

1 **REPORT OF THE BOARD OF DIRECTORS**

2
3 **Subject : Report on: Efforts to Address the Continued Competence of**
4 **Licensed Physicians**
5
6 **Referred to : Reference Committee**
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9 Since the late 1970s, the Federation of State Medical Boards (FSMB) has considered
10 whether physicians should be required to demonstrate ongoing competence as a condition
11 of relicensure. As part of its efforts, the FSMB has engaged in dialogue and collaboration
12 with a number of organizations and has convened ad hoc committees to evaluate
13 physician re-licensure and the role of continuing medical education and other measures in
14 assuring the ongoing competence of physicians.

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16 In 2002, the FSMB’s Board of Directors implemented a goal regarding the continued
17 competence of licensed physicians as part of its strategic action plan. As part of that
18 goal, the FSMB has closely monitored efforts by the American Board of Medical
19 Specialties (ABMS) and the Accreditation Council for Continuing Medical Education
20 (ACCME) to implement programs to ensure the continued competence of their
21 constituents. Specifically, the FSMB is in dialogue with the ABMS regarding its
22 Maintenance of Certification initiative and its relationship to competence and licensure.
23 The majority of U.S. licensed physicians are ABMS-board certified and ultimately will
24 be held accountable for meeting the new requirements being implemented by ABMS
25 member boards. As maintenance of licensure becomes part of medical boards’ mandate
26 to protect the public, maintenance of certification could become one of the tools or
27 resources used to evaluate if a physician has maintained his or her competence to practice
28 safely. The FSMB is also involved in discussions with the American Osteopathic
29 Association (AOA) and the American Medical Association (AMA) as part of its efforts to
30 establish collaborative relationships with other organizations regarding the ongoing
31 competence of licensed physicians.

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33 Recognizing the role that continuing medical education plays in maintaining physicians’
34 competence, the FSMB participates as a member of the Council of Medical Specialty
35 Societies’ (CMSS) Conjoint Committee on Continuing Medical Education, which is
36 evaluating the structure and utility of the current Continuing Medical Education system
37 and reviewing ways to increase its meaningfulness. The FSMB is also working with both
38 the Accreditation Council on Continuing Medical Education and the American Academy
39 of Family Practice to ensure that the accreditation of continuing medical education
40 remains relevant to licensure, focusing particularly on how best to measure the impact of
41 learning activities on physician practice and patient outcomes. Additionally, the FSMB is
42 involved with the Joint Commission on Accreditation of Healthcare Organizations’
43 (JCAHO) Credentialing and Privileging Task Force, which is reviewing ways for
44 hospitals to implement proactive methods of assessing physicians and developing
45 methods to improve the validity of hospitals’ credentialing and privileging processes.
46 Like ABMS’ Maintenance of Certification initiative, changes in continuing medical

47 education and hospital credentialing and privileging could result in such mechanisms
48 playing a role in efforts by state medical boards to ensure the ongoing competence of
49 licensed physicians.

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51 In May 2003, the FSMB convened the Special Committee on Maintenance of Licensure
52 to study the role that medical boards should play in ensuring the ongoing competence of
53 physicians and to develop recommendations for use by state medical boards in
54 implementing maintenance of licensure initiatives. In May 2004, responding in part to
55 calls from the public that the healthcare community in general and physicians in
56 particular improve both the quality of medical care provided and the system used to
57 deliver care, the FSMB's House of Delegates adopted the official policy statement that
58 state medical boards are responsible to the public for ensuring the ongoing competence of
59 physicians as a condition of relicensure. The Special Committee submitted an interim
60 report to the Board of Directors in February 2005 which outlines the conceptual
61 challenges associated with implementing maintenance of licensure requirements and
62 discusses issues considered by the committee to date; that report is provided to the House
63 for information (**attachment 1**).

64

65 As the FSMB's work with both the special committee and various external organizations
66 progresses, it is becoming increasingly clear that the issue of ensuring physicians'
67 continued competence is a key strategic initiative for many of the public and private
68 institutions that comprise medicine's system of professional self-regulation. Taking
69 advantage of our unique position as the national body representing state medical boards,
70 the FSMB convened a summit in March 2005 to begin a dialogue about how to
71 coordinate efforts across these various fronts so that what emerges is a system of self-
72 regulation that is non-duplicative and valid to both the practitioner and the public. Invited
73 participants included representatives from academic medicine, the accreditation system,
74 the profession, the public, the provider and payer communities, the hospital community,
75 and state medical boards. The dialogue focused on the future of medical self-regulation
76 and what role each stakeholder group could play to ensure the ongoing competence of
77 licensed physicians. The summit was funded in part by the Robert Wood Johnson
78 Foundation. Proceedings from the summit will be disseminated throughout the medical
79 community via a white paper. The proceedings also will be used by the Special
80 Committee on Maintenance of Licensure to inform the committee's discussions regarding
81 strategies that could be implemented by state medical boards to ensure the ongoing
82 competence of licensees.

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84 **RECOMMENDATION:**

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86 For information only.

87

88 ATTACHMENT 1

89
90 FEDERATION OF STATE MEDICAL BOARDS
91 OF THE UNITED STATES, INC.

92
93 SPECIAL COMMITTEE ON MAINTENANCE OF LICENSURE

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95 INTERIM REPORT TO THE BOARD OF DIRECTORS
96 FEBRUARY 2005
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99 **Section I: Introduction**

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101 The Special Committee on Maintenance of Licensure was established in May
102 2003 by Thomas Kirksey, MD, Chair of the Federation of State Medical Boards
103 (FSMB), and charged with the following:
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- 105 • Evaluate the responsibility of state medical boards to ensure physician
106 competence through the course of one's professional career and the
107 efficacy of methods historically used to carry out those responsibilities;
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- 109 • Research, review and evaluate systems currently used or under
110 development by national organizations to facilitate physician competence
111 and determine to what extent these systems could assist states efforts to
112 ensure physician competence;
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- 114 • Identify pertinent stakeholders and their positions regarding the role of
115 state medical boards in ensuring physician competence for purposes of
116 relicensure and where appropriate, their willingness to collaborate with
117 medical regulators to achieve improvement in physician practice;
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- 119 • Research, review, and evaluate tools and resources available to state
120 medical boards and others for use in measuring competence and
121 remediating deficiencies;
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- 123 • Develop a position statement regarding the responsibilities of state
124 medical boards in ensuring physician competence over the course of
125 his/her career;
126
- 127 • Develop strategies for state medical boards to use in implementing
128 programs to ensure physicians maintain an appropriate level of
129 competence to practice medicine safely throughout their professional
130 careers.
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132 The committee has met three times, during which it has reviewed the factors
133 precipitating the FSMB's interest in the continuing competence of physicians;

134 information about recent initiatives undertaken by state medical boards and other
135 health professions regulatory bodies to implement continuing competence
136 requirements for their licensees; initiatives being pursued by international
137 medical regulatory bodies to implement license revalidation requirements; FSMB
138 policies that contain language regarding physician competence; and initiatives
139 being implemented by medical professional organizations to increase the
140 profession's accountability to the public.

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142 The committee has also received presentations from the following organizations:

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

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151 Early in its deliberations, the committee concluded that the profession must
152 implement some form of mandated assessment of competence beyond that
153 required for entry to practice if it is to demonstrate to the public that it is
154 committed to maintaining high standards for practice. The committee further
155 concluded that state medical boards are the sole entities with the authority to
156 require all licensed physicians to periodically demonstrate their ongoing
157 competence.

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

165

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

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

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

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

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

Section II: Committee Deliberations to Date

A. Medical Board Responsibility to Ensure Physician Competence

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

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

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

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

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

234

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

245

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

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

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

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

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

277

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

287

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

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

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

303

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

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

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

313

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

322

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

330

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

339

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

345

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

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

355
356 In response to these concerns, the JCAHO established a Credentialing and
357 Privileging Task Force, which is reviewing ways to implement proactive methods
358 of assessing physicians in the hospital setting and to improve the validity of the
359 credentialing and privileging processes. The Task Force is also expanding the
360 criteria upon which privileges are granted so that hospitals will have to assess
361 physicians in areas such as interaction within the team environment, rather than
362 granting privileges solely on technical skill and ability.

363
364 The Task Force is currently developing new standards for hospital credentialing
365 and privileging that are scheduled for implementation in early 2006. As part of
366 the new standards, hospitals will be expected to engage in the continuous
367 collection of performance data for physicians, provide simulated training
368 experiences, provide proctoring as appropriate for physicians and high-risk
369 procedures and implement 360-degree reviews for physicians.

370
371 State medical boards rely on hospital credentialing and privileging to ensure that
372 physicians have the proper training and education to perform procedures safely
373 and effectively. While the committee agreed that the current system for hospital
374 credentialing is not adequate, it believes that once the new processes are
375 implemented, hospital credentialing could serve as a tool for physicians to
376 demonstrate their ongoing competence as a condition of relicensure.

377
378 The committee will continue to track efforts by non-governmental oversight
379 agencies to ensure ongoing physician competence. While the committee felt that
380 the standards being implemented by the ABMS and the JCAHO could be utilized
381 by state medical boards as part of the maintenance of licensure process, it will
382 continue to discuss, evaluate and recommend alternatives for physicians who are
383 not eligible for ABMS Maintenance of Certification or who do not practice in
384 JCAHO-accredited health care settings. The committee also plans to review
385 information from the American Osteopathic Association (AOA) regarding its
386 efforts to ensure the ongoing competence of osteopathic physicians.

387
388 *D. Assessing the Competence of Practicing Physicians*

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

396
397 *Purpose.* The first and perhaps most fundamental conceptual challenge to
398 developing an assessment process for practicing physicians is defining its

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

404
405 If the assessment is intended to identify opportunities for improvement in
406 practice, then it must be relevant to what the physician does in his or her
407 practice. Because the majority of physicians embrace lifelong learning as an
408 integral part of professionalism, an assessment process that seeks to improve
409 physician practice would be perceived more positively by physicians and would
410 likely have the greatest impact on quality of patient care. Since the outcome of
411 such a process would be improved practice, such an assessment requirement
412 could reasonably be applied to all licensees.

413
414 A number of organizations in the US and internationally are using physician
415 assessment and remediation programs as the basis of their recertification or
416 relicensure requirements. These programs fall into three broad categories:
417 periodic comprehensive assessment of all physicians, performance-focused
418 tiered approach (such as Canada's Monitoring and Enhancement of Physician
419 Performance model), and cyclical delivery of assessments over time (such as the
420 American Board of Internal Medicine's Continuing Professional Development
421 program). In general, the defined purpose of each is the continuous professional
422 development of practicing physicians. While this model is the most politically
423 acceptable, has potential for significant quality improvement and focuses on the
424 majority of physicians who are competent, it leaves unanswered how to identify
425 and respond to the remaining small percentage of physicians who are not
426 competent.

427
428 *Competence vs. Performance.* A second conceptual challenge to consider is the
429 blurred distinction between competence and performance. While there is no
430 single agreed upon definition for these terms, there is some consensus that
431 competence points to the *ability* to do (or *can do*), whereas performance refers to
432 *does do*.⁵

433
434 Standardized tests are associated with competence assessments, whereas
435 workplace assessments are associated with performance assessments. While
436 there are valid, reliable standardized tests such as multiple-choice examinations
437 that may be used to measure competence, there are few such tools available for
438 use in measuring performance. Ideally, a physician should be expected to
439 demonstrate accountability for both general competencies, including the
440 knowledge, skills and abilities to provide safe, effective patient care within the
441 scope of their professional medical practice, as well as performance in practice.

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

442

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

447

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

455

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

463

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

471

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

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

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

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

489
490 Finally, the committee also agreed that remediation must be included in any
491 program developed to ensure physicians' ongoing competence. Currently,
492 physicians who seek educational interventions to address deficiencies have few
493 resources available. In order for maintenance of licensure initiatives to succeed,
494 additional remedial education programs will need to be developed and existing
495 programs will need to be improved and expanded to assist physicians who are
496 identified through these processes. Data regarding the effectiveness of the
497 educational programs will need to be gathered and disseminated. Such issues
498 will continue to be a part of the committee's discussions as it continues its work
499 over the coming year.

500

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

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

514

515 It is the committee's opinion that the process used by physicians to maintain
516 licensure should be transparent, but information regarding physicians'
517 participation in maintenance of licensure programs should remain confidential.
518 This is based on the premise that physicians should not be penalized for
519 engaging in a process that allows them to identify and correct their deficiencies,
520 ultimately resulting in improved practice performance and patient care.

521 Physicians who do not comply with maintenance of licensure requirements or
522 who are identified through the program as incompetent should be subject to
523 normal adjudication processes and to public disclosure as required by state law.

524

525 **III. Conclusion**

526

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

537
538 Recognizing that state medical boards will need to rely on external organizations
539 to develop and provide tools for use by physicians to demonstrate competence, it
540 will be important for boards to have methods in place by which they can evaluate
541 the validity and acceptability of such tools. Over the next year, the committee will
542 seek to develop guidelines for use by state medical boards in evaluating whether
543 the activities in which a physician engages are sufficient to meet requirements for
544 ongoing competence.

545
546 State medical boards are one component of a complex healthcare system. As
547 policy makers and regulators, they play a critical role in influencing standards for
548 physicians and the environment within which physicians practice. Medical
549 boards have historically devoted the majority of their resources to identifying and
550 removing from practice physicians who are unable to practice safely and
551 competently. In order for maintenance of licensure initiatives to succeed, that
552 orientation must include facilitating practice improvement for all physicians.
553