

White Paper in Opposition to Federation of State Medical Boards (FSMB) Proposal on Maintenance of Licensure

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The Federation of State Medical Boards (FSMB) has established a Special Committee on Maintenance of Licensure in order to explore “a new way to assure the public that physicians retain skills throughout their careers.”

While state licensure boards may establish a rigorous procedure for granting initial licensure, the FSMB writes: “In virtually all states, it is possible for a physician to practice medicine for a lifetime without having to demonstrate to the state medical board that he or she has maintained an acceptable level of continuing qualifications or competence.”¹

Citing rapid advances in science and technology, the FSMB thinks this leniency is no longer acceptable, and has drafted a 58-page report that was submitted for comments due in January 2008.¹

Unnoticed by most state licensure boards and medical organizations, the effort by the FSMB to subject physicians to increasingly intrusive regulation has been going on for some time, with the support of the American Association of Retired Persons (AARP), the American Medical Association (AMA), Blue Cross/Blue Shield Association, and the Robert Wood Johnson Foundation. The “guidance”² for the “core competencies” that physicians would have to demonstrate is derived from a document published in the UK about 10 years ago.

James Carland, M.D., chief executive officer of the Mutual Insurance Company of Arizona (MICA), which provides professional liability insurance to the majority of Arizona physicians, told the Arizona Medical Association of concerns about increased liability exposure, noting a rapid escalation of malpractice claims against British physicians.³

The Association of American Physicians and Surgeons (AAPS) filed extensive comments⁴ expressing serious concerns about the need for this intrusion, its claimed effectiveness in achieving the stated goals, and the effect of the proposed requirements on physician autonomy, professionalism, and medical costs. These reflect the AAPS view of the role of the FSMB (a private body) and of government; the causes of the perceived crisis in medical costs, access, and quality; the rights and responsibilities of physicians; and the need to hold regulators accountable.

What Is the FSMB?

The Federation of State Medical Boards (FSMB) is a tax-exempt organization representing the 70 medical boards of the

United States and its territories. On its website, www.fsmb.org, it states its mission as follows: “To continuously improve the quality, safety and integrity of health care through developing and promoting high standards for physician licensure and practice.” There is no hint of recognition that beyond a certain limit, pursuit of “continuous improvement” takes more resources than it is worth, for marginal effects.

Based in Dallas, Texas, the FSMB “serves as the national voice for its member boards” and is a “recognized authority throughout the United States on issues related to medical licensure and discipline.” The authority of the FSMB may be “recognized” by state medical boards, but unlike state medical boards, it has no statutory authority. It promotes uniformity in policy and maintains an extensive database on disciplinary actions. According to its Internal Revenue Service form 990 for 2006, it has about \$31 million in revenue, of which nearly \$30 million is program service revenue, principally \$20 million from re-scoring examinations, \$3 million from exam history searches, and \$6 million from disciplinary searches.

AAPS Comments on Objectives and Priorities

AAPS suggests that if the objective of the FSMB is to improve the quality of medical services available to Americans, it should at all times employ evidence-based principles in diagnosing problems and prescribing remedies.

The first step to be taken before setting new requirements for physicians should be to prioritize the problems that may impair Americans’ access to competent medical services. This requires study of the extent and severity of problems, including (but not necessarily limited to) the following, and of their effect on the quality and availability of medical services:

1. Early retirement of physicians with years of clinical experience, including voluntary retirement due to weariness with continued harassment and busywork emanating from bureaucracies, and involuntary retirement due to unwarranted licensure board actions;
2. Poorer quality of applicants to medical school;
3. Less time devoted to patient care, or to each episode of care, by physicians, owing to (a) social factors such as expectations of more free time for other activities, (b) regulatory demands, and (c) the necessity to increase “throughput” to bring in adequate revenue;
4. Shortage of American-trained physicians, with increased reliance on foreign-trained physicians with suboptimal English language skills; and

5. Demoralization of the profession because of fear, intimidation, harassment, and regulatory excesses.

Medical Errors and Physician Competence

As it does not mention any of the above, the FSMB apparently believes that a much higher priority is the hypothetical possibility that practicing physicians, or physicians who have not been in what they consider to be a sufficiently active practice for an undefined length of time, may be incompetent. No evidence, however, has been presented. Rather, the FSMB justifies the call for increased regulation by citing political (“public”) pressure and referring to the frequently quoted Institute of Medicine (IOM) Report on medical errors.⁵

Apparently, the FSMB accepts the IOM’s conclusions without a critical look at the methodology, such as extrapolation from a small number of cases, unclear definitions of “error,” and uncertainty about whether the patient’s death had anything to do with the “error.” More to the point, the FSMB makes no analysis of the basic competence of the physicians’ care and the differential diagnosis of causes of error, for example, inadequate nursing staff, reliance on agency nurses unfamiliar with the institution, overtired nurses having to work double shifts, pharmacy error, poor intrahospital communications, poor hospital risk management, pressure to discharge patients quickly, staff distraction by excessive documentation requirements, fragmentation of nursing tasks with delegation of too much to undertrained aides or technicians, etc.

The FSMB also makes the unjustified assumption that if physician incompetence is a problem, it is the result of under-regulation by the medical board and could be corrected by more busywork imposed by the board. More likely, the existence of this problem would be an indictment of the medical education system and of its failure to select well-prepared, self-motivated applicants able to understand and meet the requirements of their jobs. It is also an indictment of the continuing medical education that physicians are already forced to receive. Indeed, the FSMB acknowledges the problem that CME may not translate into any improved outcomes or quality—despite the expensive and bureaucratic procedures that Category 1 CME sponsors must go through. The CME community is said to have made “great strides in addressing concerns about CME’s impact on physician practice and in developing CME programs and criteria that address physician performance and lifetime learning.” So far, this progress has not filtered down to our hospital’s CME Committee, of which I am chairman—only the demand from the accrediting agency that our committee somehow figure out how to make it happen and to “document” that it was accomplished.

If the system suffers from these basic failings, how would they be mitigated by demanding still more evaluations, tests, surveys, and documentation? If such unending requirements could correct problems in medical practice, why are they missing from political practice and law?

The Need for Evidence-Based Outcomes Research

Proposed remedies should be based on evidence of their effect on actual outcomes. As in medicine, all remedies have a cost and potential adverse effects.

Where is the evidence—if any—that time taken away from patient care to meet the proposed requirements results in improved outcomes for patients? Might outcomes actually be worse? Are there even any studies? Is there any evidence that studying for a specialty board’s test is a more effective method than learning about problems actually encountered in one’s individual practice or about therapies that one might actually use? The FSMB implicitly recognizes that there is none: It acknowledges that previous proposals were rejected because of concerns about a negative impact on the workforce, or resistance from professionals based on lack of evidence of a positive effect on quality of patient care. Nothing has happened to diminish these concerns.

The proposals would indeed be extremely costly. For example, a physician who wished to reenter practice, say after taking time off to bear children, might have to pay for a practice monitor who is actively practicing in the same specialty. Many, if not most, qualified specialists are likely already working harder than they wish, or even than they should. It may be impossible to find, much less afford a monitor. The cost of the other suggestions, such as a “formal assessment program” or “mini-residency,” is also likely to be prohibitive, especially for heavily indebted physicians in lower-earning specialties. If the new requirements force physicians to stay out of the workforce despite their long years of training, will patients be better off seeing physician assistants or nurse practitioners with much less education?

No additional requirements should be imposed on physicians—unless an environmental impact study were to show that the benefits clearly exceed the costs, burdens, and adverse consequences, such as misdirected study, chilled innovation, deterioration of quality in areas not subjected to measurement, and worsened physician shortages. Continuing quality assessment of any quality improvement program must be carried on, and measures that are not affirmatively found to be beneficial should be discontinued because it is harmful to force physicians to waste their time on nonproductive or counterproductive activity.

It should be noted that physicians in solo practice, once the mainstay of medical practice, would be especially burdened by new requirements. Indeed, the FSMB seems to be actually hostile to this group of physicians, although they provide services in otherwise unserved areas, and offer patients options they would be unable to find within corporate structures. In fact, one of the “core competencies” developed by the Accreditation Council for Graduate Medical Education is “systems-based practice.” This is a radical departure from patient-based practice, and it is unclear how it would exist in a solo practice. The term is undefined, not validated, and not shown to be superior to patient-based practice. There is certainly no justification for using it to demolish a form of

medical practice that has endured for centuries and is still chosen by many physicians and patients.

An Alternate Proposal

If medical licensure boards are perceived as doing a poor job, then *their* performance should be assessed. The FSMB should take responsibility for proposing appropriate methods for monitoring the monitors before suggesting methods—untested or considered, a priori, to be unsuitable for their own members—to be imposed on the profession as a whole.

State legislatures should establish a standing oversight committee to assure that the public is getting the quality performance expected of its licensure board. The oversight committee should establish performance measures. Board members should receive appropriate training, and their adherence to the measures should be periodically assessed, with review of any pertinent records. Of course, board members should have to meet exacting qualifications for the job, including certification and recertification at least as demanding as required of licensees, and their credentials should be investigated and validated. Failure to meet performance standards, or violation of ethical standards, should result in a report to a national data bank, and to sanctions against the licenses of board members who are medical professionals.

While most, if not all, of the publicized criticism of licensure boards has concerned inadequate discipline of licensees, AAPS has encountered many instances of physicians being deprived of their livelihood because of debatable quality standards, or even the whims and prejudices of influential board members. There is thus a compelling need to establish clear and rational standards for licensure boards, not simply “quality” ratings based on counts of adverse actions, whether warranted, inappropriate, or egregiously unjust.

Ethical and Performance Standards

1. ***Clear definition of, and respect for, physicians’ due process rights.*** Physicians constitute a valuable community asset, and their years of education and experience must not be squandered. Rights include:
 - a. The right to know the charges and their source
 - b. The right to confront and cross-examine the accusers
 - c. The right to view all evidence against them with adequate time to respond
 - d. The right to legal representation
 - e. The right to an unbiased tribunal
 - f. The right to present evidence and witnesses in their favor
 - g. The right to appeal serious sanctions against their license to a court of law for a de novo hearing before an objective tribunal that follows standard rules of evidence
 - h. The right to have a clear statement of the law or the standards so that a reasonable person may know when he is in violation
- i. The right to be free of retaliation for exercise of free speech or due-process rights.
2. ***Truthfulness, transparency, and accountability*** at all stages of the process. Testimony should be given under oath, with serious penalties for perjury.
3. ***Competence.*** Investigators and witnesses against a physician should be knowledgeable about the matters being investigated. Witnesses should have comparable qualifications in the pertinent specialty. Physician board members in a comparable specialty, or the experts they rely on, must prove their ability to pass the tests they impose on a licensee. Evidence of appropriate recredentialing of board members and investigators must be submitted periodically to the oversight committee. If a licensee or other citizen should complain about a board member or investigator’s apparent lack of current knowledge, this official must provide evidence of having recently passed an examination considered appropriate by the oversight committee, after comments and approval of the examination by the physician community.
4. ***High standards of ethics:***
 - a. Board members must declare any conflicts of interest, and recuse themselves from proceedings, such as those involving a competitor or associate, if impropriety or the appearance of impropriety might be associated with their participation. Association with a third-party payer to which a licensee’s patients submit claims should be deemed to be a conflict of interest.
 - b. Neither the board nor any of its members or staff should receive consideration of any type as a result of referring a physician for outside evaluation or treatment or remedial training.
5. ***Professionalism.*** Investigators, staff, and board members will treat licensees with respect. Threats, intimidation, and demeaning language will be subject to sanction as unprofessional conduct.
6. ***Cost-effectiveness.*** The board shall not waste the taxpayers’ or the licensees’ money by repetitive, onerous demands for material not likely to lead to pertinent information.
7. ***Proportionate penalties.*** Sanctions shall be proportionate to the offense. Like offenses shall be treated similarly. Targeted physicians shall not be expected to meet standards that could not be met by any reasonably qualified physician. Penalties or remedial measures shall pass a common-sense test, as determined by a blind survey of a representative random sample of the physician community.
8. ***Wise allocation of resources.*** The public cannot be protected if the board is wasting resources on trivial administrative complaints or professional differences of opinion while downplaying cases involving dangerous treatments, unethical behavior, or physician impairment.
9. ***Confidentiality.*** Physicians should be protected against dissemination of unproved allegations. Physicians should, however, be able to waive the right to confidentiality if they

choose to do so in order to expose unfair board procedures. Board members, staff, and investigators are public servants, and confidentiality must not be used as a shield to cover conflicts of interest, abuse of power, incompetence, or malfeasance. The confidentiality of patients should be protected, and physicians should not be penalized for seeking patients' consent prior to the release of their information to the board.

Conceptual Challenges Pertaining to Licensure

Physicians go through a rigorous selection and arduous training process precisely because medicine is a profession. The Report of the Board of Directors of the FSMB asserts that there is a need to "balance public interest against professional autonomy." In fact, the existence of professional autonomy is very much in the public interest. It is contrary to the public interest to have physicians (no longer correctly considered to be a profession) subservient to special interest groups or political bodies. These include insurers, pharmaceutical companies, device manufacturers, and competitors threatened by newer, more effective therapies or more skillful practitioners. If physicians merely have "permission" to earn a livelihood in their chosen vocation, after their tremendous investment and passage through innumerable tests—and this permission can be revoked at the whim of "stakeholders"—few sane, intelligent individuals will choose to enter medicine. The greater the authority of the regulator, the more there is to be gained by special interests and the greater the likelihood of corruption and abuse of power.

Physicians have a property right in their skills. This right can be properly taken or abridged only if they violate the law or the public trust—not on a manufactured pretext. Physicians fear, often with good reason, that they could lose their livelihood simply because they hold a politically incorrect view that somehow offends newly invented notions of "professionalism," or threaten the revenues of a competitor, or fail to conform with an elite committee's view about "best practices," or refuse to violate their consciences, or even because they have made an error (no physician being infallible).

The function of a licensure board is not to "ensure quality." Nor is it possible for a licensure board to accomplish this. It also cannot ensure "safety"—medical practice is by its nature unsafe. The role of the licensure board is to set up a minimal standard of competence, to assure that licensees do not misrepresent their credentials or their practices, and to remove lawbreakers. In attempting to do more, the board must arrogate to itself the unconstitutional authority to dictate medical standards and practices, and to minutely supervise all interactions between patients and physicians.

Quality and safety are improved by competition in an open society. Patients increasingly have the tools to investigate medical questions for themselves. The more physicians practice according to their own best judgment instead of in lockstep to demands of the ever-obsessive regulator, the more choices the patients have, the

more quickly the inferior or unsafe methods will be discovered and discarded, and the more incentives professionals have to hone their skills and increase their knowledge.

Conclusions

There is no evidence that physician incompetence is a major problem, or that the proposed remedies will improve competence. They will, however, greatly increase the cost of medical practice and divert resources from self-improvement to compliance with the demands of special interests including specialty boards.

Evidence-based principles should be applied before any remedies are mandated.

The FSMB needs to examine current practices of medical boards and assess integrity, competence, and efficiency of the current regulatory regime as well as its impact on the supply and quality of physicians.

In considering FSMB recommendations, state legislators need to consider that the FSMB is a private organization acting under self-conferred authority. The FSMB has a \$30 million conflict of interest—virtually its entire revenue—in recommending still more examinations, certifications, and disciplinary actions.

The relationship between the FSMB and licensure boards is a public-private partnership. Because such partnerships have quasi-governmental authority without any of the checks and balances that apply to a constitutionally limited government body, the potential for abuse and mischief is very great.

Physicians should strive to improve their knowledge and skills by voluntary participation in programs that compete for their support, rather than slavishly trying to meet ever-increasing, often counterproductive demands imposed from above in an atmosphere of fear and distrust. Greater freedom, rather than tighter governmental or quasi-governmental constraints, is the only method that has ever actually resulted in improved quality of any product or service.

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