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**ADVISORY GROUP ON CONTINUED COMPETENCE OF
LICENSED PHYSICIANS**

Report on FSMB Maintenance of Licensure Initiative

**Approved as amended
November 18, 2009**

**Amended for dissemination by FSMB Board of Directors
December 13, 2009**

**Amended by the Advisory Group on January 27, 2010 after review of
stakeholder comments**

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* Organizational affiliations are presented for purposes of identification and do not imply
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82 **ADVISORY GROUP ON CONTINUED COMPETENCE OF LICENSED PHYSICIANS**

83 **Report to the Federation of State Medical Boards, Inc**
84 **Board of Directors**

85
86
87 **INTRODUCTION AND CHARGE**
88

89 The Federation of State Medical Boards' (FSMB) Advisory Group on Continued Competence of
90 Licensed Physicians was convened in the fall of 2009 and charged to issue an opinion to the FSMB
91 Board of Directors concerning the FSMB's Maintenance of Licensure initiative and more specifically,
92 whether the framework proposed in the report of Special Committee on Maintenance of Licensure for
93 use by the state medical boards in assuring the continued competence of licensed physicians is feasible,
94 reasonable, consistent with the guiding principles adopted by FSMB's House of Delegates in May
95 2008 and suitable for use by state medical boards in assuring the continued competence of licensed
96 physicians.

97
98 In carrying out their charge, the Advisory Group was asked to include in its consideration and, where
99 appropriate, provide input regarding:

- 100
101 1. Review of the FSMB's work on Maintenance of Licensure (MOL), to include public policies,
102 reports, documents and any active engagement of state medical boards, the public, physicians
103 and other stakeholders in discussions about MOL and the solicitation of their input in the
104 evolution and development of related policy recommendations.
105
106 2. Review of the available research and published literature concerning the evidence
107 for the need for initiating an MOL program and the effects of such a program as
108 well as other quality improvement methodologies on physician practice and
109 quality care outcomes.
110
111 3. Review of further analyses of any outstanding issues that surfaced as a result of the MOL
112 impact analysis report and state medical board and other stakeholders' feedback to this
113 report.
114
115 4. In collaboration with appropriate stakeholders, review and /or develop recommendations for
116 how MOL, maintenance of certification and other continuous improvement activities could be
117 aligned to support state medical boards in achieving a regulatory system that assures the public
118 of a physician's competence while minimizing duplication and burden on the physician
119 community
120
121 5. Review of any pilot projects supported/funded by the FSMB in collaboration with
122 appropriate stakeholders centering on issues relevant to the MOL discussions.
123
124
125
126
127
128

129 **DESIRED OUTCOMES**

130

131 After reviewing the charge, the Committee developed its list of desired outcomes from the planning
132 process. It was agreed that it would like to achieve:

133

134 ➤ A brief, compelling, clear statement about the future direction of the Maintenance of
135 Licensure initiative.

136

137 ➤ A continued, strong leadership role for FSMB in medical licensure and regulation.

138

139 ➤ Momentum for FSMB to take the next steps and move the MOL agenda forward.

140

141 ➤ A simple, unified process that should not compromise patient care nor create barriers to
142 physician practice.

143

144 ➤ Very specific recommendations regarding strategies and time lines for
145 implementation, if possible.

146

147

148 **METHODOLOGY**

149

150 The Advisory Group on Continued Competence of Licensed Physicians held three conference call
151 meetings and one face to face meeting during the period from August – November, 2009. At its first
152 meeting, the Committee agreed to the following:

153

154 • A consensus-based process and report would be the goal of the Advisory Group. In addition to
155 addressing the Advisory Group charge, the Group might also consider “complementary
156 strategies” that may indirectly relate to the Group’s recommendations,

157

158 • While the members would have free access to discuss Advisory Group deliberations within
159 their organizations, it was agreed that no member of the Group would prematurely represent
160 any discussion as a decision of the Advisory Group as a whole.

161

162 The Advisory Group was cognizant that the desired deadline for its work was November, 2009, but
163 that if additional time was needed, an extension would be granted.

164

165

166 **INFORMATION PROVIDED TO THE ADVISORY GROUP**

167

168 The group used a knowledge based approach to its deliberations and considered all FSMB documents
169 regarding Maintenance of Licensure (MOL), available research, policies from other organizations,
170 including the American Medical Association. See Supplemental document A for a glossary of terms
171 and acronyms. See Supplemental document B for the Maintenance of Licensure Timeline and see
172 Supplemental document C for a complete listing of all documents distributed, read and considered by
173 the Advisory Group.

174

175 The facilitator also conducted confidential phone interviews with members of the Advisory Group and
176 FSMB staff involved in the Group. Advisory Group members were asked:

177

- 178 1. In the next few years, what are the greatest opportunities regarding the FSMB’s Maintenance of
179 Licensure Initiative? Greatest challenges?
180
181 2. To what degree is the framework proposed in the Special Committee on MOL Report
182 feasible, reasonable, and suitable for use by state medical boards?
183
184 3. What are the key issues that our Advisory Group should be addressing?
185
186 4. What preliminary advice do you have for FSMB on its Maintenance of Licensure Initiative?
187
188 5. Any other ideas and suggestions you would like to place on the Advisory Group “table?”
189

190 The results were aggregated anonymously and served to “jump start” the discussion about Maintenance
191 of Licensure and the role of FSMB. A summary of the interviews is in Supplemental document D.
192

193 In order to be absolutely clear about its charge, the Advisory Group Chair requested a legal opinion
194 about the use of the term “assure” in a Maintenance of Licensure program. The legal opinion is
195 Supplemental document E.
196

197 Finally, the Advisory Group requested and received a survey of State Medical Boards regarding their
198 level of discussion/dialogue about MOL and their ability to implement MOL requirements, either
199 through statutory authority or reinterpretation of existing Continuing Medical Education (CME)
200 language. This survey repeated several questions that had been asked in 2007. Supplemental document
201 F contains the most recent data from this survey, although the Advisory Group had the benefit of only
202 the first 30 respondents when it met face-to-face on October 12-13, 2009.
203
204

205 **ADVISORY GROUP ENDORSEMENT OF FSMB GUIDING PRINCIPLES**
206

207 In its first action, the Advisory Group recommends continued FSMB support of its five MOL
208 principles from the Board of Director Report 08-3: *Assuring the Ongoing Competence of Licensed*
209 *Physicians*, with the exception of the third bullet as modified below. The Advisory Group believes
210 that the replacement suggestion for the third bullet emphasizes the positive implications of
211 Maintenance of Licensure.
212

- 213 • *Maintenance of licensure should support physicians’ commitment to lifelong learning and*
214 *facilitate improvement in physician practice.*
- 215
- 216 • *Maintenance of licensure systems should be administratively feasible and should be developed*
217 *in collaboration with other stakeholders. The authority for establishing maintenance of*
218 *licensure requirements should remain within the purview of state medical boards.*
- 219
- 220 • *Maintenance of licensure should not compromise patient care or create barriers to physician*
221 *practice. (Previously: “Maintenance of licensure should not be overly burdensome for the*
222 *professional and should not hinder physician mobility.)*
- 223
- 224 • *The infrastructure to support physician compliance with maintenance of licensure requirements*
225 *must be flexible and offer a choice of options for meeting requirements.*
- 226
- 227 • *Maintenance of licensure processes should balance transparency with privacy protections.*
228

229 **ADVISORY GROUP OPINION ABOUT REQUIREMENTS FOR DEMONSTRATING**
230 **COMPETENCE FOR PHYSICIAN LICENSE RENEWAL**

231

232 The Advisory Group gave careful consideration to the “Framework for Maintenance of Licensure” as
233 recommended in the *Draft Report on Maintenance of Licensure*, February, 2008, and believes that, as
234 modified below, the framework is feasible, reasonable, consistent with the guiding principles adopted
235 by FSMB’s House of Delegates in May 2008 and suitable for use by state medical boards in assuring
236 the continued competence of licensed physicians.

237

238 The Advisory Group suggests the following modifications to the framework with the intent of
239 providing greater clarity, simplicity and options to the state medical boards. *The modified framework*
240 *is indicated below in italics and illustrated on the next page.* Supplemental document G includes the
241 original framework as proposed in the Draft Report on Maintenance of Licensure, February, 2008.

242

243 *As a condition of license renewal, physicians should provide evidence of participating in a program of*
244 *professional development and lifelong learning that is based on the general competencies model:*

245

- *medical knowledge*
- *patient care*
- *interpersonal and communication skills*
- *practice based learning*
- *professionalism*
- *systems based practice*

246

247

248

249

250

251

252 *The following requirements reflect the three major components of what is known about effective*
253 *lifelong learning in medicine.*

254

255

256

1. Reflective Self Assessment (What improvements can I make?)

257

258

259

260

*Physicians must participate in an ongoing process of reflective self-evaluation, self-assessment and
practice assessment, with subsequent successful completion of appropriate educational or
improvement activities.*

261

262

2. Assessment of Knowledge and Skills (What do I need to know and be able to do?)

263

264

265

266

*Physicians must demonstrate the knowledge, skills and abilities necessary to provide safe, effective
patient care within the framework of the six general competencies as they apply to their individual
practice.*

267

268

3. Performance in Practice (How am I doing?)

269

270

271

272

273

274

*Physicians must demonstrate accountability for performance in their practice using a variety of
methods that incorporate reference data to assess their performance in practice and guide
improvement.*

275 **CONTINUING COMPETENCE FOR PHYSICIAN LICENSE RENEWAL MAINTENANCE**
276 **OF LICENSURE FRAMEWORK**

277

278 *As a condition of license renewal, physicians should provide evidence of participating in a program of*
279 *professional development and lifelong learning that is based on the general competencies model:*

280

281

- *medical knowledge*
- *patient care*
- *interpersonal and communication skills*
- *practice based learning*
- *professionalism*
- *systems based practice*

282

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284

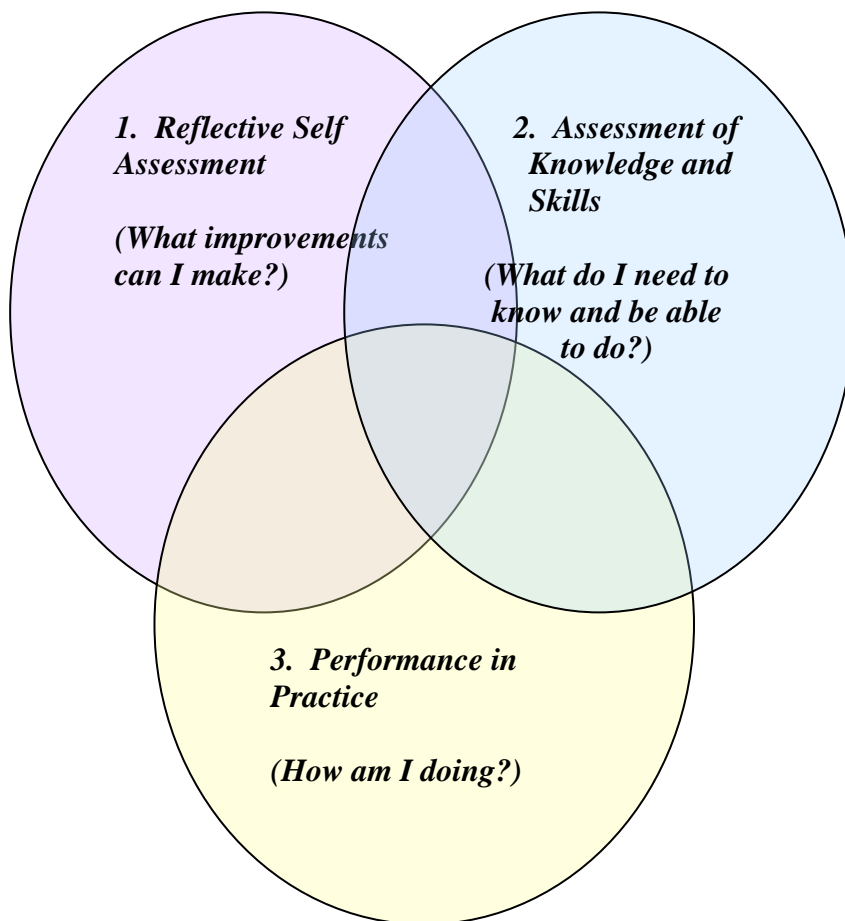
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286

287

288 *The following requirements reflect the three major components of what is known about effective*
289 *lifelong learning in medicine.*

290



291

292

293

294 **COMPONENTS OF PROFESSIONAL DEVELOPMENT PROGRAMS AND ACTIVITIES**
 295

296 Professional development programs and activities should include the following interrelated components:
 297

GOALS	STRATEGY (HOW)	OPTIONS /EXAMPLES
<p>1. Reflective Self Assessment (What Improvements Do I Need to Make?)</p> <p>Physicians must participate in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent successful completion of appropriate educational or improvement activities.</p>	<p>Self assessment incorporates external measures of knowledge and skills or performance benchmarks.</p>	<p>Assessment tools could include:</p> <ul style="list-style-type: none"> • Self-review tests such as <ul style="list-style-type: none"> - MOC and Osteopathic Continuous Certification (OCC) - Home study courses or web-based materials - Medical professional society/organization or institution-based simulation • Others approved by the state medical board <p>Professional development activities could include:</p> <ul style="list-style-type: none"> • Review of literature in the physician’s current practice area • CME in the physician’s current practice area that enhances patient care, performance in practice and or patient outcomes.
<p>2. Assessment of Knowledge and Skills (What Do I Need to Know and Be Able to Do?)</p> <p>Physicians must demonstrate the knowledge, skills and abilities necessary to provide safe, effective patient care within the framework of the six competencies as they apply to their individual practice.</p>	<p>Assessments of knowledge and skills should be structured, valid, practice relevant, and should produce data to identify learning opportunities.</p>	<p>Examples of assessments addressing one or more of the competencies include but are not limited to:</p> <ul style="list-style-type: none"> • Practice relevant multiple choice exams, e.g., MOC/OCC exams, National Board of Medical Examiners (NBME) shelf exams, National Board of Osteopathic Medical Examiners (NBOME) COMAT Achievement Tests, NBOME shelf exams • Standardized patients • Computer-based clinical case simulations • Patient and peer surveys • Mentored or proctored observation of procedures • Performance improvement (PI) CME • Other performance improvement projects such as the Surgical Care Improvement Project (SCIP), American Medical Institute (AMI), Institute for Healthcare Improvement (IHI), Healthcare Effectiveness Data and Information Set (HEDIS) • Procedural hospital privileging • Others approved by SMBs

GOALS	STRATEGY (HOW)	OPTIONS /EXAMPLES
<p>3. Performance in Practice (How am I Doing?)</p> <p>Physicians must demonstrate accountability for performance in their practice.</p>	<p>Physicians should use a variety of methods that incorporate reference data to assess their performance in practice and guide improvement.</p> <p>3rd party attestation of participation will satisfy this component.</p>	<p>Assessment tools could include but are not limited to:</p> <ul style="list-style-type: none"> • 360-degree/multi-source evaluations (self evaluation, peer assessment and patient surveys). • Patient reviews, such as satisfaction surveys • Collection and analysis of practice data such as medical records, claims review, chart review and audit, case review and submission of a case log • Registries • American Osteopathic Association (AOA) Clinical Assessment Program • An approved American Board of Medical Specialties (ABMS) MOC Part IV Practice Improvement activity • Medical professional society/organization clinical assessment/practice improvement programs • Peer review • Centers for Medicare and Medicaid Services (CMS) and other similar institutional based measures • Other performance improvement projects such as the Surgical Care Improvement Project (SCIP), American Medical Institute (AMI), Institute for Healthcare Improvement (IHI), Healthcare Effectiveness Data and Information Set (HEDIS) • Other tools approved by the state medical board

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299
300

301 **ADVISORY GROUP OPINION ABOUT REQUIREMENTS FOR DEMONSTRATING**
302 **COMPETENCE FOR PHYSICIAN LICENSE RENEWAL**

303

304 The Advisory Group also discussed the recommendations included in the *Draft Report on*
305 *Maintenance of Licensure*, February, 2008. The Advisory Group agrees that, as modified below, the
306 recommendations are feasible, reasonable, consistent with the guiding principles adopted by FSMB's
307 House of Delegates in May 2008 and suitable for use by state medical boards in assuring the continued
308 competence of licensed physicians.

309

310 *The modified recommendations are indicated below in italics.*

311

312 Documentation

313

314 *Licensees should be expected to provide documented evidence of compliance with the state medical*
315 *board's maintenance of licensure requirements. State medical boards should provide guidance to*
316 *licensees as to the types of evidence deemed acceptable and not acceptable for purposes of meeting*
317 *maintenance of licensure requirements.*

318

319 Licensed Physicians not in Active Clinical Practice

320

321 *Physicians not in active clinical practice who wish to maintain an active license should be expected to*
322 *comply with all maintenance of licensure requirements adopted by the state medical board.*

323

324 Physicians With Inactive Licenses

325

326 *Physicians whose licenses are inactive or have lapsed should be expected to meet MOL requirements*
327 *upon reentering active clinical practice.*

328

329 Practice Profile Data

330

331 *State medical boards should require licensees to report information about their practice as part of the*
332 *license renewal process. Such information may include: area of current practice, type of practice (to*
333 *include location, supervisory responsibilities), status (e.g., full-time, part-time, number of hours*
334 *worked per week), whether they are actively seeing patients, specialty board certification or*
335 *recertification status, and what activities they are engaged in if they are not engaged in clinical*
336 *practice (e.g., research, administration, non-medical work, retired, etc.). Licensees should keep the*
337 *board apprised of their practice status by reporting any subsequent changes to the board within a*
338 *specified timeframe as determined by the board.*

339

340 Practice Performance Data

341

342 *Practice performance data collected and used by physicians to comply with MOL requirements should*
343 *not be reported to state medical boards. Third party attestation of collection and use of such data (as*
344 *part of a professional development program) will satisfy reporting requirements.*

345

346

347

348

349

350

351 Research

352

353 *The Federation of State Medical Boards and its member state medical boards should work with other*
354 *stakeholder organizations to develop research aimed at assessing the impact of maintenance of*
355 *licensure programs on physician practice and patient care.*

356

357 Assessment Resources

358

359 *Assessment tools used to meet maintenance of licensure requirements should be:*

360

- *valid, reliable, and feasible*

361

- *credible with the public and the profession*

362

- *provide adequate feedback to the licensee to facilitate practice improvement*

363

364 Professional Development Activities

365

366 *Individual learning plans should address any identified needs and should include educational and*
367 *improvement activities that are shown to improve performance and include plans to assess the impact*
368 *of the educational and improvement activities on each physician's practice.*

369

370 Board Certification in the Context of MOL

371

372 *MOL is separate and distinct from MOC and OCC. However, state medical boards at their discretion*
373 *may determine that participation in MOC and OCC represents substantial compliance with MOL*
374 *requirements. Physicians who are not participating in the maintenance of certification/osteopathic*
375 *continuous certification processes may meet MOL requirements by providing evidence of participation*
376 *in available MOC or OCC activities or by participating in other approved maintenance of licensure*
377 *requirements.*

378

379

380 **COMPLEMENTARY STRATEGIES RECOMMENDED BY THE ADVISORY GROUP**

381

382 The Advisory Group recognized that additional work needs to be done to launch the MOL initiative
383 and suggested the following complementary strategies:

384

385 1. **Implementation.** FSMB consider providing a suggested beginning and ending deadline date
386 for SMB implementation of MOL. Concurrently, FSMB will need to prepare and provide
387 resources of all types including grants, temporary staffing resources, web advice, model
388 revisions of medical practice acts, and tools for state medical boards to use as they
389 develop their own tailored MOL requirements.

390

391 2. **“Starter” Plan.** A “starter” plan or concrete list of actions, deadlines, and milestones is needed
392 for FSMB’s use in planning and implementing Maintenance of Licensure among its member
393 boards. It is suggested that the “starter” plan be developed through focused dialogue with state
394 medical boards and other stakeholders, and that pilot programs be implemented in
395 parallel to those discussions.

396

397 3. **Communications.** A communications strategy is strongly recommended so that current and
398 future licensees, state medical boards, legislators, and the public understand the importance of
399 lifelong learning and how Maintenance of Licensure can result in improved outcomes for
400 patients and the health care system. The Advisory Group suggests that a tagline be developed

401

402 to clearly communicate the benefits of Maintenance of Licensure. Concepts considered were:
403 Professional Development for Continued Licensure, Lifelong Learning for Practice
404 Improvement, and Continuous Practice Improvement through License Renewal.
405

406 Additionally, there is an immediate need for a unified message, talking points, a standardized
407 “Question and Answer”, and power point presentation for use prior to the upcoming
408 FSMB Annual meeting.
409

- 410 4. **Outreach.** Continued outreach to the public and the profession, regulatory and assessment
411 organizations, national, state and specialty medical societies, and other stakeholders will be
412 critical to the success of Maintenance of Licensure. It is suggested that this begin immediately
413 in anticipation of the first wave of SMBs beginning to implement the program.
414

415 **CONCLUSION**

416
417
418 The Advisory Group on Continued Competence of Licensed Physicians agreed with current FSMB
419 policy stating that state medical boards have an obligation to the public to assure the continuing
420 competence of physicians seeking license renewal. The Advisory Group believes that the public wants
421 physicians to be up to date in medical practice and that state medical boards have the authority within
422 their public mandate to require all licensed physicians to periodically demonstrate their ongoing
423 competence. There is some evidence that supports continued lifelong medical education as an
424 effective means of physician learning and change if it is part of a system of continuous professional
425 development that includes self-assessment, remediation and reassessment. There is also a widespread,
426 national focus on improving quality of care and initiatives that are creating a “culture of improvement”
427 in medicine.
428

429 Persuaded by the information it reviewed, the Advisory Group recommends that FSMB support and
430 adopt the Advisory Group on Continued Competence of Licensed Physicians Report on FSMB
431 Maintenance of Licensure Initiative, dated November 18, 2009.
432

433 It is recognized that there may be challenges to implementation of Maintenance of Licensure.
434 However, the Advisory Group believes that the framework as amended is feasible, reasonable,
435 consistent with the guiding principles adopted by FSMB’s House of Delegates in May 2008 and
436 suitable for use by state medical boards in assuring the continued competence of licensed physicians.
437 The Advisory Group believes that these challenges can be overcome through clear communication of a
438 compelling rationale, leadership, and resources.
439

440 The Advisory Group believes that FSMB can and should commit to a leadership role with the state
441 medical boards by providing significant human, financial, and legal resources to help them implement
442 MOL programs designed to assure the public of the continuing competence of physicians seeking
443 license renewal.
444

GLOSSARY OF TERMS AND ACRONYMS

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 physicians’ 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.

CME – Continuing medical education.

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)

D.O. - Doctor of Osteopathic Medicine.

FSMB – Federation of State Medical Boards.

Federation of State Medical Boards - The Federation of State Medical Boards (FSMB) is a national non-profit organization representing the 70 medical boards of the United States and its territories. The FSMB's mission is to continuously improve the quality, safety, and integrity of health care through developing and promoting high standards for physician licensure and practice.

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.

MOC – Maintenance of Certification.

Maintenance of Certification – A program enacted by the American Board of Medical Specialties that requires physicians to provide evidence of meeting the following criteria on a continual basis in order to maintain special board certification:

- 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

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 I)

MOL – Maintenance of licensure.

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.

OCC – Osteopathic Continuous Certification.

Osteopathic Continuous Certification - A program adopted by the American Osteopathic Association’s Bureau of Osteopathic Specialists that requires physicians to provide evidence of meeting the following criteria on a continual basis in order to maintain osteopathic board certification:

- Component 1: Professional Licensure
- Component 2: Lifelong Learning
- Component 3: Cognitive Assessment
- Component 4: Performance/Practice Assessment
- Component 5: AOA Membership

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)

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

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

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

SMB – State medical and osteopathic board.

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

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

Maintenance of Licensure (MOL) Timeline

- 2002: FSMB Board of Directors approves a motion to include the issue of physicians' continued competence in its FY 2004 action plan.
- September 2003: FSMB Special Committee on Maintenance of Licensure convened. Committee is charged, in part, with 1) developing a position statement regarding the responsibility of state medical boards in ensuring physician competence over the course of his/her career and 2) developing 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.
- February 2004: The Board of Directors endorses a recommendation by the Special Committee on Maintenance of Licensure that FSMB adopt policy stating that medical boards are responsible to the public for assuring the continued competence of physicians at the time of license renewal.
- April 2004: *Board of Directors Report 04-1: Report on Special Committee on Maintenance of Licensure* sent to House of Delegates for approval. The following policy statement is adopted by the House of Delegates as FSMB policy:
- “State medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking relicensure.”
- March 2005: In response to member medical board feedback that FSMB should take a leadership role in national discussions about assuring the continued competence of licensed physicians, FSMB convenes the first national Physician Accountability for Physician Competence summit. The purpose of the summit was to engage the medical community in a dialog about the future of healthcare in the United States with the ultimate goal of answering the question, “How does the profession of medicine identify, measure and evaluate the ongoing competence of its members to assure the public of its commitment to accountability?”
- February 2005: *Special Committee on Maintenance of Licensure Interim Report* sent to Board of Directors for approval. The report outlines the conceptual challenges associated with implementing maintenance of licensure requirements and discusses issues considered by the committee to date.
- May 2005: Board of Directors report on Efforts to Address the Continued Competence of Licensed Physicians sent to the House of Delegates for information. The report includes the *Special Committee on Maintenance of Licensure Interim Report* as an attachment.
- June 2005: Recognizing that the Physician Accountability for Physician Competence initiative could positively impact the political landscape within which the Special Committee's final report would be released, the Board of Directors asks the committee to defer issuing recommendations about how state medical boards should implement maintenance of licensure initiatives until this national dialogue is further along.
- July 2005: The Board of Directors refers *Resolution 05-3, Physician and Physician Assistant Reentry to Practice*, to the Special Committee. Specifically, the Board asks the

committee to draft guidelines for reentry to practice that may be broadly applied to all health professions regulated by state medical boards.

2007: Special Committee completes work on final report with recommendations regarding MOL. Draft model guidelines for reentry to practice are also included.

October 2007: Special Committee completes initial draft of final report and submits to Board of Directors. The Board approves distributing the draft report to member boards and other interested stakeholders for comment.

February 2008: Special Committee submits final report, *Special Committee on Maintenance of Licensure Draft Report on Maintenance of Licensure*, to Board of Directors for consideration. The report includes recommendations for MOL and reentry to practice. The Board of Directors separates the recommendations regarding maintenance of licensure and reentry to practice into independent documents, with the former to be forwarded immediately to the House of Delegates and the latter to be considered by the Board of Directors later in the year. Based on questions and issues raised by state medical boards and other stakeholders concerning the committee's recommendations, the Board of Directors defers acting on the report of the Special Committee on Maintenance of Licensure and instead, recommends to the House of Delegates that the FSMB pursue further information-gathering activities to answer questions about the implications of implementing MOL policies.

May 2008: *Board of Directors Report 08-3: Assuring the Ongoing Competence of Licensed Physicians*, which includes the *Special Committee on Maintenance of Licensure Draft Report on Maintenance of Licensure* as an attachment, forwarded to House of Delegates. The report recommends 1) that the House of Delegates adopt a set of guiding principles that are based upon but broader than those developed by the Special Committee to guide its work and 2) that the House of Delegates approve a motion directing FSMB to pursue information-gathering activities.

The House of Delegates 1) endorses the Board of Directors' recommendation that prior to taking any action on the report of the Special Committee on Maintenance of Licensure, FSMB engage in further evaluation to better understand how implementation of the proposed maintenance of licensure requirements will impact state medical boards and other stakeholder groups and report back to the House of Delegates in 2009 and 2) adopts the following guiding principles as FSMB policy:

- MOL should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
- MOL systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing MOL requirements should remain within the purview of state medical boards.
- MOL should not be overly burdensome for the profession and should not hinder physician mobility.
- The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.
- MOL processes should balance transparency with privacy protections.

September 2008: Board of Directors receives a draft document prepared by staff summarizing relevant research findings concerning issues related to assuring the continuing competence of

licensed physicians (e.g., effectiveness of CME, impact of board competence over time). This document forms the basis for the white paper that is currently being developed.

The following motion is adopted by the Board of Directors:
“Given the current efforts by FSMB to carry out the 2008 House of Delegates directive regarding maintenance of licensure (MOL), the task force organized to assist with this initiative should do the following in order of priority:
(1) gather scientific evidence supporting the MOL initiative;
(2) develop strategies/programs for carrying out the initiative;
(3) analyze the impact these strategies/programs would have on state medical boards.”

October 2008: A taskforce comprised of members and staff of 13 state medical boards is convened to assist in analyzing the impact of implementing MOL requirements on state medical boards and other stakeholders. Discussions from the meeting form the basis for a draft impact analysis report to be submitted to the Board of Directors.

January 2009: The draft report, *An Analysis of the Impact of Implementation of Maintenance of Licensure Requirements*, based on the work of the taskforce convened in October 2008 is disseminated to FSMB’s member state medical boards for comment.

February 2009: The FSMB Board of Directors receives the draft report, *An Analysis of the Impact of Implementation of Maintenance of Licensure Requirements*. The Board approves a motion that the Board of Directors submit an interim report to the House of Delegates recommending that additional study on matters related to maintenance of licensure be conducted in order to assure member boards have as much comprehensive and useful guidance as possible.

Spring 2009: A workgroup of experts in the field of physician evaluation and continuous quality improvement agree to help review and expand the white paper summarizing the literature regarding various issues relevant to physician competence. When completed, the white paper will be disseminated to state medical boards for information.

May 2009: *Board of Directors Report 09-2: Assuring the Ongoing Competence of Licensed Physicians* submitted to House of Delegates. The report includes the impact analysis report, as well as a summary of feedback received on the report. The Board of Directors recommends and the House of Delegates adopts the following:

The FSMB pursue the following scope of work and report back to the House of Delegates at the FY2010 annual business meeting:

1. Conduct, collect and disseminate research on and give additional consideration to the evidence for the need for initiating an MOL program and the effects of such a program on patient care and physician practice.
2. Conduct further analysis of outstanding issues which surfaced as a result of the MOL impact analysis report and state medical board and other stakeholders feedback to this report;
3. In collaboration with appropriate stakeholders, develop recommendations for how MOL, maintenance of certification, and other continuous improvement activities could be aligned to support state medical boards in achieving a regulatory system that assures the public of a physician’s competence while minimizing

- duplication and burden on the physician community;
4. In collaboration with appropriate stakeholders, support/fund one or more pilot projects centering on issues relevant to MOL discussions;
 5. Actively engage state medical boards, the public, physicians and other stakeholders in discussions about MOL and solicit their input in the evolution and development of related policy recommendations.

July 2009: Members of the MOL Impact Taskforce reconvene to continue analysis of additional issues regarding the impact of the Special Committee's draft MOL policy on state medical boards. Specific issues of focus are:

- Strategies to mitigate possible unintended consequences that may result from implementing MOL policies
- Options for dealing with licensed physicians who are pursuing careers in nonclinical settings (e.g., administration), such as different types of licenses
- How states would address physicians who choose not to or are unable to comply with MOL requirements

Fall 2009: FSMB convenes an Advisory Group on Continued Competence of Licensed Physicians to review the FSMB's current and previous work on MOL. Upon completion of its review, the group will issue an opinion to the FSMB Board of Directors concerning the MOL initiative and more specifically, whether the framework proposed in the report of the Special Committee on Maintenance of Licensure for use by state medical boards in assuring the continued competence of licensed physicians is feasible, reasonable, consistent with the guiding principles adopted by FSMB's House of Delegates in May 2008 and suitable for use by state medical boards in assuring the continued competence of licensed physicians.

BILBIOGRAPHY

Below is a list of reports reviewed by the Advisory Group on Continued Competence of Licensed Physicians.

1. *Special Committee on Maintenance of Licensure Draft Report on Maintenance of Licensure* (February 2008)
2. *FSMB Board of Directors Report 08-3: Assuring the Ongoing Competence of Licensed Physicians* (May 2008)
3. *An Analysis of the Impact of Implementation of Maintenance of Licensure Requirements* (March 2009)
4. *FSMB Board of Directors Report 09-2: Assuring the Ongoing Competence of Licensed Physicians* (May 2009)
5. *Draft Addendum to An Analysis of the Impact of Implementation of Maintenance of Licensure Requirements* (September 2009)
6. *Board Report on Efforts to Address the Continued Competence of Licensed Physicians* (May 2005)
7. *Board of Directors Report 08-3: Assuring the Ongoing Competence of Licensed Physicians* (May 2008)
8. *Board of Directors Report 09-2: Assuring the Ongoing Competence of Licensed Physicians* (May 2009)
9. *Competence, Licensure and Improving Patient Care: An Analysis of the Literature* (draft October 2009)
10. *Report 16 of the Council on Medical Education (A-09: Maintenance of Certification/Maintenance of Licensure* (June 2009)

Summary of Interviews with Advisory Group Members

Henrichs & Associates
September, 2009

1. In the next few years, what are the greatest opportunities regarding the FSMB's Maintenance of Licensure Initiative? Greatest challenges?

OPPORTUNITIES –

Regain Public Confidence

- I do believe that there is a clamor from consumer group/ insurers/govt demand enhanced accountability for physicians. WE use clumsy surrogates to describe it – not keeping current; not professionalism; communication; surrogates for the public; consumer groups are the ones with the complaints.
- Past 10 years or so; appears to have been loss of public confidence in the practice of medicine. This is an opportunity to regain the confidence of the public by showing them that the house of medicine is taking responsibility for assuring of competence now and the future
- In reality medicine changing so fast; that even if you were certified 10 -20 years ago because of pace of change; need some way to reassure public
- Creates a significant opportunity for Federation and SMBs to demonstrate commitment to public. Public perspective – they think that we are already.
- Talk about transparency; we need to be doing something to say that MDs remain competent, not just recordkeeping.
- A matter of credibility as far as compact we have with the public; we guarantee competency and quality when we issue a license and that is where we have to regain our credibility.

Encourage Standardization

- My experience with FSMB and state medical boards; it appears that all state medical boards not on the same page – oppt to standardize the processes to make it less burdensome for physicians to go from state. Will ultimately increase public confidence in licensing boards;
- Greatest oppt is to create some standardization and ability to implement. – get states to all sign off of what we do. If FSMB comes out with a rec, state board has to have a good reason not to do it.
- This is ultimately for the public and I would hope that whatever they do around MOL will become more overarching among the 70 jurisdictions

Catalyst for Change

- This could be a catalyst to break up some old ways of doing things.
- FOCUS on positive than negative aspects – counting scalps for the positive

Improve Health Care Quality and Physician Practice

- An opportunity to improve health care quality and physician practice.

- Show what works best in preventive and standardized care. Look at long range; if FSMB is considered a resource in a new prevention mindset. Why shouldn't we be the one to say look at standardized care more.
- FSMB can find a path that acknowledges what is credible about public concerns and find a way to reasonably foster an environment, where physicians are reminded that MDs are required to maintain currency on latest medical evidence, attentiveness, etc.

Recognized and Relevant in Health Care Reform

- It makes us recognized and relevant in health care reform.

Other

- Concluded that the highest bar is set by the hospitals and let's begin with the local credentialing process and peer review process. What is happening at hospital level is getting direct observational up to minute assessments in practice; technical; knowledge base, interaction with peers, teams, how do they use the system THAT Is really what we are looking for and what we get when apply for initial licensure. That information is where competency rests.
- Needs to remain requirement neutral; can't do 20 steps to renew a license. Board certification recognized and alternates for not certified.

CHALLENGES –

Physician Understanding/Acceptance

- One of the biggest challenges is MD participating in process and perceives it as non-threatening. Feels that license is threatened will get push back. We have to have a process that the MD understands is helping them rather than hurting them.
- Convince physicians that it is necessary and that it will work to benefit patients; that is why we are looking at evidence; need to answer MD question - be able to answer "What is in it for me?"
- Licensee buy in; need to explain why this is necessary

Difficulty of Standardization

- Can we get most of the boards on the same page with same vision? We wouldn't want to have a process where state would change it for their particular constituency.
- Significant diversity between state medical boards; an appropriate goal to strive for a national standard and therefore national recommendations; challenge to find sweet spot that satisfies all of the different stakeholders; stay focused on patient safety and physician competence. More effective than if we seek political solutions.

Difficulty of Adding Value and Making a Difference

- How do they come up with something that is unifying, adds value, and is strong enough to make a difference

- Have to avoid complaint that it “takes too much time, too much money and is really not helpful or meaningful?”
- If FSMB is going to steer the course, we need to be focused on root cause analysis.

Workable and Practical/ Acceptance by SMBs

- Only concern when I reread it is that it has to be a workable system; practice info collected is ideal. For example; notify SMBs with scope and shift in practice.
- REALITY check – Can we really ask them to keep practice history up to date, when we can’t even get current addresses.
- Acceptance by our members; do they have resources and funds at this time?
- Federation wise in doing this step wise. We don’t need expensive and really intrusive test; don’t tell a licensing board what they need. If we could find easy to use, validated alternatives that are meaningful, they would drop their oppositions
- Challenge with legislators, will every SMB need to open state medical practice act
- Financial – for many SMBs, this will be a struggle financially

Danger of Irrelevancy

- Concern that quality initiatives may pass them by and they may become irrelevant. Still a pressure to stay with the status quo.
- At some point others will get ahead of FSMB – progressive SMB, federal govt in health reform;

FSMB Governance/Ability and Willingness to Act

- FSMB particularly challenged due to nature of their governance, and use it almost as an excuse. Exert some leadership and make some tough decisions.
- Concern at FSMB track record; been going on for years; yet another group.
- Our own internal structure is thin and suspect with ability to carry it out to SMBs.

Medical Politics

- Some issues with competition among other stakeholders; problem with medical system of stakeholders; everyone is jockeying for position and not a lot of stroking together.

Other

- Also legal issues; how much can you ask for from hospital is large group practice going to share
- Risks are (specialty board also) will not themselves do it the diligence required to analyze real issues is dissatisfaction with system; System is so challenging; being asked to respond.
- Future is not in discipline, but to move ourself ahead in improvement in remediation and rehabilitation
- If every MD had a requirement for standardized 360 degree process for all physicians. Then you would have national benchmark survey for that and go to licensing board. Difficulty with MOL is that you don’t have good information. If we had tools, not expensive and not time consuming and put the onus on MD

2. To what degree is the framework proposed in the Special Committee on MOL Report feasible, reasonable, and suitable for use by state medical boards?

Yes, with Phase-in

- I believe it is, but with some kind of a phase in period. Only concern is that a number of physicians in various stages in medical practice; some change specialties with no prep, and others are. Administrative physicians. How do we include all those people and ding in a way that is appropriate, but still fair.
- We need a REAL LIFE solution; define what would be ideal and do it in phases; can't do whole concept and drop into Board's lap. If a doctor asks: I am not Board certified; what does Board want me to do?, there should be a very easy answer.
- The framework is well thought out, only its practicality in question. We are looking at an evolutionary process; framework is something to build on; not the whole body of work

Yes, but it will take selling

- IS MOL report feasible? Yes, but it is going to take a selling – SMBs and Executives, but it is going to take a change in mind set

Yes, with options

- We have to offer options. Example: over a 10 year cycle at year 3 -4, do a self assessment, year 5 – 6 a second portion where you actually have a record review; at 7 – 8 take a standardized test, but have two or three opportunities to retake in a time period.
- If we have a range of options 2 – 3 that are reasonable, that still allows for standardization. We don't want it rammed down their throats.
- Another example, the Canadian model, and it weren't very expensive. Look, at a random selection of charts. - \$1,250 and if you maintain Board cert you re exempt

Need to meet public needs while not harming profession

- FSMB and member boards have the tools and resources to respond back confidently and assuredly but not to overreach. Look out for well being of public does not necessitate disadvantage and harming the profession.
- How do you reasonably, but not intrusively remind MD that they must make a credible attestation that they are current; professional in relationship and how do you represent that in a non punitive way to the public.

Other

- Say how evidence will be shown to the public. How is the public going to know if physician is competent?
- Recertification really needs to be some sort of a test. Not looking for MDs to fail. I look at it as a people person for consumer perspective. How to help MDs do better and have more of a personal relationships with them, consumer advocate asking questions but trying to get underneath for reasons for their problems.

3. What are the key issues that our Advisory Group should be addressing?

What is Evidence/Impact?

- Special Committee provided a framework, now we need evidence and the white paper group report
- Needing evidence; white paper group report
- Impact of MOL
- Need to due diligence to make sure it is not redundant.
- We need seminal articles that address the real evidence that supports a need to change/ maintenance of certification or CME reporting. What is evidence that suggests a problem, or better way? Very useful to go forward that there is credible academic research on these sorts of things.

Buy in of Profession and SMBS

- Role of SMBs and how to achieve professional buy in
- Addressing the benefits and show benefits –
- Left last call confused about what this group was supposed to do. Are we supposed to genuflect? Can we craft something that HOD will accept
- Make sure that we have options, but limit the number of options to 3 or 4
- How do we get a feel for the public's views on this?

Ensure Practicality/Feasibility

- Ensure that the process is practical, not just a mandate certain things, actually helps people
- Should not be burdensome
- Have an answer to “How costly?”
- We need to streamline the system

Action Plan

- We are not much use unless we have action plan
- Timeline for implementation

Build on What Has Been Done

- Rally around principles and timeliness of the issue = a great outcome.
- Endorse or build on recs from previous groups; strengthen those recommendations.
- Pilots – engaged in those conversations – devils in details; seems to point towards and substantive of physician competence as well as a pathway that would be tolerable by most SMBS and physicians.

Focus on Solutions

- Could FSMB work with partners to find a 360 degree product or assessment model; reasonably priced, accessible, reliable, and valid?
- And focus on challenges to solutions

Tie in with Major Payors

- Factor in Significant – quite possible that payers are going to really mandate some type of MOL/QI/Competency whether we do anything or not. Tie in with major payors. – if not we will be laggards and stumbling blocking in terms of patient safety – if not moving forward we will lose credibility.

Other

- Would MOC serve as an equivalent so we have no more jumping through hoops But once you get into that; some really tough issues with non certified physicians
- Link ABMS organizations and MOL will be very important.

4. What preliminary advice do you have for FSMB on its Maintenance of Licensure Initiative?

- As we go forward, there may not consensus on every point; foster discussion; recognize that we have a majority/minority opinion and reflect those both. Not final arbiter of MOL and what it looks like. Better outcome that striving for false consensus and having a process where individuals were unheard or solution rammed down their throats.
- Get back to reality issues; financial issues all states facing in next 2 – 3 years. Going back to phase in.
- Look at our opportunities and prepare for those to answer challenges to federation.
- We need to be all inclusive - appears as though it is all inclusive; go back to individual state. Have we gotten feedback from those that are not on same page? How do we get their input, and improve the process in their state. Make sure we include younger physicians and early training.

5. Any other ideas and suggestions you would like to place on the Advisory Group “table?”

Advisory Group Process

- Not sure that this group and timeframe is really going to have the perspective, energy and time to weigh in on the specifics. Still need to do pilot work.
- Make sure that the Advisory Group can raise disconfirming opinions
- Use organizational experience and professional judgment; what is future of medical regulation and can process meet that?
- Don’t let FSMB Board/Staff opinion to influence you. Let group do own thing with time and resources that you need.
- Wants to know status of White paper and impact analyses? These are urgent for our deliberations.

- Perhaps it would be helpful at some point to identify "deal breakers" and what we need to do to satisfy particular individuals or not.

Need for Specificity

- We need to be more specific Committee agreed MOL should support to continuous professional development; what does that mean?
- Changes in "Essentials of the modern medical practice act" What are they specifically?
- Real work – we have to have recommendation of how to implement.
- **Sell it to state boards;** Go ahead and get to some detail; some action plans; ways to accomplishing it so cost doesn't need to be prohibitive
- Need more specific outcomes Has somebody tried it and how has it gone?

Balancing Act

- Can we be menu driven and evolve; how do we start so everyone is comfortable and on board with it?
- How to be measured and effective at the same time?
- How do we differentiate between competence and performance accountability?
- Peer review doesn't always work; numerous times physicians are not disciplined through Board. Peer review at hospital is also challenging; External group review is okay, just want to make sure it helps.

Role of FSMB

- How is the federation going to facilitate this process for SMBS that are less sophisticated in other boards in how they do it and what are resources. Not every state is electronic and this impedes federation's work.

Other issues

- Still not sure if we are dealing with generalist maintenance or more specialty basis – more worried about non certified group.
- Boards have had to struggle with practice improvement component with non typical physicians.
- There are places that do retraining and maybe they would will to share it so SMBS are not reinventing the wheel.
- It may well be that MOL is not just one format; MOC other ways that can count. Do not have to have a high stakes proctored exam as only pathway. QI in practice; onus on licensee to help design their MOL program. Shouldn't just be one pathway.
- Financial impact – diversification in what it cost to get and maintain. If a process is being mandated that requires a state to develop significant resources. Where is money going to come from?

6. Ideal Outcome

- Love to see a unified process that would be non-threatening and not burdensome and cost effective.
- Looking forward to participating in this with all the experienced leaders – looking forward to learning as well as participating
- Very specific recommendation to push the envelope.
- Whatever it is the vision needs to be simple – if not, it will be so band aid as to be meaningless.
- Need to be challenged; should it be linked to board certification with 80/20 rule.
Are we dealing with 100% or 20% then go on record as having said that.
- Offer an option that the State Board’s can look at and see that it is workable and that it increases patient safety
- Help doctors – soon third party payors will be saying “show us what you have done.”

MEMORANDUM

Tuesday, 06 October, 2009

To: Carol Clothier

From: Tim Miller

Subject: Use of the term “assure” in a Maintenance of Licensure program

Using the term “assure” within maintenance of licensure program will not increase the boards’ exposure to liability. Note that the boards in almost every jurisdiction have exposure to negligent licensing suits, this exposure does not change by using the term “assure.”²

By statute and case law the boards are assuring the public that physicians meet minimum legal requirements. Some states specifically assert that they created the boards to assure the public safety; for example California, Florida, Louisiana, Minnesota, Nebraska and North Carolina.³ The states that do not specifically assert that the board is assuring public safety imply it. For instance, an Idaho court pointed out that “[t]he practice of medicine is a privilege granted by the state of Idaho, which retains the authority to license and regulate physicians practicing in this state in order to assure the public health of the citizenry.”⁴ Further, “[o]ne of the purposes of the Medical Practice Act is to assure the public health, safety and welfare. . .”⁵

Additionally, the act of licensing it self is an assurance. “States may require a variety of licenses to protect health, safety and welfare. For example, medical licenses are required to protect the public to ensure that doctors have achieved the requisite training prior to practicing medicine.”⁶ Finally, several boards have the term “assurance” in their titles and there is no indication that this has increased their liability (e.g. the Florida Board of Medicine Medical Quality Assurance, the California Board of Medical Quality Assurance, the Maryland Board of Physician Quality Assurance and North Carolina Division of Medical Quality Assurance).

² In researching this issue I have used the terms “assure” and “ensure” interchangeably.

³ CA Stats.1876, ch. 518, § 10, p. 794; F.S.A. § 458.301; LSA-R.S. 37:1261; M.S.A. § 214.001, N.R.S. 630.003; N.C.G.S.A. § 90-2; see, *Borden v. Division of Medical Quality*, 30 Cal.App.4th 874, 35 Cal.Rptr.2d 905, Cal.App. (4 Dist., December 02, 1994); *Uckun v. Minnesota State Bd. of Medical Practice*, 733 N.W.2d 778, Minn.App., June 26, 2007; *Riggs v. Woman To Woman, Obstetrics and Gynecology, P.C.*, 351 Ill.App.3d 268, 812 N.E.2d 1027, 286 Ill.Dec. 12, (Ill.App. 2 Dist., July 08, 2004); *Brockett ex rel. Brockett v. Davis*, 325 Ill.App.3d 727, 762 N.E.2d 513, 260 Ill.Dec. 854, Ill.App. (3 Dist., September 13, 2001); *Kayfetz v. State of California*, 156 Cal.App.3d 491, 203 Cal.Rptr. 33, Cal.App. (1 Dist., May 29, 1984); *People v. Tilton*, 273 Ill.App. 52, 1933 WL 2708, Ill.App. (1 Dist., December 11, 1933); *In re Kim*, 403 N.J.Super. 378, 958 A.2d 485, (N.J.Super.A.D., October 28, 2008); *Nguyen v. State, Department of Health Medical Quality Assurance Commission*, 144 Wash.2d 516, 29 P.3d 689, (Wash., August 23, 2001); *Matter of Polk*, 90 N.J. 550, 449 A.2d 7, (N.J., July 30, 1982).

⁴ *Miller v. Haller*, 129 Idaho 345, 924 P.2d 607 (Idaho, Sep 03, 1996).

⁵ *Haw v. Idaho State Bd. of Medicine*, 140 Idaho 152, 90 P.3d 902 (Idaho, Apr 22, 2004).

⁶ *Amunrud v. Board of Appeals*, 158 Wash.2d 208, 143 P.3d 571, (Wash., 2006).

The explicitly and implicitly assurances stated in the medical practice acts, the assurances pointed out in case law and some boards using the term “assurance” in their titles have not created additional liability for the boards. Adding the term “assurance” to maintenance of licensure programs will not increase the boards’ liability exposure. Assuring continued competence is no different from assuring initial competence. Most statutes and cases however, speak of assuring the public safety rather assuring physician competence. One way to express this consistently would be to say “a maintenance of licensure program ensures continuing competency to assure public safety.” However, if the sentence is reversed we get “the medical board ensures the public safety by assuring the competence of a physician.” Therefore, it’s only a matter of semantics and it should not make a difference whether the board uses ensure or assure.

While the term “assurance” may not create additional liability exposure, operating a maintenance of licensure program can create additional liability exposure. Most likely, this increased liability exposure for the boards will stem from negligent licensing. Undertaking the task of assuring a physician’s competency during the license renewal phase increases the possibility the board will conduct a negligent licensing investigation or negligently make a licensing decision.

The medical practice act specifically creates a duty upon the board to protect the public. The courts have also found a duty exists when an agency undertakes licensing responsibilities. “If an entity chooses to license and regulate an area, a duty to exercise reasonable care in doing so follows.”⁷ Further, “[o]ften, the duty to license is deemed to invoke corresponding duties of investigating and monitoring.”⁸ That assuring continued competency within a maintenance of licensure program will create a duty upon the board is unavoidable. The boards, however, have very low exposure to negligent licensing claims because they have immunities.

The broadest immunity is sovereign immunity. Almost every state has abrogated or significantly limited this immunity, so it has limited application. In those few states, however, the boards enjoy near absolute immunity for all their acts except intentional wrongdoings. As the states abrogated sovereign immunity, the courts began using the public duty doctrine to limit lawsuits against the government.

The most widely available broad immunity is the public duty doctrine. The public duty doctrine states that a duty owed to everyone is a duty owed to no one. “The rationale behind the public duty doctrine ‘is to encourage the effective administration of governmental operations by removing the threat of potential litigation.’”⁹ Essentially, the boards are immune from lawsuits by individuals because the boards’ duties are to the public and not the individuals. Almost every board enjoys this immunity, but some states have abrogated this immunity.

The assurance of continued competence will not change the boards’ duties from to the public to the individual, thus, the boards will have immunity pursuant to the public duties doctrine. There are, however, two exceptions to the public duty doctrine - the special relationship exception and the egregious conduct exception.

⁷ Amy D. Whitten, *CAUGHT IN THE CROSSFIRE: EMPLOYERS' LIABILITY FOR WORKPLACE VIOLENCE*, 2000 Article 70 Miss. L.J 505, 534; citing, *R.E. v. Alaska*, 878 P.2d 1341, 1347 (Alaska 1994).

⁸ *Id.*; citing, *Washoe County v. Transcon. Ins. Co.*, 878 P.2d 306, 308 n.3 (Nev. 1994).

⁹ *David Torres v. Kathleen Damicis*, in her capacity as Treasurer of the Town of Richmond, 853 A.2d 1233, (R.I., Jun 24, 2004).

The special relations exception to the public duty doctrine applies when there is a special relationship between the governmental entity and a recognizable plaintiff.¹⁰ This special relation gives rise to a special duty that is “more particular than the duty owed to the public at large.”¹¹ Most often, the exception fails because the governmental entity owes the duty to the public at large and not specifically to the plaintiff.

Several courts, however, have broadly interpreted the term “recognizable plaintiffs.” One court held that “[a]lthough the statute uses general terms, “all persons” and “others,” . . . that the statute imposed a duty on drivers of law enforcement vehicles and created “a special class of persons—those, who by use of the streets and highways are potential victims of a high speed chase—to whom the duty is owed. Thus, a special relationship was established and the public duty doctrine did not apply.”¹²

The problem broad interpretations cause for the boards is a court could conclude that a particular physician’s patient population would be sufficiently small enough as to open up liability for the board. Certainly, a physician’s patient population is smaller than the pedestrians and drivers on the road during a high-speed chase. One court, however, concluded that a patient could not sue the medical board for negligent licensing because the special relation exception did not apply. The court stated, “we consistently have held that allegations of negligent licensing do not establish that the state or a political subdivision thereof owes a special duty to a plaintiff or foreseeable group of plaintiffs.”¹³

On the other hand, other courts have held a special duty does exist from licensing and investigating activities.¹⁴ One court has held that “[i]ncompetent or haphazard licensing investigations contribute to problems, and are morally blameworthy.”¹⁵ In this case, the State negligently investigated and issued a license to a day care facility. In finding liability, the court noted, “[p]resumably, the effect of state licensing was to instill a greater feeling of security in parents who utilized the licensed day care facilities. Having undertaken the responsibility of licensing, the State was under a duty to exercise reasonable care in carrying out that function.”¹⁶

These cases demonstrate that some courts in certain circumstance are willing to find a special relation exists between the licensing authority and an individual plaintiff based solely upon the act of licensing. Worrisome, is a court could find that assuring competency could instill a greater feeling of security among the patients, thus, opening up the special relation exception.

¹⁰ Nelson v. State, 346 Mont. 206, 195 P.3d 293, 2008 MT 336 (Mont., Oct 06, 2008).

¹¹ Nelson v. State, 346 Mont. 206, 195 P.3d 293, 2008 MT 336 (Mont., Oct 06, 2008).

¹² Id.

¹³ David Torres v. Kathleen Damcic, in her capacity as Treasurer of the Town of Richmond. 853 A.2d 1233, (R.I., Jun 24, 2004).

¹⁴ Andrade v. Ellefson, 391 N.W.2d 836, 843 (Minn.1986) (holding that “small children in a licensed day care facility are a particular protected class”); Brasel v. Children's Servs. Div., 56 Or.App. 559, 642 P.2d 696, 699 (1982) (holding that state owed duty to plaintiff users of a state-certified day care facility as members of a protected class); Gagnon v. State, 570 A.2d 656, 659 (R.I.1990) (holding that the state may have a special duty to supervise licensed day care facilities, but noting that “a claim of negligent licensing does not allege anything more than a statutory obligation owed by the state to the public-at-large”); C.T. v. Martinez, 845 P.2d 246, 248-49 (Utah 1992) (“Because the licensing provisions were intended to protect patrons of licensed day-care facilities, a special relationship exists between [the state agency] and those patrons.”).

¹⁵ R.E. v. State, 878 P.2d 1341 (Alaska, Jul 29, 1994) (NO. S-5153)

¹⁶ Id.

The special relation exception is the most likely avenue for board liability exposure. While unlikely, a patient may be able to prove that he or she fell within a small group of foreseeable people who could be harmed by a physician relicensed by the board.

A second exception to the public duty doctrine is the egregious conduct exception. This exception provides that when “the state has knowledge that it has created a circumstance that forces an individual into a position of peril and subsequently chooses not to remedy the situation,” the state can then be held liable for its negligence.¹⁷ This exception is not widely used, but it could create liability for a board that discovers a physician is incompetent during a maintenance of licensure screening designed to assure competency but does not act upon that knowledge.

Unrelated to the public duty doctrine and its exceptions, is the official immunity doctrine. This doctrine is limited to discretionary decision making. “The official immunity doctrine protects government employees from civil liability for conduct that would otherwise be actionable.”¹⁸ This immunity has two basic components - discretionary acts and ministerial acts. Discretionary acts enjoy the immunity while ministerial acts do not.

This immunity protects board staff and members from individual liability for the performance of his or her duties when the duties are discretionary rather than ministerial duties¹⁹ “It does not, however, provide immunity when the State fails to exercise due care in carrying out its own policy, rules and regulations.”²⁰

A board’s determination as to whether a physician is currently competent would be discretionary act and immune from liability, but assuring competence through a maintenance of license program, including screening, reviewing, investigating and abiding by all policies and rules would be ministerial and not immune.

As stated above, the boards’ use of the term “assurance” does not increase the boards’ liability. Operating a maintenance of licensure program does increase the possibility of liability exposure only because it increases the opportunities for the boards to make mistakes. However, with sovereign immunity, the public duty doctrine and/or the official immunity doctrine protecting the boards, they have very little liability exposure for assuring competency through a maintenance of license program operated for the protection of the public.

¹⁷ Bowland v. Town of Tiverton, 670 A.2d 1245, (R.I., February 09, 1996)

¹⁸ Ramos v. Texas Dept. of Public Safety, 35 S.W.3d 723 (Tex.App.-Houston [1 Dist.], 2000)



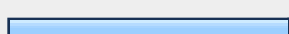


¹⁹ Id.

²⁰ R.E. v. State, 878 P.2d 1341 (Alaska, Jul 29, 1994).





Maintenance of Licensure Survey

1. Name of board		
		Response Count
		51
	<i>answered question</i>	51
	<i>skipped question</i>	4

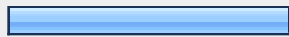
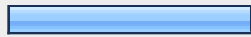
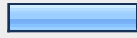
2. Completed by (include title)		
		Response Count
		51
	<i>answered question</i>	51
	<i>skipped question</i>	4

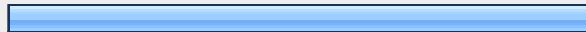

3. How frequently has your board discussed whether physicians should be required to periodically provide evidence of continued competence as a condition of license renewal/reregistration?			
		Response Percent	Response Count
Never		2.0%	1
Once in the past 12 months		21.6%	11
2 to 4 times in the past 12 months		43.1%	22
Formed a committee to study the issue		5.9%	3
Other (please specify)		27.5%	14
		<i>answered question</i>	51
		<i>skipped question</i>	4

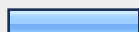
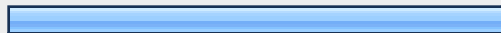

4. Based on the discussions that have occurred at board meetings about this issue, what is your board's general attitude about requiring physicians to provide evidence of continued competence as a condition of license renewal/reregistration?

		Response Percent	Response Count
Uninformed about issue		4.1%	2
Undecided about issue		44.9%	22
Supportive		42.9%	21
Not supportive		8.2%	4
Indifferent		0.0%	0
		<i>answered question</i>	49
		<i>skipped question</i>	6

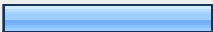



5. If your board decided to require licensees to provide evidence of continued competence as a condition of license renewal/reregistration, does your statute give you the authority to implement such requirements?

		Response Percent	Response Count
Yes		43.1%	22
No		37.3%	19
Not sure		19.6%	10
		<i>answered question</i>	51
		<i>skipped question</i>	4

6. Does your board require CME as a condition of license renewal/reregistration? If yes, please go to question #7. If no, please go to question #9.			
		Response Percent	Response Count
Yes		89.1%	49
No		10.9%	6
		answered question	55
		skipped question	0

7. Which of the following best describes how your CME requirements are set up?			
		Response Percent	Response Count
All in statutes (Statutes authorize the board to require CME and specify what the requirements are - e.g., content, number of hours)		20.0%	10
Combination of statutes and rules and regulations (Statutes contain broad language authorizing the board to require CME, but the specifics are defined in the board's rules and regulations)		76.0%	38
Other (please specify below)		4.0%	2
		Please add any additional comments here	6
		answered question	50
		skipped question	5

8. Could your board interpret the CME language in your statute or rules to allow the board to require physicians to provide evidence of continued competence as a condition of license renewal?

		Response Percent	Response Count
Very likely		32.0%	16
Somewhat likely		12.0%	6
Not at all likely		40.0%	20
Unsure		16.0%	8
		<i>answered question</i>	50
		<i>skipped question</i>	5

9. Please feel free to add any comments here.

		Response Count
		17
		<i>answered question</i>
		17
		<i>skipped question</i>
		38

SECTION V: A FRAMEWORK FOR MAINTENANCE OF LICENSURE

From Special Committee on Maintenance of Licensure
Draft Report on Maintenance of Licensure February 2008

Establishing Requirements for Demonstrating Competence

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

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.

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

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

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

3. Demonstration of accountability for performance in practice.

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

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

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

Physicians not in Active Clinical Practice

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

Disclosure

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

Reporting Requirements

In order to assure that physicians are demonstrating competence within their scope of practice, state medical boards should require licensees to report information about their practice as part of the license renewal process. 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.

Research

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

Assessment Resources

Assessment tools used to document compliance with maintenance of licensure requirements should be valid, reliable, feasible, have credibility with the profession and should provide adequate feedback to facilitate practice improvement. FSMB and state medical boards should encourage development of programs and services for use by the cohort of physicians who are not board certified or otherwise not participating in the maintenance of certification/continuous certification processes in order that they have access to resources necessary to comply with maintenance of licensure requirements.