HOD ACTION: Council on Medical Education Report 16 adopted as amended and the remainder of the report filed.

REPORT 16 OF THE COUNCIL ON MEDICAL EDUCATION (A-09)
Maintenance of Certification/Maintenance of Licensure
(Reference Committee C)

EXECUTIVE SUMMARY

Since 1904 when the American Medical Association established the Council on Medical Education, the AMA has maintained a concerted campaign to encourage high quality educational requirements for physicians. The current climate of multiple changes in the definitions and assessments of competency deserve close attention and open conversations. This informational report will outline the current changing landscape of competency, credentialing, and licensing.

The American Board of Medical Specialties (ABMS) addressed physician competency by adopting the six competency areas proposed by the Accreditation Council for Graduate Medical Education (ACGME) and by instituting a framework for Maintenance of Certification (MOC) for each of its 24 member boards. The Federation of State Medical Boards (FSMB) is developing strategies for the maintenance of licensure (MOL). The MOC and MOL represent new tools that can be used to build trust relationships between professional self regulation and the public.

Implementation of recertification examinations and the current MOC by ABMS have been successful so far because ABMS and its member boards accepted input from the physician community and modified their programs to address the needs of participating physicians. The AMA is committed to working with organizations that certify and license physicians. As an example, the AMA provided a constructive critique of the modified MOC standards to the ABMS. The concerns identified by the AMA included: costs to physicians, the compressed timeline for implementation of MOC, continuous documentation of measures, the impact on the physician workforce, flexibility in career pathways, flexibility with completing MOC modules, physician-specific data collection, the patient satisfaction survey, redundancy of physician reporting requirements in multiple venues, team performance, and patient safety.

AMA policy urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine when evaluating physicians for licensure. Currently, more than 82% of active licensed physicians are certified by one of the 24 Member Boards of the ABMS. However, more than one in six competent physicians in good professional standing are not currently board certified. It is vital that implementing the MOL processes include an appropriate accommodation to this large percentage of the medical workforce.

In addition, within this environment of increasing accountability, a number of professional organizations have joined together to form the National Alliance for Physician Competency (NAPC), to discuss the definitions of competency and propose possible methods for ensuring and assessing competency. The NAPC has produced several products including the *Guide to Good Medical Practice – USA (GGMP-USA)* document. The AMA supports the underlying principles of the *GGMP-USA*, but firmly believes it should not be accepted as a standard for certification, licensure, or as a standard of care to which physicians should be held. Adoption of this document by regulators would place physicians at significant legal risk for circumstances that are not within their control and that have no proven link to good patient outcomes. The development of documents, such as the *GGMP-USA*, that focus on a series of competencies may not be productive in improving the quality and safety of patients.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 16-A-09

Subject: Maintenance of Certification/Maintenance of Licensure

Presented by: Claudette E. Dalton, MD, Chair

Referred to: Reference Committee C
(Rodney G. Hood, MD, Chair)

INTRODUCTION

The American Medical Association (AMA) *Principles of Medical Ethics* states:

> "A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public,…"[1]

The AMA and many organizations agree that continuous learning and practice improvement should be core principles for lifelong practice. In the June 6, 2006 issue of *JAMA*, Duffy and Holmboe discussed lifelong learning:

> "A self-regulating profession holds its members accountable to the public it serves for the continuous development of the competencies they profess to hold. A central component of physician competence is professionalism, which requires lifelong learning that leads to improved performance in practice. A medical profession accomplishes accountability by providing its members periodic measurement of performance using reliable and valid instruments and judging performance against evidence-based standards, providing graduate and continuing medical education (CME) programs that advance members' knowledge and skills to meet these standards, and publicly certifying those who do so."[2]

Since 1904 when the AMA established the Council on Medical Education, the AMA has maintained a concerted campaign to encourage high quality educational requirements for physicians. The responsibility of self-regulation in medicine is the core of our profession. We accept that to retain the public trust, we must show good faith in how we certify and credential ourselves and our colleagues. The current climate of multiple changes in the definitions and assessments of competency deserve our close attention and open conversations. This report will outline the current changing landscape of competency, credentialing, and licensing. This report also summarizes the background and organizations involved in producing the current proposals for Maintenance of Certification (MOC), maintenance of licensure (MOL), and the *Guide to Good Medical Practice – USA (GGMP-USA),* the progress that has been made to date, and the implications for medical education.

Three major CME credit systems have been the gold standard of postgraduate medical education in the United States and an international example of a mature postgraduate medical education system: our own AMA Recognition Award (PRA) Credit System (*AMA PRA Category 1 and Category 2 Credit™)* established in 1968 by the House of Delegates; the American Academy of Family

Physicians (AAFP) Prescribed and Elective Credit System, and the American Osteopathic Association (AOA) Categories 1-A, 1-B, 2-A and 2-B Credit System. The AMA PRA CME Credit system, as well as the credit systems of the AAFP and AOA, have met the needs of physicians and of society over time, incorporating new formats of learning that can be awarded credit, based on their demonstrated value and impact.

Since the time when re-registration of state licenses started to require CME participation, AMA PRA credit has been accepted by all U.S. licensing boards that required CME credits, as well as by most other organizations requiring evidence of CME. The PRA Credit system is recognized and accepted by specialty boards, hospital credentialing bodies, and other entities requiring documentation of involvement in postgraduate medical education not only in the US but also in other international jurisdictions that require participation in CME. Moreover, the AMA PRA credit system is recognized and accepted by the majority of allopathic physician-learners and has become the largest CME system in the United States as well as serving to stimulate CME providers to seek accreditation.

In 1991 the standard three-year AMA PRA certificate was made available without further requirements to physicians who had obtained American Board of Medical Specialties (ABMS) member board certification or re-certification, in recognition of the learning to accomplish that distinction. More recently, the Performance Improvement CME (PICME) format was adopted by the AMA and AAFP for evidence of evaluation of performance in practice.

The Institute of Medicine (IOM) report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, focused public attention on quality and safety in medical practice. The report stated, "Safety flaws are unacceptably common, but the effective remedy is not to browbeat the health care workforce by asking them to try harder to give safe care. Members of the healthcare workforce are already trying hard to do their jobs well. In fact, courage, hard work, and commitment of doctors, nurses, and others in health care are today the only real means we have of stemming the flood of errors that are latent in our health system."[3] ***The 21st century physician has to accept as part of his or her professional responsibility the continuous improvement of his or her practice, operations, and outcomes. That means understanding data, outcomes, and problem-solving.***

Due in part to the IOM report and other similar reports and national conversations, the focus of self-regulation of physicians became one of improving competency in many areas. The ABMS addressed this competency issue by adopting the six competency areas first proposed by the Accreditation Council for Graduate Medical Education (ACGME) and then by instituting a framework for MOC for each of its 24 member boards. Furthermore, the Federation of State Medical Boards (FSMB) is developing strategies for the MOL. The MOC and MOL represent new tools that can be used to build trust relationships between regulation and the public.

In addition, within this environment of increasing accountability, a number of professional organizations have joined together to form the National Alliance for Physician Competency (NAPC), in order to discuss the definitions of competency and propose possible methods for assessing competency. The NAPC has produced several products including the *GGMP-USA* document.

ESTABLISHED REGULATORY AND CERTIFYING AGENCIES/ORGANIZATIONS

A summary of different regulatory and certifying agencies/organizations and recent endeavors to measure physician competency follows.

State Medical Licensing Authorities

The state licensing authorities (state medical boards) of the various jurisdictions are the sole entities that regulate all physicians and that operate with a direct mandate to protect the public's safety. Each state medical board grants a license to practice medicine, and sets its own rules and regulations, based on state laws (medical practice acts). The structure and authority of medical boards vary. Some 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.[4] Their goal is to measure a candidate's knowledge, competence, and patient-focused skills deemed important for promoting health, fighting disease, and constituting safe and effective patient care. In addition, they are responsible for assuring physicians' ongoing competence and continuous improvement.

Each state medical board requires graduates of accredited allopathic medical schools in the United States and graduates from medical schools abroad to pass the United States Medical Licensing Examination (USMLE) as one means to demonstrate that the physician meets the qualifications for initial licensure. The USMLE program, is cosponsored by the National Board of Medical Examiners (NBME) and the FSMB. The USMLE program is accepted and utilized by all state medical boards and provides a common evaluation system for allopathic medical licensure applicants. Graduates of AOA accredited medical schools are also eligible to take the USMLE. In 14 states, osteopathic physicians can qualify for licensure under separate Boards of Osteopathic Medical Examiners[5] which is beyond the scope of this report.

Over time, the USMLE program has undergone a number of changes, including the addition of a clinical skills examination (Step 2) in June 2004, and the use of computer-based case simulations in Step 3. The Educational Commission for Foreign Medical Graduates (ECFMG) had a clinical skills exam for international medical graduates (IMGs) that was replaced with the USMLE Step 2 Clinical Skills exam, and the ECFMG shares responsibility with the NBME for its administration. A comprehensive review of the USMLE program has been underway since 2006 to consider the changes that have occurred in the academic, regulatory, and practice environment since the original design of the USMLE, and to determine if these changes signal a need to consider modifications to the current examination system. The exact nature of these changes has not yet been clarified, and in any event, it will be at least 4 years before changes impact any test-takers.[6]

In addition to the USMLE, all medical and osteopathic boards require graduates of US or Canadian medical schools to complete at least 1 year of ACGME- or AOA-accredited graduate medical education (GME) before issuing a full, unrestricted license, and 25% of the boards require the completion of 2 or 3 years of GME. In 2007, 60,336 licenses were issued to doctors of medicine (MDs) and doctors of osteopathy (DOs) and of these, 23,837 (39.5%) were identified as initial licenses. Of the 23,837 physicians who received their initial licenses in 2007, 6,819 (28.6%) were issued to IMGs. Licenses are not awarded to IMGs until they undertake the required GME in the United States and meet other board requirements (e.g., an ECFMG certificate, personal interview, payment of fees). Most state licensing authorities (93%) require IMGs to complete 2 or 3 years of GME.[5]

Sixty-two of the seventy medical boards require CME for licensure re-registration, and some states mandate CME content or require a certain percentage of hours of CME be *AMA Physician's Recognition Award (PRA) Category 1 Credit*™ or equivalent. Forty-three states accept the AMA PRA certificate or application as equivalent for purposes of licensure re-registration. Some states accept certificates/awards of the AOA (11), ABMS (27), a state medical society (10), and a national specialty society (6) and completion of GME residency/fellowship programs (31).[5]

Educational Commission for Foreign Medical Graduates (ECFMG) and the Foundation for Advancement of International Medical Education and Research (FAIMER)

The ECFMG is responsible for assessing the readiness of IMGs to enter ACGME-accredited residency and fellowship programs in the United States by providing international access to testing and evaluation programs. ECFMG certifies individuals, but does not accredit foreign medical schools. To obtain ECFMG certification, IMGs must pass both Steps 1 and 2 of the USMLE and possess a MD degree or equivalent degree from a medical school outside the United States or Canada. The applicant's medical school and graduation year must be listed in the *International Medical Education Directory (IMED)* of the Foundation for Advancement of International Medical Education and Research (FAIMER). FAIMER, a nonprofit foundation of ECFMG incorporated in 2000 in partnership with ECFMG, promotes excellence in international health professions education through programmatic and research activities. FAIMER is not an accrediting agency.[5]

During 2007, 10,172 standard ECFMG certificates were issued and 6,795 IMGs entered residency training programs in the United States.[5, 7] Of the top five countries from which IMGs graduate medical school, three (Dominica, Grenada, and Netherlands Antilles) are in the Caribbean and most of these IMGs are US citizens. Approximately 2,500 US citizens enter medical schools outside the United States, mostly in the Caribbean, each year. Annually, 1,500 US IMGs return to the United States and enter GME.[8] Many concerns about the quality of these graduates are being raised. Van Zanten and Boulet studied the performance of physicians who attended medical schools in the Caribbean and found considerable variation in quality indicators and first-attempt pass rates on the USMLE.[9]

The General Competencies

In 1999, the ACGME and the ABMS defined and agreed upon six general competencies as the new assessment modalities to increase emphasis on competency and educational outcomes at the residency level. Residency programs must require their residents to obtain competencies in six areas to the level of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate the six areas of competence: patient care; medical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; and systems-based practice. Furthermore, each residency program must demonstrate that it has an effective plan for evaluating resident performance throughout the program and for utilizing assessment results to improve resident performance.[10] These competencies also serve as the baseline for MOC.

The Federation of State Medical Boards and Maintenance of Licensure

The FSMB, founded in 1912, is a national non-profit organization representing the 70 licensing jurisdictions in the United States, the District of Columbia, and US territories. The FSMB's membership also includes the licensing jurisdictions of 14 state boards of osteopathic medicine, the Canadian provincial medical licensing authorities, and individuals, physicians, and non-physicians who are courtesy members through application to the FSMB.[11]

In 2003, the FSMB established a Maintenance of Licensure committee to develop a position statement regarding the responsibility of state medical boards to ensure licensees are competent over the course of their professional careers and to develop strategies for state medical boards to use in implementing programs to carry out that responsibility. On May 3, 2008, the FSMB House of Delegates (HOD) approved the next steps toward a model policy for new state regulations that

would ask physicians to demonstrate continuing competence in order to maintain active medical licenses. The FSMB HOD approved the five following guiding principles for policy development and endorsed a recommendation for additional research into the impact the model policy would have on state medical boards, licensed physicians, and other stakeholder organizations.

1. "Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
2. 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.
3. Maintenance of licensure should not be overly burdensome for the profession and should not hinder physician mobility.
4. The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.
5. Maintenance of licensure processes should balance transparency with privacy protections."[12]

FSMB's model policy suggests that state medical boards should require physicians to:

- "Participate in an ongoing process of reflective self-evaluation, self-assessment, and practice assessment, with subsequent successful completion of educational activities tailored to meet the gaps in knowledge and skills identified by the assessment.
- Demonstrate continued competence in the assessment modalities developed by ACGME and ABMS. The demonstration of competence should include the knowledge, skills, and abilities to provide safe, effective patient care within the scope of their professional medical practice.
- Demonstrate accountability for performance in practice."[12]

Currently, most physicians demonstrate their competence to their licensing boards only once—when they first apply for a license to practice medicine. If MOL requirements are implemented by state medical boards, physicians will be expected to demonstrate their competence periodically in order to maintain active medical licenses.[12]

The AMA has robust policies related to medical licensure. The policies are updated and published annually by the AMA in *US Medical Licensure Requirements and Statistics* (Appendix A). Initial licensure is a threshold event that includes standardized and proven assessments of knowledge and a wealth of individualized and first hand assessments of performance throughout undergraduate and graduate medical education. For the foreseeable future, initial licensure will be conducted according to existing national norms. The state medical boards have the latitude to examine a wide range of physician behaviors and to hold providers accountable for competence and professionalism. They can independently investigate physician behaviors and inappropriate conduct using experienced investigators. They also have the ability as single entities to assess sanctions in a consistent manner.[13]

Medical Specialty Board Certification and Maintenance of Certification

Established in 1933, the ABMS oversees the certification of physician specialists in the United States, and assists its Member Boards in developing and implementing educational and professional standards to evaluate and certify physician specialists. Certification includes initial specialty and subspecialty certification and MOC throughout the physician's career. The process of certification by one or more of the 24 American Specialty Boards entails a complex and rigid series of requirements which vary from specialty to specialty but generally include successful

completion of an approved residency training program and both written and oral examinations. Although the attainment of certification demonstrates proficiency within a chosen discipline, medical specialty board certification is an additional process to receiving a medical degree, completing residency training, and receiving a license to practice medicine.

In 2000, under the direction of the Committee on Oversight and Monitoring of Maintenance of Certification (COMMOC), the Member Boards collaboratively agreed to evolve their recertification programs to one of periodic professional development—Maintenance of Certification (MOC) by the ABMS. ABMS MOC focuses on four components: (1) evidence of professional standing (hold a valid and unrestricted license); (2) evidence of commitment to lifelong learning and periodic self-assessment (CME); (3) evidence of cognitive expertise (written and/or oral examinations); and (4) evidence of evaluation of performance in practice (usually performance improvement or quality improvement activities).[14]

ABMS plans to identify appropriate metrics and promote research to demonstrate how MOC improves physician performance and patient outcomes, and use this information to improve the MOC programs of the Member Boards. Individual specialty boards, e.g., the American Board of Internal Medicine (ABIM), are also conducting research to assess the relationship between performance in MOC and outcomes, processes, and systems of care and the relevance of MOC for key stakeholders, including physicians, health plans, and health care system managers. Although no national mandates have been developed, the ABIM has developed web-based quality improvement tools to assist diplomates to report practice performance to health plans, insurance companies, and hospitals.

In 2007, well over 80% (686,578) of the approximately 830,000 active practicing physicians (not including resident physicians) were certified by one of the 24 Member Boards of the ABMS. Of the total certified, 67.7% were initial certifications, 23.1% were recertifications, and 9.2% had both.[15, 16]

By 2012, all 24 Member Boards of the ABMS will have programs in place that require physicians to demonstrate competence periodically in order to maintain their board certification. The American Osteopathic Association Bureau of Osteopathic Specialists will also have periodic certification requirements in place for its 18 specialty boards by 2012.[11]

PROPOSED CHANGES TO MAINTENANCE OF CERTIFICATION

In November and December of 2008, substantial revisions to the previous MOC process were proposed by COMMOC. These revisions shortened the time line for implementation and revisions and added many new requirements to achieve MOC. In January 2009, the AMA Board of Trustees (BOT) and the AMA Council on Medical Education responded to changes proposed by the ABMS in its MOC processes. Although the AMA shares the same goal of promoting patient-care safety and quality that underlie the proposed changes to MOC, the AMA BOT and Council on Medical Education raised specific concerns that rested on the following guiding principles:

1. Changes in specialty board certification requirements can have far-ranging impacts on not only individual physicians but also on access to specialty care by patients and confidence in the certification system. Therefore, it is extremely important for MOC programs to be longitudinally stable in structure although flexible in content.

2. Any timeline proposed by the ABMS for implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures

3. Each specialty board has established intervals for its MOC process. Therefore, any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals currently used by each board.

4. Any changes in the MOC process should not result in significantly increased cost or burden to the physician participants. For example, the already heavy requirements for accountability that physicians face should not be shifted to a system that mandates continuous documentation. Likewise, the AMA does not support requiring physicians to complete annual milestones to participate in the program.

5. Recertification requires time and effort and implementation of any additional MOC requirements should not reduce the capacity of the overall physician workforce. For example, it is important to retain a structure of MOC programs that permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.

6. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey or other equivalent patient satisfaction program would not be appropriate nor effective survey tools to assess physician competence in many specialties.

7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research, and teaching responsibilities.

8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.

9. The AMA affirms the current language regarding CME: "By 2011, each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part 2. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (*AMA PRA Category 1*, American Academy of Family Physicians (AAFP) Prescribed, American College of Obstetricians and Gynecologists (ACOG), and or AOA Category 1A)."

10. Although MOC is an essential component to promote patient-care safety and quality, it is not sufficient in and of itself. Maintaining patient safety and quality in complex health-care systems is a team effort and the AMA believes that physicians cannot by themselves change the systems in which they practice. The AMA is therefore concerned that the proposed MOC changes may create an unrealistic expectation that failures in patient safety are primarily failures of individual physicians.

On March 26, 2009, the ABMS announced acceptance of a new set of standards proposed by the ABMS COMMOC to further enhance physician qualification principles assessed through its (MOC) program. Information about the new MOC standards is available at:

http://www.abms.org/News_and_Events/Media_Newsroom/Releases/release_NewMOCStandards_03262009.aspx

AMA POLICY ON BOARD CERTIFICATION

The AMA has several Policies related to this issue, including:

- D-270.989, Improvements to the Maintenance of Certification Process
- D-275.969, Specialty Board Certification and Recertification
- D-275.971, American Board of Medical Specialties-Standardization of Maintenance of Certification Requirements
- D-275.977, Update on American Board of Medical Specialties Program on Maintenance of Certification
- H-405.974, Specialty Recertification Examinations
- D-275.987, Internal Medicine Board Certification Report – Interim Report
- H-275.996, Physician Competence
- H-275.936, Mechanisms to Measure Physician Competency
- H-275.956, Demonstration of Clinical Competence
- H-275.933 Specialty Board Recertification Requirements for Employment
- H-405.972, Recertification Alternatives
- H-405.973, Board Certification
- H-275.950, Board Certification
- H-405.970, Specialty Board Certification Fee Requirement
- H-405.975, Recertification Exam for the American Board of Medical Specialties

(Appendix B).

It is AMA policy that:

- Board certification by one or more of the 24 American Specialty Boards represents a voluntary effort and achieved validation of excellence on the part of the physician.
- MOC be streamlined to reduce the cost, inconvenience, and disruption of practice due to MOC requirements for all its member boards, including subspecialty requirements.
- Specialty Board recertification not be the sole condition of employment.
- Specialty board certification be accepted as evidence of continuing competence for the purpose of re-registration of licensure.
- All physicians be urged to participate in CME as a professional obligation; and that licensing boards be urged not to require mandatory reporting of CME as part of the process of reregistering the license to practice medicine.

THE NATIONAL ALLIANCE FOR PHYSICIAN COMPETENCE (NAPC)

First convened in 2006, the NAPC is a voluntary “commons” of the public and representatives of most of the groups involved in MOC and MOL. The group holds facilitated conversations about the definitions of competency, the impact of assessment of competency, and the methods of assessment. The NAPC is a voluntary coalition of individuals from more than 60 organizations who come together to engage the medical community in the development of work products and strategies with a focus on physician self-regulation. Three main products have been produced by this group: The *GGMP-USA* document, the e-Folio system, and the Trusted Agent pilot program.

The Trusted Agent Pilot Program

The Trusted Agent pilot program is a joint effort by the FSMB and NBME designed to facilitate license portability, increase convenience, and reduce redundancies within the licensing process. The possibility of building a web-based system that will allow physicians to complete state licensing applications and obtain confidential credentialing data from primary sources in a secure environment is being explored during the pilot program. The Common License Application Form (CLA-F), the first phase of the program, will allow for the collection of uniform information and adds convenience for physicians applying to multiple states for licensure. In December 2006 the State Medical Board of Ohio went live with the CLA-F.[18]

eFolio System

The ACGME, the NBME, the FSMB, and the AAMC have been discussing and studying existing and future portfolio systems. Several medical schools and residency programs are using different portfolio systems, but there is no standardization between them. The eFolio system would function as a hub, connecting users in real time to data repositories containing physician test scores, résumés, self-reflections, goals, patient outcomes, and other professional development measures. Maintaining an ongoing record of these metrics may foster more self-assessment, mentoring, and performance improvement among physicians, and make relevant data available to regulatory bodies that certify and license physicians, and track their CME activities. There is currently no timetable for when a national eFolio system might be created or implemented.[19]

THE GUIDE TO GOOD MEDICAL PRACTICE – USA (GGMP-USA)

The *Guide to Good Medical Practice – USA (GGMP-USA)* Version 1.0. (available at: *http://www.ama-assn.org/go/councilmeded)* was conceived in June 2006 by the National Alliance for Physician Competence. The *GGMP-USA* intends to describe desirable and aspirational characteristics of competent physicians licensed to practice medicine in the United States. This document was modeled after the UK document, *Good Medical Practice*, General Medical Council, UK 13 November, 2006, which provided guidance to UK doctors, defined competence, and let the public know what to expect from them. Although the intent of the *GGMP-USA* is not to set the standard for how competence is defined and measured, it is being promoted to provide a common language and a common framework for how organizations responsible for educating, training, and regulating physicians should think about competence and to provide guidance for physicians and those who educate them.[20]

AMA Concerns About The Guide to Good Medical Practice – USA

The AMA supports many of the underlying aspirations of the *GGMP-USA*. However, the AMA firmly believes that the *GGMP-USA* should not be accepted as a standard for certification, licensure, or as a standard of care to which physicians should be held. Adoption of this document by regulators would place physicians at significant legal risk for circumstances that are not within their control and that have no proven link to good patient outcomes. The AMA views *GGMP-USA* as an aspirational document for the medical profession that needs to be grounded in more established professional standards such as the AMA *Code of Medical Ethics*. The AMA Council on Ethical and Judicial Affairs develops ethics policy for the AMA, prepares reports that analyze and address timely ethical issues that confront physicians and the medical profession, and maintains the AMA *Code of Medical Ethics*.

Major concerns with the *GGMP-USA* as written include: (1) the underlying assumption that the physician is in total control of the process and outcomes of care, when, in fact, the fragmented health care delivery system in the United States means that the outcome of patient care is always the result of many factors in addition to the ability of physicians to provide high quality, safe, and effective care; and (2) the inclusion of an extensive list of physician behaviors that cannot be directly linked to improved patient outcomes. These metrics have no evidence base to support their widespread adoption. Efforts directed toward systems of care would be much more effective than the *GGMP-USA* in improving patient quality and safety, as has been shown by the success of similar efforts in other industries. In summary, the development of documents, such as the *GGMP-USA*, that focus on a series of competencies may not be productive in improving the quality and safety of patients.

SUMMARY AND RECOMMENDATIONS

Looking forward, AMA policy urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine when evaluating physicians for licensure. Currently, about 82% of active licensed physicians are certified by one of the 24 Member Boards of the American Board of Medical Specialties (ABMS); conversely, at least one in six competent physicians in good professional standing is not currently board certified. It is vital that implementing the maintenance of licensure (MOL) processes include an appropriate accommodation to this large percentage of the medical workforce.

All organizations involved in regulating education, certification, and licensure will have to coordinate their efforts, and use the tools that are now available to do this. The Council on Medical Education calls on the AMA House of Delegates to make this happen by collaborating with these organizations and participating in their forums whenever the opportunity arises.

The issues surrounding MOC and MOL are complicated as these programs strive for a balance between insuring physician competency and protecting the care of patients. Throughout its history, the AMA has promoted professionalism for the good of the public. Many of the proposed changes threaten the continuation of self-regulation by the members of the profession. The AMA leadership responses to the MOC and the *Guide to Good Medical Practice – USA* actions illustrate our belief that *nothing less than self-regulation is at stake*. It is vital that all members of the House of Medicine work together to continue to reassure the public that the profession can accept the responsibility of objectively maintaining the highest standards.

The Council on Medical Education recommends that the following recommendations be adopted and that the remainder of the report be filed.

1. That our American Medical Association: Reaffirm Policies regarding Specialty Board Certification, including:

   D-270.989, Improvements to the Maintenance of Certification Process
   D-275.969, Specialty Board Certification and Recertification
   D-275.971, American Board of Medical Specialties – Standardization of Maintenance of Certification Requirements
   D-275.977, Update on the American Board of Medical Specialties Program on Maintenance of Certification (MOC)
   H-405.974, Specialty Recertification Examinations
   D-275.987, Internal Medicine Board Certification Report-Interim Report
   H.275.996, Physician Competence

H-275.936, Mechanisms to Measure Physician Competency
H-275.956, Demonstration of Clinical Competence
H-275.933, Specialty Board Recertification Requirements for Employment
H-405.972, Recertification Alternatives
H-405.973, Board Certification
H-275.950, Board Certification
H-405.970, Specialty Board Certification Fee Requirements
H-405.975, Recertification Exam for the American Board of Medical Specialties
(Appendix B). (Reaffirm HOD Policy)

2. Adopt the following AMA Principles on Maintenance of Certification (MOC):

(1) Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.

(2) Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.

(3) Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by each board for MOC.

(4) Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).

(5) MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.

(6) Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey would not be appropriate nor effective survey tools to assess physician competence in many specialties.

(7) Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research, and teaching responsibilities.

(8) Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.

(9) The AMA affirms the current language regarding continuing medical education (CME): "By 2011, each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part 2. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA Physician's Recognition Award (PRA) Category 1, American Academy of Family

Physicians Prescribed, American College of Obstetricians and Gynecologists, and or American Osteopathic Association Category 1A)."
(10) MOC is an essential but not sufficient component to promote patient-care safety and quality. Health care is a team effort and changes to MOC should not create an unrealistic expectation that failures in patient safety are primarily failures of individual physicians. (New HOD Policy)

3. Continue to work with the Federation of State Medical Boards (FSMB) to establish and assess maintenance of licensure (MOL) principles with the AMA to assess the impact of MOC and MOL on the practicing physician and the FSMB to study the impact on licensing boards. (Directive to Take Action)

4. Recommend that the American Board of Medical Specialties (ABMS) not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety. (Directive to Take Action)

5. Encourage rigorous evaluation of the impact on physicians of future proposed changes to the MOC and MOL processes including cost, staffing, and time. (Directive to Take Action)

6. Review all AMA policies regarding medical licensure (Appendix A); determine if each policy should be reaffirmed, expanded, consolidated or is no longer relevant; and in collaboration with other stakeholders, update the policies with the view of developing AMA Principles of Maintenance of Licensure in a report to the HOD at the 2010 Annual Meeting. (Directive to Take Action)

7. Urge the National Alliance for Physician Competence (NAPC) to include a broader range of practicing physicians and additional stakeholders to participate in discussions of definitions and assessments of physician competence. (Directive to Take Action)

8. Continue to participate in the NAPC forums. (Directive to Take Action)

9. Encourage members of our House of Delegates to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups. (Directive to Take Action)

10. Continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for post graduate medical education in the US, including the Performance Improvement CME (PICME) format; and continue to develop relationships and agreements that may lead to standards, accepted by all US licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME. (Directive to Take Action)

11. <u>Collaborate with the American Osteopathic Association and its eighteen specialty boards in implementation of the recommendations of this report.</u>

Fiscal Note: $75,000 to continue to participate in the NAPC forums and work with the Federation to establish principles.

APPENDIX A

AMA Policy on Medical Licensure

The AMA has a number of policy statements concerning medical licensure. Following is representative AMA policy in this regard, as found in the AMA's online Policy Finder at www.ama-assn.org/go/policyfinder, using a search for the term "licensure" (returning 101 results total) in June 2008.

Graduates of Non-United States Medical Schools
H-255.983
The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character.
(Sub. Res. 45, A-88; Reaffirmed by Res. 311, A-96; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 1, I-03; Reaffirmed: CME Rep. 7, A-04; Reaffirmed: Sub. Res. 314, A-04)

Equality in Licensure and Reciprocity
H-255.982
Our AMA
1. Reaffirms its policy that it is inappropriate to discriminate against any physician because of national origin or geographical location of medical education
2. Continues to recognize the right and responsibility of states and territories to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdiction
3. Supports the development and distribution of model legislation to encourage states to amend their Medical Practice Acts to provide that graduates of foreign medical schools shall meet the same requirements for licensure by endorsement as graduates of accredited US and Canadian schools.

(Res. 69, A-89; Rescinded: Sunset Report, A-00; Restored: CME Rep. 3, A-02; Reaffirmed: CME Rep. 7, A-04; Reaffirmed in lieu of Res. 320, A-04)

International Medical Graduates
H-255.995
The AMA believes that reduced requirements for licensure should not be applied under any circumstances to graduates of foreign medical schools.
(Res. 23, A-82; Reaffirmed: CLRPD Rep. A, I-92; Modified: CME Rep. 5, A-04)

Physician Exemption from Medical School Standards and Performance Evaluation Requirements
H-255.994
1. The AMA recommends to medical licensing boards that those physicians who are foreign medical graduates currently duly licensed by any licensing jurisdiction in the US should not be denied endorsement of their licenses, or denied admission to reexamination when this is required by law, solely because they are unable to provide documentation of graduation from a school meeting "equivalent standards and performance evaluation requirements" to those of programs accredited by the Liaison Committee on Medical Education.

2. The AMA encourages licensing boards, in reviewing applications for licensure endorsement, to take into account a physician's ethical standards and his or her having practiced medicine of an acceptable quality.

(Sub. Res. 108, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

Discrimination Against Physicians
H-255.992
Our AMA:
1. Believes that the quality of a physician's medical education is an appropriate consideration in the recruitment and licensure of physicians and discrimination against physicians on the basis of the country in which they completed their medical education is inappropriate
2. Affirms that the residency application process should be free of discrimination, including discrimination arising from the electronic submission of applications.

(Sub. Res. 44, A-85; Reaffirmed: CLRPD Rep. 2, I-95; Appended: Sub. Res. 305 and Reaffirmation A-00)

Arbitrary Exclusion of International Medical Schools Which Impacts Physician Licensure
H-275.928
Our AMA opposes the practice by state medical boards of creating arbitrary and non criterion-based lists of approved or unapproved international medical schools.
(Res. 310, A-05)

USMLE Part III and Licensure
H-275.938
Our AMA will lobby the Federation of State Medical Boards to discourage states from linking mandatory application for licensure with application to take the USMLE Part III.
(Res. 325, A-98)

Licensure of IMGs
H-275.935
Our AMA asks the Federation of State Medical Boards to ask all the state licensing boards to adopt a uniform standard governing the allowed number of administrations of the licensure examinations.
(Res. 314, A-99)

Alternatives to the Federation of State Medical Boards' Recommendations on Licensure
H-275.934
Our AMA adopts the following principles:
1. Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Parts 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Part 1 of COMLEX. There should be provision made for students who have not completed Step 2 of the USMLE or Part 2 of the COMLEX to do so during the first year of residency training.
2. All applicants for full and unrestricted licensure, whether graduates of US medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the US, have passed all licensing examinations (USMLE or COMLEX), and must be certified by their residency program director as ready to advance to the next year

of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content.

3. There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Part 1 of COMLEX.
4. Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians.
5. Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements.
6. There should be no reporting of actions against medical students to state medical licensing boards.
7. Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills.
8. The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.

(CME Rep. 8, A-99; Reaffirmed: CME Rep. 4, I-01)

Self-Incriminating Questions on Applications for Licensure and Specialty Boards
H-275.945

The AMA will:

1. Encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information
2. Seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards
3. Until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked.

(BOT Rep. 1, I-933; CME Rep. 10 - I-94; Reaffirmed: CME Rep. 2, A-04)

Out-of-State Residents in Training and State Licensing Board Requirements for Temporary Licenses
H-275.941

The AMA will work with the Federation of State Medical Boards (FSMB) to facilitate a timely process so that residents in a training program can meet the licensure requirements to avail themselves of opportunities for educational experiences in states other than that of their primary program location.

(Sub. Res. 301, A-97; Reaffirmed: CME Rep. 2, A-07)

Demonstration of Clinical Competence
H-275.956
It is the policy of the AMA to
1. Support continued efforts to develop and validate methods for assessment of clinical skills
2. Continue its participation in the development and testing of methods for clinical skills assessment
3. Recognize that clinical skills assessment is best performed using a rigorous and consistent examination administered by medical schools and should not be used for licensure of graduates of Liaison Committee on Medical Education (LCME)- and American Osteopathic Association (AOA)-accredited medical schools or of Educational Commission for Foreign Medical Graduates (ECFMG)-certified physicians.

(CME Rep. E, A-90; Reaffirmed: CME Rep. 5, A-99; Modified: Sub. Res. 821, I-02; Modified: CME Rep. 1, I-03)

Board Certification
H-275.950
Our AMA
1. Reaffirms its opposition to the use of board certification as a requirement for licensure or reimbursement
2. Seeks an amendment to the new Medicaid rules that would delete the use of board certification as a requirement for reimbursement and would address the exclusion of internal medicine, emergency medicine, and other specialties.

(Res. 143, A-92; Reaffirmed by Res. 108, A-98; Reaffirmation A-00)

Postgraduate Training Requirements for Obtaining Permanent Medical Licensure
H-275.960
Our AMA continues to oppose lengthy residency training requirements for licensure.
(CME Rep. A, I-89; Reaffirmed: Sunset Report, A-00)

Medical Licensure
H-275.978
The AMA:
1. Urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent
2. Encourages licensing boards to require a certificate of competence for full and unrestricted licensure
3. Urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends
4. Will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice
5. Urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public

6. Urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94)
7. Urges licensing boards to maintain strict confidentiality of reported information
8. Urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board
9. Recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician
10. Urges all physicians to participate in continuing medical education as a professional obligation
11. Urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine
12. Opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient
13. Supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review
14. Believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation
15. Urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public
16. Encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses
17. Urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses
18. Urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination
19. Urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education
20. Urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement
21. Urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement.

(CME Rep. A, A-87; Modified: Sunset Report, I-97; Reaffirmation A-04)

State Control of Qualifications for Medical Licensure
H-275.973

1. The AMA firmly opposes the imposition of federally mandated restrictions on the ability of individual states to determine the qualifications of physician candidates for licensure by endorsement.
2. The AMA actively opposes the enactment of any legislation introduced in Congress that promotes these objectives.

(Res. 84, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07)

Licensure Confidentiality
H-275.970

The AMA

1. Encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials
2. Encourages boards to include in application forms only requests for information that can reasonably be related to medical practice
3. Encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training
4. Encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards
5. Encourages state licensing boards to require that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine.

(CME Rep. B, A-88; Reaffirmed: BOT Rep. 1, I-933; CME Rep. 10 - I-94; Reaffirmed: CME Rep. 2, A-04)

Graduate Medical Education Requirement for Medical Licensure
H-275.985

The AMA reaffirms its policy that all applicants for full and unrestricted licensure should be required to provide evidence of satisfactory completion of at least one year of an accredited program of graduate medical education in the US.

(CME Rep. E, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)

Legislative Action
H-275.984

The AMA

1. Vigorously opposes legislation which mandates that, as a condition of licensure, physicians who treat Medicare beneficiaries must agree to charge or collect from Medicare beneficiaries no more than the Medicare allowed amount
2. Strongly affirms the policy that medical licensure should be determined by educational qualifications, professional competence, ethics and other appropriate factors necessary to assure professional character and fitness to practice

3. Opposes any law that compels either acceptance of Medicare assignment or acceptance of the Medicare allowed amount as payment in full as a condition of state licensure.

(Sub. Res. 117, I-85; Modified by CLRPD Rep. 2, I-95; Reaffirmed: BOT Rep. 12, A-05)

Licensure by Specialty
H-275.997

Experience with licensure by specialty is too limited to determine what the long-range effects will be in the provision of timely, safe and comprehensive medical care. However, the AMA does not consider licensure by specialty to be desirable even in unusual cases.

(CME Rep. F, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

Physician Competence
H-275.996

Our AMA:

1. Urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence
2. Urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure
3. Favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base.

(CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07)

Content-Specific CME Mandated for Licensure
H-300.953

1. The AMA, state medical societies, specialty societies, and other medical organizations should reaffirm that the medical profession alone has the responsibility for setting standards and determining curricula in continuing medical education.
2. State medical societies should establish avenues of communication with groups concerned with medical issues, so that these groups know that they have a place to go for discussion of issues and responding to problems.
3. State medical societies should periodically invite the various medical groups from within the state to discuss issues and priorities.
4. State medical societies in states which already have a content-specific CME requirement should consider appropriate ways of rescinding or amending the mandate.

(CME Rep. 6, A-96; Reaffirmed: CME Rep. 2, A-06)

Resident Physician Licenses
H-405.966

The AMA supports the option of limited educational licenses in all states for resident physicians to provide care within their residency programs; and supports reduced licensure fees for resident physicians for participation solely in graduate medical education training programs when full medical licensure is required by a state.

(Sub. Res. 312, A-96; Reaffirmed: CME Rep. 2, A-06)

The Promotion of Quality Telemedicine
H-480.969

1. It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles: (a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state; (b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation; (c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.
2. The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (eg, teleradiology) must sometimes perform necessary functions in the licensing state (eg, interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions.
3. The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties).

(CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99)

Licensure and Liability for Senior Physician Volunteers
D-160.991

Our AMA

1. And its Senior Physician Group will inform physicians about federal and state-based charitable immunity laws that protect physicians wishing to volunteer their services in free medical clinics and other venues
2. Will work with organizations representing free clinics to promote opportunities for physicians who wish to volunteer.

(BOT Rep. 17, A-04)

Depression and Physician Licensure
D-275.974
Our AMA will
1. Recommend that physicians who have major depression and seek treatment not have their medical licenses and credentials routinely challenged but instead have decisions about their licensure and credentialing and recredentialing be based on professional performance
2. Make this resolution known to the various state medical licensing boards and to hospitals and health plans involved in physician credentialing and recredentialing.

(Res. 319, A-05)

Simplifying the State Medical Licensure Process
D-275.980
Our AMA Board of Trustees will assign appropriate individuals from within the AMA to work with the Federation of State Medical Boards and keep the AMA membership apprised of the FSMB's actions on developing a standardized medical licensure application, and the individuals assigned by the AMA Board of Trustees regarding the FSMB's work on standardized medical licensure application will report back to the AMA on a yearly basis beginning at the 2005 Annual Meeting, until decided by the Board of Trustees that this is no longer necessary.
(Res. 324, A-04)

Unified Medical License Application
D-275.992
Our AMA will request the Federation of State Medical Boards to examine the issue of a standardized medical licensure application form for those data elements that are common to all medical licensure applications.
(Res. 308, I-01)

Facilitating Credentialing for State Licensure
D-275.994
Our AMA will:
1. Encourage the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible
2. Work with the Federation of State Medical Boards and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions
3. Encourage the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license.

(Res. 302, A-01)

Licensure and Credentialing Issues
D-275.995
Our AMA will:
1. Support recognition of the Federation of State Medical Boards' (FSMB) Credentials Verification Service by all licensing jurisdictions

2. Work jointly with the FSMB to take measures to encourage increased standardization of credentials requirements, and improved portability by increased use of reciprocal relationships among all licensing jurisdictions
3. Communicate, either directly by letter or through its publications, to all hospitals and licensure boards that the Joint Commission on Accreditation of Healthcare Organizations encourages recognition of both the Educational Commission for Foreign Medical Graduates' Certification Verification Service and the AMA's Masterfile as primary source verification of medical school credential; and
4. Encourage the National Commission on Quality Assurance (NCQA) and all other organizations to accept the Federation of State Medical Boards' Credentials Verification Service, the Educational Commission for Foreign Medical Graduates' Certification Verification Service, and the AMA Masterfile as primary source verification of credentials.

(Res. 303, I-00; Reaffirmation A-04)

Response to the Federation of State Medical Boards Recommendations on Licensure
D-275.998
Our AMA will collaborate with other appropriate external groups to develop model state medical licensing legislation or regulations that ensure the public safety.
(Res. 319, I-98)

State Authority and Flexibility in Medical Licensure for Telemedicine
D-480.999
Our AMA will:
1. Develop a policy regarding the practice of medicine as it relates to the prescribing of prescription-only pharmaceuticals or other therapies via the Internet
2. Continue its opposition to a single national federalized system of medical licensure.

(CME Rep. 7, A-99)

Appendix B

AMA Policy on Specialty Board Certification

D-270.989 Improvements to the Maintenance of Certification Process
By September 15, 2008, our AMA Board of Trustees will write a letter to the American Board of Medical Specialties (ABMS) asking that it work with its 24 member boards to: a. coordinate with each other, the ABMS, specialty societies and the AMA to ensure that the demands of Maintenance of Certification (MOC) are reasonable; b. educate physicians and increase their understanding of the MOC process and its requirements; c. solicit physician input and feedback regarding MOC implementation; d. make transparent all recertification-related costs; e. work to minimize the disruption of physician practice due to MOC requirements; and f. ensure that the number of MOC-related testing dates and the locations of testing sites are ample enough to minimize the burden on physician practices and their time away from clinical care. (Res. 323, A-08)

D-275.969 Specialty Board Certification and Recertification
1. Our AMA will continue to monitor the progress by the ABMS and its member boards on implementation of Maintenance of Certification (MOC) and encourage ABMS to report its research findings on the issues surrounding certification, recertification and MOC on a periodic basis. 2. An update report will be prepared for the AMA House of Delegates no later than 2010. 3. Our AMA will encourage dialogue between the ABMS and its respective specialty societies to work on development, implementation, and monitoring of MOC that meets the needs of practicing physicians and improves patient care. 4. Our AMA will exercise its full influence to protect physicians from undue burden and expense in the Maintenance of Certification process. (CME Rep. 7, A-07)

D-275.971 American Board of Medical Specialties - Standardization of Maintenance of Certification Requirements
Our AMA will work with the American Board of Medical Specialties to streamline Maintenance of Certification (MOC) to reduce the cost, inconvenience, and the disruption of practice due to MOC requirements for all of their member boards, including subspecialty requirements. (Sub. Res. 313, A-06; Reaffirmed: CME Rep. 7, A-07)

D-275.977 Update on the American Board of Medical Specialties Program on Maintenance of Certification (MOC)
Our AMA will: (1) continue to monitor the progress of Maintenance of Certification (MOC) and its ultimate impact on the practice community; (2) encourage the Physician Consortium for Performance Improvement, the American Board of Medical Specialties, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC; and (3) encourage the ABMS Maintenance of Certification Task Force to develop and adopt recommendations for re-entry into clinical practice and entry into Step IV of MOC for diplomates not involved in direct patient care. (CME Rep. 9, A-05; Reaffirmed:
CME Rep. 7, A-07)

H-405.974 Specialty Recertification Examinations
Our AMA (1) encourages the American Board of Medical Specialties and its member boards to continue efforts to improve the validity and reliability of procedures for the evaluation of candidates for certification; and (2) believes that the holder of a certificate without time limits

should not be required to seek recertification. (CME Rep. E, A-92; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07)

D-275.987 Internal Medicine Board Certification Report - Interim Report
Our AMA shall: (1) support the ACP/ASIM in its efforts to work with the American Board of Internal Medicine (ABIM) to improve the Maintenance of Certification (MOC) program; (2) encourage specialty societies to work with their respective ABMS member board to develop, implement and evaluate the Maintenance of Certification (MOC) program; (3) continue to assist physicians in practice performance improvement; (4) continue to monitor the progress by the American Board of Internal Medicine and the other member boards of the American Board of Medical Specialties (ABMS) on implementing the Maintenance of Certification (MOC) program; (5) encourage the ABMS to include practicing physicians and physicians with time limited board certificates to assist in designing and evaluating the Maintenance of Certification (MOC) process for each of the ABMS member boards; and (6) shall study the ethical implications of the Maintenance of Certification (MOC) program including the patient assessment component vis-à-vis the doctor-patient relationship and the ethical implications of the peer review component vis-à-vis the practice environment. (CMS Rep. 7, A-02; Reaffirmed: CME Rep. 9, A-05; Reaffirmed: CME Rep. 7, A-07)

H-275.996 Physician Competence
Our AMA: (1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base. (CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07)

H-275.936 Mechanisms to Measure Physician Competency
Our AMA (1) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (2) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency. (Res. 320, I-98; Amended: Res. 817, A-99; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07)

H-275.956 Demonstration of Clinical Competence
It is the policy of the AMA to (1) support continued efforts to develop and validate methods for assessment of clinical skills; (2) continue its participation in the development and testing of methods for clinical skills assessment; and (3) recognize that clinical skills assessment is best performed using a rigorous and consistent examination administered by medical schools and should not be used for licensure of graduates of Liaison Committee on Medical Education (LCME)- and American Osteopathic Association (AOA)-accredited medical schools or of

Educational Commission for Foreign Medical Graduates (ECFMG)-certified physicians. (CME Rep. E, A-90; Reaffirmed: CME Rep. 5, A-99; Modified: Sub. Res. 821, I-02; Modified: CME Rep. 1, I-03)

H-275.933 Specialty Board Recertification Requirements for Employment
Our AMA opposes specialty board recertification as a sole condition of employment. (Res. 303, I-01; Reaffirmed: CME Rep. 7, A-07)

H-405.972 Recertification Alternatives
Our AMA continues to support the development and validation of alternatives to recertification by standardized testing. (Res. 317, I-92; Reaffirmed: Res. 306, I-97; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07)

H-405.973 Board Certification
It is the policy of the AMA (1) to continue to work with other medical organizations to educate the profession and the public about the board certification process; and (2) that, when the occasion arises that equivalency of board certification must be determined, the Essentials for Approval of Examining Boards in Medical Specialties be utilized for that determination. (CME Rep. D, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 7, A-07)

H-275.950 Board Certification
Our AMA (1) reaffirms its opposition to the use of board certification as a requirement for licensure or reimbursement; and (2) seeks an amendment to the new Medicaid rules that would delete the use of board certification as a requirement for reimbursement and would address the exclusion of internal medicine, emergency medicine, and other specialties. (Res. 143, A-92; ; Reaffirmed by Res. 108, A-98; Reaffirmation A-00)

H-405.970 Specialty Board Certification Fee Requirements
The AMA strongly encourages member boards of the American Board of Medical Specialties to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms. (Res. 303, A-93; Reaffirmed: CME Rep. 2, A-03)

H-405.975 Recertification Exam for the American Board of Medical Specialties
Our AMA actively encourages those specialty boards that issue time limited certificates to include young physicians with such certificates in the decision-making process for any design of plans for recertification. (Res. 303, A-92; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 7, A-07)