Health Law: Quality & Liability

Professor Thaddeus M. Pope

Reading Packet for Week 13 (Fall 2018)

Weekly Summary

This week, we move away from our focus on liability. The threat of liability is only one tool that helps assure the quality of healthcare. We will cover a new and different category of legal tools that help assure quality healthcare. These tools control the existence and scope of a physician's ability to practice medicine and access patients.

Credentialing of Clinicians

We already looked at the credentialing done by hospitals and managed care organizations. When this is done poorly, it opens the hospital or MCO to a claim of direct (aka corporate) liability (if it causes the patient's injuries). But when done appropriately, credentialing helps ensure that patients are treated by qualified clinicians. We might refer to credentialing as "private" regulation, since it is done by private non-profit and for-profit entities instead of by federal or state government agencies.

Licensing and Certification of Clinicians

All healthcare clinicians (physicians, nurses, others) must have a license to practice. Licenses are granted by boards established by statute in each U.S. jurisdiction. Practicing without a license or practicing outside the scope of one's license is a crime. But healthcare licensing board do more than serve a gatekeeping function. They also serve a discipline function.

The term "certification" is used in two different senses. First, most physicians obtain certification to participate in federal payment programs like Medicare. This is legally voluntary, though practically necessary, because Medicare and Medicaid pay for a large percentage of all U.S. healthcare. Second, most physicians obtain board certification. This is a legally voluntary, though often practically necessary to obtain privileges or employment. Obtaining a medical license sets the minimum competency requirements to diagnose and treat patients, it is not specialty specific. Board Certification demonstrates a physician's exceptional expertise in a particular specialty and/or subspecialty of medical practice.

Licensing, Accreditation, and Certification of Hospitals

State governments license not only individual clinicians but also healthcare facilities. You may not operate a hospital or nursing home (or other facility) without a license. We will distinguish among licensing, accreditation, and certification of hospitals. Many healthcare facilities obtain voluntary accreditation from The Joint Commission. This is legally voluntary, but practically important. Most facilities also obtain certification to participate in federal payment programs like Medicare. Of course, what is given can also be taken away. As we saw early in the course, EMTALA compliance is a Condition of Participation in Medicare. EMTALA violations (among other things) are grounds for termination and exclusion.

Reading

All the following materials are collected into a single PDF document:

- Minn. Stat. § 147.081 (practice of medicine definition)
- Thompson & Robin, J. Leg. Med. 2012 (licensing - medical board functions)
- Federation of State Medical Boards, *2016 Trends* (licensing - medical board functions)
- DHHS OIG, *Exclusions* (certification)
- Joint Commission, *Understanding TJC* (accreditation)
- American Board of Medical Specialties, *Fact Sheet* (board certification)

Objectives

By the end of this week, you will be able to:

- Analyze and apply principles regarding the state licensure of individual providers,
- distinguishing the gatekeeping role and the discipline role of medical boards. (7.1)
- Distinguish licensing, Medicare certification, credentialing, and specialty board certification of individual clinicians. (7.2)
- Analyze and apply principles regarding the state licensure of healthcare facilities. (7.3)
- Distinguishing licensing, Medicare certification, and TJC accreditation of healthcare facilities. (7.4)

147.081 PRACTICING WITHOUT LICENSE; PENALTY.

Subdivision 1. **Unlawful practice of medicine.** It is unlawful for any person to practice medicine as defined in subdivision 3 in this state unless:

(1) the person holds a valid license issued according to this chapter; or

(2) the person is registered to provide interstate telemedicine services according to section 147.032.

Subd. 2. **Penalty.** Any person violating the provisions of subdivision 1 is guilty of a gross misdemeanor.

Subd. 3. **Practice of medicine defined.** For purposes of this chapter, a person not exempted under section 147.09 is "practicing medicine" or engaged in the "practice of medicine" if the person does any of the following:

(1) advertises, holds out to the public, or represents in any manner that the person is authorized to practice medicine in this state;

(2) offers or undertakes to prescribe, give, or administer any drug or medicine for the use of another;

(3) offers or undertakes to prevent or to diagnose, correct, or treat in any manner or by any means, methods, devices, or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity or defect of any person;

(4) offers or undertakes to perform any surgical operation including any invasive or noninvasive procedures involving the use of a laser or laser assisted device, upon any person;

(5) offers to undertake to use hypnosis for the treatment or relief of any wound, fracture, or bodily injury, infirmity, or disease; or

(6) uses in the conduct of any occupation or profession pertaining to the diagnosis of human disease or conditions, the designation "doctor of medicine," "medical doctor," "doctor of osteopathy," "osteopath," "osteopathic physician," "physician," "surgeon," "M.D.," "D.O.," or any combination of these designations.

History: *(5717) RL s 2300; 1927 c 188 s 4; 1963 c 45 s 6; 1971 c 485 s 5; 1974 c 43 s 1; 1985 c 247 s 13,25; 1986 c 444; 1993 c 121 s 1; 2002 c 361 s 2*

147.09 EXEMPTIONS.

Section 147.081 does not apply to, control, prevent or restrict the practice, service, or activities of:

(1) A person who is a commissioned medical officer of, a member of, or employed by, the armed forces of the United States, the United States Public Health Service, the Veterans Administration, any federal institution or any federal agency while engaged in the performance of official duties within this state, if the person is licensed elsewhere.

(2) A licensed physician from a state or country who is in actual consultation here.

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STATE MEDICAL BOARDS

FUTURE CHALLENGES FOR REGULATION AND QUALITY ENHANCEMENT OF MEDICAL CARE

James N. Thompson, M.D., F.A.C.S. and Lisa A. Robin, M.L.A.*

> Consider building a home for medicine in which every physician finds a renewed vocation, a secure source of strength and courage for the daily struggle that is the practice of medicine.[1]

INTRODUCTION

The future of health care in this country is fraught with many challenges, including workforce needs, cost and quality of care, and appropriate use of medical technology. The role of state medical boards (SMBs) in their responsibilities for licensure and regulation of physicians in practice has evolved into a more meaningful obligation to improve quality of care. That quality of care depends upon medical boards to assure the public that those entering and continuing in the practice of medicine have and maintain those qualities and competencies that lead to excellent medical care.

The enactment of the Health Care Quality Improvement Act of 1986 led to the creation of the National Practitioner Data Bank and encouraged low-risk peer review among physicians.[2] This Act was designed to improve the quality of health care. Subsequently all health professional regulatory agencies began enhancing oversight of practitioners to comply with the

* Dr. Thompson is a Senior Consultant with The Hayes Group International. He served from 2002-2008 as president and chief executive officer of the Federation of State Medical Boards, a national non-profit association that serves as a collective voice for the 70-member allopathic and osteopathic state medical licensing and regulatory boards in the United States and its territories. He also recently served as interim president of the Medical College of Georgia (2009-2010). Ms. Robin is Chief Advocacy Officer for the Federation of State Medical Boards. Please address all correspondence to Dr. Thompson via e-mail at james.n.thompson44@gmail.com.

[1] Ralph S. Crawshaw, *Searching for a New Wisdom*, 88 J. MED. LICENSURE & DISCIPLINE 155, 158 (2002).

[2] Elisabeth Ryzen, *The National Practitioner Data Bank*, 13 J. LEGAL MED. 415 (1992).

government initiative to raise the quality of patient care. Over the past 25 years, SMBs have moved to a greater involvement in assuring physician competence. This movement has evolved into creating a methodology that attempts to assure ongoing competence throughout the lifetime of a physician's practice. As the health care system is in continuous change, so have been the demands on regulatory authorities to meet the needs of patients and society.[3]

With physicians being moved into a system of reimbursement that is in part based upon the quality of care given—and on satisfactory outcomes of that care—the burden on medical boards will continue to increase. In particular, the obligation to create a system that assures the ongoing competence of physicians in practice is clearly evident. Considerable planning and work by SMBs has preceded the implementation of such programs.[4]

This article reviews the past and current role of state medical boards in licensure and regulation. The authors present the obstacles and some mechanisms to overcome those obstacles that lie ahead with the increasing role medical boards may play in providing a system that assures quality health care.

I. OVERVIEW OF LICENSING LAWS

A license is legal authorization from a government agency that allows an individual to practice a given occupation that requires a high level of specialized skill. Licensing is a regulatory process that protects public safety and ensures competence. Within the medical community, licensure guarantees uniform standard of practice in that state and assures patients that the treatment they receive will be delivered by trained professionals. Licensure protects patients by ensuring physicians have met the competency standards required in order to enter the practice of medicine in the state.

Every state and the District of Columbia have laws and rules that oversee all health care practitioners, including allopathic and osteopathic physicians. Medical Boards are able to effectuate licensure via the constitutionally derived regulatory power of the state. Such power allows states to pass laws that protect health, safety and the general welfare of its citizens. Generally, state statutes delegate enforcement of specific public health issues to the state medical board. Thus, the board is permitted to regulate physicians that practice within its borders.

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[3] Humayun J. Chaudhry et al., *Maintenance of Licensure: Protecting the Public, Promoting Quality Health Care*, 96 J. MED. 1 (2010).

[4] Frances E. Cain, Regina M. Benjamin, James N. Thompson, *Obstacles to Maintaining Licensure in the United States*, 330 BRIT. MED. J. 1443 (2005).

Ultimately, licensure in any field protects both the consumer and licensee. Because the legal standards of the medical community are well established and enforced by the medical board, physicians are expected to practice in a professional and accountable manner. This in turn should allow patients to feel assured and safe in the care of their doctor.

II. HISTORY OF STATE LICENSURE AND REGULATION

The system of licensure in the United States began well over a century ago when West Virginia passed a medical practice act that subsequently was upheld in the Supreme Court. The act was determined to be a valid exercise of a state's police powers over the practice of medicine.[5] The Supreme Court of the United States in 1889 adopted the following language regarding the profession of medicine:

> Few professions require more careful preparation by one who seeks to enter it than that of medicine. It has to deal with all those subtle and mysterious influences upon which health and life depend . . . of the human body in all its complicated parts . . . . The physician must be able to detect readily the presence of disease and prescribe appropriate remedies . . . comparatively few can judge of the qualifications of learning and skill he possesses. Reliance must be placed upon the assurance given by his license, issued by an authority competent to judge in that respect, that he possesses requisite qualifications. Due consideration, therefore, for the protection of society may well induce the State to exclude from practice those who have not such a license, or who are found upon examination not to be fully qualified.[6]

State medical boards were established over the next 50 years and increasingly physicians were required to register in states in which they desired to practice medicine. Also, states began introducing examination requirements prior to licensure. For most of the twentieth century, there was little uniformity in the examinations administered by the states. These examinations varied so widely in scope that it placed limitations on reciprocity of licensure between states. The National Board of Medical Examiners (NBME) was founded in 1915 and administered its first examinations in 1916 as a voluntary exam. The NBME examination co-existed with state examinations for decades and only in the 1960's did it assume a greater role in physician assessment for licensure. Also in the 1960's the NBME created for the Federation of State Medical Boards (FSMB) a licensure assessment termed the Federation Licensing Examination (FLEX). This examination consisted of test materials used by the NBME for certifying examinations. Both the NBME and FLEX examinations were utilized until the 1990's at which time they merged to form

[5] JOHN DERBYSHIRE, MEDICAL LICENSURE & DISCIPLINE IN THE UNITED STATES 183 (1969).
[6] Dent v. West Virginia, 129 U.S. 114 (1889).

the United States Medical Licensing Examination (USMLE), now required for all individuals seeking to obtain license to practice allopathic medicine.[7]

With the advent of state-based licensure, medical boards were indirectly given authority to dictate duration of medical school education. With increasing uniformity of assessment (acceptance of a single examination for MDs and a single examination for Doctors of Osteopathy), state medical boards then gained control over curriculum, since licensure to practice was limited to those who passed the examinations. This potential conflict has been resolved by the fact that the committees that create the examinations are comprised mostly of faculty of medical and osteopathic medical schools.

In each state a medical board is given authorization by the equivalent of a legislative medical practice act. This statutory authority is based upon the premise of self-regulation by the profession of medicine. The majority of medical boards are composed of professional and lay members appointed by state authority, usually the governor. The FSMB, the membership association of United States medical boards, has 69 licensing members, since 14 states have separate boards for osteopathic physicians. The other members are United States territories with medical regulatory boards.

III. MEDICAL BOARD RESPONSIBILITIES

State medical boards have the significant responsibility to protect the public. That responsibility includes multiple opportunities to assure that the physicians practicing within the state have the requisite qualifications and skills to safely provide health care services to the public.

The initial opportunity is licensure to practice medicine. Every state empowers a medical board to determine which physicians meet the standards of the state to legally practice medicine. The licensure is considered a privilege and not necessarily a right, since the boards have the capability of denying as well as removing the licensure which permits medical practice.

Second, and of great importance, is the responsibility of medical boards to establish standards for physician practice. Medical boards have the charge of legislatures in most states to determine what the boundaries of an individual physician's practice may be and set standards for what is considered appropriate medical practice.

Finally, state medical boards have the obligation by law and tradition in most states to remove incompetent and otherwise unfit physicians when they violate the standards of practice set within the state.[8] Disciplining members of

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[7] Donald E. Melnick et al., *Medical Licensing Examinations in the United States*, 66 J. DENTAL ED. 595 (2002).

[8] F. Douglas Scutchfield & Regina Benjamin, *The Role of the Medical Profession in Physician Discipline*, 279 J.A.M.A. 1915 (1998).

the same profession is a tremendous responsibility and requires that medical board members be willing to adhere to the burden of determining what is best for the safety and medical care of citizens in the state. Boards must enforce standards for professional and ethical conduct. For physicians serving on the medical board, the judgment of another physician is not an easy task, but certainly demands that public protection become the principal goal of the board's process. The Medical Practice Act can provide for action against physicians licensed within that state. The wide range of actions that might be available for the medical board can include, but not be limited to:

- Revocation of the medical license;
- Suspension of the medical license;
- Probation;
- Limitations, restrictions, and conditions relating to practice;
- Censure;
- Reprimand;
- Chastisement, letters of concern, and advisory letters;
- Monetary redress to another party;
- A period of free public service;
- Satisfactory completion of an education/training program;
- Fine;
- Payment of administrative and disciplinary costs.

Thus, for physicians who have not violated standards to the extent that removal of licensure is warranted, discipline can vary from a minor "hand slap" to significant punishment and requirement for remediation.[9]

IV. ELEMENTS OF LICENSURE

Over history, the elements of licensure have evolved and currently have at least four components. The first is evaluation of medical education. Graduates of United States medical schools will have the benefit of being educated in a school or program that has been reviewed by an accreditation system that is overseen by the American Medical Association and the Association of American Medical Schools. The American Osteopathic Association Commission on Osteopathic College Accreditation accredits osteopathic medical schools. The accreditation process in the United States seeks to assure that schools have met national educational standards for physicians.

States vary in their acceptance of students graduating from international medical schools. California has its own system of judging the quality of

[9] Federation of State Medical Boards, *Essentials of a Modern Medical and Osteopathic Practice Act* (May 2010), http://www.fsmb.org/pdf/GRPOL_essentials.pdf.

medical schools outside the United States. Many other states look to the California system to evaluate candidates whose medical education took place at a school outside the United States.

Not all SMBs have regulatory authority over resident physicians in training, despite the medical care provided by trainees. Thirty-nine states require a limited license or permit for physicians enrolled in postgraduate training. Five other states at least require registration of those physicians enrolled in postgraduate training. The remaining states have no regulatory authority over individual resident physicians. The FSMB advocates that physicians enrolled in postgraduate programs should be subject to medical board regulation and oversight. This oversight would include all residents being required to have a training permit or limited license issued by the SMB in order to participate in the training program.[10] Information available to the SMBs would include any criminal history and annual reporting of performance by residency program directors.

All states require some years of graduate medical education (GME), accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association for full, unrestricted licensure. Two SMBs require 3 years of GME or residency training, 12 require 2 years and 53 boards require 1 year. In some states, international medical school graduates (IMGs) may be subject to an additional one or two year GME requirement over United States medical graduates, but the maximum GME requirement is three years. The Educational Commission for Foreign Medical Graduates (ECFMG) is a private nonprofit organization that has a program of certification that assesses whether international medical graduates are ready to enter residency or fellowship programs in the United States that are accredited by the ACGME. Twenty-five medical boards require 3 years of post-graduate training for international graduates; 15 boards require 2 years and 12 require 1 year.

A full and unrestricted license to practice medicine in the United States does not limit a physician to a certain practice (for example, dermatology, internal medicine, surgery). A license in the United States is an undifferentiated license to practice medicine. As a result, organizations such as FSMB have recommended that post graduate training include some exposure to general medical experience.[11]

To become licensed in the United States, all physicians must pass an examination of knowledge and skills. The majority take the United States

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[10] *Id.*

[11] Federation of State Medical Boards, Special Committee on Uniform Standards and Procedures, *Maintaining State-based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession* (May 1998), http://www.fsmb.org/pdf/1998_grpol_Uniform_Standards_and_Procedures.pdf.

Medical Licensing Examination (USMLE) that is provided by the NBME and FSMB. The examination has three parts that include written questions and a clinical skills examination that tests communication skills as well as the ability to take a patient's history and perform an appropriate physical examination. Graduates of osteopathic medical schools take the Common Osteopathic Medical Licensing Examination (COMLEX-USA), similarly a three part examination provided by the National Board of Osteopathic Medical Examiners (NBOME). At the completion of the required years of accredited GME, physicians are prepared to enter into unsupervised practice and will seek state licensure to do so. Many other nations, such as the United Kingdom, may require supervision for a period of time even after completing the equivalent of residency training. The licensure process in the United States requires SMBs to thoroughly evaluate the competency and qualifications of physicians seeking licensure to practice medicine after GME.

The subsequent area of assessment occurs after licensure and is a re-registration process that allows medical boards to evaluate a physician's ongoing ability to practice medicine safely. Most states require that there be evidence of continuing medical education. Many are considering a more formidable assessment of the continuing competence of physicians in practice.

V. SMB AUTHORITY

For SMBs to achieve their mandate of effectively protecting the public from unqualified, incompetent, and/or unprofessional physicians, SMBs must have the support of their state legislature to assure sufficient resources, structure and authority are available to the agency.[12] Several factors affect the ability of SMBs to protect the public:

1. Independent/Autonomous Boards are the most effective in regulating the practice of medicine. Operation characteristics of an independent board include: authority to establish fees; access to 100% of funds generated by board activities; authority to retain a reserve fund for specific uses; and authority to hire, dismiss, set compensation, direct activities, and evaluate medical board staff.
2. Most states have requirements that entities such as hospitals, managed care organizations, and liability insurers must report disciplinary actions, changes in privileges and/or liability claims/settlements/awards against a physician. It is important for the boards to have the authority to enforce such reporting requirements.

[12] Medical Regulatory Authorities and the Quality of Medical Services in Canada and the United States, Milbank Memorial Fund (2008), http://www.milbank.org/reports/0806MedServicesCanada/0806MedServicesCanada.pdf.

The majority of states use "preponderance of the evidence" as the burden of proof for board actions. "Clear and convincing evidence" errs on the side of the provider and may limit a board's ability to discipline problem physicians.[13]

VI. CREDENTIALS VERIFICATION

One of the advances facilitating the oversight and responsibility medical boards have to regulate the practice of medicine was the initiation of the FSMB Federation Credentials Verification Service (FCVS). Since 1996, FCVS has verified credentials of physicians and has created a permanent and data secure repository for these primary-source verified credentials. Among the data stored is physician identity, medical education, graduate medical education, examination history, specialty certification, ECFMG certification, and disciplinary history. Primary-source verification ensures that state medical boards receive information verified directly from the source, eliminating the possibility of fraudulent documentation. In addition to providing accurate documentation, FCVS reduces duplicate efforts by SMBs. FCVS maintains primary source verified credentials for more than 125,000 physicians.

Some states are taking the credentialing process a step further and looking at ways a state can assure that physicians on a medical staff continue to provide competent and safe patient care throughout their careers. The Massachusetts Board of Registration in Medicine has taken a lead in this quality of care movement by creating an Expert Panel on Credentialing that was established to set a framework for health care facilities to develop standards for credentialing and re-credentialing physicians. The panel used in its recommendations the six competencies that were identified initially by the ABMS and the ACGME. The medical board approved the panel's report in 2007 and the guidelines suggest several assessment measurements from each of the six core competencies.[14]

VII. DISCIPLINE OF PHYSICIANS

As of 2010, there were over 850,000 physicians licensed to practice in the United States.[15] Annually the FSMB publishes a compilation of disciplinary actions by the SMBs. The report also includes information about how each

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[13] Federation of State Medical Boards, *supra* note 11.

[14] Anthony D. Whittemore et al., *Competency-based Credentialing: A New Model from the Massachusetts Board of Registration in Medicine Expert Panel on Credentialing*, 96 J. MED. REG., No. 1, 2010, at 10.

[15] Aaron Young et al., *A Census of Actively Licensed Physicians in the United States*, 96 J. MED. REG., No. 4, 2010, at 10.

board operates, such as standards of proof required when prosecuting cases. In 2009, SMBs took 5721 actions against physicians. This number was an increase of 342 over 2008 and a 25% increase over the number of disciplinary actions taken 10 years earlier (4569 actions in 1999). Although this number is less than 1% of those licensed, it represents significant disciplinary activity by state medical boards. The FSMB cautions against using data from this report to compare or rank states, because states operate with different financial resources, levels of autonomy, legal constraints, and staffing levels.[16]

It is believed that the most common reasons for SMB action are social behavior problems, such as unprofessional conduct or substance abuse. Between 1997 and 2006, the two leading reasons for disciplinary action were unprofessional conduct and negligence. These two were followed closely by substance abuse. Other reasons included controlled substance violations, fraud, sexual misconduct, and failure to maintain adequate medical records.

The FSMB has accumulated a listing of examples of violations under a State Medical Practice Act (MPA) characterized as unprofessional and/or immoral conduct.[17] Many include:

- violation of confidentiality;
- violation of statute or regulation setting a standard of practice;
- performing a medical act incompetently;
- unconditionally guaranteeing that a cure will result;
- advertising of medical business intended to deceive;
- practicing medicine fraudulently or recklessly;
- practicing medicine while impaired;
- permitting the unlicensed practice of medicine;
- practicing medicine with an expired license;
- using controlled drugs for other than acceptable medical practice;
- use of secret methods or procedures for treatment;
- charging for a medical service not performed;
- delegating practice to a non-qualified person;
- harassing, abusing or intimidating a patient;
- abandoning a patient;
- failure to make medical records available;
- misrepresentation of material facts on licensure application; and
- commission of an act involving moral turpitude.[18]

The FSMB was the first to disseminate names of physicians who were disciplined by SMBs. The Federation Physician Data Center (FPDC) has the

[16] A summary of state board actions is available on the Physician Data Center at www.fsmb.org.
[17] Federation of State Medical Boards, *supra* note 9.
[18] *Id.*

oldest reliable information on board actions taken against errant physicians and has data going back to the 1960's. The FPDC continues to receive data from SMBs and has the information available on its DocInfo database.[19]

In years past, a physician who was licensed in multiple states could move to a second state following disciplinary action against him/her and begin practicing without the SMB in the second state having any awareness of the action. The Health Care Quality Improvement Act of 1986, among other things, was intended to prevent incompetent physicians from moving to another state without disclosing disciplinary action from previous negligent performance.[20] In the late 1990's, the FSMB initiated a Disciplinary Alert Service that gives SMBs the ability to identify disciplined physicians who relocate into their state. Every state in which a physician is licensed is notified by the FSMB any time a SMB disciplinary action is taken against that physician. Similarly, hospitals and other healthcare organizations are notified if one of their physicians is disciplined.

VIII. ASSESSING PHYSICIAN COMPETENCE

A number of current mechanisms exist to assess physician competence. At the start of a physician's practice, the initial licensure process is significant and thorough. The examinations required and the primary-source credentials verification process allow the medical boards to reasonably assure that a physician is ready and able to practice competently and safely in an independent setting. When seeking licensure in another state while in practice, state medical boards have a mechanism to review a physician's practice history and if he/she has had a disciplinary action taken by the state(s) in which the physician is licensed.

All states have a license renewal process that is typically annual or biennial. At this time SMBs have an opportunity to verify any disciplinary actions, review malpractice history, and review the physician's continuing medical education (CME). Of the 69 licensing boards that are members of the Federation of State Medical Boards, 63 require CME. The range of required hours varies with a low of 16 hours per year and a high of 50 hours per year. Few records are audited to confirm that a physician has participated in CME and several states do not require that the CME be linked with the physician's actual practice. Currently CME is the main tool used by SMBs to facilitate ongoing physician competence.

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[19] The database can be found at http://www.docinfo.org.

[20] Margot Heffernan, *The Health Care Quality Improvement Act of 1986 and the National Practitioner Data Bank: The Controversy Over Practitioner Privacy Versus Public Access*, 84 BULL. MED. LIBR. ASS'N 263 (1996).

SMBs have a post-licensure system that encourages review of performance of those physicians who are brought to the attention of the board for possible disciplinary action. A medical board can receive complaints from physician peers and external entities, including the public or health care colleagues. The NBME offers a post-licensure assessment that includes examination of knowledge. There are several programs which may or may not be affiliated with medical schools that offer a complete assessment of a physician's current competence to practice safely. In addition, a growing number of facilities are available for physician health programs, remediation training, and re-entry programs for physicians returning to practice.

IX. PEW FOUNDATION AND INSTITUTE OF MEDICINE RECOMMENDATIONS TO STATE MEDICAL BOARDS

In 1995, the Pew Charitable Trust Health Professions Commission recognized that licensing authorities were doing little to assess competency of physicians at the time of re-licensure. A task force report from that commission called for greater transparency and accountability in how regulatory authorities carry out their responsibility to protect the public. In its report, *Reforming Healthcare Workforce Regulation*, the Commission called for state medical licensing boards to establish mechanisms to assure continued competence of licensed physicians.[21]

In 1999, the Institute of Medicine (IOM) released a report entitled *To Err Is Human* funded by The Commonwealth Fund and The National Research Council. The report brought the issue of medical errors and patient safety to the forefront and created high visibility of medical mistakes for media coverage. This report and subsequent tort reform debate highlighted the need to eliminate problem physicians and establish better health care systems for patient safety.[22]

The IOM report was the first in a series of reports produced by the Quality of Health Care in America Project. Members of this task force were charged to develop strategy that would result in a threshold improvement in health care quality over the next decade. Among the recommendations from the IOM report were:

- Establish a Center for Patient Safety;
- Establish "non-punitive" mandatory and voluntary reporting systems to collect data on medical errors;

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[21] Leonard J. Finocchio et al., *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century* (1995).

[22] INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 278 (Linda T. Kohn et al., eds., 2000).

- Extend peer review protections to patient safety data;
- Explicit standards for safety through regulatory and related mechanisms; and
- Increase attention to medication safety.[23]

In addition to many general recommendations, several were specific to licensing and regulatory medical boards. First was the recommendation that medical boards implement periodic re-examination and re-licensing of doctors, nurses, and other key providers, based on both competence and knowledge of safety practices. Also, medical boards were encouraged to work with certifying and credentialing organizations to develop more effective methods to identify unsafe providers and take action.

X. DEFICIENCIES IN THE CURRENT SYSTEM

As SMBs attempt to improve patient safety, they are confronted with numerous systemic challenges. Despite considerable research on patient safety, there remains a significant lack of scientific information regarding medical errors. There is considerable information about the errors that occur in health care delivery, but the picture of the epidemiology of errors remains elusive.[24] Certainly, this information could enhance patient care and be more readily available if there were a non-punitive reporting system for providers. Physicians continue to be reluctant to report errors for fear of being sued for malpractice.

In addition, our current regulatory system is reactive. State medical boards cannot function as police overseeing the practice of medicine. The boards are set up to respond to complaints from individuals or organizations within the state. A more proactive system could benefit and reduce errors in practice. Fortunately, more providers and payers are committing resources to patient safety initiatives. The theme of much research is patient-centered care. As such, this encourages dissemination of information about "best practices" and improves patient education and available information.

Furthermore, the lack of a uniform and reliable system to assure physicians are maintaining their competence highlights deficiencies in the current licensure and regulatory system. Reliance alone on CME to assure competence after initial licensure is inadequate.[25]

Education of physicians and patients also needs to be addressed. There is no universal method to disseminate information to practicing physicians about

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[23] *Id.* at 1-16.
[24] *Id.* at 27-28.
[25] David A. Johnson, Dale L. Austin & James N. Thompson, *Role of State Medical Boards in Continuing Medical Education*, 25 J. CONT. ED. IN HEALTH PROF. 183 (2005).

"best practices." Patients, as consumers, must assume greater responsibility for their health care choices and be more proactive in questioning health care delivery. Furthermore, when it comes to safety within the health care delivery system, many health care institutions and facilities often are hampered by their limited resources to implement patient safety systems.[26]

Finally, there is an historic lack of complete collaboration across state lines when the issue of disciplining a practicing physician is the issue. State medical boards have argued for state-based licensure and regulation, which has resulted in variability in the enforcement of policies governing the practice of medicine. With increased use of technology and a rapidly changing health care system, many SMBs have recognized the need for greater uniformity to better protect the public.

XI. MAINTENANCE OF COMPETENCE

Medical licensing authorities have initiated a process to respond to the call for greater accountability for competence among practicing physicians. SMBs agree that licensed physicians should be able to demonstrate continued competence at the time of re-licensure. Patient expectations have been enhanced by the revelation that medical errors account for a sizeable number of avoidable hospital deaths. Consequently, professional and medical organizations, as well as regulatory agencies, have been working to reduce medical errors, and improve physician accountability.

The America Board of Medical Specialties (ABMS) initiated the process of maintenance of competence by the development of a recertifying program that requires physicians to demonstrate continuing improvement in their medical practice to maintain board-certified status.[27] The ABMS program entitled maintenance of certification (MOC) responds to the need for documentation that a board-certified physician has practice-related knowledge in his/her specialty of medicine. Acknowledging the public desire for greater physician accountability, the MOC program encourages focused, lifelong learning and ongoing self-assessment that leads to improved quality of patient care. The ultimate goal is fewer medical errors, improved communication between doctors and patients and better quality clinical outcomes.

The FSMB responded by establishing a committee to look at ways the SMBs could begin to assure patients that their doctor was maintaining competence throughout his/her lifetime of practice. The committee was charged with investigating current statutes and board processes, identifying pertinent

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[26] Lucien L. Leape & John A. Fromson, *Problem Doctors: Is There a System-Level Solution?*, 144 ANN. INT. MED. 107 (2006).

[27] Kirstyn Shaw et al., *Shared Medical Regulation in a Time of Increasing Calls for Accountability and Transparency*, 302 J.A.M.A. 2008 (2009).

stakeholders, and recommending a policy statement. This research required review of works in progress by other organizations and healthcare professions and a determination of potential collaborators while assessing the available and necessary tools for such a task.

A policy adopted by the Federation of State Medical Boards in 2004 reads: "State medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking re-licensure."[28] This action followed the compelling public sentiment that appeared in reports such as the 1995 Pew Charitable Trust Health Professions Commission recommendation that states "require each licensing board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals."[29]

In a profession with continually expanding knowledge base, there is need to be certain that physicians keep up with accepted practice standards. The Institute of Medicine, in its report *Crossing the Quality Chasm: A New Health System for the 21st Century*, states: "There are no consistent methods for ensuring the continued competence of health professionals within current state licensing functions or other processes."[30] The report went on to state: "Properly conceived and executed, regulation can both protect the public's interest and support the ability of health care professionals and organizations to innovate and change to meet the needs of their patients."[31]

Following adoption of the policy that calls for the states to establish methods for assuring ongoing physician competence, the FSMB agreed that the breadth of such a movement required national agreement from major health care organizations that deal with physician regulation. The first of the United States national summits on physician self-regulation was held in Fort Worth, Texas, in March 2005, and titled the Physician Accountability for Physician Competence Summit. Attendees represented 35 medical or health care related organizations. Among those in attendance were representatives from organized medicine, academic medicine, hospitals, regulatory agencies, the insurance industry, accrediting organizations, payers, and the public.[32] At this meeting the representatives created five future scenarios from which further discussions developed. The goal was to determine:

1. How to define a competent physician;
2. How competency would be measured; and

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[28] FEDERATION OF STATE MEDICAL BOARDS, PUBLIC POLICY COMPENDIUM (2007).

[29] Finocchio, *supra* note 21, at 14-17.

[30] INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY, 217-18 (Rona Brier et al., eds., 2001).

[31] *Id.*

[32] James N. Thompson, *Maintenance of Licensure and Continuing Medical Education*, 24 AMA CPPD REP., WINTER 2008, at 1.

3. How medical organizations in the future would assure the public that physicians are maintaining competence throughout the lifetime of their practice.[33]

Using the backdrop of the five scenarios, the attendees agreed that the current system of physician regulation was not adequate for the rapidly changing health care system in the United States.[34] At the national meeting, the participants began developing the definition of physician competence and the mechanisms to measure that competence, thereby moving toward assuring the public that the profession was doing what it could to see that physicians maintain their competence throughout their careers.

In 2010, the FSMB adopted a policy outlining a framework by which SMBs might require licensees to periodically demonstrate their current clinical competence as a precondition for license renewal. The policy states that as a condition of license renewal, physicians "should provide evidence of participation in a program of professional development and lifelong learning that is based on the general competencies model: medical knowledge, patient care, interpersonal and communication skills, practice-based learning, professionalism, and systems-based practice."[35] Three components make up the Maintenance of Licensure (MOL) framework: reflective self-assessment; assessment of knowledge and skills; and performance in practice.

Reflective self-assessment is consistent with the obligation physicians have to keep updated about the discipline in which they practice. This component will require lifelong learning through CME. Physicians will likely have to review their practice and evaluate opportunities for improving their knowledge and/or skills. The second component, the assessment of knowledge and skills, does not necessarily demand a structured examination. Physicians certified by the ABMS (MOC program) or the American Osteopathic Association Bureau of Osteopathic Specialists' Osteopathic Continuous Certification (OCC) program will likely meet the standards for assessment that will be set by SMBs. Medical boards will need to deal with an alternative assessment for those physicians not certified by the two national organizations, ABMS and OCC. The third component of MOL is performance in practice. This will require physicians to review their practices using data that is currently acquired by specialty societies and hospitals. Many physician groups are also already involved in practice analysis.

The MOL framework and implementation have involved a number of stakeholders in addition to the FSMB and its member SMBs. A guiding principle throughout the process has been that MOL should not be overly

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[33] *Id.*

[34] James N. Thompson, *The Future of Medical Licensure in the United States*, 81 ACAD. MED. S36 (2006).

[35] Federation of State Medical Boards, *Public Policy 250.004: Maintenance of Licensure*, Public Policy Compendium 2011, *available at* http://www.fsmb.org/pdf/GRPOL_Public_Policy_compendium.pdf.

burdensome for the profession nor compromise physician mobility. For example, physicians participating in maintenance of certification programs of the ABMS or AOA are expected to essentially meet the MOL requirement.[36]

A number of state medical boards will be implementing MOL demonstration projects in 2012 and beyond. Full implementation of MOL throughout the country will require statutory changes in many states.

XII. PROFESSIONALISM

Recognizing that quality medical care requires physicians to possess more than knowledge, many medical organizations have adopted six competencies for all physicians. Residency training programs have been encouraged to integrate these competencies into their training programs. The competencies were first introduced by the ACGME and the American Board of Medical Specialties (ABMS)[37] and include:

- Patient care;
- Medical knowledge;
- Practice-based learning and improvement;
- Interpersonal and communication skills;
- Professionalism; and
- Systems-based practice.[38]

Organizations that have adopted these competencies include the FSMB, the NBME, the AOA, and the NBOME. These organizations recognize the importance of the competencies to the practice of medicine. The qualities of medical practice that are embedded within the six competencies create a necessary lifetime continuum of medical education. This principle is inherent in the policies being adopted for maintenance of licensure.

As one of the six core competencies, professionalism has risen to the forefront of conversation about physician competency. The Canadians have defined professionalism in a way that clarifies the regulatory responsibilities that physicians have for the practice of medicine:

> Professionalism is the moral understanding among professionals that underpins the concept of a social contract between the profession and the public. Under this contract, professional occupations have been granted authority to self regulate, and

[36] Chaudhry, *supra* note 3.

[37] *MOC Is the Path, Better Care Is the Destination*, AM. BD. MED. SPECIALTIES, http://www.abms.org/About Board Certifcation/MOC.aspx.

[38] *Minimum Competencies*, AM. BD. MED. SPECIALTIES, http://www.acgme.org/outcome/comp/compMin.asp.

> independence to control key aspects of their working conditions through accreditation, licensing, credentialing and professional conduct review.[39]

Several United States organizations also define physician professionalism: *Professionalism is the basis of medicine's contract with society. It demands placing the interests of patients above those of physician, setting and maintaining standards of competence and integrity.*[40]

A group of researchers, headed by Maxine Papadakis and working with the FSMB, reported on a study designed to determine if there are indicators in medical school that would identify future physicians who are likely to have later disciplinary action by a SMB while in practice. Dr. Papadakis reviewed medical school records from graduates of the University of California San Francisco School of Medicine between 1943 and 1989. As a result of this investigation, it was discovered that 70 graduates of that school had received disciplinary actions against them by their SMB. The actions ranged from public reprimand to license revocation and most were based upon violation of professional behavior.[41]

The research team looked at various predictors, including gender, undergraduate grade point average, medical college admission test scores, medical school grades, National Board of Medical Examiner Part I scores, negative excerpts describing unprofessional behavior from course evaluation forms, dean's letters of recommendation for residencies, and administrative correspondence. The most reliable predictor for a subsequent disciplinary action by a SMB was an indication of problematic behavior in medical school. Dr. Papadakis concluded that professionalism is an essential competency that must be demonstrated for a student to graduate from medical school.[42]

A follow up report studied graduates from three other medical schools, and the results were consistent. Disciplinary action among practicing physicians by medical boards was strongly associated with unprofessional behavior in medical school. Students with the strongest association were those who were described as irresponsible or as having diminished ability to improve their behavior. Professionalism should be central in medical academics and throughout a physician's career.[43]

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[39] Health Canada, Social Accountability: A Vision for Canadian Medical Schools, 2001, http://www.afmc.ca/pdf/pdf_sa_vision_canadian_medical_schools_en.pdf.

[40] ABIM Foundation et al., *Medical Professionalism in the New Millennium: A Physician Charter*, 136 Ann. Int. Med. 243, 244 (2002).

[41] Maxine A. Papadakis et al., *Unprofessional Behavior in Medical School Is Associated with Subsequent Disciplinary Action by a State Medical Board*, 79 Acad. Med. 244 (2004).

[42] *Id.*

[43] Maxine A. Papadakis et al., *Disciplinary Action by Medical Boards and Prior Behavior in Medical School*, 353 N. Eng. J. Med. 2673 (2005).

It is apparent that the SMBs have a substantial role in maintaining the professionalism that the medical practitioners embrace. Over a decade ago the *Journal of the American Medical Association* published a patient-physician covenant[44] that reveals the role that physicians must play and the responsibility they have in serving patients. It reads:

> Medicine is, at its center, a moral enterprise grounded in a covenant of trust. This covenant obliges physicians to be competent and to use their competence in the patient's best interest. Physicians, therefore, are both intellectually and morally obliged to act as advocates for the sick wherever their welfare is threatened and for their health at all times. Medicine is a special kind of human activity—one that cannot be pursued effectively without the virtues of humility, honesty, intellectual integrity, compassion, and effacement of excessive self-interest. Physicians are members of a moral community dedicated to something other than its own self-interest. The medical profession must reaffirm the primacy of its obligation to the patient through national, state, and local professional societies, our academic research and hospital organizations, and especially through personal behavior. Physicians are called upon to discuss, defend and promulgate medical care by every ethical means available. Only by caring and advocating for the patient can the integrity of our profession be affirmed.[45]

XIII. PROFESSIONALISM IN MEDICAL EDUCATION

The adoption of the six competencies first introduced by the ABMS and the ACGME is becoming central to medical education. This initiative comes at a time in which the need for teamwork in a medical setting has stimulated health related schools to seek interdisciplinary pathways to educate the next generation of providers.

The marked increase in interest in the aspects of professional behavior has led medical educators to emphasize the importance of professionalism throughout the career of a physician. Medical schools that in the past graduated individuals solely on their ability to pass written and oral examinations have begun to consider behavioral factors in deciding who will be granted the M.D. or D.O. degree. Much research has led to measures of professional behavior that are increasingly objective. Procedures are becoming available that will allow a medical school to determine professional behavior aspects of applicants and students.[46]

The focus on the continuum of medical education has led SMBs to consider requiring that continuing medical education credits be granted only for education that relates to the practice of the individual, something that many

[44] Ralph Crawshaw et al., *Patient-Physician Covenant*, 273 J.A.M.A. 1553 (1995).
[45] *Id.*
[46] David T. Stern & Maxine Papadakis, *The Developing Physician—Becoming a Professional*, 355 N. ENG. J. MED. 1794 (2006).

states disregarded in the past.[47] This direction is consistent with the call for physicians to demonstrate their competency throughout their careers.

XIV. FUTURE OF STATE MEDICAL BOARDS AND THEIR RESPONSIBILITIES

Despite the tremendous efforts that SMBs have taken to assure patient safety and protection, they face myriad future challenges. As the emphasis of health care is shifting to electronic record keeping and information sharing, the burden of medical boards to educate their constituencies will increase. Physicians will clearly be challenged to assure the public of continued competency. SMBs will carry the responsibility of establishing criteria for continued licensure that correlates with a physician's efforts at staying current with best practices. Continuing medical education will be an essential element in this process and SMBs will increasingly be called upon to monitor and assure that each physician is participating in CME that is relevant to his/her practice of medicine.[48]

SMBs also should enhance education of physicians and those in training (medical students and residents) about the role of medical regulatory authorities in promoting patient safety and protection.[49] Some state boards have begun to participate in undergraduate and graduate medical education, but many students and residents enter practice without knowing the scope of regulatory activity that a medical board assumes. In addition, with the continued variation between states regarding regulation policies and practices, each state board should assume responsibility for making certain that licensed physicians in that state have an understanding of the regulations under which they are allowed to practice.

And finally, the education of patients is increasingly essential. For maximum safety and protection, the public needs to be informed about the role of SMBs in assuring patient protection and safety. Patients need to know of that role and how they can contact and bring to the attention of medical boards those practitioners who are not satisfying the health needs of the public.

Part of the ongoing confusion among physicians is the variability of licensure and regulation policies among the states and their boards of medicine. Greater uniformity would go a long way to resolve some of the confusion that

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[47] Johnson, *supra* note 25.

[48] Stephen H. Miller et al., *Continuing Medical Education, Professional Development, and Requirements for Medical Licensure: A White Paper of the Conjoint Committee on Continuing Medical Education*, 94 J. MED. LICENSURE & DISCIPLINE 8 (2008).

[49] Henry M. Litchman, *Medical Professionaism and Public Regulation*, 90 J. MED. LICENSURE & DISCIPLINE 5 (2004).

exists. Most states forbid a physician prescribing for his or her family, while some allow self-prescribing. The requirements for licensure or to maintain a license vary widely. The FSMB tried nearly a decade ago to simplify application for licensure and after several years of effort, finally adopted a single application process. Yet, even that process includes a supplemental application for states that have unique questions. As of June 2011, only 14 states had adopted the process.[50] For success in the future, SMBs are likely to be forced into improved uniformity.

Despite the progress that has been made toward establishing a process of licensure renewal that assures the public that physicians have continued to be competent, no state has yet adopted a plan to assure that competence. Such a process will also need to be accompanied by opportunities for remediation. Several programs have developed over the past two decades, but they remain insufficient for the ongoing needs of physicians either following disciplinary action or upon re-entry to practice.[51]

Finally, the globalization of medical practice is becoming a reality. The International Association of Medical Regulatory Authorities (IAMRA) was founded in 2000 to serve all nations in information exchange. One of the primary concerns of the originating countries was the migration of disciplined doctors. The FSMB has served as secretariat of that organization and it has set goals of promoting collaboration and cooperation to better protect the public through high standards for medical regulation.

One of the challenges accepted by IAMRA was the development of a Medical Passport to allow migration of medical practitioners between participating jurisdictions of different countries. A Medical Passport will require international cooperation. Such globalization of the regulation of medicine leads to the possibility of an international license to practice medicine. The World Health Organization (WHO) and the World Federation of Medicine (WFME) have worked to create standards for the continuum of medical education.

The ECFMG has maintained a database of acceptable medical schools—those that have the approval of the ministry of health or an equivalent agency within the country. These organizations, working together, means that the establishment of an international accreditation system becomes an increasing possibility and would allow for easier portability of licensure between cooperating nations. Certainly, an international system of recognized licensure places pressure upon the United States state-based system that, by lack of uniformity, encumbers physicians from nationwide practice of medicine. Greater uniformity of SMBs and their practices and policies would go a long way to

[50] Correspondence with Ingo Hagemann, M.B.A. Uniform Application Director, Federation of State Medical Boards, June 16, 2011 (on file with author).
[51] Leape, *supra* note 26.

improve state to state license portability. This uniformity would also support the continued viability of state-based licensure and prevent nationalization of medical licensure.[52]

Currently in this country the medical license allows a physician to practice the full scope of medical practice. This was established over a century ago, long before the advent of specialization within the profession. A residency program within a specialty is now required for licensure. Some have advocated a link between specialty boards and licensure, so that the renewal or perhaps even the entry into the practice of medicine be assessed on specialty knowledge, rather than the broad assessment as is currently done. Under this system re-licensure would be specialty based, or based upon the scope of the individual physician's practice. SMBs under this system need greater collaboration with the societies and boards that represent the multiple medical specialties.

CONCLUSION

SMBs over the past 25 years have made extensive changes in practice and policy for the purpose of improving the quality of health care given to patients in this country. Much of the change resulted from the evolving health care system and increasing demands of the public for greater accountability from the profession of medicine.

What we have observed is a shift from simply assessing the professional ability of those entering the practice of medicine to the early development of a reliable system that will do much to assure the public that physicians are maintaining their competence throughout the lifetime of their practice. Although in its early stages, maintenance of licensure will place demands upon physicians that will not only enhance their abilities but add to the documentation that competence continues. Greater demands will also be upon SMBs, because the work associated with accounting for every physician complying with MOL will be voluminous. States will need to provide necessary resources for technology and staffing.

As the practice of medicine has become more challenging, with accelerated advances in technology and concerns about quality medical care, patient safety, and cost, so the regulation of the practice of medicine has become more complex. Maintenance of licensure creates challenges previously unthinkable by the profession. The consistent demand for improved quality must, in part, be met by state medical boards stepping up to the responsibility of assuring the public that physicians maintain competence throughout the lifetime of their practice. For this system to be effective and practical, state legislators as

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[52] Federation of State Medical Boards, *supra* note 11.

well as other health care organizations will need to cooperate and collaborate with SMBs to assist board members in carrying out their responsibilities.

In addition for SMBs to be maximally effective in their role of disciplining errant physicians, there must be improved education of the public and the profession about the responsibility functions of the regulatory agency. Citizens must know that SMBs, for the most part, do not function as policing boards and only respond to complaints. Everyone must be informed of the need for responsible reporting to and from the SMBs to improve the oversight that the members of these boards have for the profession of medicine. That oversight is an awesome responsibility that carries with it the charge not only to regulate the practice of medicine, not only to determine who is qualified to enter the practice medicine, not only to discipline errant doctors, but also to oversee the continued improvement in physician practices with a system of maintenance of licensure. The public expects a great deal from these individuals. Indeed, much of the integrity of the profession of medicine rests on the shoulders of those individuals appointed to a state medical board.

Federation of STATE MEDICAL BOARDS

U.S. Medical Regulatory Trends and Actions

2016

Section 1: State Medical Boards and Public Protection

About State Medical Boards

The 10th Amendment of the United States Constitution authorizes states to establish laws and regulations protecting the health, safety and general welfare of their citizens. The practice of medicine is not an inherent right of an individual, but a privilege granted by the people of a state acting through their elected representatives.

To protect the public from the unprofessional, improper and incompetent practice of medicine, each of the 50 states, the District of Columbia and the U.S. territories have enacted laws and regulations that govern the practice of medicine and outline the responsibility of state medical boards to regulate that practice. This guidance is outlined in a state statute, usually called a Medical Practice Act. Seventy state and territorial medical boards are currently authorized to regulate physicians.

All state medical boards issue licenses for the general practice of medicine. State licenses are undifferentiated, meaning physicians in the United States are not licensed based upon their specialty or practice focus, and certification in a medical specialty is not absolutely required in order to obtain a license to practice medicine.

In many states, other health care professionals are also licensed and regulated by medical boards in addition to physicians. Examples include physician assistants and acupuncturists.

In addition to licensing physicians, state medical boards investigate complaints, discipline those who violate the law, conduct physician evaluations and facilitate rehabilitation of physicians when appropriate. State medical boards also adopt policies and guidelines related to the practice of medicine and designed to improve the overall quality of health care in the state.

Medical Board Structure

The structure and authority of medical boards vary from state to state. Some boards are independent and maintain all licensing and disciplinary powers, while others are part of a larger umbrella agency, such as a state department of health, exercising varied levels of responsibilities or functioning in an advisory capacity.

State medical boards are typically made up of volunteer physicians and members of the public who are, in most cases, appointed by the governor. In recent years, non-physician board members — often referred to as "public members" — have become common. The vast majority of boards in the United States now have public members.

The state legislature determines the financial resources of most boards. Funding for medical board activities comes from physician licensing and registration fees. Most boards employ an administrative staff that includes an executive officer, attorneys, investigators and licensing specialists. Some boards share staff — such as investigators and attorneys — with other state regulatory agencies.

How Physicians Gain Licenses to Practice Medicine

Obtaining a license to practice medicine in the U.S. is a rigorous process (see "Becoming a Licensed Physician in the United States," Section II). Through licensing, state medical boards ensure that all practicing physicians have appropriate education and training, and that they abide by recognized standards of professional conduct while serving their patients.

Those entering the profession must meet predetermined qualifications that include medical school graduation, postgraduate training, and passage of a comprehensive national medical licensing examination that tests their knowledge of health and disease management and effective patient care. Applicants must submit proof of their education and training and provide details about their work history. They also must reveal information that may affect their ability to practice, such as health status, malpractice judgments/settlements and criminal convictions. Only those who meet a state's qualifications are granted permission to practice medicine in that state.

After physicians are licensed, they must renew their license periodically, usually every one or two years, to continue their active status. During this license renewal process, physicians must demonstrate that they have maintained acceptable standards of ethics and medical practice and have not engaged in improper conduct. In nearly all states, physicians must also show that they have participated in a program of continuing medical education.

The Interstate Medical Licensure Compact

In 2015, a group of U.S. state medical boards joined together to launch the Interstate Medical Licensure Compact, which offers a new, expedited pathway to licensure for qualified physicians who wish to practice in multiple states.

A compact is a legal agreement that allows states to collectively work together to address shared needs or issues. They are authorized by the Compact Clause of the U.S. Constitution. There are more than 200 interstate compacts in effect today.

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Among the issues driving the need for the Interstate Medical Licensure Compact are physician shortages, the recent influx of millions of new patients into the health care system, and the growing need to increase access to health care for individuals in underserved or rural communities through the use of telemedicine. Proponents of telemedicine have often cited the state-by-state licensure process required for multiple-license holders as a barrier to telemedicine's growth, and the Compact is intended to help overcome this hurdle.

In addition to significantly streamlining the process of gaining medical licenses in multiple states for physicians, the Compact is designed to increase access to health care for patients in underserved or rural areas, and to allow them to more easily connect with medical experts through the use of telemedicine technologies. Any state or territory may join the Compact. As of late 2016, 18 states are participating members.

States participating in the Compact formally agree to adopt common rules and procedures that streamline medical licensure, thus substantially reducing the time it takes for physicians to obtain multiple state licenses. The Interstate Medical Licensure Compact Commission provides oversight and the administration of the Compact, creating and enforcing rules governing its processes, but each participating state maintains its individual authority and control over the practice of medicine within its borders. Participating states retain the authority to issue licenses, investigate complaints, and discipline physicians practicing in their state.

The Compact's multi-state licensing process is expected to begin in 2017. To be eligible for licensure by utilizing the Compact process, physicians will need to possess a full and unrestricted license in a Compact member state, be certified (or "grandfathered") in a medical specialty, have no history of being disciplined, penalized or punished by a court, a medical licensing agency or the Drug Enforcement Administration, and meet several other robust requirements. It is estimated that approximately 80% of the physician population licensed in the United States could be eligible for expedited licensure via the Compact, once its process formally begins.

To participate, an eligible physician will designate a member state as the State of Principal Licensure and select the other member states in which a medical license is desired. Upon receipt of this verification in the additional Compact states, the physician will be granted a separate, full and unrestricted license to practice in each of those states.

The Compact is voluntary for both states and physicians. Physicians who cannot or do not want to participate in the Compact's expedited licensure process will still be able to seek additional licenses in those states where they desire to practice by applying through that state's traditional and existing licensure processes.

In order for a state to join the Interstate Medical Licensure Compact, its state legislature must enact the Compact into state law. Since 2015, half of the states in the nation have either introduced or enacted legislation for the Compact.

To learn more, please visit www.licenseportability.org.

How State Medical Boards Regulate Physicians after Licensing

The ongoing duty of a state medical board goes far beyond the licensing and re-registration of physicians. Boards also have the responsibility of determining when a physician's professional conduct or ability to practice medicine warrants modification, suspension or revocation of a license to practice medicine.

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

Board members devote much time and attention to overseeing the practice of physicians. When a board receives a complaint about a physician, the board has the power to investigate, hold hearings and impose discipline, including suspension, probation or revocation of a physician's license, public reprimands and fines.

While medical boards find it necessary to suspend or revoke licenses when appropriate, some problems can be resolved with additional education or training in appropriate areas. Boards may place restrictions on a physician's license or put a physician on probation to protect the public while a physician receives special training or rehabilitation aimed at an existing issue.

What Is Considered Unprofessional Conduct?

Each state's Medical Practice Act defines unprofessional conduct within the state. Although laws vary from jurisdiction to jurisdiction, some examples of unprofessional conduct include the following:

- Alcohol and substance abuse
- Sexual misconduct
- Neglect of a patient
- Failing to meet the accepted standard of care in a state
- Prescribing drugs in excess or without legitimate reason
- Dishonesty during the license application process
- Conviction of a felony
- Fraud
- Delegating the practice of medicine to an unlicensed individual
- Inadequate record keeping
- Failing to meet continuing medical education requirements

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The Rights of Physicians under Investigation

Whatever the complaint, physicians are afforded the right of due process as a state medical board investigates an allegation of unprofessional conduct.

Due process asserts that an individual is innocent until proven guilty. This principle applies to formal hearings and judicial procedures that the medical board conducts. Boards must adhere to established rules and principles to ensure that a physician is not treated unfairly, arbitrarily or unreasonably. In instances when the alleged behavior threatens patients with immediate harm, such as sexual misconduct or impairment from alcohol or drug abuse, boards have authority to issue an emergency suspension until the investigation of the physician is completed.

Understanding the Difference between a Medical Board Disciplinary Action and Malpractice

The differences between a disciplinary action taken by a medical board and a malpractice judgment or settlement against a physician are significant.

Board actions and malpractice claims are two different things. Board actions are issued against physicians after a formal process of complaint, investigation and hearing. While an action taken by a medical board against a physician indicates that a violation of the Medical Practice Act has occurred, malpractice claims are not always reliable measures of a physician's competence or a violation of the law. Issues such as a physician's time in practice, the nature of his or her specialty, the types of patients treated, and geographic location can have a significant influence on the number and amounts of malpractice judgments and settlements.

Malpractice settlements are sometimes handled by insurance companies who opt for settlement based on the terms of coverage, not the validity of the underlying claim. These terms may also authorize settlement of a claim without any consultation of the physician involved or an ultimate determination of fault.

It is common practice for medical boards to use malpractice data as a tool to detect unprofessional conduct that may violate the Medical Practice Act. Some boards have built-in levels of malpractice that trigger investigations, such as a certain number of malpractice settlements in a certain span of time.

How State Medical Boards Share Information about Disciplined Physicians

All state medical boards engage in an ongoing, cooperative effort to share licensure and disciplinary information with one another by regularly contributing data to the FSMB's Physician Data Center — a comprehensive data repository that contains information about the more than 900,000 actively licensed physicians in the United States, as well as board disciplinary actions dating back to the early 1960s.

Medical boards use the Physician Data Center in several ways. Boards query the Data Center when new applicants apply for licensure in a state. The Data Center alerts boards if an applicant has been disciplined in another jurisdiction. The Data Center's Disciplinary Alert Service proactively alerts all states in which a disciplined physician is licensed within 24 hours after a disciplinary action taken by one of those states has been reported to the Data Center. This service helps prevent disciplined doctors from practicing undetected across state lines.

The Importance of Reporting

While the overwhelming majority of patient-physician interactions that occur each day in the United States are conducted in an appropriate and professional manner, state medical boards recognize that issues such as physician alcohol and substance abuse, fraud and sexual misconduct exist. These issues are taken very seriously by state medical boards, which in recent years have advocated for strengthened reporting requirements to ensure individuals or organizations who are aware of, or witness, inappropriate behavior come forward to report the problem. Physicians, hospitals, law enforcement agencies and consumers all can help reduce future issues by reporting inappropriate behavior. To help address the issue of under-reporting, the Federation of State Medical Boards House of Delegates unanimously adopted new policy in 2016 that urges physicians, hospitals and health organizations, insurers and the public to be proactive in reporting instances of unprofessional behavior to medical boards whenever it is suspected. Consumers must feel safe and secure in any medical interaction, and they should always speak up if they suspect inappropriate behavior. Information and tips to help consumers are provided in the next section.

Information for Consumers

How State Medical Boards Serve the Public

As they fulfill their role of overseeing the practice of medicine in a state, medical boards provide value for both patients and physicians. By following up on complaints and disciplining physicians when needed, medical boards ensure public trust in the basic standards of competence and ethical behavior in their physicians. By striving to ensure that physicians have been properly trained and are maintaining their professional skills, medical boards help protect the integrity of the medical profession.

By defining the practice of medicine in a state, boards play an influential role in how medical care is delivered. A state's Medical Practice Act may contain many important regulations on the use of medical devices, the administering of certain kinds of drugs and the conditions under which medical care can be provided.

One of the most important roles state medical boards play is serving as a repository of publicly available information about physicians. This information can be useful to consumers in helping them choose a physician when they need medical care. Boards provide a valuable service to consumers who are seeking information about

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physicians by disclosing if a physician is currently licensed in good standing, if disciplinary action has ever been imposed, or if formal disciplinary charges are pending.

The public can also inquire if the board has other public information in a physician's record, such as criminal convictions, sanctions taken by hospitals, and malpractice judgments and settlements.

Consumers who believe that a physician has engaged in unprofessional conduct or that the quality of medical care they received is substandard should contact their state medical board. (For more information, see "How and When to File a Complaint Against a Physician," page 10.)

The Consumer's Role

With the rise of consumer empowerment in recent years, and the expanding influence of the Internet, patients have begun to play a much more proactive role in learning about physicians' credentials and background. Patients are increasingly likely to verify their physician's credentials and ask questions about their training and qualifications to perform certain procedures.

One simple way state medical boards can help is by providing information about physicians' training in certain specialties or modes of practice. While the vast majority of licensed physicians practice within their areas of training, if a physician operates outside of his or her scope of expertise and provides substandard care that harms a patient, he or she will be held accountable by a state medical board for failing to meet standards.

Other mechanisms are built into the health care system to prevent physicians from practicing in areas of training in which they may not be able to practice safely. For example, hospitals often require physicians to be board certified in a medical specialty before they will grant privileges to practice in the hospital.

But a good first step for consumers to learn more about a physician is to check a physician's credentials and training through a state medical board.

How to Check a Physician's Qualifications

State medical boards have responded to the growing trend toward consumer empowerment in recent years by greatly improving access to meaningful information about the physicians licensed in their respective states.

Once a patient has identified a physician he or she is interested in seeing, it is wise to invest some time and energy in learning more about their skills and training, as well as the quality of care they provide. Here are some resources to help find out more about a physician's qualifications.

State Medical Board Physician Profiles

State medical boards make available a variety of physician information on their individual state websites through online "physician profiles." At a minimum, medical board profiles include licensure status and disciplinary history. More comprehensive profile systems may include full board orders of disciplinary actions, malpractice judgments and criminal convictions.

Some also provide information that creates important context to help consumers make decisions about their health care providers. For example, a profile including data on physician medical malpractice may include details about the length of a physician's time in practice, the nature of his or her specialty, the types of patients treated and geographic location — all of which can significantly influence the number and size of malpractice judgments, settlements and awards.

Much of this information may be available at your state medical board's website. The types of information available from your state board may include:

- Medical licenses (active or inactive)
- Final disciplinary orders or actions by regulatory boards or agencies, including state medical boards, the U.S. Drug Enforcement Administration and Medicare
- Final suspensions or revocations of hospital privileges
- Criminal convictions
- Malpractice payment information
- Medical schools attended and graduation dates
- Graduate medical training (residency) programs attended and completion dates
- Specialty board certifications
- Area(s) of practice

A list of information available on state physician profiles and links to state profile websites is available at the FSMB's website at www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/GRPOL_Physician_Profiling.pdf.

FSMB National Database (DocInfo)

For consumers, the FSMB has made available its national database of consolidated physician licensure and disciplinary information. This is the same database used by state medical boards and various U.S. and international health care entities during the licensure and credentialing process.

The service, called DocInfo, is available at www.docinfo.org. DocInfo includes:

- Disciplinary actions
- License history
- Medical school
- Type of degree
- American Board of Medical Specialties (ABMS) specialty
- American Osteopathic Association (AOA) specialty

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How and When to File a Complaint Against a Physician

Many consumers are unaware of where they should turn when they encounter an issue of competence or ethics with a physician. State medical boards are the designated state agencies to investigate complaints about physicians and, when warranted, take action against them.

Depending on the size of a state's physician population, medical boards typically will receive hundreds to thousands of complaints annually, each of which must be investigated by board staff. Complaints are prioritized according to the potential for patient harm; cases in which an investigator determines imminent patient harm is possible are typically "fast-tracked" to ensure swift action by the medical board. Examples of complaints receiving high priority by investigators may include a physician engaging in sexual misconduct, practicing medicine while under the influence of alcohol or drugs, and providing substandard care.

The most common complaint received by medical boards is an allegation that a physician has deviated from the accepted standard of medical care in a state. Some of the most common standard-of-care complaints include:

- Overprescribing or prescribing the wrong medicine
- Failure to diagnose a medical problem that is found later
- Failure to provide a patient with medical test results in a timely manner, which can lead to harm
- Failure to provide appropriate post-operative care
- Failure to respond to a call from a hospital to help a patient in a traumatic situation

To file a complaint against a physician, please contact the state medical board in your state. A directory of state boards is available in the next section of this report and at www.fsmb.org.

How the Complaint Process Works

While the details, terminology, and order of events vary from state to state, once a complaint is received by a state medical board the complaint process commonly includes the following steps:

1. The complaint is assessed for jurisdiction. When a complaint arrives at the medical board, the first step is to determine whether the board has the authority to investigate it under the state's Medical Practice Act.

If yes: Go to Step 2.

If no: The complaint may be referred to another agency with jurisdiction. If that isn't possible, the person who lodged the complaint is sent a letter stating that the board has no jurisdiction.

2. The case is prioritized and an investigation begun. Before taking any action, the board determines if there is an imminent threat to the public. If this is the case, it typically has the power to immediately suspend a physician's license and order the physician to cease seeing patients. Other restrictions may also be applied if there is an imminent threat.

3. The investigation proceeds; all parties involved are contacted. After the case is prioritized, the board begins a comprehensive investigation, identifying all the individuals and facilities that may have pertinent information. Individuals involved in the case are asked to describe the events that took place and provide any information they may have.

4. The physician and complainant receive formal notification. At this stage a letter is typically sent to the physician, stating the allegation, seeking a response to the complaint and requesting any relevant records. The complainant is also notified.

5. The case is given medical review. Investigators for the board determine whether a patient's medical care has been impacted as a result of the complaint or whether the complaint involves other issues, such as fraud or behavioral/ethical problems. During this stage, an expert with professional credentials in the same specialty as the physician in question may be called in to provide an additional opinion about the care provided.

6. The board decides what action to take. A wide variety of disciplinary measures or other actions in response to the original complaint are available to boards, ranging from revoking or placing restrictions on a physician's medical license to imposing fines. For the most serious cases, especially those that impact patient safety, the board may opt to file a formal complaint against the physician, leading to disciplinary action that may include suspension or revocation of a license. For less serious offenses, options may include, but are not limited to, a letter of concern; an appearance before the board; or the requirement of a physical, medical or psychiatric competency evaluation.

For serious infractions or issues, which warrant filing of a formal complaint: Go to Step 7.

For lesser infractions or issues: Board may consider imposing lower-level options or closing the case without formal action.

7. The case is set for a hearing. For serious infractions or issues, state medical boards schedule a hearing – a formal review of the case in which physicians have an additional opportunity to respond to the complaint. As sometimes happens in the U.S. legal system, some cases may be settled before the hearing date. When that happens, the settlement offer goes before the full board at a regularly scheduled board meeting, where a decision is made about whether to accept the settlement agreement. If accepted, it is placed into effect. If not, the matter proceeds to a hearing before the board.

If no settlement: Go to Step 8.

If settlement: Board closes case.

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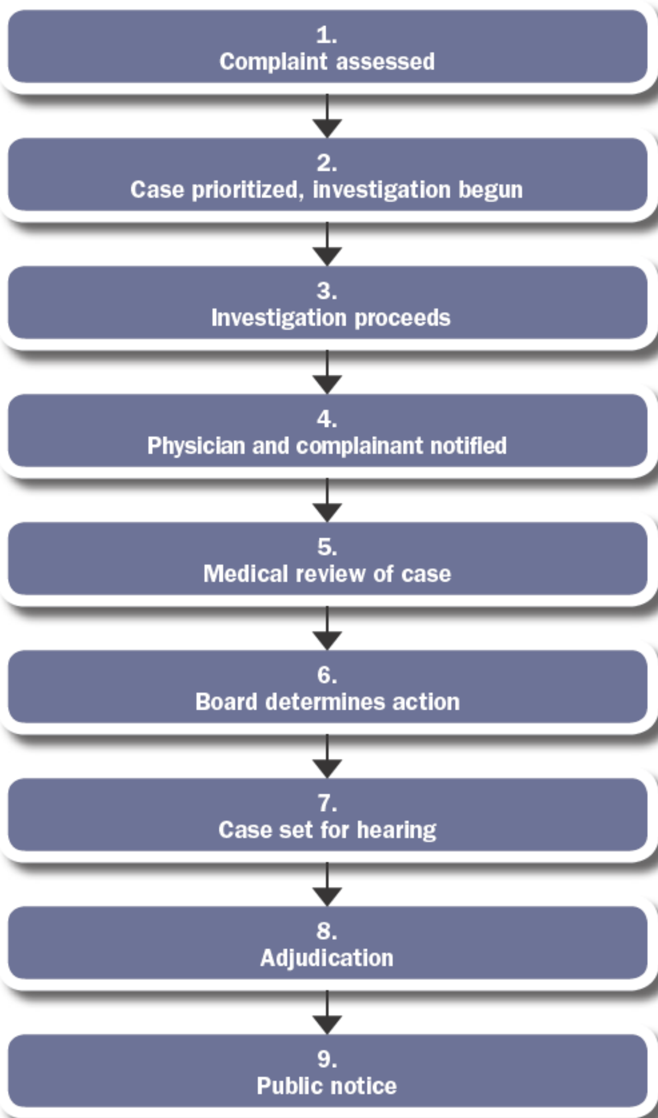
8. Adjudication. Cases that are not settled are adjudicated, meaning they go to a full hearing, similar to a court trial. There is a formal proceeding, with presentation of evidence and witnesses. Afterward, the board deliberates and makes findings on whether one or more violations of a state's Medical Practice Act have been proven. If a violation has been proven, the board determines the appropriate disciplinary actions to impose on the physician, which can include a reprimand; conditions or restrictions placed on the physician's license; or suspension or revocation of the license.

9. Public notice. If a board finds that a violation of the Medical Practice Act has taken place, and disciplinary action has been taken, this information is entered into the public record. The information becomes part of the physician's permanent professional record and is shared with other state medical boards via the FSMB's Physician Data Center. Patients have access to this information directly from their state medical board or by accessing the FSMB's DocInfo online service (www.docinfo.org).



Contacting Your State Medical Board

If you are searching for information about a physician's qualifications, or if you want to file a complaint against a physician, you should contact your state medical board.

A directory of all boards in the Federation of State Medical Boards is included here. The directory can also be accessed at the FSMB website, www.fsmb.org.

Alabama Board of Medical Examiners
Larry D. Dixon, Executive Director
P.O. Box 946
Montgomery, AL 36101-0946
(Street address: 848 Washington Ave.)
(334) 242-4116 / Fax: (334) 242-4155
(800) 227-2606
www.albme.org

Alaska State Medical Board
Debora J. Stovern, CMBE, Executive Administrator
550 West Seventh Ave., Suite 1500
Anchorage, AK 99501-3567
(907) 269-8163 / Fax: (907) 269-8196
www.commerce.alaska.gov/web/

Arizona Medical Board
Patricia E. McSorley, JD, Executive Director
9545 East Doubletree Ranch Road
Scottsdale, AZ 85258-5514
(480) 551-2700 / Fax: (480) 551-2704
Toll Free: (877) 255-2212
www.azmd.gov

Arizona Board of Osteopathic Examiners in Medicine and Surgery
Jenna Jones, CPM, Executive Director
9535 East Doubletree Ranch Road
Scottsdale, AZ 85258-5539
(480) 657-7703 / Fax: (480) 657-7715
www.azdo.gov

Arkansas State Medical Board
Karen Whatley, JD, Executive Secretary
Victory Bldg.
1401 West Capitol Avenue, Suite 340
Little Rock, AR 72201-2936
(501) 296-1802 / Fax: (501) 296-1805
www.armedicalboard.org

Medical Board of California
Kimberly Kirchmeyer, Executive Director
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
(916) 263-2389 / Fax: (916) 263-2387
(800) 633-2322
www.mbc.ca.gov

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State medical boards regularly contribute updates of license and discipline data to the FSMB's database. Reports from the DAS include data such as which board took a disciplinary action, the nature of the action (e.g., license revocation or suspension) and why the board took the action. Using this information, medical boards can launch their own investigations of the sanctioned physician or, in cases of particularly egregious behavior, take an emergency summary suspension against the physician's license. Medical boards may also impose a "reciprocal action" — one based on the action taken by the originating board — to prevent or limit the physician from practicing in their state.

State medical boards and organizations that employ physicians are also able to query the FSMB's Physician Data Center to obtain a practitioner profile containing license information and disciplinary actions taken against their physicians. Government agencies such as the Veterans Administration and the Centers for Medicare and Medicaid's Advanced Provider Screening solution and international regulatory authorities also access the Physician Data Center as well as credentials verification services, hospitals, insurance carriers, physician associations, medical groups, medical societies, managed care organizations, and physician placement services. In 2015, more than 340,000 queries were made to the FSMB's Physician Data Center, including 89,315 queries by state medical boards.

2015 Physician Disciplinary Actions and Trends

The *U.S. Medical Regulatory Trends and Actions* report provides aggregated national data about medical licensing and disciplinary trends as well as key data about state board governance and activities. It does not provide detailed, comprehensive and comparative data about medical board disciplinary activities on a state-by-state basis. Detailed information about the activities of specific states is available from individual state boards, which can be contacted using the board directory in Section I of this report or by visiting www.fsmb.org. National regulatory information included in this report has been compiled using the FSMB's Physician Data Center.

Modern medical boards are using better tools in their efforts to discipline physicians, a trend which may help account for changes in the number and types of actions state boards take against physicians licensed in their jurisdictions. With relatively minor fluctuations, more than 4,000 physicians per year have received actions from state boards during the past eight years (Figure 1).

A comparison of data from 2015 and 2008 demonstrates some categories of board actions have experienced increases, particularly reprimands, requirements for additional continuing medical education, licenses surrendered and revocations. Others, such as restrictions and suspensions, have remained about the same, while actions related to administration, fines, probation, conditions imposed and licenses denied have seen decreases (Figure 2).

Key 2015 U.S. Statistics — Disciplinary Actions

State Medical Board Actions	2015
Total state medical board actions	7,942
Board actions by category	
License Restricted	1,238
Reprimand	1,043
Administrative	840
Fine	831
Suspension	706
Probation	693
CME Required	687
Conditions	582
Surrendered	448
Revoked	290
Denied	141
Other	443
Reciprocal actions taken by state boards	**1,197**
Number of disciplinary alerts issued by the FSMB	**12,555**
Number of physicians disciplined	**4,091**
Physicians put on probation	655
Physicians with a license suspension	594
Physicians with a license revocation	267

Source: Federation of State Medical Boards

State medical boards often work together to discipline physicians who practice in multiple jurisdictions. According to FSMB data, 21% of U.S. physicians hold two or more active licenses from different state medical boards. When a state medical board is notified that a physician licensed in its jurisdiction received a board action in another jurisdiction, the board can choose to open its own investigation or in many cases will choose to take a reciprocal action.

Based on the time sequence of physicians receiving disciplinary actions, the total disciplined physician population is comprised of three subgroups: physicians who received initial disciplinary actions; physicians who received reciprocal actions because of actions taken by other state boards; and physicians who received follow-up or additional actions taken later. As seen in Figure 3, there have been relatively minor fluctuations in the number of physicians disciplined for the first time during the past eight years. A look at the trend for reciprocal actions shows a rise in 2012 and 2013 with a return to previously seen levels in 2014 and 2015 (Figure 4).

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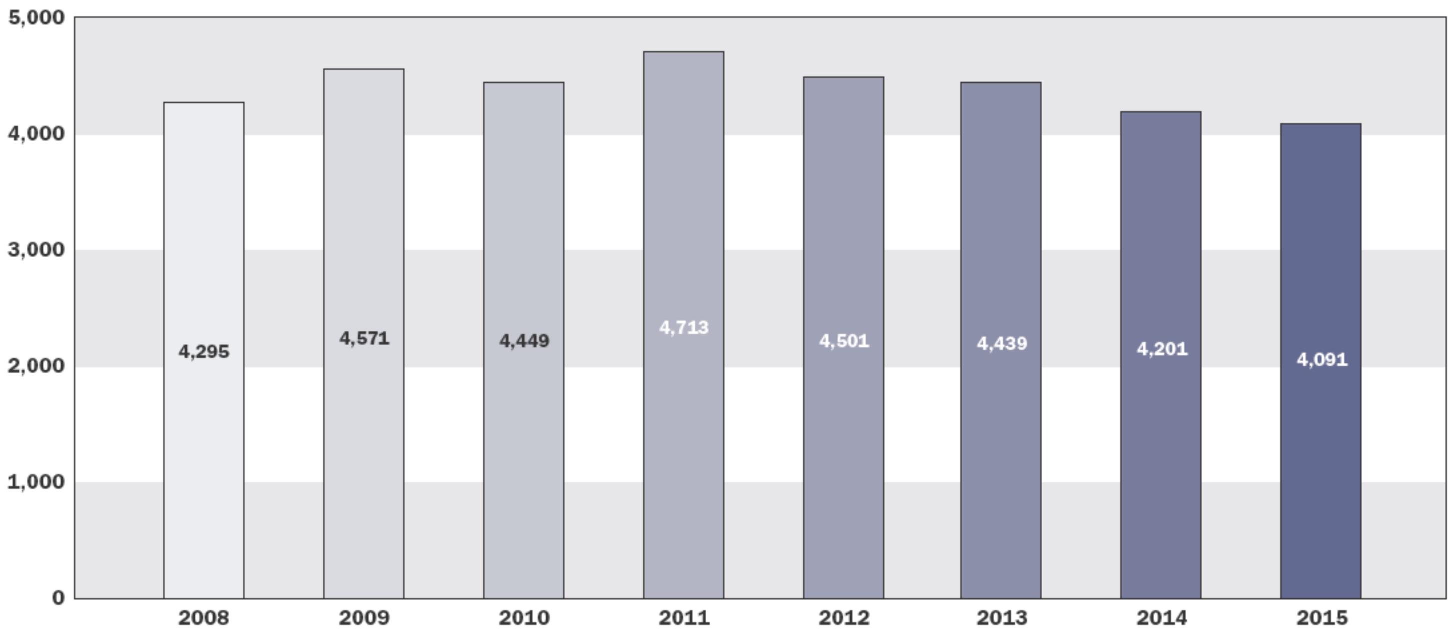
Figure 1
Number of Physicians with a Board Action by Year



Source: Federation of State Medical Boards

Understanding Board-Action Categories

State and territorial medical boards utilize a variety of tools as they go about the process of regulating the activities of physicians and other health professionals. When issues arise — whether they are minor, such as failure to pay a fee, or more serious, such as inappropriate behavior with a patient — "board actions" may be taken by state boards, allowing them the flexibility to apply a level of disciplinary response that is appropriate for the issue being addressed. Categories of board actions include:

Administrative action: Non-punitive action that does not result in the modification or termination of a physician's license. These actions are generally administrative and may be issued for reasons such as failure to pay a licensing fee.

Fine: In some cases, state boards may levy a monetary penalty against a physician.

CME required: Physician is required to complete continuing medical education (CME).

Conditions imposed: Physician must fulfill certain conditions to avoid further sanction by the state board.

License denied: Physician's application for a medical license or renewal of a current license is denied.

License restricted: Physician's ability to practice medicine is limited (e.g., loss of prescribing privileges).

License revoked: Physician's license is terminated; individual can no longer practice medicine within the state or territory.

License surrendered: Physician voluntarily surrenders medical license, sometimes during the course of a disciplinary investigation.

License suspended: Physician may not practice medicine for a specified period of time, perhaps due to disciplinary investigation or until other state board requirements are fulfilled.

Probation: Physician's license is monitored by a state board for a specified period of time.

Reprimand: Physician is issued a warning or letter of concern.

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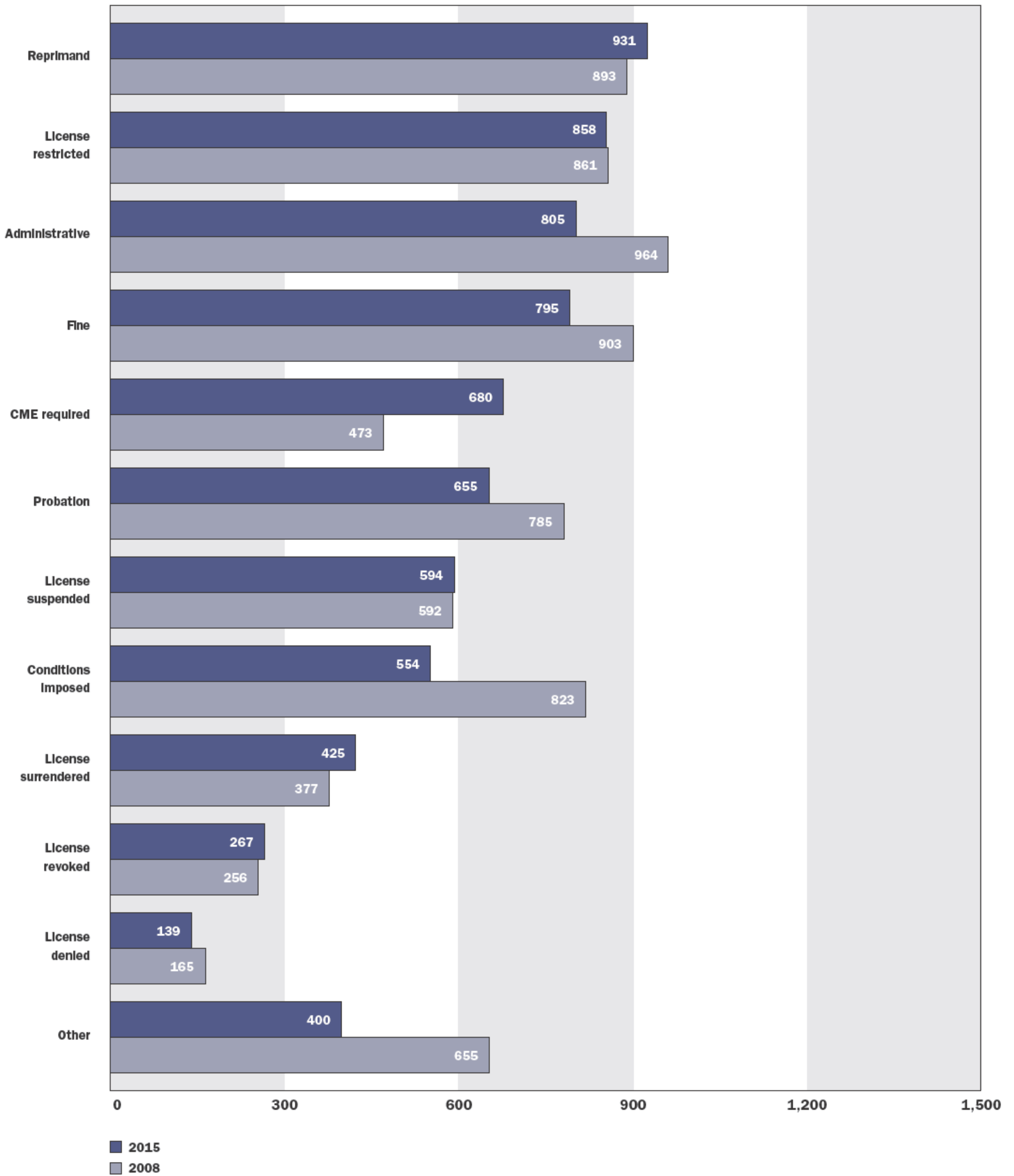
Figure 2

Number of Physicians Disciplined by Category of Action, 2008 and 2015



Source: Federation of State Medical Boards

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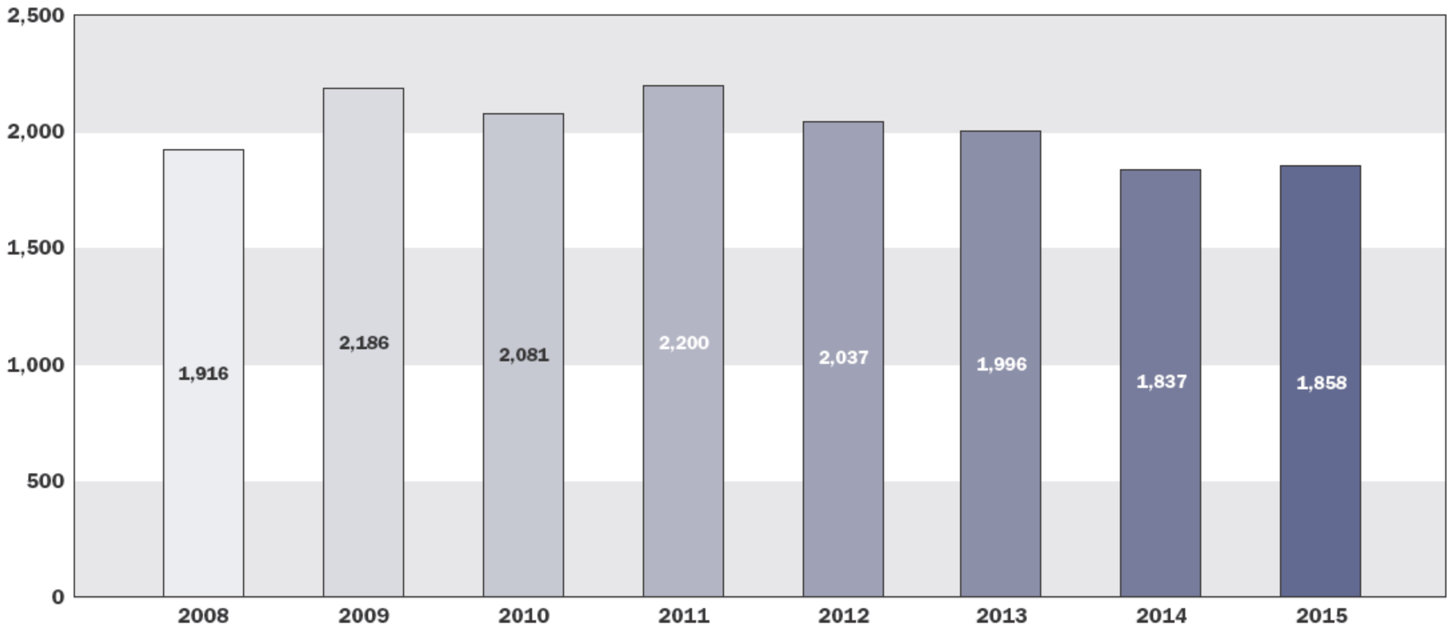
Figure 3

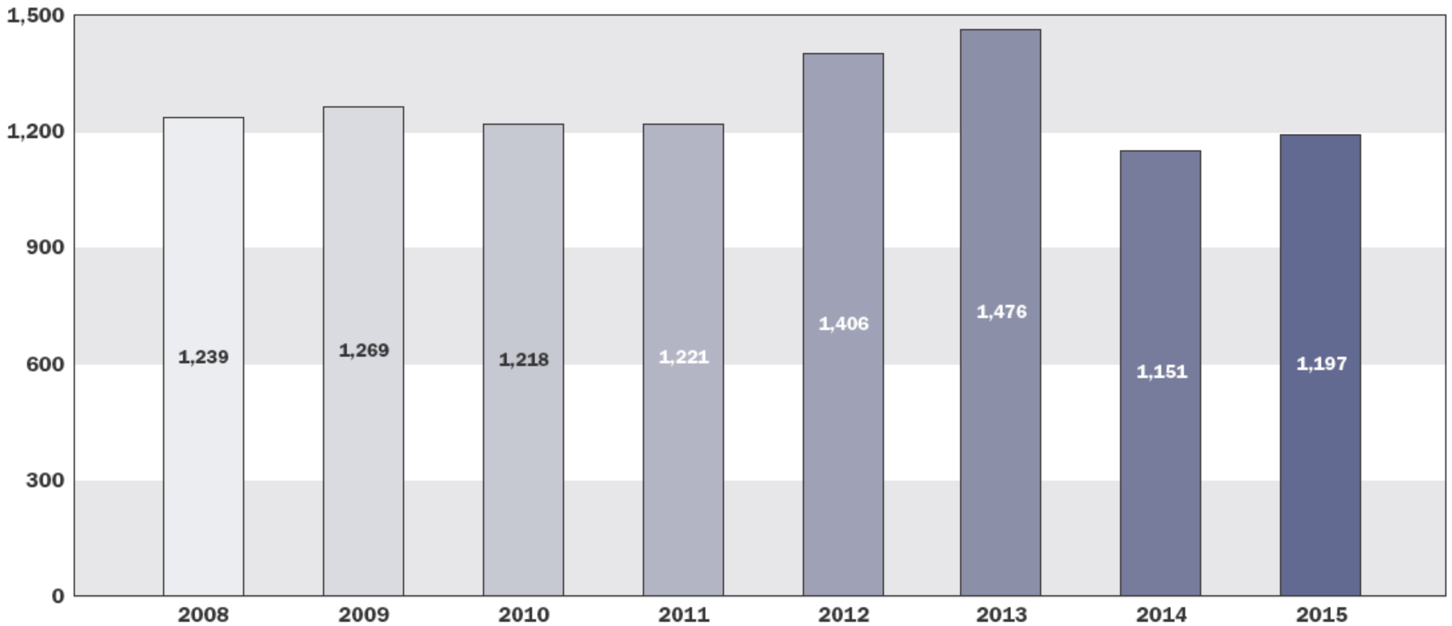
Number of First Time Disciplined Physicians By Year



Source: Federation of State Medical Boards

Figure 4

Number of Reciprocal Actions Taken by State Boards Each Year



Source: Federation of State Medical Boards

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Physician Licensure

Introduction

One of the most important functions of the 70 state and territorial medical boards in the United States is issuing licenses to physicians. This section provides background information and statistics about the licensing activities of these medical boards, including information from the FSMB's most recent analysis of licensed physicians in the United States.

Becoming a Licensed Physician in the United States

In the United States, medicine is a licensed profession regulated by the individual states. The nation's medical boards license both allopathic (MD) and osteopathic (DO) physicians. This includes 51 allopathic and composite (MD and DO) licensing boards, 14 osteopathic boards, and boards for the following jurisdictions: Guam, Puerto Rico, the U.S. Virgin Islands and the Commonwealth of the Northern Mariana Islands.

While the specific requirements for obtaining a medical license vary somewhat between jurisdictions, state medical boards review the credentials of applicants and look closely at a number of factors, including:

- Medical education
- Medical training (i.e., residency training)
- Performance on a national licensing examination
- Mental, moral and physical fitness to safely practice medicine

Medical Education: All jurisdictions require that candidates for physician licensure must have obtained an MD or DO degree. For most medical education programs in the United States, the MD or DO degree involves a post-baccalaureate four-year program of education. Graduates of international medical schools (IMGs) may present the equivalent of the MD degree (e.g., MBBS)

There are 147 allopathic and 33 osteopathic medical schools in the United States. All of these medical school programs are accredited by either the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association Commission on Osteopathic College Accreditation (AOA COCA).

It should be noted that acquisition of an MD or DO degree does not automatically confer a license to practice medicine in the United States. Indeed, the medical practice act in most jurisdictions restricts individuals holding a physician credential (i.e., MD or DO) from publicly representing themselves as physicians unless they hold a medical license in that jurisdiction.

Medical Training: After graduation from medical school, physicians routinely enter into postgraduate training (i.e., a residency training program). At one time it was common for physicians to spend their first year of postgraduate training (PGY-1) in an internship exposing them to a broad array of clinical scenarios. After this intern year, the physician then moved into the more specialized training of their chosen residency training program. Most physicians today do not experience a true rotating internship during PGY-1 but instead move directly into the specialized training of their residency program.

All state medical boards require licensure candidates to complete at least one year of postgraduate training in order to be eligible for a full and unrestricted medical license. In some jurisdictions, the requirement is higher — the physician must complete two or three years of residency training to obtain their license. In more than a dozen jurisdictions, progress through postgraduate training requires a physician to successfully complete the licensing examination sequence (see below) and obtain their full, unrestricted license before entering a designated point in their postgraduate training. For example, some jurisdictions require physicians in training to complete the licensing examination sequence prior to entering PGY-2 or PGY-3.

The postgraduate training period often marks the first formal interaction of prospective physicians with a state medical board, as most jurisdictions issue a resident or training permit for physicians to practice within the limited, supervised context of their program. Additionally, state medical boards require that the training be completed in a residency program accredited by either the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA)*. These programs are approximately three to seven years in duration, depending upon the specialty. (Note: Some state medical boards recognize training in accredited programs conducted in other countries, e.g., residency programs accredited by the Royal College of Physicians and Surgeons of Canada (RCPSC).)

* The AOA, ACGME, and the American Association of Colleges of Osteopathic Medicine (AACOM), agreed in 2014 to a single accreditation system for graduate medical education program in the United States, which will be implemented between 2015 and 2020.

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Licensing Examination: All state medical boards require completion of either the United States Medical Licensing Examination (USMLE®) or the Comprehensive Osteopathic Licensing Examination-USA (COMLEX).* These are national multi-part examinations taken at various points in the prospective physician's career and designed to assess physician knowledge, clinical and communication skills. Students in U.S. medical schools routinely take the first two Steps of the licensing examination prior to graduation from medical school. The final portion of the examination sequence is usually taken during residency training.

Many state medical boards impose specific criteria relative to the number of attempts and the time utilized by the physicians to complete the licensing examination sequence. Many boards limit the number of attempts a physician can make at the USMLE or COMLEX. Additional attempts are often allowed but only after redirecting physicians for additional training prior to their next sitting for the exam. Most boards place some limit on the time period for completing the examination sequence. These time and attempt limits are designed to ensure the currency and adequacy of knowledge of newly licensed physicians. More detailed information on "State-Specific Requirements for Initial Medical Licensure" is available from the FSMB at www.fsmb.org/licensure/usmle-step-3/state_specific

Fitness to practice: All state medical boards are concerned with the physical, mental and moral fitness of prospective licensure candidates. A number of boards explicitly define the practice of medicine in their licensure applications to ensure that physicians clearly understand the expectations for minimally acceptable performance. The licensure application in each state commonly asks questions about the personal history and background of the applicant, including work history, physical and/or mental conditions that might impact their ability to safely practice medicine. Criminal background checks at the time of license application are also conducted by many boards.

* The USMLE is open to physicians holding an MD or DO degree. Physicians with a DO degree usually complete the COMLEX-USA sequence.

Compared with U.S. medical graduates, IMGs follow a slightly different pathway after completing their medical education at a school outside the United States. Before entering into a residency training program in the United States, they must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG). This certification is required in order for IMGs to enter into an ACGME-accredited residency training program in the United States. ECFMG certification requires verification of the physician's medical degree and successful completion of USMLE Step 1 and 2. The timing with which IMGs complete the USMLE differs somewhat from that of U.S. medical students/graduates. While some IMGs begin the USMLE sequence during their medical school years, many more do not begin the sequence until after their graduation from medical school. Ultimately, IMGs take the same licensing examinations as U.S. MD graduates and obtain residency training in the same accredited programs.

When a physician submits an application and fee for a medical license within a jurisdiction, staff at the state medical board will verify credentials (e.g., medical degree, postgraduate training), confirm passage on the USMLE or COMLEX, query the FSMB's disciplinary data bank and closely review the responses to questions on the licensure application for missing or inconsistent information. In some instances, the board may request that the applicant appear for a formal interview before either the full membership, or a subcommittee, of the board.

The license that the physician receives from a state medical board is for the general, undifferentiated practice of medicine. Physicians in the United States are not licensed based upon their specialty or practice focus. Certification in a medical specialty, such as by a member board of the American Board of Medical Specialties (ABMS), is not required to obtain a medical license. However, other practical considerations (e.g., obtaining hospital privileges) lead most physicians to obtain specialty certification. The majority of physicians in the United States hold specialty certification through the ABMS or the AOA's Bureau of Osteopathic Specialists.

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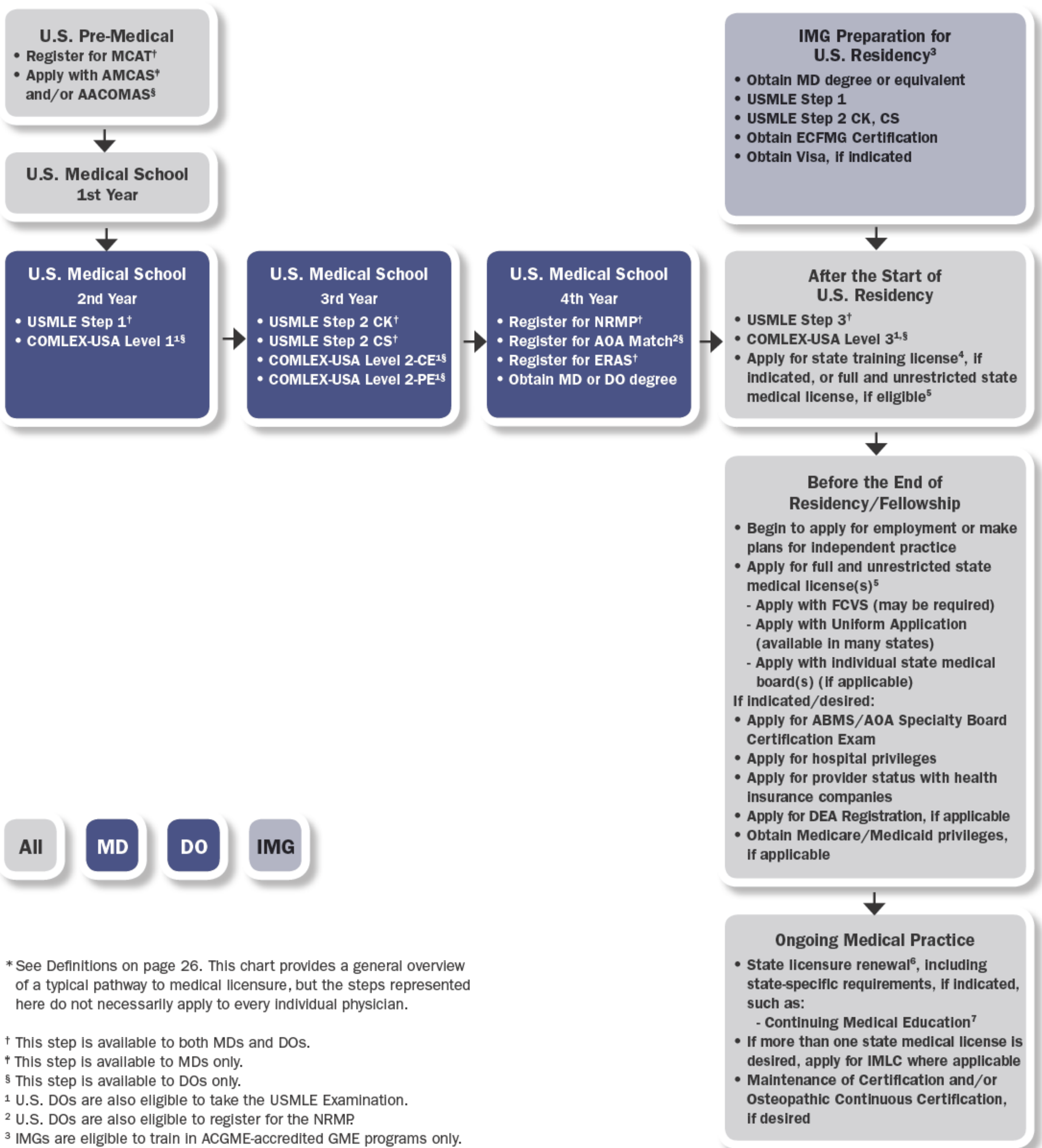
Figure 5

Pathway to Medical Licensure in the United States*



* See Definitions on page 26. This chart provides a general overview of a typical pathway to medical licensure, but the steps represented here do not necessarily apply to every individual physician.

† This step is available to both MDs and DOs.
‡ This step is available to MDs only.
§ This step is available to DOs only.
[1] U.S. DOs are also eligible to take the USMLE Examination.
[2] U.S. DOs are also eligible to register for the NRMP.
[3] IMGs are eligible to train in ACGME-accredited GME programs only.
[4] Training licensure requirements vary from state to state (41 state boards issue a resident/training license).
[5] Licensure eligibility differs from state to state.
[6] State licensure renewals vary from 1- to 3-year cycles.
[7] CME is usually accredited by the ACCME, AMA, AAFP and AOA.

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Figure 5 *continued*
Pathway to Medical Licensure in the United States

Definitions

(Note: These definitions explain terminology used in the Pathway to Medical Licensure *chart on the preceding page.)*

AACOMAS — The American Association of Colleges of Osteopathic Medicine Application Service is a centralized application service for colleges of osteopathic medicine in the United States through the American Association of Colleges of Osteopathic Medicine®.

AMCAS® — The American Medical College Application Service®, a program of the Association of American Medical Colleges, is a centralized application processing service that is only available to applicants to first-year entering classes at participating allopathic (MD) U.S. medical schools.

COMLEX-USA — The Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) is a multi-part assessment given by the National Board of Osteopathic Medical Examiners (NBOME) to students and graduates of osteopathic medical education programs accredited by the American Osteopathic Association's Commission on Osteopathic College Accreditation. The NBOME eligibility criterion requires COMLEX Level 1 to be taken after successful completion of the 1st academic year of an osteopathic medical school program. Level 2 Cognitive and Performance Evaluations (CE and PE) cannot be taken until after successful completion of the 2nd academic year and passing Level 1. The COMLEX-USA Level 3 is usually taken during residency training and after successful completion of Levels 1-2, though in certain circumstances Level 3 may be taken by osteopathic medical school graduates prior to beginning residency training.

ECFMG® — The Educational Commission for Foreign Medical Graduates (ECFMG) provides a certification program for international medical graduates (IMGs) to assess their readiness prior to entering into ACGME-accredited residency or fellowship training programs in the United States.

ERAS® — The Electronic Residency Application Service (ERAS®) was developed by the Association of American Medical Colleges (AAMC) to allow medical school students and graduates to apply electronically for residency positions in accredited U.S. programs of graduate medical education.

FCVS — The Federation Credentials Verification Service, a service of the Federation of State Medical Boards, establishes a permanent, lifetime repository of primary-source verified core credentials (medical education, postgraduate training, examination history, board action history, board certification and identity) for physicians and physician assistants. This repository can be forwarded, at the applicant's request, to nearly any state medical board, hospital, health care facility or other entity.

IMLC — The Interstate Medical Licensure Compact offers a new, voluntary, expedited pathway to licensure for qualified physicians who wish to practice in multiple states. While making it easier for physicians to obtain licenses to practice in multiple states, the Compact strengthens public protection by enhancing the ability of states to share investigative and disciplinary information. The Compact is being implemented in a growing number of states, with others expected to adopt it soon (www.licenseportability.org).

MCAT® — The Medical College Admission Test® is a standardized, multiple-choice examination designed to assess the examinee's problem solving, critical thinking, knowledge of science concepts and principles prerequisite to the study of medicine.

MOC® — The American Board of Medical Specialties (ABMS) assists 24 approved medical specialty boards in the development and use of standards in the ongoing evaluation and certification of physicians. In 2000, the 24 Member Boards of ABMS agreed to evolve their recertification programs to one of continuous professional development— ABMS Maintenance of Certification® (ABMS MOC®). In 2006, all Member Specialty Boards received approval of their ABMS MOC programs, which have 8-10 year renewal cycles.

NRMP® — The National Resident Matching Program provides a uniform date of appointment to positions in graduate medical education (GME). It provides an impartial venue for matching applicants' and programs' preferences for each other consistently.

OCC — The American Osteopathic Association (AOA) Bureau of Osteopathic Specialists consists of 18 specialty certifying boards. Effective in 2013, each AOA specialty-certifying board requires an Osteopathic Continuous Certification (OCC) process for all doctors of osteopathic medicine (DOs) with time-limited certifications. OCC runs on a 6-10 year cycle depending upon the specific specialty board.

UA — The Uniform Application, a service of the Federation of State Medical Boards, is a Web-based application that standardizes, simplifies and streamlines the licensure application process for MDs, DOs and Residents. Applicants fill out the online UA once and then use it whenever they apply for a license in another state for the rest of their careers. The UA is a standard licensure application form that serves as the core of a state's license application without replacing unique state-level requirements, which are collected and submitted via a state-specific addendum.

USMLE® — The United States Medical Licensing Examination® (USMLE®) is a jointly sponsored program of the Federation of State Medical Boards and the National Board of Medical Examiners®. The USMLE is open to students/graduates of accredited medical school programs issuing the MD or DO degree and to students/ graduates of international medical schools eligible for certification by the ECFMG. In general, Step 1 is usually taken at the end of the 2nd academic year of medical school; Step 2 Clinical Knowledge (CK) and Step 2 Clinical Skills (CS) are generally taken before the end of the 3rd academic year. Most examinees take Step 3 within the first 18 months of residency training, though under certain circumstances some IMGs and U.S. medical school graduates may take Step 3 prior to beginning residency training.

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FSMB Physician License Data

During the past 150 years, state medical boards in the United States have steadily evolved from entities that simply issued medical licenses based on minimal qualifications that at one time did not include a high school diploma prior to admission into medical school. Today, boards are multi-faceted and multi-staffed authorities responsible for protecting the public by granting licenses to only qualified individuals and ensuring that disciplinary and competency standards are upheld.

Because an active license is required to legally practice medicine, and physicians sometimes have more than one license, accurate information about a physician's credentials and licensure status has always been crucial to state medical boards to enable them to monitor a physician's practice, protect the public and promote quality health care. Accurate and up-to-date aggregate information about physicians' licensure status and credentials is also of critical value to state and federal policymakers interested in health care workforce assessments, predictions and planning.

Since 2010, the FSMB has been gathering information about physician licensure status and publishing it in the form of a national census of licensed physicians. The FSMB has published three censuses since 2010 and will publish its next census in 2017. Provided in this report are a summary, analysis and discussion of updated license statistics using FSMB's 2015 data from each of the state medical boards in the United States and the District of Columbia. In aggregate, the information included in this report offers a snapshot of the number, gender, age, specialty board certification and location by state of all actively licensed physicians in the United States.

License data is drawn from the Physician Data Center (PDC), the FSMB's central repository of data from every state medical board in the United States. To obtain an accurate count and precise information about physicians with an active, current license to practice medicine, the FSMB conducted a comprehensive analysis using 2015 license data obtained by the Physician Data Center.

License data is continuously provided throughout the year to the Physician Data Center by the 51 state medical boards (which regulate both allopathic and osteopathic physicians) and 14 state osteopathic boards (which only regulate osteopathic physicians) in the United States and the District of Columbia. Four additional territorial medical boards (Guam, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands and Puerto Rico) are also member boards of the FSMB, but their physician data was excluded from the current analysis. Because of their differing capacities and resources, state boards submit information to the Physician Data Center at varying intervals throughout the year. Most state boards provide medical licensure information to the Physician Data Center on a monthly basis, with some boards able to provide such data weekly or even daily.

A physician record in the Physician Data Center is typically initiated when a U.S. medical school student or an international medical graduate (IMG) first registers to take the United States Medical Licensing Examination (USMLE), a program created in 1992 that is co-sponsored by the Federation of State Medical Boards and the National Board of Medical Examiners and is required of U.S. and IMG allopathic physicians for licensure eligibility by state medical boards.

For U.S. osteopathic medical students who do not register for the USMLE* and for physicians who were first licensed prior to the introduction of the USMLE and the Comprehensive Osteopathic Medical Licensure Examination (COMLEX-USA) in the early 1990s, license files from state boards serve as the initial Physician Data Center record and the source for a physician's record of successful completion of a licensure examination.

When the Physician Data Center receives additional physician data, each record is matched to a master physician identity table using a set of algorithms developed by the FSMB. This systematic process allows the FSMB to track the same physician across multiple jurisdictions if more than one state license is sought at any time during the physician's professional career.

Though physicians in the United States are not licensed based on their specialty or practice focus, and specialty board certification is not a requirement for medical licensure, the Physician Data Center receives and supplements license data provided by state boards with specialty and subspecialty certification information obtained from the American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AOA). Deceased physicians are also identified and flagged in the Physician Data Center by cross-referencing physician records with the Death Master File of the Social Security Administration (SSA), a federal database that contains more than 94 million records of reported deaths.

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* Doctors of Osteopathic Medicine (DO) usually take the Comprehensive Osteopathic Medical Licensure Examination (COMLEX-USA)

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2015 Physician License Statistics and Trends

An analysis of license data collected in 2015 in the United States and the District of Columbia reveals that there were 931,921 physicians with an active license to practice medicine, representing a net increase of 6% since 2012. State medical boards issued 79,629 new licenses to physicians during 2015, a figure which includes physicians obtaining their first license, one or more additional licenses (enabling practice in multiple jurisdictions) or a new license when moving from one jurisdiction to another. 20,857 physicians received their first medical license from a state medical board in 2015.

Table 1
2015 Physician License Statistics

Physicians with an Active License to Practice Medicine in the United States and the District of Columbia	Counts	Percentages
Total Number of Licensed Physicians in the United States	**931,921**	**100.0%**
Total Number of Licenses Issued during 2015		
Total	79,629	8.5%
First Licenses Issued	20,857	2.2%
Degree Type		
Doctor of Medicine (MD)	852,534	91.5%
Doctor of Osteopathic Medicine (DO)	77,228	8.3%
Unknown	2,159	0.2%
Medical School Type		
U.S. and Canadian Graduates (MD or DO)	699,661	75.1%
International Medical Graduates	210,703	22.6%
Unknown	21,557	2.3%
Age		
Less than 30 years	17,453	1.9%
30–39 years	202,910	21.8%
40–49 years	224,660	24.1%
50–59 years	216,253	23.2%
60–69 years	177,556	19.1%
70 + years	87,290	9.4%
Unknown	5,799	0.6%
Gender		
Male	608,203	65.3%
Female	306,691	32.9%
Unknown	17,027	1.8%
ABMS or AOA Board Certified vs. Non-Board-Certified		
Yes	744,833	79.9%
No	187,088	20.1%
Number of Active Licenses		
1	735,507	78.9%
2	141,547	15.2%
3 or more	54,867	5.9%

Source: 2015 FSMB Census of Licensed Physicians

As in 2012, the vast majority (92%) of actively licensed physicians in 2015 are allopathic physicians (MDs), while osteopathic physicians account for 8% of the actively licensed population (Table 1). Although there are substantially fewer physicians with a DO degree compared to those with a MD degree, the osteopathic medical profession is growing at a faster rate. From 2012 to 2015, the number of licensed physicians with a DO degree increased by 22%, compared to a 5% increase in the number of licensed physicians with an MD degree.

In 2015, 75% of physicians graduated from a U.S. or Canadian medical school (allopathic or osteopathic), 23% were international medical graduates (IMGs), and for 2% of physicians, the medical school of graduation could not be determined because the information was not provided to the PDC. The actively licensed physicians identified in 2015 graduated from a total of 1,993 medical schools in 167 countries around the world. From 2012 to 2015, the number of actively licensed physicians who graduated from U.S. or Canadian medical schools increased by 6%, compared to a 7% increase of IMGs.

Table 2 lists the 10 U.S. allopathic and osteopathic medical schools with the largest number of graduates who have an active license to practice medicine in the United States. The 10 largest allopathic programs have produced about 10% of all licensed allopathic physicians. The 10 colleges of osteopathic medicine with the largest number of licensed physicians account for the majority (63%) of the nation's osteopathic physicians.

Table 3 provides a list of the 10 medical schools outside the United States or Canada that had the largest number of graduates with an active license to practice medicine in the United States. These 10 international medical schools account for 20% of IMGs with an active license in the United States.

Among the 210,703 actively licensed IMG physicians, the most graduated from India (48,704 or 23%), followed by the Caribbean (33,340 or 16%), the Philippines (13,662 or 6%), Pakistan (12,028 or 6%) and Mexico (10,032 or 5%). The data also highlights a continued and substantial increase in the number of actively licensed physicians who graduated from a medical school in the Caribbean (Figure 6).* Caribbean medical school graduates represent 16% of actively licensed IMG physicians in 2015 compared to 13% in 2012. While the total number of IMGs with an active license in the United States increased by only 7% since 2012, the number of physicians who graduated from the Caribbean increased by 28% during the same time period (Figure 7). More than half (58%) of the licensed IMGs from Caribbean medical schools are U.S. citizens, an increase of 43% since 2012 (Figure 8).

* Medical schools in Puerto Rico and the U.S. Virgin Islands are not included in the FSMB's census in the listing of graduates from medical schools in the Caribbean because they are territories of the United States and have medical schools that are accredited by the Liaison Committee on Medical Education.

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Background Information

- Exclusion Authorities

OIG has the authority to exclude individuals and entities from Federally funded health care programs pursuant to sections 1128 and 1156 of the Social Security Act and maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals and Entities (LEIE). Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties (CMP).

Exclusions are imposed for a number of reasons:

Mandatory exclusions: OIG is required by law to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses: Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare, Medicaid, SCHIP, or other State health care programs; patient abuse or neglect; felony convictions for other health care-related fraud, theft, or other financial misconduct; and felony convictions relating to unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

Permissive exclusions: OIG has discretion to exclude individuals and entities on a number of grounds, including misdemeanor convictions related to health care fraud other than Medicare or a State health program, fraud in a program (other than a health care program) funded by any Federal, State or local government agency; misdemeanor convictions relating to the unlawful manufacture, distribution, prescription, or dispensing of controlled substances; suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; provision of unnecessary or substandard services; submission of false or fraudulent claims to a Federal health care program; engaging in unlawful kickback arrangements; and defaulting on health education loan or scholarship obligations; and controlling a sanctioned entity as an owner, officer, or managing employee.

To avoid CMP liability, health care entities need to routinely check the LEIE to ensure that new hires and current employees are not on the excluded list.

The effects of an exclusion are outlined in the Updated Special Advisory Bulletin on the Effect of Exclusions From Participation in Federal Health Programs, but the primary effect is that no payment will be provided for any items or services furnished, ordered, or prescribed by an excluded individual or entity. This includes Medicare, Medicaid, and all other Federal plans and programs that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan).

OIG's exclusions process is governed by regulations that implement sections of the Social Security Act. When an individual or entity gets a Notice of Intent to Exclude, it does not necessarily mean that they will be excluded. OIG will carefully consider all material provided by the person who received the Notice as we make our decision. All exclusions implemented by OIG may be appealed to an HHS Administrative Law Judge (ALJ), and any adverse decision may be appealed to the HHS Departmental Appeals Board (DAB). Judicial review in Federal court is also available after a final decision by the DAB.

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Accreditation Options: Understanding The Joint Commission

Written by Sena Blickenstaff, MBA, BSN, RN | July 07, 2014

The Joint Commission is, by far, the biggest name in hospital accreditation.

Formerly known as the Joint Commission on the Accreditation Healthcare Organizations, TJC's mission is "to continuously improve healthcare for the public in collaboration with other stakeholders, by evaluating healthcare organizations and inspiring them to excel in providing safe, effective care of the highest quality and value." Currently, TJC accredits more than 4,067 general, children's, long-term acute, psychiatric, rehabilitation and specialty hospitals throughout the United States.

Officially founded in 1951, TJC was granted deeming authority for hospitals through Social Security Amendments enacted in 1965. Organizations accredited by TJC are "deemed" to be in compliance with CMS' Conditions of Participation. However, accreditation by TJC does not mean an organization will not be surveyed by CMS. Like other accrediting bodies, TJC is required to reapply for deemed status on a regular basis, and its current deeming authority for acute-care hospitals extends to 2014. In addition, TJC maintains deemed status for ambulatory healthcare, behavioral healthcare, clinical laboratory services, critical access hospitals, home health, hospitals, nursing care centers and office-based surgery. Disease-specific certification is available in a variety of topics and includes core-level and advanced programs. TJC also provides international accreditation and certification.

The standards
TJC presents its standards as "the basis of an objective evaluation process that can help healthcare organizations measure, assess and improve performance." The standards target important elements of patient care and functions within an organization's structure that are essential to providing safe, high-quality care. In essence, TJC standards are meant to encourage continuous progress toward high-quality and safety in patient care, treatment and services by setting the bar high. Whereas the CMS CoPs are basic requirements designed to ensure that a minimum, fundamental level of safety and quality is achieved, TJC standards reach beyond the CoPs and reward hospitals for attempting to deliver a higher level of service.

TJC standards and National Patient Safety Goals are developed through a thorough process involving consideration of scientific literature and input from healthcare professionals, providers, subject matter experts, consumers, government agencies and employers. New standards and NPSG are added only if they relate to patient safety or quality of care, have a positive impact on health outcomes and can be accurately measured. They are then reviewed by TJC's Board of Commissioners and distributed nationally (and posted on the TJC website) for comment from healthcare providers. If necessary, the draft standards and NPSG may be revised and again reviewed by the appropriate experts before finally being approved by the Board of Commissioners.

The survey process
The Joint Commission utilizes a combination of tracer methodology, documentation review, staff, medical staff and leadership interviews, and additional on-site observation to verify compliance with standards. During an actual TJC survey, surveyors will conduct individual and system tracers to validate

compliance with TJC standards (and CMS Conditions of Participation for deemed status organizations) and individual elements of performance and to identify any risks to patient safety and/or quality of care, treatment and services. Individual tracers follow the experience of care through the entire healthcare process in the organization. System tracers evaluate the integration of related care processes, including coordination of care amongst all disciplines and departments involved in the patient's care, the competency of staff to provide safe, effective and high-quality patient care, and the use of data and performance improvement methodology to enhance and sustain improvement.

For hospitals, TJC surveys are unannounced and can occur between 18 and 36 months after each organization's previous full survey. So, as an example, if a hospital's last survey occurred on Jan. 1, 2011, its next survey could take place as early as July 1, 2012, or as late as Jan.1, 2015.

There are 18 over-arching TJC standards that focus on patient safety and quality of care. Each standard is broken down into elements of performance, which are used by TJC surveyors to validate and measure compliance with the quality and safety of patient care, treatment and services. During a survey, EPs are scored on a three-point scale (0 = insufficient compliance, 1 = partial compliance, 2 = satisfactory compliance); those scores lead to an overall picture of compliance and, ultimately, an accreditation decision. The accreditation decision process focuses on how critical an issue is to patient care or safety.

At the organization exit conference, the survey team presents a Summary of Survey Findings Report. In this preliminary report, organizations do not receive an accreditation decision or any scores. Rather, the final accreditation decision is made after TJC receives and approves the hospital's submitted Evidence of Standards Compliance for any Requirements for Improvement identified during the survey. As of January 1, 2013, TJC's accreditation decision categories are as follows:

- Preliminary accreditation
- Accreditation
- Accreditation with follow-up survey
- Contingent Accreditation
- Preliminary denial of accreditation
- Denial of accreditation

Benefits

TJC accreditation can be considered to encourage a culture of continuous improvement and attention to compliance, due to the way it measures adherence to standards, which are based on industry standards of care, such as the CDC, AAMI, WHO, NFPA, etc., and evidence-based best practice. Apart from the accreditation survey itself, TJC requires other measures of an organization’s compliance status, most notably an annual Focused Standards Assessment.

The Joint Commission implemented a new Intracycle Monitoring process, which became effective Jan.1, 2013. The underlying premise to this new process, the FSA, is for the organization to conduct a "proactive risk assessment" specific to patient quality and safety to help identify and manage risks. According to TJC, this process replaces and is designed to enhance the former Periodic Performance Review process. Many organizations find the use of mock tracer activities to be an effective means of managing the proactive risk assessment and coordinating the completion of the FSA process.

Under the new FSA process, risk is assessed by probability of harm, severity of harm, proximity to the patient and potential number of patients at risk. Standards that are identified by the organization as high risk will be reported on annually. And while all standards and elements of performance can be scored as part of the FSA, TJC only requires that those standards identified as "Risk Standards" (denoted with the R icon in the standards manuals), must be scored and a plan of correction developed, with a supporting

measure of success if required under the element of performance, to address each non-compliant element of performance. There are several options for completing the FSA and communicating that process to TJC, which is outlined in the Accreditation Process Chapter of TJC's standards manual. When preparing for the FSA process, organizations should also review TJC's Accreditation Participation Requirements (APR.03.01.01) specific to the FSA for additional elements of performance that must be followed when performing the FSA.

Costs
As with most accreditation bodies, the costs associated with TJC accreditation derive primarily from participation fees. Hospitals and other healthcare organizations are charged an annual fee (in January of each participating year) to be part of TJC's accreditation program. Annual fees for hospitals are based on the size and complexity of each individual organization and range significantly. In addition, participating healthcare organizations are billed for the costs associated with surveys.

TJC standards are provided electronically to hospitals free of charge. Accredited organizations can purchase a print copy of the appropriate standards manual, as well as access to the electronic edition of the manual for institutional use.

More information about accreditation by The Joint Commission can be found at www.jointcommission.org.

Read the other installments of our "Accreditation Options" series, which discuss accreditation as a strategic choice, as well as HFAP, DNVHC (coming soon), and CIHQ accreditation (coming soon).

Sena Blickenstaff has more than 25 years of progressive experience in healthcare leadership and is uniquely equipped to help hospitals achieve compliance with regulatory and accreditation standards and to enhance clinical programs and services and service lines. She previously served as a Joint Commission and CMS deemed-status surveyor, and her close familiarity with the standards along with her collaborative and integrative approach enable her to effectively engage, educate and empower organizations to enhance quality and safety.

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American Board of Medical Specialties
353 North Clark Street, Suite 1400
Chicago, IL 60654
T: (312) 436-2600
F: (312) 436-2700 www.abms.org

Fact Sheet

American Board of Medical Specialties® (ABMS®)

Established in 1933, the American Board of Medical Specialties (ABMS) is the leading not-for-profit organization overseeing physician certification in the United States. ABMS establishes the standards its 24 certifying boards (Member Boards) use to develop and implement professional standards for the certification of physicians in their declared medical/surgical specialty. Certification by an ABMS Member Board is widely recognized as the highest health care industry standard and trusted credential for assuring a physician's knowledge, experience, and skills within a medical specialty.

- The Joint Commission, NCQA, URAC, health care institutions, insurers, government, physicians, and patients all use Board Certification status by an ABMS Member Board as an essential tool for physician credentials within a given medical specialty.
- Board Certification and the ABMS Program for Maintenance of Certification (ABMS MOC®) are highly-visible indicators that physicians know today's standards of practice.
- Board Certification is the beginning of a physician's personal commitment to providing quality patient care.
- ABMS Member Boards certify more than 80 percent of all licensed physicians in the United States.
- ABMS Program for MOC activities emphasize ongoing professional development and assessment that is aligned with other professional expectations and requirements within health care.
- More than 880,000 physicians are certified in one or more of the approved 40 specialties and 85 subspecialties offered by the ABMS Member Boards.
- The 24 Member Boards of ABMS include the: American Board of Allergy and Immunology, American Board of Anesthesiology, American Board of Colon and Rectal Surgery, American Board of Dermatology, American Board of Emergency Medicine, American Board of Family Medicine, American Board of Internal Medicine, American Board of Medical Genetics and Genomics, American Board of Neurological Surgery, American Board of Nuclear Medicine, American Board of Obstetrics and Gynecology, American Board of Ophthalmology, American Board of Orthopaedic Surgery, American Board of Otolaryngology – Head and Neck Surgery, American Board of Pathology, American Board of Pediatrics, American Board of Physical Medicine and Rehabilitation, American Board of Plastic Surgery, American Board of Preventive Medicine, American Board of Psychiatry and Neurology, American Board of Radiology, American Board of Surgery, American Board of Thoracic Surgery, and American Board of Urology.

Initial Board Certification
Physicians demonstrate their expertise in a medical specialty by earning Board Certification through one of the 24 ABMS Member Boards. Before physicians can become Board Certified, however, they must first:

- Finish four years of premedical education in a college or university;
- Earn a medical degree (MD, DO or other credential approved by an ABMS Member Board) from a qualified medical school;
- Complete three to five years of full-time experience in a residency training program accredited by the Accreditation Council for Graduate Medical Education (ACGME);
- Provide letters of attestation from their program director and/or faculty;
- Obtain an unrestricted medical license to practice medicine in the United States or Canada; and
- Pass a written and, in some cases, an oral examination created and administered by an ABMS Member Board.

Maintenance of Certification
Once Board Certified, physicians maintain their medical specialty expertise by participating in a robust continuous professional development program known as the ABMS Program for MOC. This program provides physicians a structured approach to improving the effectiveness, safety, and efficiency of their practices through focused assessment, learning, and improvement activities.

The ABMS Program for MOC involves ongoing measurement of six core competencies defined by ABMS and ACGME.

- Practice-based Learning and Improvement
- Patient Care and Procedural Skills
- Systems-based Practice
- Medical Knowledge
- Interpersonal and Communication Skills
- Professionalism

These competencies, which are the same ones used in the ACGME's Next Accreditation System, are measured in the ABMS Program for MOC within a four-part framework:

- Part I: Professionalism Professional Standing
- Part II: Lifelong Learning and Self-Assessment
- Part III: Assessment of Knowledge, Judgment and Skills
- Part IV: Improvement in Medical Practice

All Programs for MOC implemented by the Member Boards measure the same six competencies within the same four-part framework. While these elements are consistent across all Member Boards, what may vary, according to the specialty, are the specific activities the Member Boards use to measure these competencies. Despite some variation in the activities, they are all built upon evidence-based guidelines, national clinical and quality standards, and specialty best practices.

Professional Standards
For more than 85 years, ABMS and the Member Boards have evolved the educational and professional standards for certification and medical specialty practice to support advancements in medicine, science, and technology.

The Member Boards look to the standards to guide the assessment process for their Board Certification programs and the development of their Programs for MOC. The ABMS Member Boards Community routinely reviews the standards to help ensure that the ABMS Program for MOC reflects the proliferation of medical knowledge and advancing technology, the rapidly changing skill sets required by Board Certified physicians to provide optimal care for their patients, and the increasingly complex environment in which Board Certified physicians practice. In 2015, the ABMS standards were updated, placing a greater emphasis on:

- Professionalism (how physicians carry out their responsibilities safely and ethically).
- Patient safety (how physicians use patient safety knowledge to reduce harm and complications).
- Performance improvement (how physicians use the best evidence and practices compared with peers and national benchmarks to treat patients as well as engage in quality and practice improvement activities).
- Incorporating judgment (not just what the physicians know but what they do with that knowledge) into examinations.

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