

HOD ACTION: Council on Medical Education Report 3 adopted as amended and the remainder of the report filed.

REPORT 3 OF THE COUNCIL ON MEDICAL EDUCATION (A-15)

An Update on Maintenance of Licensure

(Resolution 934-I-14)

(Reference Committee C)

EXECUTIVE SUMMARY

To provide greater clarity to the reports and avoid ongoing confusion about the relationship between Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC) versus Maintenance of Licensure (MOL), the Council on Medical Education will be addressing these issues in two separate reports beginning with the 2015 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD). This report will address Resolution 934-I-14, Creation of AMA Principles for Physician Demonstration of Current Professional Expertise, the mandate of AMA Policy D-275.960 (2) as it relates to MOL, and the most recent activities on this topic.

This report traces the origins of state-based medical licensure and licensure renewal in the United States and its territories back to the passage of the Bill of Rights. It explains the role of the Federation of State Medical Boards (FSMB) in assisting state medical boards (SMBs) in protecting the public's health through promotion of high standards for physician licensure and regulation. AMA's commitment to continuing professional development through its ethical principles and policies, including its AMA Physician Recognition Award and its attendant *AMA PRA Category 1 Credit*[™] System, and how these have contributed to support physicians in the licensure renewal process are explained.

The AMA's influence on the evolution of MOL components and implementation of recommendations is described. Congruence with the three components of MOL (i.e., Reflective Self-assessment, Assessment of Knowledge and Skills, and Performance in Practice) and tenets of continuing professional development supported by AMA are illustrated. The AMA's success in advocating that MOC not be a requirement of MOL but be recognized as one way to meet MOL requirements is noted.

The report analyzes the principles for physician demonstration of current professional experience proposed in Resolution 934-I-14 and recommends adoption of a number of those principles that are reasonable to implement as guidelines for state MOL programs. No state has yet implemented a program of MOL so it is impossible to study the impact MOL will have on workforce. If, however—as the FSMB has indicated—MOL programs will recognize activities that physicians currently use/should use for continuing professional development, there should not be an increase in time or costs to physicians to comply with MOL requirements.

The report concludes that the Components and Principles of MOL adopted by FSMB have been influenced by input from the AMA and align with AMA policies related to CME/CPD and AMA ethical principles. The AMA will continue its advocacy for physicians at the national level with the FSMB and other stakeholders related to licensure and MOL policy, and will explore products and services to support physicians in the licensure renewal process. The report also points out that as implementation of MOL moves to local jurisdictions, state medical societies will be at the frontline in influencing what SMBs will adopt, such that the AMA Advocacy Resource Center and AMA policy are assets that are available to state medical societies, as needed.

HOD ACTION: Council on Medical Education Report 3 adopted as amended and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-A-15

Subject: An Update on Maintenance of Licensure
(Resolution 934-I-14)

Presented by: William A. McDade, MD, Chair

Referred to: Reference Committee C
(Daniel B. Kimball, Jr., MD, Chair)

1 Policy D-275.960, An Update on Maintenance of Certification, Osteopathic Continuous
2 Certification, and Maintenance of Licensure, calls on our American Medical Association (AMA)
3 to:

- 4
- 5 • Continue to monitor the evolution of maintenance of certification (MOC), osteopathic
6 continuous certification (OCC), and maintenance of licensure (MOL), continue its active
7 engagement in the discussions regarding their implementation, and report back to the
8 House of Delegates (HOD) on these issues.
9

10 The Council on Medical Education has prepared single reports covering both MOC/OCC and the
11 principles of MOL for the past six years.^{1,2,3,4,5,6} However, MOC/OCC and MOL are distinctly
12 different processes, designed by independent organizations with different purposes and mandates.
13 While MOC and OCC describe programs that address continued specialty certification for
14 allopathic and osteopathic physicians, MOL principles, once implemented by each licensing
15 authority (“state medical board,” or SMB), will define the process by which physicians are to meet
16 requirements for renewing their medical license.⁵ To provide greater clarity and avoid confusion
17 about the relationship between MOC/OCC and MOL, the Council will address these issues
18 separately in its reports beginning with the 2015 Annual Meeting of the HOD.
19

20 Resolution 934-I-14, Creation of AMA Principles for Physician Demonstration of Current
21 Professional Expertise, introduced by the Organized Medical Staff Section and referred by the
22 HOD, asked that our AMA adopt the following Principles on Maintenance of Licensure (MOL) as
23 a resource and make them available to state medical societies that seek guidance in determining
24 MOL Principles for their states:
25

- 26 1. The AMA supports continuous lifelong learning by physicians and quality
27 improvement in the practice of medicine and will only support implementation of
28 MOL requirements when substantial and convincing evidence demonstrates that such
29 requirements will improve clinical outcomes/patient care.
30
- 31 2. That in the event that substantial and convincing evidence exists that such MOL
32 requirements will improve clinical outcomes/patient care, and implementation of these
33 requirements moves forward, the AMA will support the following:
34
- 35 a. Any MOL activity should be able to be integrated into the existing infrastructure of
36 the health care environment.

- 1 b. Any MOL educational activity under consideration should be developed in
2 collaboration with physicians, should be evidence-based, and should be specialty
3 specific. Accountability for physicians should be led by physicians.
4
- 5 c. Any proposed MOL activity should undergo an in-depth analysis of the direct and
6 indirect costs, including physician's time and the impact on patient access to care,
7 as well as a risk/benefit analysis with particular attention to unintended
8 consequences.
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- 10 d. Any MOL activity should be flexible and offer a variety of compliance options for
11 all physicians, practicing or non-practicing, which may vary depending on their
12 roles (e.g., clinical care, research, administration, education, etc.).
13
- 14 e. Any MOL activity should be designed for quality improvement and lifelong
15 learning.
16
- 17 f. Participation in quality improvement activities, such as chart review, should be an
18 option as an MOL activity.
19
- 20 3. The AMA shall work in collaboration with state and specialty medical societies and
21 state agencies responsible for establishing criteria for MOL regarding any continuing
22 medical education and lifelong learning. The physician community must be involved
23 with the discussions and final deliberations before enactment.
24

25 At the 2014 Interim Meeting of the HOD, Reference Committee K reported that it heard mixed
26 testimony on Resolution 934-I-14. There was concern with the first resolve setting unrealistic
27 expectations. There also was confusion about MOC being a requirement for MOL. Due to the
28 complexity of the issues raised in this Resolution and the need for additional study, the HOD
29 referred this resolution for report back at the 2015 Annual Meeting.
30

31 BACKGROUND

32 *State-based Medical Licensure/Licensure Renewal*

33 With the passage of the Bill of Rights in 1791, states were given the right to regulate health, and
34 formal licensing of physicians through state medical boards was implemented in the 1800s. To be
35 licensed, physicians must demonstrate that they meet the requirements for each state in which they
36 will practice; these requirements vary from state to state.
37

38 For many decades, the licensure process focused on reviewing standards for initial licensure. In
39 1967, a Presidential Commission on Medical Manpower recommended that "state governments
40 explore the possibility of periodic relicensing of physicians and other health professionals." This
41 included the recommendation that medical license renewal be contingent upon participation in
42 acceptable continuing medical education (CME) activities or assessment in the physician's specialty.
43 44

45 In 1971, the state of New York passed a regulation requiring physicians not serving on a hospital
46 staff or holding specialty certification to match the CME requirements set by the American
47 Academy of Family Physicians (AAFP). In that same year, New Mexico became the first state
48 medical board (SMB) to implement a CME requirement for licensure renewal. Today, all but five
49 states have CME requirements that physicians must meet to maintain their state licenses. Thus,
50

1 while the process of MOL that is evolving may be new, physician demonstration of activities to
2 maintain competence to practice has long been part of states' licensure renewal processes.

3
4 The AMA has consistently supported states' rights to determine the qualifications of physician
5 candidates for medical licensure and has opposed efforts to set national requirements for state
6 licensure. AMA Policy D-480.999, State Authority and Flexibility in Medical Licensure for
7 Telemedicine, states that our AMA will continue its opposition to a single national federalized
8 system of medical licensure. That said, with the advent of telemedicine and physicians seeking
9 licensure in multiple states, movement toward compatibility of licensure/licensure renewal/MOL
10 requirements across SMBs will become essential.

11
12 *Federation of State Medical Boards (FSMB)*

13
14 The FSMB is a national non-profit umbrella organization representing 70 medical and osteopathic
15 boards in the United States and its territories. The FSMB assists SMBs in protecting the public's
16 health, safety and welfare through promotion of high standards for physician licensure and
17 regulation. FSMB services to SMBs include assessment tools and policy documents as well as
18 credentialing and disciplinary alert services. It is important to note that while the FSMB represents
19 the interests of all SMBs, each SMB operates in accordance with the laws of its respective state and
20 is not bound by FSMB policies.

21
22 *AMA's Physician Recognition Award, AMA PRA Category 1 CreditTM, other CME Credit Systems*
23 *and Medical Ethics*

24
25 Since its founding in 1847, and moreover with the establishment in 1904 of the Council on Medical
26 Education, the AMA has pursued a concerted campaign to encourage high quality educational
27 requirements for physicians. The responsibility of self-regulation in medicine is the core of the
28 profession. To retain the public trust, physicians must show good faith in how they certify and
29 credential themselves and their colleagues.

30
31 As part of its role in ensuring the quality of medical education and practice, the Council on Medical
32 Education reported to the HOD in 1955 that almost a third of the 5,000 physicians responding to a
33 survey reported no participation in formal CME for at least five years and declared that CME
34 "lacked direction and was suffering from a lack of clearly defined objectives." As a result of the
35 report, the HOD took actions in the 1960s to support CME. For example, in 1968, the AMA began
36 awarding the Physician Recognition Award (PRA)⁷ to physicians who demonstrate a commitment
37 to staying current with advances in medicine by providing documentation to the AMA of
38 completion of a minimum of 50 CME credits per year. The credit system developed by the AMA to
39 support the Award, *AMA PRA Category 1 CreditTM* and *AMA PRA Category 2 CreditTM*, has
40 become a "common currency" for physicians across all specialties to meet requirements from
41 multiple organizations that mandate participation in CME.

42
43 The *AMA PRA Category 1 CreditTM* system, along with CME credit systems of the AAFP and the
44 American Osteopathic Association (AOA), are recognized by SMBs as metrics to demonstrate that
45 a physician has maintained a commitment to study, apply, and advance scientific knowledge.

46
47 Underlying this commitment to CME/continuing professional development (CPD) is the AMA
48 Principle of Medical Ethics, which states: "A physician shall continue to study, apply, and advance
49 scientific knowledge, maintain a commitment to medical education, make relevant information
50 available to patients, colleagues, and the public..."

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

4
5 “A self-regulating profession holds its members accountable to the public it serves for the
6 continuous development of the competencies they profess to hold. A central component of
7 physician competence is professionalism, which requires lifelong learning that leads to
8 improved performance in practice. A medical profession accomplishes accountability by
9 providing its members periodic measurement of performance using reliable and valid
10 instruments and judging performance against evidence-based standards, providing graduate
11 and CME programs that advance members’ knowledge and skills to meet these standards,
12 and publicly certifying those who do so.”⁸

13 14 EVOLUTION OF MOL

15
16 Since the early 1980s, the FSMB has been calling for physicians to continuously display
17 characteristics that demonstrate that they are thoroughly educated, highly qualified, and staunchly
18 ethical throughout their active careers. Increasing calls from outside the regulatory community for
19 more proactive evaluation of physicians’ continued competence at the time of license renewal,
20 including reports from the Pew Charitable Trust and the Institute of Medicine (IOM), were a
21 significant impetus in the early 2000s for the FSMB to more closely evaluate the responsibility
22 SMBs have to ensure physicians’ competence over the course of their careers.⁹

23
24 As a result of these efforts, in 2004 the FSMB’s HOD adopted the following policy statement:
25 “State medical boards have a responsibility to the public to ensure the ongoing competence of
26 physicians seeking licensure.” Following adoption of this policy, FSMB focused on developing
27 strategies that SMBs could use in implementing programs to ensure physicians maintain an
28 appropriate level of competence to practice medicine safely throughout their professional careers.

29 30 *MOL Framework/Components*

31
32 A framework for MOL was formally adopted by the FSMB’s HOD in 2010, following seven years
33 of study that included input and guidance from physicians and health care organizations across the
34 house of medicine, including the AMA. The three components of MOL are:

- 35
36 1. Component One (Reflective Self-assessment)
37 Physicians must participate in an ongoing process of reflective self-evaluation, self-
38 assessment, and practice assessment, with subsequent successful completion of appropriate
39 educational or improvement activities.
40
- 41 2. Component Two (Assessment of Knowledge and Skills)
42 Physicians must demonstrate the knowledge, skills and abilities necessary to provide safe,
43 effective patient care within the framework of the six general “core competencies” as they
44 apply to their individual practice.
45
- 46 3. Component Three (Performance in Practice)
47 Physicians must demonstrate accountability for performance in their practice using a
48 variety of methods that incorporate reference data to assess their performance in practice
49 and which guide improvement.

1 These components are aligned with Policy D-295.328, Promoting Physician Lifelong Learning,
2 which encourages that physicians be trained to: 1) assess one's own learning needs and to create an
3 appropriate learning plan; 2) assess practice performance; and 3) engage in reflective practice.

4
5 A common misperception is that MOL Component Two calls for a secure examination, like that
6 required for MOC, but the FSMB has made clear that a secure examination is not what is
7 mandated. It is simply one option that is available for meeting Component Two requirements. The
8 MOL Implementation Group report, discussed below, describes the expectations for how
9 assessment of knowledge and skills may be accomplished.

10
11 *FSMB MOL Implementation Group*

12
13 The AMA has been actively involved in providing input to the FSMB on implementation plans for
14 MOL since the FSMB's adoption of the MOL framework. Steven J. Stack, MD, served as chair of
15 the FSMB MOL Implementation Group, which issued its report in February 2011.¹⁰ The AMA
16 provided comments on drafts of that report, and AMA issues were reflected in the final version.

17
18 The FSMB Implementation Group developed a series of recommendations to enable SMBs to
19 implement MOL programs that are consistent with FSMB policy. These include:

- 20
21 1. Phased Approach—The entire MOL program should be implemented as expeditiously as
22 possible with SMBs moving forward together. For practical reasons, some SMBs may
23 institute MOL in a phased implementation. Regardless of the implementation approach, all
24 SMBs should complete the implementation process within a 10-year period.
- 25
26 2. Implementation of Component One—Reflective Self-assessment: SMBs should require
27 each licensee to complete certified and/or accredited CME, a majority of which is practice-
28 relevant and supports performance improvement.
- 29
30 3. Implementation of Component Two—Assessment of Knowledge and Skills: SMBs should
31 require licensees to undertake objective knowledge and skills assessments to identify
32 learning opportunities and guide improvement activities. These activities should meet all of
33 the following criteria: a) be developed by an objective third party with demonstrated
34 expertise in these activities; b) be structured, validated, and consistently reproducible; c) be
35 credible with the public and profession; d) provide meaningful assessment feedback to the
36 licensee appropriate to the scope of the activity to guide subsequent education; and,
37 e) provide formal documentation that describes both nature of the activity (i.e., content and
38 areas assessed) and successful completion of the activity as designed.
- 39
40 4. Implementation of Component Three—Performance in Practice: SMBs should require
41 licensees to use comparative data and, when available, evolving performance expectations
42 to assess the quality of care they provide and then apply best evidence or consensus
43 recommendations to improve and subsequently reassess their care.
- 44
45 5. Periodicity of MOL Requirements: SMBs should require each licensee to complete a
46 minimum Component One activity on an annualized basis, a majority of which is devoted to
47 practice-relevant CME that supports performance improvement, and to document
48 completion of both one Component Two and one Component Three activity every five to
49 six years.

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6. Board Certification in the Context of MOL: SMBs should consider physicians who provide evidence of successful ongoing participation in American Board of Medical Specialties (ABMS) MOC or AOA OCC to have fulfilled all three components of MOL.
7. Types and Nature of Physician Practices: SMBs should regularly collect data from individual licensees about the extent of their engagement in direct patient care and the nature of their daily professional work.
8. Consistency of MOL across Aurisdictions: SMBs should strive for consistency in the creation and execution of MOL programs.

MOL Guiding Principles

The FSMB has adopted principles that SMBs should consider in developing MOL processes:

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 the SMBs.
3. Maintenance of licensure should not compromise patient care or create barriers to physician practice.
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 (e.g., should capture what most physicians are already doing, not be onerous, etc.).

These principles proactively address concerns physicians have expressed about potential burdens and costs resulting from the implementation of MOL. It will be critical for state medical societies to ensure that these principles are followed as SMBs develop processes for implementing MOL.

Status of State Implementation of MOL

No SMB has yet implemented the MOL framework; the Washington Medical Quality Assurance Commission has announced that it intends to begin implementing MOL requirements in 2016. While further study is under way to gather information on resources required, it is not anticipated that SMBs will need to make any significant additional investments in order to implement MOL. The FSMB has indicated that it is committed to supporting its member boards by providing information about appropriate activities and processes that ought to allow physicians to comply with the MOL framework. It would then follow that if there is not an additional cost to states for implementing MOL, there should not be an additional cost to physicians for licensure renewal. Again, state medical societies should monitor closely any increased costs to physicians for state implementation of MOL programs.

1 *MOL Pilot Projects*

2

3 While the FSMB's MOL policy provides a general framework for the implementation of MOL,
4 questions remain about specific aspects of MOL programs at the state level. Several feasibility
5 studies or "pilot projects" have been designed to answer these questions.

6

7 Shortly after the adoption of the MOL framework, several SMBs expressed an interest in becoming
8 involved in the development of MOL through engagement in these projects. The first pilot project
9 was the State Readiness Inventory, an electronic survey of the participating boards to identify
10 issues SMBs need to consider and possibly resolve to ensure the successful implementation of
11 MOL.

12

13 The second pilot project was a survey of practicing physicians to solicit opinions about their
14 preferences for features of an MOL system as well as to determine what types of educational
15 activities physicians are currently engaged in and what they find useful or beneficial about these
16 activities.

17

18 Ongoing work includes studying the license renewal processes of SMBs, in particular how they
19 verify CME compliance to determine how best to accommodate implementation of MOL with
20 minimal impact on board resources.

21

22 In 2014, the FSMB MOL Task Force on CPD Activities¹¹ presented an informational report to the
23 FSMB HOD that included recommendations regarding tools and activities that could meet a state's
24 requirements for MOL. The report addressed issues such as models for compliance as well as
25 standards and criteria for CPD activities, and included recommendations for SMBs, the FSMB, and
26 other stakeholders.

27

28 **IMPACT OF MOL ON WORKFORCE**

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30 There is no evidence to suggest that MOL will have an impact on the physician workforce, and it is
31 impossible to study the effect of MOL on the physician workforce since no state MOL programs
32 have yet been implemented. (See CME Report 2-A-15 for additional information.) Physicians
33 routinely engage in CME activities, and should be participating in performance improvement and
34 self-assessment as part of regular practice. If, as the FSMB has suggested, such activities will be
35 counted for MOL, then conceivably there should not be a significant, if any, increase in time or costs
36 beyond that which physicians already spend, or should spend, on CME/CPD, and documenting their
37 participation in these activities. This is another issue that state medical societies will need to
38 monitor closely as states consider how to implement MOL.

39

40 **RESOLUTION 934-I-14: CREATION OF AMA PRINCIPLES FOR PHYSICIAN**
41 **DEMONSTRATION OF CURRENT PROFESSIONAL EXPERTISE**

42

43 The AMA should work with state medical societies to ensure that, as MOL programs are
44 implemented in states, these programs reflect the MOL Guiding Principles that the FSMB has
45 adopted, as outlined previously, and do not impose additional burdensome or costly requirements
46 on physicians.

47

48 However, as the reference committee appropriately noted, the first proposed principle sets
49 unrealistic expectations: "The AMA supports continuous lifelong learning by physicians and
50 quality improvement in the practice of medicine and will only support implementation of MOL
51 requirements when substantial and convincing evidence demonstrates that such requirements will

1 improve clinical outcomes/patient care.” This principle calls for convincing evidence before the
2 AMA would support MOL, but until MOL is implemented, there is no way to collect that evidence.
3 Moreover, the components of MOL align with the tenets of CME/CPD, which the literature has
4 already shown to be effective.¹²

5
6 The second proposed AMA principle asks that:

- 7
- 8 a. Any MOL activity should be able to be integrated into the existing infrastructure of the health
9 care environment.
 - 10
11 b. Any MOL educational activity under consideration should be developed in collaboration with
12 physicians, should be evidence-based, and should be specialty specific. Accountability for
13 physicians should be led by physicians.
 - 14
15 c. Any proposed MOL activity should undergo an in-depth analysis of the direct and indirect
16 costs, including physician’s time and the impact on patient access to care, as well as a
17 risk/benefit analysis with particular attention to unintended consequences.
 - 18
19 d. Any MOL activity should be flexible and offer a variety of compliance options for all
20 physicians, practicing or non-practicing, which may vary depending on their roles (e.g., clinical
21 care, research, administration, education).
 - 22
23 e. Any MOL activity should be designed for quality improvement and lifelong learning.
 - 24
25 f. Participation in quality improvement activities, such as chart review, should be an option as an
26 MOL activity.
- 27

28 This language mirrors many of the recommendations the FSMB has already made around MOL
29 (e.g., evidence-based, specialty/practice-specific, flexible, variety of options, designed for quality
30 improvement, and lifelong learning) as noted in the FSMB MOL Implementation Group Report
31 recommendations, referenced above, and the FSMB MOL Task Force on CPD Activities Report, as
32 well as the report of the FSMB MOL Workgroup on Clinically Inactive Physicians.¹³ Quality
33 improvement and performance improvement activities and projects would be acceptable activities
34 for MOL. The FSMB has stated that the intent behind MOL is not to force physicians to engage in
35 extra activities, but to ensure that the activities physicians are engaging in to maintain their
36 competence are practice-focused, objective, and aimed to practice improvement and lifelong
37 learning. The AMA should consider adoption of this principle proposed in Resolution 934-A-14 as
38 an AMA guideline for MOL.

39

40 The third proposed principle states: “The AMA shall work in collaboration with state and specialty
41 medical societies and state agencies responsible for establishing criteria for MOL regarding any
42 continuing medical education and lifelong learning. The physician community must be involved
43 with the discussions and final deliberations before enactment.” This principle might also be
44 adopted, though the emphasis should be on the state medical societies working with SMBs within
45 their respective states. The FSMB reached out to the spectrum of organized medicine as the
46 concepts for MOL were developed, and they were responsive to input they received as reflected in
47 what was finally adopted. This model of collaboration needs to continue now between state
48 medical and specialty societies and SMBs as state MOL programs are being developed.

1 RELATIONSHIP OF MOC AND OCC TO MOL

2
3 MOC, OCC and MOL are distinctly different processes, designed by independent organizations
4 with different purposes and mandates. Board certification granted by one of the 24 ABMS Member
5 Boards or 18 specialty certifying member boards of the Bureau of Osteopathic Specialists provides
6 assurance of a physician's expertise in a particular specialty and/or subspecialty of medical
7 practice.

8
9 The ABMS MOC program is an ongoing program of education and assessment activities for
10 certified physicians to improve practice performance. The ABMS and its member boards are
11 developing MOC requirements that are supported by evidence-based guidelines, national clinical
12 and quality standards, and specialty best practices. In addition, they periodically evaluate and
13 update professional and educational standards to reflect the changes in medical specialty practice
14 and health care delivery processes. In 2013, over 78 percent (659,756) of the approximately
15 840,000 active practicing physicians (not including resident physicians) were certified by one of
16 the ABMS Member Boards.

17
18 The FSMB website defines MOL as "... a system of continuous professional development for
19 physicians that supports, as a condition for license renewal, a physician's commitment to lifelong
20 learning that is relevant to their area of practice and contributes to improved health care." MOC
21 and OCC are not intended to become mandatory requirements for medical licensure but should be
22 recognized as meeting some or all of a state's requirements for MOL, for physicians who are
23 participating in MOC or OCC, to minimize the burden and avoid unnecessary duplication of work.

24
25 Components of MOL do offer a mechanism for physicians who are not certified, or not
26 participating in MOC or OCC, to maintain their licenses to practice medicine. The AMA has
27 advocated that SMBs accept programs created by specialty societies as evidence that the physician
28 is participating in continuous lifelong learning and allow physicians choices in what programs they
29 participate in to fulfill their MOL criteria.

30
31 The AMA encourages rigorous evaluation of the impact on physicians of future proposed changes
32 to the MOL process, including cost, staffing, and time. State medical societies working with SMBs
33 on implementing MOL programs should also advocate that MOC fulfill the requirements for MOL,
34 to minimize regulatory burdens for physicians who choose to maintain specialty board certification.

35
36 AMA CONTINUING SUPPORT FOR PHYSICIAN LICENSURE AND MOL

37
38 The AMA has been actively engaged in the discussions and development of reports related to
39 establishing MOL. The Council on Medical Education and Medical Education staff meet several
40 times each year with leadership of the FSMB; these meetings have provided opportunities for frank
41 discussions of physician concerns related to the implementation of MOL. As previously noted, the
42 AMA has provided feedback on the reports the FSMB has offered for comments, and AMA
43 perspectives are reflected in final FSMB documents. The Council on Medical Education is
44 committed to fostering this relationship with the FSMB to ensure that the actual implementation of
45 MOL mirrors the MOL Guiding Principles adopted by the FSMB and adheres to relevant AMA
46 policies.

47
48 As implementation of MOL moves into the state regulatory arena, the AMA Advocacy Resource
49 Center can be an asset to state medical societies in discussions with SMBs about how MOL will be
50 implemented, but the AMA cannot lead these efforts, as this is the rightful role of the state medical
51 societies. State medical societies should be proactive in engaging SMBs early in the MOL

1 development process to ensure that the resulting programs do not create an undue burden for the
2 physicians in their states.

3
4 While the FSMB has stated that the components of MOL reflect what physicians already do in
5 practice, a potential challenge for physicians may be how to maintain records of assessment, CME,
6 and performance improvement activities for MOL. The HOD has previously asked that the AMA
7 consider implementing a data collection/tracking system to assist physicians with documentation
8 for credentialing purposes, but for a variety of reasons AMA has elected not to establish such
9 programs.

10
11 The AMA PRA CME Credit system (*AMA PRA Category 1 CreditTM* and *AMA PRA Category 2*
12 *CreditTM*) and the AAFP and AOA credit systems were well positioned in the early 1970s, and were
13 adopted by SMBs instead of creating new systems/requirements for physicians to renew their
14 licenses. The movement toward MOL should be a stimulus for the AMA to explore the feasibility
15 of developing, in collaboration with other stakeholders, physician-friendly documentation or other
16 tools that would be recognized by SMBs as mechanisms for physicians to demonstrate how they
17 meet MOL requirements. As with the AMA PRA and its associated CME credit system of the
18 1970s, a physician-developed solution to addressing MOL may be welcomed in shaping how states
19 will implement MOL.

20 21 AMA POLICY

22
23 The AMA has robust policies related to medical licensure. AMA policy supports the underlying
24 principles of MOL, which are consistent with the direction that the practice of medicine is
25 evolving. AMA policy directs our AMA to monitor MOL as being led by the FSMB and work with
26 the FSMB and other stakeholders to develop a coherent set of principles for MOL. (H-
27 275.923[11]). AMA policy also encourages rigorous evaluation of the impact on physicians of
28 future proposed changes to the MOL process, including cost, staffing and time, and opposes any
29 MOL initiative that creates barriers to practice, is administratively unfeasible, is inflexible with
30 regard to how physicians practice (clinically or not), that does not protect physician privacy, and
31 that is used to promote policy initiatives above physician competence. (H-275.923[3, 13]). The
32 complete text of policies cited in this report can be found in the Appendix.

33 34 SUMMARY AND RECOMMENDATIONS

35
36 MOC and MOL are distinct processes that impact physician credentialing. While CME Report 2-A-
37 15 provides an update on MOC, this report has focused on issues related to the evolving process of
38 MOL. The Components and Principles of MOL adopted by FSMB have been influenced by input
39 from the AMA and align with AMA policies related to CME/CPD and AMA ethical principles. The
40 AMA will continue its advocacy for physicians at the national level with the FSMB and other
41 stakeholders related to licensure and MOL policy. But as implementation of MOL moves to local
42 jurisdictions, the state medical societies will be at the frontline in influencing what SMBs will adopt.
43 The AMA Advocacy Resource Center and AMA policy are assets that state medical societies may
44 depend on in these discussions. Continued work is needed to explore the feasibility of developing
45 products and services to support physicians as MOL becomes a reality.

46
47 The Council on Medical Education recommends that the following recommendations be adopted in
48 lieu of Resolution 934-I-14 and that the remainder of this report be filed.

- 1) That our American Medical Association (AMA) establish the following guidelines for implementation of state MOL programs:
 - a. Any MOL activity should be able to be integrated into the existing infrastructure of the health care environment.
 - b. Any MOL educational activity under consideration should be developed in collaboration with physicians, should be evidence-based, and should be practice-specific. Accountability for physicians should be led by physicians.
 - c. Any proposed MOL activity should undergo an in-depth analysis of the direct and indirect costs, including physicians' time and the impact on patient access to care, as well as a risk/benefit analysis, with particular attention to unintended consequences.
 - d. Any MOL activity should be flexible and offer a variety of compliance options for all physicians, practicing or non-practicing, which may vary depending on their roles (e.g., clinical care, research, administration, education).
 - e. Any MOL activity should be designed for quality improvement and lifelong learning.
 - f. Participation in quality improvement activities, such as chart review, should be an option as an MOL activity. (New HOD Policy)
- 2) That our AMA support the FSMB Guiding Principles for MOL, which state that:
 - a. Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
 - b. 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.
 - c. Maintenance of licensure should not compromise patient care or create barriers to physician practice.
 - d. The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.
 - e. Maintenance of licensure processes should balance transparency with privacy protections (e.g., should capture what most physicians are already doing, not be onerous, etc.). (New HOD Policy)
- 3) That our AMA work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL. (Directive to Take Action)
- 4) That our AMA explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may be helpful tools to shape and support MOL for physicians. (Directive to Take Action)

Fiscal Note: \$5,000.

APPENDIX – AMA POLICIES RELATED TO MAINTENANCE OF LICENSURE

H-275.923, Maintenance of Certification / Maintenance of Licensure

Our AMA will: 1. 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. 2. 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. 3. Encourage rigorous evaluation of the impact on physicians of future proposed changes to the MOC and MOL processes including cost, staffing, and time. 4. Review all AMA policies regarding medical licensure; 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. 5. 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. 6. Continue to participate in the NAPC forums. 7. 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. 8. 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. 9. Collaborate with the American Osteopathic Association and its eighteen specialty boards in implementation of the recommendations in CME Report 16-A-09, Maintenance of Certification / Maintenance of Licensure. 10. Continue to support the AMA Principles of Maintenance of Certification (MOC). 11. Monitor MOL as being led by the Federation of State Medical Boards (FSMB), and work with FSMB and other stakeholders to develop a coherent set of principles for MOL. 12. Our AMA will 1) advocate that if state medical boards move forward with the more intense MOL program, each state medical board be required to accept evidence of successful ongoing participation in the American Board of Medical Specialties Maintenance of Certification and American Osteopathic Association-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL if performed, and 2) also advocate to require state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians choices in what programs they participate to fulfill their MOL criteria. 13. Our AMA opposes any MOL initiative that creates barriers to practice, is administratively unfeasible, is inflexible with regard to how physicians practice (clinically or not), that does not protect physician privacy, and that is used to promote policy initiatives above physician competence. (CME Rep. 16, A-09; Appended: CME Rep. 3, A-10; Reaffirmed: CME Rep. 3, A-10; Appended: Res. 322, A-11; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 919, I- 13; Reaffirmed in lieu of Res. 610, A-14; Appended: Res. 319, A-14)

D-275.960, An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure

1. Our AMA will encourage the American Board of Medical Specialties (ABMS) and the specialty certification boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients as an alternative to high stakes closed book examinations.

2. Our AMA will continue to monitor the evolution of Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC), and Maintenance of Licensure (MOL), continue its active engagement in discussions regarding their implementation, and report back to the House of Delegates on these issues. 3. Our AMA will (a) work with the ABMS and ABMS specialty boards to continue to examine the evidence supporting the value of specialty board certification and MOC and to determine the continued need for the mandatory high-stakes examination; and (b) work with the ABMS to explore alternatives to the mandatory high-stakes examination. 4. Our AMA encourages the ABMS to ensure that all ABMS specialty boards provide full transparency related to the costs of preparing, administering, scoring, and reporting MOC and certifying/recertifying examinations and ensure that MOC and certifying/recertifying examinations do not result in significant financial gain to the ABMS specialty boards. 5. Our AMA will work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, in particular to ensure that MOC is specifically relevant to the physician's current practice. 6. Our AMA will solicit an independent entity to commission and pay for a study to evaluate the impact that MOL and MOC requirements have on physicians' practices, including but not limited to: physician workforce, physicians' practice costs, patient outcomes, patient safety and patient access. Such study will look at the examination processes of the ABMS, the American Osteopathic Association, and the Federation of State Medical Boards. Such study is to be presented to the AMA HOD, for deliberation and consideration before any entity, agency, board or governmental body requires physicians to sit for MOL licensure examinations. Progress report is to be presented at Annual 2014; complete report by Annual 2015. 7. Our AMA: (a) supports ongoing ABMS specialty board efforts to allow other physician educational and quality improvement activities to count for MOC; (b) supports specialty board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs such as pay for quality/performance or PQRS reimbursement; (c) encourages the ABMS specialty boards to enhance the consistency of such programs across all boards; and (d) will work with specialty societies and specialty boards to develop tools and services that facilitate the physician's ability to meet MOC requirements. 8. Our AMA Council on Medical Education will continue to review published literature and emerging data as part of the Council's ongoing efforts to critically review MOC, OCC, and MOL issues. 9. Our AMA will continue to explore with independent entities the feasibility of conducting a study to evaluate the impact that MOC requirements and the principles of MOL have on physicians' practices, including, but not limited to physician workforce, physicians' practice costs, patient outcomes, patient safety, and patient access. 10. Our AMA will work with the ABMS and the ABMS Member Boards to collect data on why physicians choose to maintain or discontinue their board certification. 11. Our AMA will work with the ABMS and the Federation of State Medical Boards to study whether MOC and the principles of MOL are important factors in a physician's decision to retire and have a direct impact on the US physician workforce. 12. Our AMA: (a) encourages specialty boards to investigate and/or establish alternative approaches for MOC; (b) will prepare a yearly report regarding the maintenance of certification process; and (c) will work with the ABMS to eliminate practice performance assessment modules, as currently written, from the requirement of MOC. (CME Rep. 10, A-12; Modified: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 610, A-14; Appended: CME Rep. 6, A-14; Appended: Sub. Res. 920, I-14)

D-480.999, State Authority and Flexibility in Medical Licensure for Telemedicine

Our AMA will continue its opposition to a single national federalized system of medical licensure. (CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: BOT Rep. 3, I-14)

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