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The privilege and responsibility of self-regulation for physicians: A "win-win" for the physician community and our patients

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Background: Physicians have long understood that the privilege of professional autonomy would only continue to be granted to the profession by demonstration of effective self-regulation.
Discussion: Although initiatives in demonstration of continued fitness for practice are sometimes looked upon with concern by practicing physicians, there is the potential that alignment of maintenance of certification, osteopathic continuous certification, and maintenance of licensure could actually reduce the inefficiencies and redundancies of the current regulation system for physicians.
Results: Collaboration among educational, testing, accreditation, certification, and licensure communities is essential to ensure that redundancy is reduced and barriers to practice are avoided, to retain the privilege of self-regulation, while at the same time honoring the profession's responsibility to ensure that those who are caring for patients are indeed remaining competent to do so.

Introduction

In the United States, society confers professional autonomy and the privilege of self-regulation upon the medical profession. This long-standing social contract is based on the explicit trust that society puts in the individual physician as well as the profession.[1] This self-regulation is a complex system, involving many levels of oversight designed to assure the competence of practicing physicians and to enhance patient safety. It starts with the rigor and accreditation standards of undergraduate medical education in the nation's osteopathic and allopathic medical schools and graduate medical education programs. This is furthered with the high-quality and standardized assessment programs of medical knowledge and clinical skills (eg, Comprehensive Osteopathic Medical Licensing Examination of the United States and United States Medical Licensing Examination), state licensure requirements, widespread use of peer review and disciplinary processes, and well-regarded board certification or recertification programs.

Physicians have long understood that the privilege of professional autonomy would only continue to be granted to the profession by demonstration of effective self-regulation.[2] However, individual physician conduct and competence as well as the profession's ability to adequately fulfill its self-regulatory obligation have again come under question in recent decades, both in the United States and globally.[3] As early as 1967, there were recommendations from President Lyndon B. Johnson's Commission on Medical Manpower concerning periodic relicensing of physicians, and in 1971 a report by the United States

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Department of Health, Education, and Welfare under President Richard M. Nixon cited the "growing problem of physician obsolescence" as it related to lifelong physician licensure. More recent reports from the Pew Charitable Trust Health Professions Commission[4] and the Institute of Medicine[5,6] have called for enhanced regulation in the area of continued fitness for practice over the practicing lifespan of a physician. In particular, the notion that a physician can be licensed and certified as a recent residency-program graduate and that this would assure continued competence for a clinical practice career is no longer credible.[7] The rapid advances in the clinical practice of medicine, along with evidence that physician competencies may indeed deteriorate over time, have strengthened the position of the public and the profession in this regard.

In the United States and in other areas of the world, the physician community and the profession are responding to these challenges by enhancing the opportunities for physicians to demonstrate ongoing fitness to practice. It can be thought of as continuous quality improvement processes for individual physicians and their clinical competencies. Such initiatives include enhancements to Continuing Medical Education (CME) Programs, Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC) programs, and Maintenance of Licensure (MOL).

Enhanced CME

In recent years, the value of traditional CME has been questioned. Additionally, 6 states in the United States do not have any requirements for CME credits for licensure renewal.[8,9] Over the past decade, "new CME" types have been introduced by the American Academy of Family Physicians, the American Osteopathic Association (AOA), and the American Medical Association, among others. "Evidence-based CME" evolved into Internet Point of Care CME and Performance Improvement (PI) CME. Point of Care CME allows the physician to consult an evidence-based resource while confronting a clinical question about a patient, documenting the learning and changed behavior that occurs. PI CME incorporates actual performance in practice data, first by assessing actual practice data, then by comparison to national benchmarks or peer performance. After the implementation of an intervention based on the analysis of the practice performance data, reevaluation of the performance in practice allows for reflection and review of outcomes resulting from the PI CME program. Examples of such PI CME programs available include Education in Quality Improvement for Pediatric Practice (American Academy of Pediatrics), Clinical Assessment Program (AOA), and Practice Improvement Modules (American Board of Internal Medicine). There is growing evidence to support that these new types of CME programs are associated with improvements in physician knowledge and are also effective in changing physician performance in practice.[10-13] By incorporating national standardized performance measures into PI CME, the enhancements to CME in the profession now help to assure the public that physicians are continually measuring, reflecting on, and demonstrating practice improvements that are linked by evidence to improved patient outcomes.

MOC and OCC Programs

In the past decade, the American Board of Medical Specialties (ABMS) and the AOAs Bureau of Osteopathic Specialists (AOA-BOS) have also implemented processes to ensure ongoing and continuous quality improvement and competence amongst their board certified physicians.[14-16] The ABMS MOC program and the AOA-BOS OCC program are widely regarded as equivalent continuous certification programs designed to provide their diplomats with the opportunities to demonstrate ongoing competence. Components of these programs are noted in Table 1. However, it is estimated that more than 30% of actively licensed physicians (DOs and MDs) are not specialty board certified, and therefore are not eligible to participate in these programs.[17] Furthermore, most physicians with time-unlimited ("grandfathered") specialty board certification have elected not to recertify.

The Federation of State Medical Board's MOL Framework 2010

In the United States, after a period of 8 years of research and development, the Federation of State Medical Boards (FSMB) has issued a policy statement recommending that all state medical and osteopathic medical licensing boards

Table 1 MOC, OCC, and MOL requirements and proposed recommendations

ABMS MOC[14]	AOA-BOS OCC[15]	FSMB MOL[18]
Part 1. Professional standing and licensure	Component 1. Unrestricted licensure	
Part 2. Lifelong learning and self-assessment	Component 2. Lifelong learning or continuing medical education	Component 1. Reflective lifelong learning
Part 3. Cognitive expertise—secure exam	Component 3. Cognitive assessment	Component 2. The assessment of knowledge and skills
Part 4. Performance in practice	Component 4. Practice performance assessment and improvement	Component 3. Performance in practice
	Component 5. Continuous AOA membership	

require physicians with active medical licenses to periodically demonstrate their ongoing clinical competence as a condition for licensure renewal.[13,14,17,18] Reflective self-assessment, the assessment of knowledge and skills, and performance in practice are the 3 components of the FSMB MOL framework. As noted in Table 1, these components are quite consistent with the requirements for MOC and OCC, recommending that all physicians are involved in lifelong learning that is objective, relevant to practice, and improves care. Notably, the FSMB has assured physicians that those who are enrolled in an ABMS MOC program or an AOA-BOS OCC program would likely have these efforts qualify to substantially comply with MOL requirements. The FSMB has also issued recommendations that adoption of MOL programs should be evolutionary, not revolutionary, and that they should not compromise patient care or create barriers to physician practice. Various work groups are still evaluating key issues such as reciprocity and consistency of MOL across jurisdictions, requirements for physicians who are reentering clinical practice after a period of inactivity, and the periodicity of MOL requirements.[19] While ultimately the prerogative and responsibility of each individual state licensing authority, already there are 11 such jurisdictions that are involved with the FSMB in piloting MOL initiatives, with 1 state (Massachusetts) already targeting implementation as early as 2015.

Internationally, MOL or revalidation processes that aim to assure the continued competence of practicing physicians have been adopted or are in various phases of implementation in numerous jurisdictions, including, Canada, United Kingdom, Australia, New Zealand, and Ireland.

So why is this enhanced regulation potentially a win-win for physicians and patients?

In addition to continuing to enjoy the privilege of autonomy and professional self-regulation, physicians and the profession stand to benefit from enhanced efficiencies gained from a new era in medical regulation. The expanded use of health information technology and electronic health records not only have the potential to enhance patient safety and quality of care, but also to make the performance in practice components of MOL, OCC, and MOC become much more efficient over time. Both physicians and patients stand to gain by the potential effect on quality of care and patient safety, though certainly more research is needed.

Currently, complex requirements for CME credits for board certification, recertification, and licensure renewal can be cumbersome. Particularly for an osteopathic physician who is board certified by the ABMS specialty board and the AOA specialty board, there may be separate CME requirements currently for recertification or MOC (eg, AOA-approved CME credits vs Accreditation Council for Continuing Medical Education–approved CME credits). With more than 50% of osteopathic physicians now completing their residency training programs in Accreditation Council for Graduate Medical Education–accredited programs, and much higher percentages with some specialties, the number of DOs affected by these differing and often redundant requirements is increasing.[20] In addition, if he or she is licensed to practice in a state that has an osteopathic medical licensing board (for DOs) in addition to a separate state medical licensing board (for MDs), then there may be additional CME requirements specified for licensure renewal. DOs must satisfy requirements for state licensure which vary across jurisdictions, while satisfying specific specialty board certification requirements which may not necessarily be recognized by the jurisdiction in which they practice. This becomes exponentially more complex if the physician is licensed in multiple states, as states vary in CME requirements pertaining to the number of credit hours, legislatively mandated topics (eg, infection control, cultural competency, and disaster preparedness), and sponsorship.[3,8,21,22] It is estimated that 23% of the nation's physicians have more than 1 active state license.

The FSMB has initiated an MOL Pilot Collaboration Information Forum that includes representatives from the FSMB, the AOA-BOS, the ABMS, the National Board of Osteopathic Medical Examiners, and the National Board of Medical Examiners. This group and several other collaborative groups representing the entire house of medicine and consumer advocate groups are actively seeking ways to assure that enhancements in physician self-regulation can be made in such a way that they potentially better protect the public and enhance patient care, preserve physician autonomy and the privilege of professional self-regulation, and perhaps even improve the efficiency of current CME and other practice and continuous quality improvement requirements for physicians.

Summary

Although initiatives in demonstration of continued fitness for practice are sometimes looked upon with concern by practicing physicians,[23] there is the potential that alignment of MOC, OCC, and MOL could actually reduce the inefficiencies and redundancies of the current regulation system for physicians. Collaboration among educational, testing, accreditation, certification, and licensure communities is essential to ensure that redundancy is reduced and barriers to practice are avoided, to retain the professional privilege of self-regulation, while at the same time honoring the profession's responsibility to ensure that those who are caring for patients are indeed remaining competent to do so.

References

1. Creuss SR, Creuss RL. Professionalism: a contract between medicine and society. *Can Med Assoc J*. 2000;162:668–669
2. Saunders, GL. Will physicians lose the privilege of self-regulation? President's message: North Carolina Medical Board. 2008: No. 4. Archived at http://www.ncmedboard.org/articles/detail/will_physicians_lose_the_privilege_of_self_reg on July 28, 2011

3. Irvine D. *The Doctor's Tale: Professionalism and Public Trust*. Abington, UK: Radcliffe Medical Press; 2003
4. Pew Health Professions Commission. (1995). *Critical challenges: Revitalizing the health professions for the twenty-first century*. San Francisco: UCSF Center for the Health Professions.
5. Institute of Medicine. *To Err is Human: Building a Safer Health System*, 2. Washington, DC: National Academy Press 1999. http://www.nap.edu/openbook.php?isbn=0309068371
6. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001. 25-26
7. Houle CO. *Continuing Learning in the Professions*. San Francisco, California: Jessey-Bass; 1980
8. American Medical Association. *State Medical Licensure Requirements and Statistics 2011*. United States: American Medical Association Publications and Clinical Solutions; 2011
9. Federation of State Medical Boards (FSMB). Directory of state medical and osteopathic boards. Available at: http://www.fsmb.org/directory_smb.html. Archived at http://www.webcitation.org/5zL1DfTQr on June 10, 2011
10. Kahn N, Bagley B, Tyler S. Performance Improvement CME: Core of the new CME. CPPD Report, American Medical Association Continuing Medical Education, Spring 2007/No. 22. Archived at http://www.ama-assn.org/resources/doc/cme/cppd22.pdf on July 28, 2011
11. Johns Hopkins University Evidence-based Practice Center. *Effectiveness of Continuing Medical Education*. Rockville, MD: Agency for Healthcare Research and Quality; 2007. [AHRQ Publication No. 07-E006]
12. Bordage G, Carlin B, Mazmanian PE. Continuing medical education effect on physician knowledge: Effectiveness of continuing medical education. *Chest*. 2009;135(suppl):36S
13. David D, Galbraith R. Continuing medical education effect on practice performance: Effectiveness of continuing medical education. *Chest*. 2009;135(suppl):48S
14. American Board of Medical Specialties–Maintenance of Certification. Archived at http://www.abms.org/Maintenance_of_Certification/ on July 23, 2011.
15. American Osteopathic Association–Osteopathic Continuous Certification. Archived at http://www.osteopathic.org/inside-aoa/development/aoa-board-certification/Pages/osteopathic-continuous-certification.aspx on July 23, 1011
16. Ayres RE, Scheinthal S, Gross C, Bell EC. Osteopathic specialty board certification. *J Am Osteopath Assoc*. 2011;111(4):280–288
17. Chaudhry HJ, Rhyne J, Cain FE, Young A, Crane M, Bush F. Maintenance of licensure: protecting the public, promoting quality health care. *J Med Regul*. 2010;96(1):1–8
18. Federation of State Medical Boards (FSMB). Maintenance of Licensure Information Center. Available at: http://www.fsmb.org/mol.html. Archived at http://www.webcitation.org/5zL1OqLFa on June 10, 2011.
19. National Board of Osteopathic Medical Examiners. The Osteopathic Examiner, March 2011. Available at: http://www.nbome.org/docs/The_Osteopathic_Examiner_03-2011.pdf. Archived at http://www.webcitation.org/5zPjoHYPE on June 13, 2011
20. Burkhart DN, Lischka TA. Dual and parallel postdoctoral training programs: implications for the osteopathic medical profession. *J Am Osteopath Assoc*. 2011;111(4):247–256 [American Osteopathic Association (AOA). Opportunities—AOA-Approved Internships and Residencies. Available at: http://www.opportunities.osteopathic.org/search/search.cfm. Archived at http://www.webcitation.org/5zKwW8VgV on June 10, 2011
21. Young A, Chaudhry HJ, Rhyne J, Dugan M. A census of actively licensed physicians in the United States, 2010. *J Med Regul*. 2011;96(4):10–20
22. Miller SH, Thompson JN, Mazmanian PE, et al: Continuing medical education, professional development, and requirements for medical licensure: a white paper of the Conjoint Committee on Continuing Medical Education. *J Contin Educ Health Prof*. 2008;28(2):95–98
23. Dubravec M. Board certification/recertification/maintenance of certification: a malignant growth. *J Am Phys Surg*. 2011;16(2):52–53

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1. c, 2. d, 3. a, 4. a, 5. d, 6. a, 7. a, 8. c, 9. b, 10. b