Maintenance of Licensure: Supporting a Physician's Commitment to Lifelong Learning

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Initially focused on preventing the unlicensed practice of medicine by "quacks" and "charlatans," state medical boards evolved necessarily over time to promote higher standards for undergraduate medical education; require assessment of knowledge and skills to qualify for initial licensure; develop and enforce standards for professional discipline; and, beginning in 1971, promote continuing medical education (CME). More than a century ago, state medical boards were instrumental in securing legislation that authorized them to refuse to examine graduates of poor-quality medical schools—even before the 1910 publication of Abraham Flexner's scathing indictment of proprietary schools, which hastened their demise and closure (1, 2). Twenty years ago, the Federation of State Medical Boards (FSMB) partnered with the National Board of Medical Examiners to create the 3-step United States Medical Licensing Examination (which includes a clinical skills component added in 2004) as a qualifying examination for initial licensure accepted by all state medical boards (osteopathic physicians typically take the Comprehensive Osteopathic Medical Licensing Examination of the National Board of Osteopathic Medical Examiners).

When the FSMB's House of Delegates voted in 2010 to adopt a framework for maintenance of licensure (MOL), it was a seminal event because the primary focus of medical licensure up to that point had been the rigorous sequence of decision points and milestones—from admission into medical school through postgraduate training—that lead to the initial privilege to practice medicine. Although CME was first required for licensure renewal in New Mexico in 1971, and nearly all state medical boards now require a prescribed number of CME credit hours (and sometimes content-specific CME), the process by which physicians maintain their license has remained a concern among policymakers and regulators, particularly as the knowledge and skills needed to practice medicine grow exponentially. The MOL framework helps address these concerns by envisioning 3 components (reflective self-assessment, assessment of knowledge and skills, and performance in practice) that would be periodically required of actively licensed physicians in their area of practice in order for them to renew their license.

The earliest calls to reform licensure renewal date back to 1967, when the National Advisory Commission on Health Manpower recommended that "state governments . . . explore the possibility of periodic relicensing of physicians and other health professionals" (3). In a report 4 years later, the U.S. Department of Health, Education, and Welfare (now the Department of Health and Human Services) noted that state boards provide a de facto lifelong medical license to most physicians and that state requirements were adequate as safeguards for entry into the profession but ineffective against "professional obsolescence" (4). These recommendations encouraged state medical boards to eventually adopt CME requirements. In more recent years, the Pew Charitable Trusts and the Institute of Medicine separately called for "continuing competency requirements" and "a mechanism to ensure that practitioners remain up to date with current best practices" to improve patient safety and reduce medical errors (5–7).

With a national shortage of physicians and more than 30 million people soon eligible for health insurance under the Patient Protection and Affordable Care Act, striking the right balance between what is necessary to protect the public and promote quality health care—the primary mission of state medical boards—and what will be administratively reasonable for practicing physicians to demonstrate their commitment to lifelong learning without substantively disrupting patient care has been a priority of the FSMB and its state boards as they consider the specific means by which physicians will be able to meet MOL requirements. A series of guidelines adopted alongside the MOL framework has guided these deliberations (**Table**).

Three MOL Components

The 3 components of MOL incorporate the core competencies for physicians adopted by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties (ABMS) in 1999 (8). Although states will not mandate a high-stakes, secure examination for MOL, the FSMB has begun to identify various educational and practice improvement activities across all specialties and areas of practice that could satisfy a state's MOL requirements.

The first component, reflective self-assessment ("What improvements can I make?"), relies heavily on a physician's participation in CME, which could be supplemented by such self-review exercises as home-study courses or Web-based activities, including reviews of the literature in the physician's area of practice. The second component, assessment of knowledge and skills ("What do I need to know and be able to do?"), could be met by completion of computer-based case simulations; performance improvement CME; procedural hospital credentialing; or the com-

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Table. **MOL Guiding Principles***

Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing MOL requirements should remain within the purview of state medical boards.
Maintenance of licensure should not compromise patient care or create barriers to physician practice.
The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.
Maintenance of licensure processes should balance transparency with privacy protections.

MOL = maintenance of licensure.
* Guiding principles were adopted by the House of Delegates of the Federation of State Medical Boards in 2010 and were obtained from the Federation of State Medical Boards MOL Information Center (www.fsmb.org/mol.html).

pletion of performance improvement activities offered by the Institute for Healthcare Improvement, American Medical Institute, or American College of Physicians (for example, the Medical Knowledge Self-Assessment Program), to name 3 examples. The third component, performance in practice ("How am I doing?"), could be evaluated with patient and peer surveys; such activities as ABMS practice improvement activities or the Clinical Assessment Program of the American Osteopathic Association; 360-degree multisource evaluations; or, over time, submittal of practice activities adhering to regional or national performance improvement benchmarks. The third component may be facilitated in the coming years by the adoption of electronic health records, which would enable practice performance information to be voluntarily shared with state boards more easily.

The overriding philosophy of the timeline for MOL implementation can best be summarized as "evolutionary, not revolutionary." The FSMB's MOL Implementation Group has recommended that state boards spend at least a year educating their physicians and public about their MOL plans before implementing them (9). The group also suggested implementing each of the 3 components sequentially over time, rather than all at once, allowing 2 to 3 years for each component to be fully implemented (although state boards may wish to implement the program faster if they are able to). Finally, the group recommended that activities in the first component, such as CME, be required annually, but that activities in the second and third components be reported to state boards no more often than every 5 to 6 years. If all of these recommendations are followed, the earliest state boards could begin to implement an MOL program (or, at the least, its first component) would be 2014.

The Value of Specialty Certification

As state boards consider recommendations for physician participation in MOL, it is apparent that many of the activities required by specialty boards to maintain certification already meet, if not exceed, the requirements that state boards are seeking for MOL (10). In 2011, the FSMB's MOL Implementation Group recommended that physicians actively engaged in the Maintenance of Certification program of the ABMS or the Osteopathic Continuous Certification program of the American Osteopathic Association Bureau of Osteopathic Specialists be recognized as having substantially fulfilled the requirements of all 3 components of any state's MOL. For most actively licensed, specialty-certified physicians—comprising well more than half of the nation's 850 085 allopathic and osteopathic physicians (11)—meeting the requirements for MOL could be as simple as providing an attestation of their ongoing participation in certification maintenance activities of the ABMS or American Osteopathic Association Bureau of Osteopathic Specialists.

Because more than 230 000 physicians are not specialty certified in the United States, and physicians "grandfathered" for specialty certification (that is, physicians who have certificates that do not expire) are not required to participate in the Maintenance of Certification or Osteopathic Continuous Certification programs, the FSMB and collaborating organizations are working to identify, and in some cases develop, activities and tools to enable these physicians to meet MOL requirements. This will be important for specialty-certified physicians who elect not to participate in the Maintenance of Certification or Osteopathic Continuous Certification programs, which, like specialty certification, remain activities that will not be required for medical licensure.

Although a few important elements of MOL implementation remain to be worked out, such as what should be required of nonclinical physicians, state medical boards are proceeding with the MOL initiative with the intent of improving patient care through support of quality improvement and continuous professional development activities for all licensed physicians.

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