicant for licensure to pass an examination to ensure the physician is competent to practice medicine safely. The FSMB and the National Board of Medical Examiners administer the United States Medical Licensing Examination

(USMLE), a three-step examination designed to be taken at different points during medical education and training. The USMLE evaluates a physician's ability to apply medical knowledge, concepts and principles to patient care and management across multiple settings. It also tests an applicant's clinical and communications skills in situations that replicate a doctor's typical mix of cases in a busy medical clinic.

Credentials Verification


Established in 1996 at the request of the FSMB's member boards as a tool to facilitate license portability, the Federation Credentials Verification Service (FCVS) is a permanent repository of core medical credentials for physicians and physician assistants, including medical education, postgraduate training, examination history, board action history, board certification and identity. Because FCVS provides primary source verification, this process eliminates the potential for fraudulent documentation and lessens the duplicative credentialing activities among medical boards that participate in the service. These credentials are subsequently available at a physician's request whenever he or she seeks licensure in another jurisdiction. Currently, 85,000 physicians have profiles with FCVS.

Education

The FSMB offers a variety of educational forums designed to assist state medical boards in carrying out their mission of public protection. The FSMB Annual Meeting is an intensive three-day program that brings together medical regulators from around the world to discuss trends impacting public safety. In an effort to meet the changing needs of its member boards, the FSMB offers Web-based educational programs that bring boards together with national experts to discuss current issues in medical regulation; recent Webinars have addressed sexual boundary issues and disruptive behavior by physicians. Other program offerings include the Executive Management Seminar, which assists medical board executives and senior staff in honing management skills critical to effective medical board operations; and the New Executives Orientation, a comprehensive overview of FSMB programs and services for executives new to medical boards.



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