State of California

Department of Consumer Affairs
Medical Board of California

Memorandum

Agenda Item #10

To : Members, Division of Licensing

Date: April 16, 2002

From : Kevin A. Schunke, Manager
Physician's and Surgeon's Licensing Section

Subject : Background and Discussion of Continuing Competency/Requalification for Physicians and Surgeons

During its last several meetings, the Division of Licensing (DOL) members have been discussing the continuing competence and requalification of our licensees. This memo is to provide some history on this subject and to afford an opportunity for further discussion.

At the November 2001 Division of Licensing (DOL) meeting, Dr. Terence Davidson, Associate Dean for Continuing Medical Education, UCSD, and Chairperson for the Consortium of Continuing Medical Education Departments for the five UC schools, addressed the DOL regarding the issue of continuing medical education (CME). He stated that there has been a decline in the quality of CME that physicians are offered, partly due to the rate of information advance in the profession and partly due to the fact that two-thirds of the CME offered is provided by private sector for-profit organizations.

After this presentation, Dr. Gitnick directed staff to allow for a discussion on CME, based on Dr. Davidson's comments, at the February 2002 meeting. To lay the groundwork for this planned discussion at the next meeting, Dr. Gitnick suggested that the DOL members could use Dr. Davidson's further presentation on Pain Management/Palliative Care CME.

At the February 2002 meeting, Dr. Gitnick noted that the Division for some time has been struggling with the problems associated with, and the Division's role in overseeing, the proper assessment of continuing competency for physicians and surgeons. He introduced Dr. Stephen Miller, Executive Vice President, American Board of Medical Specialties (ABMS), and a California physician with prior associations at both the University of California, Los Angeles and the University of California, San Diego, who spoke to this issue.

Dr. Miller stated that almost 90% of all licensed U.S. physicians are certified by a member board of the ABMS. In 1973, recertification was adopted as a way to guarantee continuing competency of physician specialists. By 1998, ABMS had defined these recertification programs to include four integral components: 1) professional standing; 2) lifelong learning and self-assessment; 3) cognitive expertise; and 4) practice performance assessment. Additionally, Dr. Miller stated that the ABMS, in concert with the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME), developed the following six general competencies deemed necessary and sufficient to assess continuing competency of physician specialists: 1) medical knowledge; 2) patient care; 3) interpersonal skills and communication; 4) professionalism; 5) practice-based learning and improvement;

and, 6) systems-based practice. He added that the goal is to define and develop measures in each of these six areas that must be psychometrically reliable, clinically valid, and economically feasible for the venue in which they are evaluated.

Regarding the concept of CME, Dr. Miller stated that: there should be a tighter, more collaborative relationship between the CME providers, the state licensing boards, and the certifying bodies. Dr. Miller made several suggestions: the course content should be specialty-specific and decided upon by boards and specialty societies within that discipline; the courses should be accredited by organizations already in place; and, the ultimate indicator is a continuous maintenance of certification on a recurring, regular basis to insure public protection. He proposed that the goal of more effective CME should be to insure competency through an expansion and renewal of the skills and knowledge necessary to practice current medicine by assessment-driven, self-directed, specialty-specific learning. His recommendations included defining the goal of CME, which he sees as working with the ABMS to allow them to develop programs to maintain certification systems using practice performance assessment for all physicians, working in collaboration to use the appropriate proxies to measure achievement, and educating the legislature and public. (For the members' edification, Attachment A is the AMA's summary of the CME requirements for the various boards.)

Dr. Gitnick added that, as there seems to be no evidence that didactic CME effectively improves practice patterns, perhaps the current CME courses required of licensees should be replaced with some other measure of continuing learning that will enhance practice patterns for the next five years. Dr. Miller suggested that the Division look at the parameters of the specialty boards that have currently established recertification, as more than half now contain CME requirements. He also suggested asking what the alternative is to reporting CME hours, asking if the CME course is worth the cost, defining what the measurement criteria is, and looking at those programs that have recertified physicians. (For the members edification, Attachment B is the ABMS' listing of recertification requirements for the various specialty boards.)

Discussion ensued among the members, who offered the following suggestions on ways to ensure continuing competency for physicians: 1) allow no exemptions to CME requirements for physicians who administer patient care, including those that received board certification through grandfathering; 2) require case review by the Medical Board for two or more judgements of negligence or incompetence and one case of egregious activity; 3) establish a relationship with the ABMS for a direct connection through member boards to the continuing education of 90% of licensed physicians; 4) continue to explore a way to use the ABMS recommendation of working in collaboration using proxies to provide a mechanism by which the Division could measure CME achievement in California; and 5) focus on developing curriculum that would lead to continuing competency rather that focusing only on assessment.

Ms. Sandra Bressler, representing the California Medical Association (CMA), addressed the Division, stating that CME is a complex issue, measurement of CME is a complex task, and that there needs to be careful thought behind moving towards a better assessment of practicing physicians before the current system is replaced. She added that the CMA is currently looking at a Canadian certification process called the Physician Achievement Review (see discussion

on the College of Physicians and Surgeons of Alberta, below), where physicians are evaluated by colleagues, patients, and hospitals, the mean for all physicians is determined, and the individual results can then be measured against the mean.

Dr. Gitnick declared it would be the intent of the Division to pursue an objective assessment of the Division's relicensure/recertification approach, including issues related to malpractice, CME, and physicians' practice as a whole, and that the Division consider its role in changing the criteria for relicensure/requalification in California.

In furtherance of that direction, the following additional information is provided:

The Medical Board's Past Efforts

The Board's Post-Licensure Assessment Committee (PLAC) began in early 1997 as the Committee on Physician Requalification, with initial plans for a decennial requalification process for all licensees. As the committee members determined that requalification via examination was not a feasible reality, the name was changed to Post-Licensure Assessment to more accurately define the "new" purpose of the committee.

In early discussions, it was recognized that while both the Physician Assessment and Clinical Education Program (PACE, in San Diego) and the Post-Licensure Assessment System (PLAS, in Denver) would be valuable assessment tools, it was too expensive to ask all physicians to participate in these programs as a requalification method. PLAS is a joint program of the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME) and was established in 1998; with all the efforts put forth in creating PLAS, there have not been any additional programs created offering other post-licensure assessment tools. (PLAS estimates the participation costs for a 2½ day assessment at a minimum $7,500, with a high range of $15,000 for a few days' longer assessment. Participation in the PACE program costs approximately $2,500.)

Development of an exam was investigated by the Board's PLAC. With input from qualified psychometricians, it was determined that it would take 5-7 years to develop a legally defensible exam – the cost would be $10 million just for exam development.

There was a split among the participants and interested parties on the appropriateness of a broad exam covering all aspects of medicine (since that is what the plenary physician's and surgeon's license covers) and the reality that specialists, many years after licensure, have developed specific skills that would not be tested by a general, undifferentiated medical exam.

The committee's efforts waned in mid-1999 with a lack of mutually-acceptable and fiscally-sound approaches having been identified.

FSMB's Post-Licensure Assessment System (PLAS)

The PLAS is a joint program of the FSMB and the NBME established in 1998. PLAS is intended to provide comprehensive services to medical licensing authorities for use in assessing the ongoing competency of licensed physicians. PLAS comprises two independent,

yet complementary, programs: the Special Purpose Examination (SPEX) program and the Assessment Center Program. Collectively, they provide a standardized, national program for assisting state medical boards in their ongoing mission to assure that qualified, competent physicians are licensed to practice medicine. Participation in a PLAS is estimated at a minimum $7,500 for a 2½ day assessment; this cost is borne by the physician.

SPEX is an objective and standardized, cognitive examination of current knowledge requisite for the general, undifferentiated practice of medicine. The examination is intended for physicians who currently hold, or who have previously held, a valid, unrestricted license to practice medicine in a U.S. or Canadian jurisdiction. Initially introduced by the FSMB in 1988, SPEX became part of the PLAS in 1998. Appropriate candidates for SPEX include physicians seeking licensure reinstatement or reactivation after some period of professional inactivity, or physicians involved in disciplinary proceedings in which the board determines the need for evaluation.

The Institute for Physician Evaluation (IPE) is a national system of planned assessment centers for the evaluation of licensed practicing physicians. The location of the first assessment center is the IPE-Colorado, where assessment protocols are currently administered by Colorado Personalized Education for Physicians (CPEP)

The Assessment Center Program provides medical licensing authorities an in-depth analysis of physicians' clinical competency through a combination of standardized and personalized assessment tools. This program focuses on four complementary facets of medical practice: medical knowledge, clinical reasoning, communication skills, and documentation skills. The FSMB and NBME have contracted with the CPEP program to provide the physician assessment services at the Institute for Physician Evaluation. CPEP, an established assessment program founded by a consortium of Colorado medical organizations, has worked with more than 400 physicians over the past eleven years.

The organizational structure of PLAS consists of a Governing Committee and two program committees. The Governing Committee is responsible for developing and maintaining PLAS policies, prioritizing PLAS activities and supervising the SPEX Program and Assessment Center Program. Each program committee reports to the Governing Committee and is responsible for determining the content and structure of the evaluations, scoring and standard-setting policies, test administration policies, and for continually developing and enhancing the programs.

College of Physicians & Surgeons of Ontario (Canada)

A peer assessment process has been operational in Ontario since 1980. Annually, there are some physicians selected at random, as well as all physicians who reach age 70. As the Program has become more accepted (and has been received with less anxiety and trepidation) for its success in helping physicians improve and in identifying physicians who may benefit from more focused assistance, other routes of access have been made available; for example, the College states that some physicians have asked the Committee to assess them. The assessment occurs in the licensee's office and consists of three core components: physical facilities, medical records, and quality of patient care. Unfortunately, the costs of this program

have risen to about $8,000 per physician; this high cost is forcing the Board to consider an abatement or cancellation of the program. Since 1980, the program has visited an average of 200 physicians a year.

The College of Physicians and Surgeons of Alberta

The province of Alberta has a program entitled the Physician Achievement Review (PAR). Every five years, each physician in Alberta must participate in the program, which goes beyond peer review - but it is much less detailed than the program in Ontario. Annually, 1,000 physicians are required to have their performance reviewed by way of questionnaires completed by 25 patients, eight physician colleagues, and eight non-physician healthcare co-workers. Topics range from medical competency and management abilities to communication skills and patient management.

Once the questionnaires have been completed, they are sent to an independent research agency that has been contracted to manage all the collection, tabulation, and reporting for the program. The research firm provides the doctor with detailed aggregate responses for their own practice, as well as a comparison to the summary profile of all physicians with similar types of practices. In the event that the PAR surveys flag a potential problem, the resulting profiles are then reviewed by members of the Physician Performance Committee (PPC), a nine-member Council-appointed group responsible for administering the program; the PPC will work with the physician from a quality-improvement perspective.

The costs to administer this program is borne by the College. All licensees are assessed an additional $40 a year to fund the program.

The Nevada Board of Medical Examiners

The Nevada Board has recently undertaken an effort to look into relicensure and requalification of their licensees. Board member Dr. Donald H. Baepler, former chancellor of the University of Nevada system and President of the University of Nevada-Las Vegas, has been appointed to chair this effort. To date, he has facilitated six meetings, providing an opportunity to brain storm the subject.

Dr. Baepler does not intend to hold any more committee meetings until after the April FSMB Annual Meeting in San Diego, when it is anticipated that a lengthy discussion will take place on this subject. Thereafter, he will reconstitute the committee and anticipates within 12 months to begin more focused meetings.

Dr. Baepler stated that discussions at his numerous round-table meetings have led to a few ideas to which most participants agreed:

1) SPEX may offer a viable opportunity, with the assistance of the FSMB. There is a concern among interested parties on the appropriateness of a broad exam covering all aspects of medicine if the reality is that specialists, many years after licensure, could not be expected to pass such an all-encompassing exam. However, it is possible that there are a significant number of questions in the SPEX item bank, so that a variety of "speciality" SPEX exams might be created by FSMB. Since every physician needs to have a good understanding of general

medicine, Dr. Baepler has investigated, for example, the feasibility of an exam with 20-25% general medicine questions, combined with 75-80% questions in OB/GYN for those licensees who focus in that area. Similarly constructed exams would be offered to all licensees in their respective fields. Dr. Baepler states that in recent lengthy discussions with the FSMB, they have indicated that such specially constructed SPEX exams are a viable option which warrant further dialog.

2) In-house peer review sessions, like those mandated by the Ontario [Canada] College, seem like a good alternative; however, the costs of this program, whether borne by the Board or the individual licensee, would be quite high. Lower costs would be recognized by using a questionnaire process like that in Alberta, but the benefits would also be diminished.

3) Participation in an assessment program, like PACE or PLAS, might be considered, but the costs to the physician produce a hurdle. The PLAS program, which Dr. Baepler seems to hold in high regard, is quite expensive, at over $7,500 per a 2½ day session.

4) ABMS recertification is an alternative to consider - but only when all the specialty boards offer equally viable recertification exams. Today, several of the specialty boards offer very strong, in-depth, and secure recertification exams; however, some of the boards have not developed exams at that level of quality. Dr. Baepler believes that not all exams are a clear indicator of continued competence. Besides, many licensees are not Board certified, and thus, this option would not fairly apply to all licensees.

The foregoing provides some alternatives to guide the discussion of the members. Once the members have reached a consensus as to how staff should proceed, we will move forward as appropriate. Dr. Neal Kohatsu and I will be available at the Division meeting to answer any questions you might have.

KAS