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Competency-based Credentialing

A New Model from the Massachusetts
Board of Registration in Medicine
Expert Panel on Credentialing

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Members on State
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The great use of life is to spend it for something that will outlast it.

— William James

WILLIAM JAMES earned his place in history as a pioneering psychologist and philosopher, but he was also a physician, receiving his M.D. from Harvard University in 1869. Though he never practiced medicine, James was well suited to the academic rigors of the profession. He went on to teach physiology, anatomy, psychology and philosophy at Harvard, leading a life devoted to self-discovery and intellectual growth. James' suggestion that a fulfilled life is one that is devoted to achievement and building something of enduring value provides food for thought for today's physician—who is increasingly being called upon to demonstrate a lifelong commitment to learning and advancement. Earlier this year, the FSMB House of Delegates formally endorsed a groundbreaking framework for the Maintenance of Licensure (MOL) concept, which would eventually require physicians to periodically provide evidence of participation in lifelong learning activities as a condition of license renewal. MOL fits squarely within a larger national trend toward quality improvement initiatives in medicine. [In this issue of the *FSMB Journal*, we feature an overview of one such initiative—from the Massachusetts Board of Registration in Medicine—which would bolster lifelong learning among physicians through more rigorous hospital credentialing requirements \(p. 10\).](#) The work in Massachusetts contributes valuable thinking that could help move concepts such as MOL forward and keep us on a path toward a new paradigm of physician training and quality improvement. It is a path that promises long-lasting results.



Bill Wargo, Editor-in-Chief

Physician Reentry to Practice: A Longstanding Challenge with New Relevance

Freda Bush, M.D., FACOG
Chair, Board of Directors
Federation of State Medical Boards

IN BRIEF Dr. Bush outlines FSMB's plan to develop new policy recommendations regarding licensure for physicians returning to the workforce after extended absence.

The question of how physicians reenter the practice of medicine after an extended absence for a significant period of time has always been important—and challenging—to state medical boards. Ensuring physicians are qualified to reenter practice after a period of clinical inactivity is a complex process, which involves close coordination of education, testing, monitoring and regulation.

Finding the right balance between public protection and ensuring that competent physicians can begin practicing again without an overly burdensome level of evaluation is the key to successful reentry. FSMB has worked with partner organizations in the medical community for many years in establishing a basic approach to help ensure that this balance is achieved by state medical boards.

The longstanding challenge of physician reentry has recently become more pressing for state medical boards. With the economic downturn and a general physician workforce shortage, many boards are reporting an increased number of physicians seeking to reenter practice. Other health professions regulated by state boards are experiencing similar trends.

Recognizing the importance of reentry as a professional issue for all of us in the regulatory community, I recently appointed a Special Committee on Reentry to Practice, made up of members of the FSMB House of Delegates and various stakeholders including the Accreditation Council for Continuing Medical Education, American Medical Association, American Academy of Pediatrics, American Academy of Physician Assistants, American Osteopathic Association and others.

The Special Committee will seek to develop new guidelines on reentry that can be broadly applied to all health professionals regulated by state medical boards. Barbara Schneidman, M.D., MPH, who last year served so ably as FSMB's interim CEO, will lead this effort as chair. The Special Committee begins its work during the summer of 2010 and we expect it to continue over the next 12 to 18 months.

Background

In 1995, the FSMB House adopted as policy a recommendation that applicants for licensure by endorsement who have not been active in medical practice for the previous 24 months due to non-disciplinary reasons be required to demonstrate competence by passing the Special Purpose Examination (SPEX) or some other appropriate assessment approved by a licensing board.

Ten years later, the North Carolina Medical Board submitted a resolution to the House, calling for development of guidelines that could be more broadly applied. This question became a part of the House's

WHATEVER THE REASON, PHYSICIAN REENTRY IS LIKELY TO BE MORE FREQUENT IN COMING DECADES AS WE CONTINUE TO EXPERIENCE DEMOGRAPHIC AND ECONOMIC SHIFTS IN THE UNITED STATES.

general deliberations as it worked to create an overarching policy on Maintenance of Licensure (MOL) from 2003 to 2010. Ultimately, the House decided to separate the question of reentry to practice from its MOL discussions to give both problems directed attention for solution. A synopsis of the problem of reentry is seen in the following, which was pulled from the draft final report of the Special Committee on Maintenance of Licensure (2008).

"Many licensees who take voluntary leaves of absence from clinical practice choose to maintain

*full and unrestricted licensure status while on leave. Currently, because states do not have maintenance of licensure requirements in place, such practice poses a dilemma for state medical boards. Most state medical boards currently do not gather data about their licensees' practice status, thus they have no means of identifying those who are clinically inactive or validating that these individuals are adequately prepared to reengage in patient care duties. Limited information is available to inform discussions about policy issues."*¹

This summer, the newly appointed Special Committee will review all work on this issue to date by the House, including a set of draft physician-reentry recommendations drawn up by the House in 2008. It will also evaluate the reentry policies and procedures that state medical boards currently use, the reentry standards of other medically oriented professional organizations, and FSMB's new recommendations related to MOL.

Following review and evaluation, the Special Committee is charged with recommending guidelines or pathways that state boards can use to determine clinical competence for physicians who have been inactive.

Recommendations appropriate for physicians whose absence is due to disciplinary actions or impairment are also to be considered, as are recommendations on how to best align reentry-to-practice requirements with maintenance-of-licensure requirements.

Collaborating with Others

As FSMB begins work on this project, it will communicate and coordinate its efforts with others in the medical community.

For example, the American Medical Association has explored the issue of reentry to practice for the past five years as part of its Initiative to Transform Medical Education. In May, the AMA held a Physician Reentry to Clinical Practice conference in collaboration with the FSMB and another organization with a keen interest in physician reentry—the American Academy of Pediatrics (AAP). Representatives of numerous stakeholder organizations, including six state medical boards, gathered at this conference to review the obstacles to physician reentry, share the expectations of medical regulators and identify key issues and possible solutions.

A number of organizations and individuals are also working on reentry to practice through a collaborative initiative called the Physician Reentry into the Workforce Project, which is being managed by AAP.

According to Holly Mulvey, co-director of the AAP project, approximately 54 percent of all pediatricians and more than 70 percent of all pediatric residents are female. The likelihood of many of them having to deal with physician reentry policies as a result of temporary inactivity related to childbearing is very real.²

The AAP project includes a diverse group of representatives from the FSMB, AMA, AAP, AAPA and other organizations. The group has worked to identify reentry to clinical practice barriers and develop a broad consensus among stakeholders. Now its focus is shifting to approaches that are specific to helping individual physicians by providing tools to help plan for a possible departure from and subsequent reentry into the workforce.

According to Mulvey, state medical boards can help by assisting physicians in understanding the boards' requirements for reentering the workforce.

For many physicians—especially those who start families—leaving the workforce temporarily is a part of a long-term plan. Others don't plan to leave the workforce at all, but circumstances lead them to do so—whether it is illness, changes in career focus or any other number of unexpected turns in the professional path. Whatever the reason, physician reentry is likely to be more frequent in coming decades as we continue to experience demographic and economic shifts in the United States.

During my year as FSMB chair, this Special Committee will continue the valuable collaborations that have been established with various stakeholders. The FSMB is committed to helping state medical boards facilitate a physician's and physician assistant's reentry to practice while simultaneously ensuring the safety of the public.

More information on The Physician Reentry into the Workforce Project is available at www.physicianreentry.org.

More information on the AMA Initiative to Transform Medical Education and related work on reentry to practice can be found on the AMA website at www.ama-assn.org under the Council on Medical Education.

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The Role of Public Members on State Medical Boards

Stephen E. Heretick, Esq.

Public member and past president, Virginia Board of Medicine.

IN BRIEF Mr. Heretick makes the case for bolstering the presence and role of public members on state medical boards.

The concept of adding public or consumer members to state medical boards has gained increased public awareness and support since the rise of consumer activism in the early 1980s. But recent trends have significantly increased the need—and the demand—for strong public representation on these boards.

There are many reasons for the growing interest and importance of public participation with state medical boards, most significantly:

- Drastic changes in the quantity and timeliness of health-related information available to patients and the general public.
- An increased focus on consumer-driven medicine and a new era of consumer empowerment in health care.
- A continuing societal trend towards increased representation of diverse constituencies within government.

Recognizing these trends, the FSMB Foundation, a not-for-profit organization providing research and education programs that enhance physician regulation activities, has unveiled plans for a national initiative aimed at bolstering and enhancing the work of public members on state medical boards.

The Foundation believes that public members bring unique value to the process of medical regulation, and that we should be doing more in the regulatory community to recruit and retain them. As a public member, I am convinced, more than ever, that public membership makes state medical boards stronger.

Our initiative is intended to build greater awareness and understanding of the roles of public members of state medical boards, recommend recruitment

and retention strategies for state boards, and provide specialized training materials to enhance the effectiveness of public members. The initiative was launched with a formal presentation at the FSMB Annual Meeting in April 2010.

What Is Driving Public Interest in Health Care Regulation?

Some might argue that the seminal event in recent years that drove up public interest in health care regulation was the 1999 release of the Institute of Medicine (IOM) report, “To Err Is Human.”¹ Major news outlets and popular media programs covered the shocking statistical analysis that concluded that medical errors kill between 45,000 and 98,000 patients in American hospitals each year. Patient safety expert Dr. Robert Wachter wrote: “...it was the IOM’s use of the Harvard Medical Practice Study’s decade-old results—in particular, the jarring analogy that deaths in the United States from medical errors would equal the downing of one jumbo jet per day—that generated the public and media attention that finally undermined the status quo.”² The IOM, known for its scholarly but arcane research publications, had touched off a firestorm among patients that greatly increased public concern about the safety of the U.S. health care system.

The IOM report shook public confidence in health care, but other factors strained the relationship between doctors and patients as well. One extensive study of public attitudes and confidence in the medical profession found that confidence in physicians had eroded in a manner and magnitude that was similar to erosion in public confidence in other social institutions. In 2001, Bernice Pescosolido, Steven Tuch, and Jack Martin wrote in the *Journal of Health and Behavior*: “To date, our data do not indicate that physician authority, and the consulting status of medicine, faces serious public challenge. They do show, however, a set of trends toward

greater disillusionment and a more widespread critique that requires tracking, particularly in the face of managed care.”³

Growing Use of the Internet for Health Information

The increased public discourse about patient safety, and a growing interest in consumer-related information about medical practices, coincided with the growing use of the Internet to gather health information. In 1997, the U.S. Census Bureau began tracking Internet usage in American households, and found that year that 18 percent of U.S. households had Internet access. By 2000, the number had jumped to 41.5 percent, and by 2007 it had reached 62 percent.⁴

Many state medical boards began to see a growing consumer use of online information resources offered to the public. The Massachusetts Board of Registration in Medicine launched the nation’s first “Physician Profiles” program in 1996, providing information about physicians, and it offered web-based access the following year. The Massachusetts board

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MEDICAL PROFESSION.

reported 529,250 web-based interactions with its profiles website in 1997. By 2008, the number had grown to more than 6.5 million profiles interactions.⁵

Increased Focus on Consumer-Driven Medicine

A second change in health care that has contributed to the need for, and interest in, public membership on medical boards has been the rise of consumer-driven health plans (CDHPs) and a move toward a greater consumer orientation in health care decision-making. A CDHP is defined as a “.... health plan—which is high-deductible health insurance with a personal account to pay for health expenses.”⁶ A Kaiser Foundation report offers a practical definition: “This term applies to a broad range of health plan designs such as Health Savings Accounts (HSAs) or Health Reimbursement Accounts (HRAs), but is most commonly used to describe the combination of a high-deductible health insurance plan with a tax-deferred savings account used to pay for routine health care

expenses.”⁷ These plans have increased in availability and use since the passage of the 2003 Medicare Prescription Drug, Improvement, and Modernization Act.⁸

There are demonstrable changes in behavior among patients in such plans,⁹ and among those who bring a consumer-oriented mindset to their medical decision-making.

It is important to note that consumer-driven health plans are only one part of the overall consumer health care market, but the upward trend in high-deductible health plan options and increased consumer decision-making in health care settings is well documented.¹⁰ The important point to be made is that the consumer voice is becoming more prominent in health care overall, and that public members can help bring these perspectives to medical boards. As the move toward consumer empowerment in health care continues, public members will have increased potential to provide a critical link between the changing attitudes and behaviors of consumers and the medical profession.

Continuing Societal Trend Towards Diverse Representation in Government and Broader Community Involvement

The third societal factor contributing to the importance of public membership on medical boards is our society’s continuing demand for more diverse representation in government and involvement of a broader community in decision-making, which has been on the rise in the United States for decades.

My experience with the Virginia Board of Medicine has taught me that when people of diverse backgrounds are placed on public boards, multifaceted viewpoints result. And these invariably contribute to a more robust discussion of any issue.

Our society’s movement toward greater diversity in public service should be fully reflected in the practices of the regulatory community. It is both in our boards’ best interests and in the best interests of those we serve.

This is particularly important as the regulatory community seeks to inform the public more effectively about the role of state medical boards. Public members with diverse backgrounds and broad experience in community organizing can lead board efforts to inform underserved communities about the resources boards offer.

For example, a Latino public member may have the strong community resources needed to help propel an effort at building greater awareness of

the work of medical boards to the Spanish-speaking community through cultural literacy and sensitivity initiatives. Such efforts to engage previously underserved and unreached communities can strengthen support for a board and help it achieve its mission.

Legislators who represent such communities are more likely to support public agencies that provide appropriate services and support for their constituents. Doing the board's work well, on behalf of all constituents, is a board's greatest asset. Public members can, and should, be leaders in these efforts.

The Task at Hand

The FSMB Foundation's public member initiative aims at two fundamental needs: first, ensuring that guidelines are created to assist states in the recruitment of the best-qualified public members; and second, providing the training and orientation needed to ensure that public board members without medical backgrounds can quickly and effectively assume their responsibilities.

A look back at the environment for public board members over the last two decades sheds light on why this effort is important. In 1992, the American Association of Retired Persons (AARP) Consumer Affairs Section released a report on research it conducted regarding the needs of public members of state licensing boards. Although not specific to boards of medicine alone, the AARP study offered recommendations that would have strengthened the role of public members on state medical boards.

The AARP report cited a 1992 study from the Citizen Advocacy Center (CAC) that found that training or orientation sessions for public members, when offered, did not meet the needs identified by the public members themselves.¹¹ While licensing board staff emphasized process and procedural requirements of the board, the public members identified "issues training" and "leadership training" as important, but usually unavailable. In fact, the CAC report lamented that leadership training was "virtually non-existent—only 7% [of public member survey respondents] said it was offered."

A later report by the CAC identified specific qualities in potential candidates for appointments that appointing authorities should consider. Issues such as potential ties to the regulated profession, level of education, demonstrated commitment to participation in public service, and knowledge of the regulated industry or profession were all identified as vetting criteria upon which appointing

authorities could rely. The study also addressed public members' perceptions about the appropriate percentage of public member representation on the boards. More than 28 percent of respondents reported that the ideal board composition would be 25 percent public members; an additional 22 percent of survey respondents indicated that at least one-third of board members should be public members.¹²

Despite the clearly established need for better recruitment, training and preparation of public members, nearly 20 years after these studies

DESPITE THE CLEARLY ESTABLISHED NEED FOR BETTER RECRUITMENT, TRAINING AND PREPARATION OF PUBLIC MEMBERS, NEARLY 20 YEARS AFTER THESE STUDIES LITTLE PROGRESS HAS BEEN MADE IN CREATING BEST PRACTICES FOR PUBLIC-MEMBER TRAINING OR THE ESTABLISHMENT OF CRITERIA FOR SELECTION.

little progress has been made in creating best practices for public-member training or the establishment of criteria for selection. In a survey of state medical boards and public members conducted in 2010, the FSMB Foundation discovered that although public-member representation has increased over the last 20 years, the ideal board composition numbers suggested by respondents in the CAC survey are not reflected in current board compositions across the country.¹³ Clearly, the CAC's recommendations have not permeated into the ranks of state decision-makers as they fill their boards.

Additionally, the Foundation's 2010 survey showed that AARP and CAC training recommendations also have not been comprehensively adopted. The survey shows that significant numbers of currently serving public board members believe that the hours allotted to initial training and orientation for new members should be increased, for example. Moreover, while more than 80 percent of public board members want ongoing training about their roles and responsibilities, less than half of boards offer such training.¹³

Conclusion

The need and interest in greater representation on medical boards are well-established and coincide with several significant societal and consumer

trends in recent years. But important tools are missing to help boards build a stronger public-member presence. These include the need for best practices in public-member recruitment and training and better strategies for raising awareness among stakeholders of the significant role public members can play in medical regulation.

The FSMB Foundation supports the unique role of public members on state medical boards and will collaborate with the member boards of the FSMB to support and enhance this vital work. Through its public-member initiative, the FSMB Foundation will continue an effort to better understand the needs and perspectives of public members, while seeking ways to help public members become more effective in their work.

The Foundation's public-member initiative will create training and educational materials for public members, as well as materials to assist state boards and the authorities who appoint their members in the establishment of a process to identify and appoint the best possible public members. The FSMB Foundation will also create and make available online content later in 2010 for all state medical boards, focused on helping raise awareness of the importance of public-member participation in the medical regulatory process. ■

(Editor's note: Mr. Heretick is chair of the FSMB Foundation's Education Committee. The Foundation has begun its effort to provide new resources to help public members become more effective in their jobs. To learn more, visit its website: www.fsmb.org/foundation.html)

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Competency-based Credentialing: A New Model from the Massachusetts Board of Registration in Medicine Expert Panel on Credentialing

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ABSTRACT: Concern about the adequacy of the credentialing process led the Massachusetts Board of Registration in Medicine to create the Expert Panel on Credentialing for the purpose of ensuring that all physicians on a medical staff are providing safe and competent care throughout the entire duration of their careers. The Panel was charged with creating a standardized framework that facilities could use for both the initial credentialing and the re-credentialing processes.

The Panel began its deliberations in September 2006. An initial survey of selected health care facilities in Massachusetts was conducted to understand the current spectrum of credentialing criteria. The Panel reviewed the literature and developed core credentialing criteria. These criteria, or guidelines, suggest several assessment measures for each of the six core competencies endorsed by The Accreditation Council for Graduate Medical Education and The Joint Commission (Table 4). Health care facilities may elect to use these guidelines during the credentialing process to ensure that every licensed and certified physician is competent to provide current evidence-based care.

Keywords: Competency-based credentialing process

A decade has passed since the publication of the IOM report *To Err Is Human*.¹ Yet the pressing question remains: are patients any safer? A recent report from the Agency for Healthcare Research and Quality (AHRQ) suggests that progress toward a safer environment is mixed. Overall, measures of patient safety have actually declined recently.² There was a positive finding in that hospitals are responding with performance improvement initiatives, but unfortunately their effects will take some time to show up in the statistics.^{2,3} As the AHRQ report notes, progress has been slow with regard to optimizing health care quality, measurement of that quality and therefore patient safety. Safety initiatives stagnate unless there is active involvement of leadership and the medical staff.^{4,5} Missing from the discussion are any data concerning physician competence. Yet, successful implementation of these initiatives requires well-qualified, knowledgeable, currently competent physicians. The primary method for ensuring competence is the hospital credentialing process.

Concern about the adequacy of the credentialing process led the Massachusetts Board of Registration in Medicine (Board), in September 2006, to create the Expert Panel on Credentialing (Panel) through its Patient Care Assessment (PCA) division. The Board’s PCA has statutory and regulatory authority over quality improvement, patient safety, medical error prevention, and credentialing activities at Massachusetts health care facilities. PCA monitors these processes through review of quarterly reports submitted by the facilities describing all serious, unexpected patient outcomes, results of their investigations, and corrective plans undertaken by the institution. Through examination of these reports and communication with health care facility leadership, PCA concluded that the credentialing process in many hospitals is weak and haphazard, making it difficult to achieve the purpose of ensuring that all physicians on the medical staff are providing safe and competent care.

Since there seemed to be no uniform or reproducible method common to all hospitals for the required biennial physician credentialing, the Panel was charged with creating a standardized framework that facilities could use for both the initial credentialing and the re-credentialing processes. The overall objective was to develop a mechanism whereby populations served could be assured that the hospitals' credentialed physicians remain competent throughout the entire duration of their careers. Optimally, this framework should include a broad array of methods, such as evaluation of patient outcomes through case reviews, analysis of data, review of accomplishments, complaints, certifications, and other competency assessments as recommended by specialty boards, professional societies, or regulatory agencies.

The Panel acknowledged at the outset that satisfactory completion of a training program does not ensure sustained competency. The Accreditation Council for Graduate Medical Education (ACGME) and American Board of Medical Specialties (ABMS) recognized this reality several years ago. These organizations, together with the Federation of State Medical Boards (FSMB), are working to establish standardized, comprehensive, and continuing methods for assessing physician competencies, both for physicians in training, at the hospital level, and for physicians in practice.^{6,8} As part of this process, the ACGME identified six areas of core competencies, for which each specialty has developed its own specifics. The driving purpose of the Panel, as well as these organizations, is to assure the public that every licensed and certified physician is competent to provide current evidence-based care.

The Panel began its deliberations in September 2006. An initial survey of selected health care facilities in Massachusetts was conducted to understand the current spectrum of credentialing criteria. As evidenced in Table 1, while there were several common elements, considerable variation in criteria was observed. Based on this finding, the Panel reviewed the literature and developed the Core Credentialing Criteria listed in Table 2. Primary Criteria are those typically used by facilities to meet mandatory credentialing requirements, while Secondary Criteria are suggested as elective depending upon the needs of the specific facility. In addition to ensuring compliance with the basic essentials of credentialing, these criteria or guidelines, taken in the aggregate, provide a basis for assessing the six major areas embraced by the ACGME, ABMS, Joint Commission, and FSMB as defined in Table 4.^{6,9}

On Oct. 17, 2007, the Board approved this report, including the proposed guidelines.¹⁰

The responsibility for measuring competency rests with the hospitals or health care facilities where physicians practice. The guidelines suggest several assessment measures for each of the six core competencies. As the science of measuring competency is in its early stages of development, the

PCA CONCLUDED THAT THE CREDENTIALING PROCESS IN MANY HOSPITALS IS WEAK AND HAPHAZARD, MAKING IT DIFFICULT TO ACHIEVE THE PURPOSE OF ENSURING THAT ALL PHYSICIANS ON THE MEDICAL STAFF ARE PROVIDING SAFE AND COMPETENT CARE.

Panel did not believe that use of any specific measures should be mandated at this time. These metrics will undoubtedly be modified and expanded over time. However, the broad array of assessment methods currently available is more than adequate to permit more meaningful competency measurement than has been the case in the past.

To test the feasibility of implementing these core guidelines, the Panel asked four hospitals to use them in their credentialing processes. One was a large teaching hospital (735 beds). The others were community hospitals: two mid-sized (360 beds and 270 beds), and one a small hospital (78 beds).

Results

The level of adoption of the proposed criteria was proportional to hospital size. The large teaching hospital adopted and harmonized the guidelines with other certifying standards, including the new mandates from The Joint Commission requiring frequent practice evaluations.^{8, 11} An administrative arm, Medical Staff Services, worked closely with department chiefs and members of the Credentials Committee and rolled the end product out to departments one at a time. As of this writing, 12 of 14 departments have selected appropriate measures: 11 have a written plan in place and have fully implemented the process. Medical Staff Services maintains central administrative oversight and provides monthly reminders to chiefs and/or designees as to which physicians need evaluation. The centralized service also maintains summary documentation and conducts periodic audits of departmental files to ensure regulatory compliance.

The larger mid-sized hospital developed an Excel™ spreadsheet for departments to use, which incorporated the name of the competency, a description of what was meant, and a request for the department to indicate the measurement used for the assessment. The spreadsheet was rolled out to all departments at the same time. This change brought about some initial reluctance to adopt this new method of assessing competency,

but a year later, and with significant administrative support, a solid majority of departments are using the standards.¹²

The smaller mid-sized hospital withdrew from the pilot study because their clinical champion relocated.

The small hospital implemented the proposed credentialing framework in 2007. Initially, the chairs

Table 1:
Spectrum of Core Credentialing Criteria

Checklist Data	Academic Medical Center	Community Hospital	Extended Care Facility	Health Plan	Liability Carrier
Application	YES	YES	YES	YES	YES
Photograph	90%	YES	NO	NO	NO
Copy of the State License	YES	YES	YES	YES	YES
Other State License	YES	50%	YES	50%	YES
License Application	YES	YES	YES	NO	NO
Visa Status if applicable	YES	YES	YES	NO	NO
NPI/UPIN Numbers	YES	YES	YES	50%	NO
Federal Drug Enforcement Administration (DEA)	YES	YES	YES	YES	NO
Narcotics Waiver, when NO DEA	20%	NO	NO	NO	NO
State Controlled Substance Certificate	50%	YES	YES	50%	
Curriculum Vitae (CV)	YES	YES	YES	YES	YES
Verification of Education/Training	YES	YES	YES	YES	YES
Educational Commission for Foreign Medical Graduates (ECFMG®)	YES	YES	YES	50%	YES
Verification of Board Certification	YES	YES	YES	YES	YES
Verification of Other Hospital Appointments	YES	YES	YES	YES	YES
Description of Clinical Responsibility Form	YES	NO	NO	NO	NO
Delineation of Privileges	YES	YES	YES	50%	YES
Privileges at Other Institutions	NO	15%	50%		YES
Number of Procedures at Other Institutions	NO	50%	50%	NO	NO
Privileges from Former Hospital	10%	NO	NO	NO	NO
Authorization/Release	YES	YES	YES	YES	YES
Reference Letters	YES	YES	YES	NO	NO
Explanation of Gaps		YES	YES	YES	YES
Quality Data	20%	NO	NO	NO	NO
American Medical Association (AMA) Profile	20%	75%	NO	YES	NO
Teaching Title Verification	20%	NO	NO	NO	NO
Criminal Background Check	Initial	85%	YES	NO	NO
NPDB/HIPDB	YES	YES	YES	YES	YES

Continued on next page

and chiefs of departments and divisions had some concerns about the quality and reliability of the data available to use for evaluation. Once a method for supplying clear, precise, up-to-date data was provided, they endorsed and adopted the framework. Like the large teaching hospital, this small community hospital coupled use of the guidelines with other mandates and initiatives, and all departments initiated the change at once.¹³

Discussion

The proposed elements of core competencies parallel initiatives by the ABMS, ACGME, Joint Commission, and FSMB. They are designed to standardize expectations through professional development from medical student to senior physician. Our intent is to provide guidelines for facilities to incorporate within their credentialing process, along with suggested measures where available and applicable (Table 3).

Table 1 (Continued):
Spectrum of Core Credentialing Criteria

Checklist Data	Academic Medical Center	Community Hospital	Extended Care Facility	Health Plan	Liability Carrier
Verification of Medicare Sanctions	80%	YES	NO	YES	NO
Malpractice Confirmation Sheet	YES	YES	YES	YES	YES
10-Year Claim History	YES	YES	YES	YES	YES
Patient Complaint Data	0	NO	NO	NO	NO
Member Complaints from Health Plans	20%	NO	NO	NO	NO
Clinical Competence Form	10%	NO	NO	NO	NO
Declaration of Health	20%	YES	YES	YES	YES
Substance Abuse Test	20%	NO	NO	NO	NO
Tbc Test	10%	30%	NO	NO	NO
Signed Confidentiality Agreement	50%	30%	NO	NO	NO
Computer Key Confidentiality Statement	10%	NO	NO	NO	NO
Infection Control Paperwork	30%	NO	NO	NO	NO
Child Abuse Check	10%	NO	NO	NO	NO
Point-of-Care Course	10%	NO	NO	NO	NO
Physician Impairment Course	10%	NO	NO	NO	NO
Occupational Safety and Health Administration (OSHA) Regulations	NO	NO	NO	NO	NO
CME Requirements met	NO	1	NO	NO	NO
Attestations:*					
Bylaws	NO	YES	NO	NO	NO
Advanced Cardiac Life Support (ACLS)	NO	85%	NO	NO	NO
Intravenous Conscious Sedation (IVCS)	YES	85%	NO	NO	NO
Code of Conduct Policy	YES	30%	NO	NO	NO
Corporate Compliance Policy	NO	30%	NO	NO	NO
Orientation Form	NO	15%	NO	NO	NO
National Patient Safety Goals	NO	15%	NO	NO	NO
Medicare Attestations	70%	30%	NO	NO	NO
Quality Improvement (QI)/Patient Care Assessment (PCA) Orientation	NO	15%	NO	NO	NO
Orientation Manual	NO	15%	NO	NO	NO

*Attestations confirm applicant compliance with bylaws and standard policies and procedures of the institution.

Table 2:
Primary and Secondary Credentialing Criteria

Primary Criteria
Application
Photograph
Copy of the License
Other State License
License Application
Visa Status if applicable
National Provider Identifier (NPI)/Unique Physician Identification Number (UPIN)
Federal Drug Enforcement Administration (DEA)
Narcotics Waiver, when no DEA
State Controlled Substance Certificate
Curriculum Vitae (CV)
Primary Source Verification of Education/Training
Educational Commission for Foreign Medical Graduates (ECFMG®)
Primary Source Verification of Board Certification
Primary Source Verification of Other Hospital Appointments
Description of Clinical Responsibility Form
Delineation of Privileges
Privileges at Other Institutions
Number of Procedures at Other Institutions
Privileges from Former Hospital
Authorization/Release
Reference Letters
Explanation of Gaps
Quality Data
American Medical Association (AMA) Profile
Teaching Title Verification
Criminal Background Check—Initial/Reapp/Both
National Practitioner Data Bank (NPDB)/Healthcare Integrity and Protection Data Bank (HIPDB)
Verification of Medicare Sanctions
Malpractice Confirmation Sheet
10-Year Malpractice Claim History
Patient Appreciation and Complaint Data
Member Complaints from Health Plans
Clinical Competence Form
Declaration of Health

Continued on next page

Table 2 (Continued):
Primary and Secondary Credentialing Criteria

Secondary Criteria
Substance Abuse Testing
Tbc Test
Signed Confidentiality Agreement
Computer Key Statement—Confidentiality
Child Abuse Check
Point-of-Care Course
Physician Impairment Course
Occupational Safety and Health Administration (OSHA) Regulations
CME Requirements Met
Attestations:
Bylaws
Advanced Cardiac Life Support (ACLS)
Intravenous Conscious Sedation (IVCS)
Code of Conduct Policy
Corporate Compliance Policy
Orientation Form
National Patient Safety Goals
Medicare Attestations
Quality Improvement (QI)/Patient Care Assessment (PCA) Orientation
Orientation Manual
Federation of State Medical Boards (FSMB) Reports
MassPRO Acknowledgement Statement
Massachusetts Department of Public Health (DPH) Volunteer Registration for Disasters
Incident Command System (ICS) 100
Incident Command System (ICS) 200.HealthCare
IS-800.A National Response Plan (NRP)

The Panel also provided a sample template based upon the six core competencies to facilitate the annual or biannual evaluation (Table 4).

While these guidelines are not provided as regulations, institutions are accountable for implementing a sustainable process for ensuring competency. The proposed framework endorsing the six core competencies and associated measures presents a spectrum of options for measurement. Some may not be applicable to a specific health care facility or specialty practice. However, the measures listed provide several alternatives from which a facility can select those deemed most appropriate.

The predominant impediment to implementation of this standardized approach to competency-based

credentialing is the established culture of medicine, which is fiercely individualistic, skeptical, professionally autonomous, and generally resistant to monitoring or proctoring. In most health care organizations, accountability is diffuse, and physician authority structures tend to be rigid and hierarchal. Therefore, imposing measurement of current competency as the most important element in credentialing generates fear of judgment and suspicion of motives. Use of data that may be marginally accurate adds uncertainty to the mix, fueling an atmosphere of distrust. In this environment, granting authority figures considerable power over how a physician practices constitutes a clear threat to the physician, and a risk for the evaluators.

The Panel believes this culture generates the first barrier for implementing standardized credentialing guidelines: obtaining buy-in by hospital leaders and the medical staff. The objective measurement of competency beyond those specified for specialty board maintenance of certification is difficult. When individual performance measures are adopted that are not based upon financial or clinical process indicators, skepticism rapidly emerges regarding objective validity. Most physicians believe that meaningful measures of medical staff performance are determined not only by evidence-based medical practice and outcome parameters, but also by thoughtful deliberation led by a respected clinical champion.¹⁴ In our pilot testing, it was very clear that sensitive hospital leadership was crucial in getting physicians to adopt and implement the Panel’s credentialing criteria.

The second major barrier is the threat inherent in change itself. Many physicians live by routines; the “same way everyday” philosophy in surgery has

led to the use of checklists, which have been shown to lower mortality.¹⁵ If one approach has worked successfully in the past, why risk that comfort zone for unproven, and only potential, improvement? Leading change is about listening and taking time for people to voice opinions and process new information. The eight-step change process developed by John Kotter requires communication across constituencies and then more communication (Table 5).^{16, 17} This thoughtful communication process was evident in each hospital which successfully implemented the standardized credentialing scheme.

In addition to endorsement by the medical staff, ensuring compliance with competency-based credentialing will require more administrative resources. However, these are probably no more than those now required to comply with new The Joint Commission standards for physician evaluation.⁸ More difficult is the challenge posed by physicians who provide care to a low volume of patients, or do

Table 3:
Generic Measures Applicable to Assessment of Clinical Competence

1. ABMS certification, re-certification, and/or MOC
2. Malpractice claims
3. Co-worker or peer recognition of excellence or complaints
4. Academic recognition of excellence or complaints
5. Professional society recognition of excellence or complaints
6. Patient/family recognition of excellence or complaints
7. Outcomes analysis
a. Deaths
b. Complications
c. Readmissions
8. Portfolio analysis of outcome data and 360 reviews for performance improvement
9. Appropriateness analysis (unnecessary surgery, imaging, etc)
10. Process indicators (core measures, e.g., eye exams, B-blockers)
11. Peer review record (American Board of Internal Medicine [ABIM] tool, etc)
12. Retrospective record review
13. Communication assessment (Kalamazoo and other instruments)
14. Observation assessment of a “standardized patient”
15. Observation of a video or CD of actual case and presentation to experts
16. Participation, observation, and assessment in high fidelity simulation
17. Multisource (360) evaluation
18. Department chairman assessment
19. Reports to Risk Management
20. Attendance and participation in departmental meetings and conferences

Table 4:
Sample Evaluation for Medical Staff Appointment

Assessment of Current Clinical Competence

Applicant’s Name: _____

Evaluating Institution: _____

Current Status: Active ____ Affiliate ____ Fellow ____ Resident

Dates of Appointment: From _____ To _____

Competency	Characteristic	Measures	Excellent	Good	Fair	Poor	Unknown
1. Patient Care	Access						
	Assessment						
	Diagnosis						
	Treatment						
	Coordination of care						
	Referral						
	Record keeping						
2. Medical Knowledge	Aware of best practices						
	Keeps up to date						
3. Practice-Based Learning and Improvement	Learning and investigation						
	Evaluation/improvement						
4. Interpersonal and Communication Skills	Communicates effectively with patients and families						
	Involves patients in care						
	Communicates honestly and openly when things go wrong						
	Communicates effectively with non-physician coworkers						
	Communicates effectively with physician colleagues						
5. Professionalism	Demonstrates personal integrity						
	Maintains personal competence						
	Places patients’ interests first						
	Ensures competency and professionalism of colleagues						
6. Systems-Based Practice	Understands systems of care						
	Participates in quality audits						
	Partners with others to redesign systems as needed						
	Practices cost-effective care						

Goals/Objectives for Next Year: 1. _____
2. _____

Signature of Evaluator: _____ Signature of Applicant: _____

Table 5:
Kotter's 8-Step Change Model

Step 1	Create Urgency
Step 2	Form a Powerful Coalition
Step 3	Create a Vision for Change
Step 4	Communicate the Vision
Step 5	Remove Obstacles
Step 6	Create Short-Term Wins
Step 7	Build on the Change
Step 8	Anchor the Changes in Corporate Culture

not admit patients to the hospital at all.Yet another daunting issue is the current variability in training and performance measures for physicians from different disciplines who provide the same therapeutic modalities.

The issue of granting privileges once a physician has satisfied the criteria for credentialing is not addressed in this document. It is recognized that a number of issues enter into this decision, such as practice volume, emerging technology and type of supervision required for the privileged physician, all of which significantly impact quality of care and need to be considered. In addition, we have not addressed the challenge inherent in assuring competency of physicians who have no affiliation with an institution or are so remotely affiliated as to preclude informed assessment. The Massachusetts Medical Society has agreed to pursue this latter task.

The Panel puts forth this proposal to initiate a process that is hoped to evolve as entities such as the FSMB, ABMS, The Joint Commission, state medical societies, professional societies, health plans, insurers, and various institutions work together to standardize a competency-based credentialing process. ■

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Massachusetts Board of Registration in Medicine Expert Panel on Credentialing

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A Study of Medical Board Peer Reviews in Nevada

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ABSTRACT:

Study Objective: The purpose of this study was to obtain data on various characteristics of peer reviews. These reviews were performed for the Nevada State Board of Medical Examiners (NSBME) to assess physician licensees’ negligence and/or incompetence. It was hoped that this data could help identify and define certain characteristics of peer reviews.

Methods: This study examined two years of data collected on peer reviews. The complaints were initially screened by a medical reviewer and/or a committee composed of Board members to assess the need for a peer review. Data was then collected from the peer reviews performed. The data included costs, specialty of the peer reviewer, location of the peer reviewer, and timeliness of the peer reviews.

Results: During the two-year study, 102 peer reviews were evaluated. Sixty-nine percent of the peer-reviewed complaints originated from civil malpractice cases and 15% originated from complaints made by patients. Eighty percent of the complaint physicians were located in Clark County and 12% were located in Washoe County. Sixty-one percent of the physicians who performed the peer reviews were located in Washoe County and 24% were located in Clark County. Twelve percent of the complaint physicians were in practice in the state for 5 years or less, 40% from 6 to 10 years, 20% from 11 to 15 years, 16% from 16 to 20 years, and 13% were in practice 21 years or more. Forty-seven percent of the complaint physicians had three or less total complaints filed with the Board, 10% had four to six complaints, 17% had 7 to 10 complaints, and 26% had 11 or more complaints. The overall quality of peer reviews was judged to be good or excellent in 96% of the reviews. A finding of malpractice was found in 42% of the reviews ordered by the medical reviewer and in 15% ordered by the Investigative Committees. There was a finding of malpractice in 38% of the overall total of peer reviews. The total average cost of a peer review was \$791. In 47% of the peer reviews requested, materials were sent from the Board to the peer reviewer within 60 days of the original request and 33% took more than 120 days for the request to be sent. In 48% of the reviews, the total time for the peer review to be performed by the peer reviewer was less than 60 days. Twenty seven percent of the peer reviews took more than 120 days to be returned.

Conclusion: Further data is needed to draw meaningful conclusions from certain peer review characteristics reported in this study. However, useful data was obtained regarding timeliness in sending out peer review materials, total times for the peer reviews, and costs.

Introduction

Peer reviews are defined as evaluations performed by peers in the respective physician’s specialty regarding care that was rendered. Peer reviews are important tools used in many arenas in medicine to evaluate the care and treatment rendered by physicians to patients. They are not only important in the education process, the granting of privileges, and the credentialing of physicians, but also in the disciplining of physicians. At the NSBME, these reviews are used as one of the tools to determine whether care provided was substandard.

Surprisingly, there is a lack of published data by state medical boards for such an important tool. It was hoped sufficient data would be collected in this study to shed light on the process and characteristics of peer reviews. It was also hoped that this study would generate interest by other state medical boards to collect such data. This collective shared data then could be used to identify certain commonalities of peer reviews regardless of which state medical board had them performed. Monitoring such data may enhance the performance of state medical boards.

Method

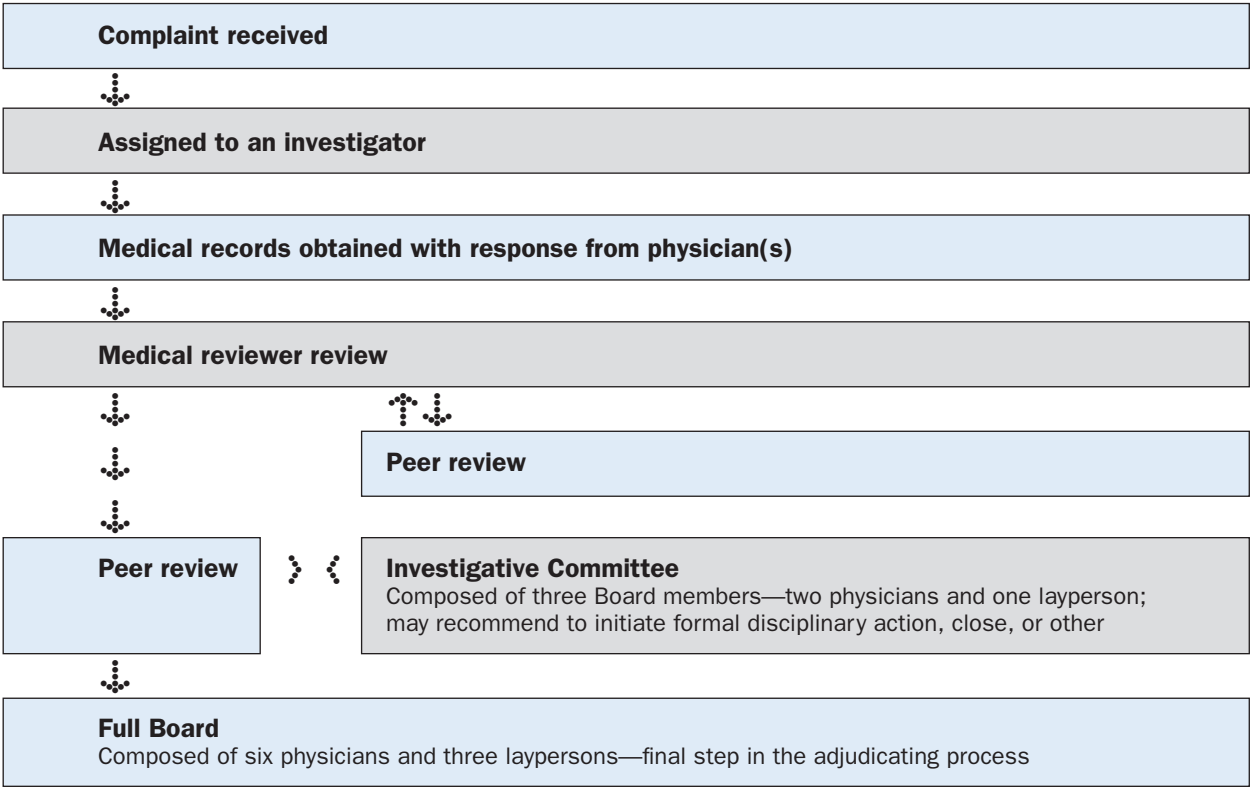
The medical reviewer, who is a physician employee for the NSBME, conducted the study with the approval of the Board. Each peer review performed on a physician was counted as a separate review for the ease of statistical reporting. In some instances, multiple peer reviews were required regarding a single complaint. All percentages were rounded off to the nearest whole percentage. The physician against whom the complaint was filed is referred to as the complaint physician in this study.

Peer reviews were generally obtained only regarding complaints containing allegations of negligence or incompetence. Nevada’s statutory definition of malpractice and its use in this text is “the failure of a physician, in treating a patient, to use reasonable care, skill, or knowledge ordinarily used under similar circumstances.” The protocol for the processing of complaints is addressed in table 1. Complaints filed against a licensee are generally reviewed at the onset by the Board’s medical reviewer. The medical reviewer, who reviews all complaints dealing with negligence and/or incompetence, determines which complaints should be sent out for a peer review. Once the peer review is returned, the medical reviewer again reviews

the matter. All peer reviews requested by the medical reviewer during the two-year period of this study were included in the data collected. Peer reviews were also occasionally requested by the Investigative Committees of the Board based on their initial review of the complaint. These committees are composed of two physician Board members and one layperson Board member. They are responsible for determining whether formal disciplinary action will be initiated against a licensee. The peer reviews requested by the Investigative Committee were also included in this study.

The study was divided into two time periods. The first was from Dec. 1, 2007 to Nov. 30, 2008. The second period was from Dec. 1, 2008 to Nov. 30, 2009. Totals were then compiled not only for each time period but also for the total two-year period. It should be noted that the total number of peer reviews from Dec. 1, 2007 to Nov. 30, 2008 most accurately reflects the actual number of peer reviews for that time period. For the later time period, there was an internal change in the manner in which peer reviews were processed through the system. This did not bias the results but did account for a decrease in the number of peer reviews entered into the study.

Table 1:
Present method of handling complaints



The actual number of peer reviews performed was roughly the same as the prior year.

Most of Nevada’s physicians are concentrated in two counties, Washoe and Clark. These counties account for 92% of the total physicians practicing in the state. Washoe County is in the northwestern part of the state and includes the city of Reno. Clark County is in the southern part of the state and includes the cities of Las Vegas and Henderson. According to statistics kept by the licensing division of the NSBME, in 2008 a total of 4,481 physicians were actively practicing in the state of Nevada. Of these, 1,056 physicians, or 24% of the total, resided in Washoe County and 3,060, or 68% of the total, resided in Clark County.

The distance between the physician communities (approximately 500 miles) helped determine the

selection of the peer reviewer. When a complaint involved a physician from one community, a peer reviewer from another community was generally chosen. This minimized any conflicts of interest. Whenever possible, physicians were used from within the state, which helped control costs if their testimony was needed in a hearing. Based on the prior stated distribution of physicians in the state, it is therefore not surprising that our data indicated 80% of the complaint physicians were located in Clark County and that only 12% were located in Washoe County (see table 2), and that 61% of the peer reviewers were located in Washoe County and 24% in the Clark County (see table 3).

The origins of the complaints initiating the peer reviews are addressed in table 4. The NSBME is statutorily required to investigate all civil malpractice cases filed in court. Sixty-nine percent of the total

Table 2:
Location of complaint physician

	Dec 2007–Nov 2008 location of complaint physician and percentage of the total (67)		Dec 2008–Nov 2009 location of complaint physician and percentage of the total (34)		Total Dec 2007–Nov 2009 (101)	
Las Vegas (C)	50	75%	29	85%	79	78%
Reno (W)	11	16%	1	3%	12	12%
Henderson (C)	2	3%	0	0%	2	2%
Carson City	2	3%	3	9%	5	5%
Elko	1	1%	0	0%	1	1%
Incline	1	1%	0	0%	1	1%
Ely	0	0%	1	3%	1	1%

C symbolizes location is in Clark County; W is in Washoe County.

Table 3:
Location of the peer reviewer

	Dec 2007–Nov 2008 location of the peer reviewer and percentage of the total (68)		Dec 2008–Nov 2009 location of the peer reviewer and percentage of the total (34)		Total Dec 2007–Nov 2009 (102)	
Reno (W)	43	63%	19	56%	62	61%
Las Vegas (C)	15	22%	4	12%	19	19%
Tahoe	2	3%	0	0%	2	2%
Henderson (C)	2	3%	3	9%	5	5%
Carson City	4	6%	2	6%	6	6%
Elko	0	0%	2	6%	2	2%
Other	2	3%	4	12%	6	6%

C symbolizes location is in Clark County; W is in Washoe County

were from civil malpractice cases filed in court, 15% from patient complaints, 5% from coroner-prompted investigations, 3% from family member complaints, and 9% involved other origins of complaints—such as from government agencies or other physicians.

The number of years the complaint physicians had practiced in the state inclusive to the time the complaint was made is reflected in table 5. Physicians in practice for five years or less accounted for 12% of the total, 40% had practiced for

6 to 10 years, 20% for 11 to 15 years, 16% for 16 to 20 years, and 13% for more than 21 years. This five-year increment division was arbitrarily selected. Also recorded was the total number of complaints filed for each complaint physician, including the present complaint (see table 6). Forty-seven percent of the physicians had 1 to 3 complaints filed, 10% had 4 to 6 complaints, 17% had 7 to 10 complaints, and 26% had 11 or more complaints. These increments were also arbitrarily chosen.

Table 4:
Origin of complaint

	Dec 2007–Nov 2008 origin of complaint initiating the peer review and percentage of the total (68)		Dec 2008–Nov 2009 origin of complaint initiating the peer review and percentage of the total (34)		Total Dec 2007–Nov 2009 (102)	
Civil malpractice filed court cases	50	74%	20	59%	70	69%
Patient complaints	9	13%	6	18%	15	15%
Coroner	4	6%	1	3%	5	5%
Family	2	3%	1	3%	3	3%
Other	3	4%	6	18%	9	9%

Table 5:
Years in practice of complaint physician

	Dec 2007–Nov 2008 years in practice of the complaint physician and percentage of the total (68)		Dec 2008–Nov 2009 years in practice of the complaint physician and percentage of the total (34)		Total Dec 2007–Nov 2009 (102)	
0–5 years	6	9%	6	18%	12	12%
6–10 years	30	44%	11	32%	41	40%
11–15 years	14	21%	6	18%	20	20%
16–20 years	10	15%	6	18%	16	16%
21+ years	8	12%	5	15%	13	13%

Table 6:
Total number of complaints filed with the Board, inclusive, of each reviewed physician

	Dec 2007–Nov 2008 physician total (57)		Dec 2008–Nov 2009 physician total (31))		Total Dec 2007–Nov 2009 (88)	
1–3	29	51%	12	39%	41	47%
4–6	6	11%	3	10%	9	10%
7–10	14	25%	1	3%	15	17%
11+	8	14%	15	48%	23	26%

The overall quality of the peer reviews was evaluated by the medical reviewer based on the overall content of the peer review, including the detail of the review and whether the peer reviewer’s conclusion was justified by the supporting content of the review. Supporting content included specific references to the medical record supporting conclusions, along with pertinent reference materials included in the review. Fifty-nine percent were

deemed to be excellent, 37% good, 1% adequate, and 3% sub-adequate (see table 7).

Forty-two percent of the peer reviews ordered by the medical reviewer had a finding of malpractice as defined legally by statute. Fifteen percent of the peer reviews ordered by the Investigative Committees had a finding of malpractice. Overall, 38% of the peer reviews requested had a finding of malpractice (see tables 8, 9, and 10).

Table 7:
Overall quality of the peer review

	Dec 2007–Nov 2008 review totals (68)		Dec 2008–Nov 2009 review totals (34)		Total Dec 2007–Nov 2009 (102)	
Excellent	39	57%	21	62%	60	59%
Good	26	38%	12	35%	38	37%
Adequate	1	1%	0	0%	1	1%
Sub-adequate	2	3%	1	3%	3	3%

Table 8:
Findings of malpractice by the peer reviewer for reviews that were ordered by the medical reviewer

	Dec 2007–Nov 2008 reviews and percentage of the total (39)		Dec 2008–Nov 2009 reviews and percentage of the total (27)		Total Dec 2007–Nov 2009 (66)	
Malpractice	13	33%	15	56%	28	42%
No malpractice	26	67%	12	44%	38	58%

Table 9:
Findings of malpractice by the peer reviewer for reviews that were ordered by the Investigative Committees

	Dec 2007–Nov 2008 reviews and percentage of the total (6)		Dec 2008–Nov 2009 reviews and percentage of the total (7)		Total Dec 2007–Nov 2009 (13)	
Malpractice	0	0%	2	29%	2	15%
No malpractice	6	100%	5	71%	11	85%

Table 10:
Total findings of malpractice by the peer reviewer

	Dec 2007–Nov 2008 reviews and percentage of the total (45)		Dec 2008–Nov 2009 reviews and percentage of the total (34)		Total Dec 2007–Nov 2009 (79)	
Malpractice	13	29%	17	50%	30	38%
No malpractice	32	71%	17	50%	49	62%

Table 11:
Number and percentage of specialty of the complaint physicians and number and percentage of malpractice findings of the peer reviewers from Dec 2007–Nov 2008

	Number of physicians (68 total)	% of Total in Specialty	Malpractice	% Malpractice in Specialty
Cardiology	13	19%	2	15%
Orthopedic	9	13%	1	11%
Internal Medicine	8	12%	2	25%
Radiology	6	9%	1	17%
ER Medicine	5	7%	2	40%
General Surgery	5	7%	1	20%
Family Practice	5	7%	1	20%
OB-GYN	3	4%	2	67%
Vasc, Cardio-Thoracic Surgery	3	4%	1	33%
Gastroenterology	3	4%	0	0%
Ophthalmology	3	4%	2	67%
Psychiatry	2	3%	2	100%
Infectious Disease	1	1%	0	0%
Preventive Medicine	1	1%	1	100%
Physician Assistant	1	1%	1	100%

Table 12:
Number and percent of the specialty of the complaint physicians and number and percentage of malpractice findings of the peer reviewers from Dec 2008–Nov 2009

	Number of physicians (34 total)	% of Total in Specialty	Malpractice	% Malpractice in Specialty
Cardiology	2	6%	0	0%
Orthopedic	3	9%	0	0%
Internal Medicine	4	12%	3	75%
Radiology	2	6%	1	50%
ER Medicine	3	9%	2	67%
General Surgery	5	15%	1	20%
OB-GYN	3	9%	1	33%
Gastroenterology	3	9%	2	67%
Ophthalmology	2	6%	1	50%
Psychiatry	1	3%	1	100%
Physician Assistant	2	6%	2	100%
Anesthesia	1	3%	0	0%
Urology	1	3%	0	0%
General Practice	1	3%	1	100%
ENT	1	3%	1	100%

We recorded not only the number and percentage of the complaint physicians by specialty but also the number and percent of findings of malpractice found in each specialty for each year of the study and during the total two years of the study (see tables 11, 12, and 13). Costs were recorded for each peer

PEER REVIEWERS, AS DEFINED AND UTILIZED BY OUR BOARD, DELIVER 'EXPERT OPINIONS' RENDERED ON THE BOARD'S BEHALF. THEREFORE, IT IS NOT UNREASONABLE TO ESTABLISH QUALIFICATIONS FOR THOSE RENDERING SUCH OPINIONS.

review with further sorting by the specialty of the peer reviewer. Average costs and highest cost were recorded by specialty of the peer reviewer (see table 14). These costs were further sorted by the

year that the peer review was entered into the study and for the total two years of the study. The average cost of a peer review over the two-year study was \$791. Costs were determined based on the hours spent performing the review as relayed by the peer reviewer. The hourly rate was \$150. Many peer reviewers did not charge the Board for their time. Generalities concerning the data above are only suggestive at best due to the limited numbers in the study.

The time from when the peer review was requested until materials were sent from the Board to the peer reviewer was included in the data collection (see table 15). Forty-seven percent of the time materials were sent from the Board to the peer reviewer in 60 days or less, 21% were sent between 61 and 120 days, and 33% percent were sent more than 120 days from the request. Also included in this study was the time for the peer review to be performed by the peer reviewer, defined by when the materials for review were

Table 13:
Total number and percentage of specialty of the complaint physicians and the grand total number of and percentage in each specialty fo malpractice findings of the peer reviewers from Dec 2007–Nov 2009

	Number of physicians (102 total)	% of Total in Specialty	Malpractice	% Malpractice in Specialty
Cardiology	15	15%	2	13%
Orthopedic	12	12%	1	8%
Internal Medicine	12	12%	5	42%
Radiology	8	8%	2	25%
ER Medicine	8	8%	4	50%
General Surgery	10	10%	2	20%
Family Practice	5	5%	2	40%
OB-GYN	6	6%	3	50%
Vasc, Cardio-Thoracic Surgery	3	3%	1	33%
Gastroenterology	6	6%	2	33%
Ophthalmology	5	5%	3	60%
Psychiatry	3	3%	3	100%
Infectious Disease	1	1%	0	0%
Preventive Medicine	1	1%	1	100%
Physician Assistant	3	3%	3	100%
Anesthesia	1	1%	0	0%
Urology	1	1%	0	0%
General Practice	1	1%	1	100%
ENT	1	1%	1	100%

sent from the Board to the peer reviewer and the date the completed peer review was received by the Board (see table 16). Forty-eight percent were received back in 60 days or less, 24% were received back between 61 and 120 days, and 27% took 121 days or more to return.

Analyzing such data can be an effective tool in streamlining state medical board practices. Addressing outliers indentified by ongoing dynamic review can enhance state medical board performances. Regarding the time it took to send the materials from the Board to the peer reviewer,

Table 14:
Average cost along with highest cost of peer reviews per specialty from Dec 2007–Nov 2008, Dec 2008–Nov 2009, and Total Dec 2007–Nov 2009

	Dec 2007–Nov 2008 (60 total)		Dec 2008–Nov 2009 (34 total)		Dec 2007–Nov 2009 (94 total)	
	Average	Highest	Average	Highest	Average	Highest
OB-GYN	\$1675	\$2625	\$356	\$750	\$921	\$2625
Psychiatry	\$1650	\$3000	\$600	\$600	\$1300	\$3000
General Surgery	\$1525	\$2775	\$540	\$900	\$1032	\$2775
Family Practice	\$1425	\$2400	\$675	\$750	\$1175	\$2400
Physician Assistant	\$1350	\$1350	\$1350	\$1350	\$1350	\$1350
ER Medicine	\$1062	\$2250	\$750	\$750	\$945	\$2250
GI	\$763	\$1090	\$712	\$1200	\$738	\$1200
Orthopedic	\$739	\$1050	\$1200	\$2250	\$854	\$2250
Vasc, Cardio- Thoracic Surgery	\$700	\$1050	no reviews		\$700	\$1050
Internal Medicine	\$600	\$2250	\$842	\$1875	\$757	\$2250
Ophthalmology	\$600	\$600	\$600	\$600	\$600	\$600
Cardiology	\$482	\$2250	\$150	\$450	\$418	\$2250
Preventive Medicine	\$450	\$450	no reviews		\$450	\$450
Infectious Disease	\$225	\$225	no reviews		\$225	\$225
Radiology	\$150	\$300	\$375	\$750	\$206	\$750
Anesthesia	no reviews		\$2100	\$2100	\$2100	\$2100
Endocrinology	no reviews		\$1500	\$1500	\$1500	\$1500
Urology	no reviews		\$0	\$0	\$0	\$0
Total Cost	\$48,500		\$25,837		\$74,337	
Average Cost	\$808		\$760		\$791	

Table 15:
Time from when peer review requested to be performed until materials sent to peer reviewer from the Board for Dec 2007–Nov 2008, Dec 2008–Nov 2009, and Total Dec 2007–Nov 2009

	Dec 2007–Nov 2008 (39 total)		Dec 2008–Nov 2009 (34 total)		Dec 2007–Nov 2009 (73 total)	
	Number	% of total	Number	% of total	Number	% of total
1–60 days	14	36%	20	59%	34	47%
61–120 days	13	33%	2	6%	15	21%
>120 days	12	31%	12	35%	24	33%

one could initially define outliers as having taken more than 120 days for the materials to be sent. By this initial definition of outliers, it would not be unreasonable to project that times for material distribution could be improved to an ultimate goal of 30 days. The same goal could be set for improving times for peer reviews to be returned within 30 days. Introducing a call-back system when target times are exceeded could achieve this goal. For example, if the time for return of the peer review exceeded the allotted target time of 30 days, a reminder call would be made at day 31 and every two weeks thereafter.

Peer reviewers, as defined and utilized by our Board, deliver “expert opinions” rendered on the Board’s behalf. Therefore, it is not unreasonable to establish qualifications for those rendering such opinions (see table 17), including having an active license and actively practicing in the state whenever possible. It may be necessary to utilize out-of-state physicians due to a shortage of a particular specialty in the state. Controlling costs for transportation, time, and lodging are additional

important considerations for utilizing in-state physicians whenever possible—especially should testimony in a hearing be required. Board certification is preferable, along with the physician practicing for three or more years in his or her particular specialty following the completion of specialty training. It is also important that the peer reviewer have current experience in the procedure at issue. It is essential that the peer reviewer have a low complaint history with the Board and be of high moral and ethical character. Knowledge of the peer reviewer’s communication skills, in case testimony is needed in a hearing, can also be helpful.

Ideally, the peer reviewer should have guidelines stated in an agreement developed by the Board outlining what is expected of them. An example of such an agreement is delineated in table 18. This agreement should be discussed at the onset of the peer reviewer selection process so all parties know what is expected of each other in order to avoid problems down the road, such as instances in which consultation and preparation with Board attorneys is needed for hearing

Table 16:
Time from when peer review materials sent from the Board to the peer reviewer until peer review received back for Dec 2007–Nov 2008, Dec 2008–Nov 2009, and Total Dec 2007–Nov 2009

	Dec 2007–Nov 2008 (68 total)		Dec 2008–Nov 2009 (34 total)		Dec 2007–Nov 2009 (102 total)	
	Number	% of total	Number	% of total	Number	% of total
1–60 days	29	43%	20	59%	49	48%
61–120 days	21	30%	4	12%	25	25%
>120 days	18	26%	10	29%	28	27%

Table 17:
Suggested peer reviewer qualifications

1. Active practice in the state.*
2. Resides in the state.*
3. Board certified.
4. Experienced (includes actively practicing in their specialty for three years or more following the completion of their post-graduate/residency training and current experience in the procedure at issue).
5. High moral and ethical character.
6. No conflicts of interest.
7. Low complaint history with the Board(s).
8. Willingness to abide by the agreement set forth by the Board in performing the peer review.

*Whenever possible

testimony. This agreement may be flexible, but it should include an established hourly reimbursement for time spent performing the peer review. Our reimbursement rate is \$150 per hour. A standard format should also be established, which can be flexible, provided by the Board to the peer reviewer to guide the manner the peer review is to be written.

Spelled out in the agreement should be the peer reviewer's acceptance to participate in any consultation needed by the Board's attorney for preparation of the complaint for a hearing, and the peer reviewer agreeing to testify at a hearing if one should take place. There should be a brief discussion establishing that the peer reviewer has no conflicts of interest. The following question should be asked once a potential peer reviewer has been selected: If you find malpractice, would you have difficulty stating this? Once it is determined that the peer reviewer does not have difficulty in stating malpractice, an understanding should be sought as to the precise terminology the Board wishes the peer reviewer to use if malpractice is found to ensure it is correctly stated. There should also be a discussion regarding the timeframe for the peer review to be performed. Lastly, the Board should provide a statement in writing to the peer reviewer that he or she is immunized from any potential damages and liability in rendering his or her own forthright, honest opinion.

By ongoing review of peer reviewers, a medical board may develop a number of physicians in each specialty who can be utilized to perform peer reviews. A commitment is then made by each party. Of course, this is an ideal situation if a high number of physicians are willing to perform peer reviewers. Utilizing reviewers that the Board is comfortable with

by past experience helps ensure these physicians gain more experience in performing reviews and in testifying during hearings. These peer reviewers then become themselves more comfortable with a process that can sometimes be daunting.

Conclusion

Further data is necessary to draw meaningful conclusions from some of the peer review characteristics that were reported in this study. However, useful data was obtained in regards to timeliness in sending materials to peer reviewers once the peer review was requested, total time for the peer reviewers to perform their reviews, and costs.

Many questions that this study sought to evaluate need to be further explored, including: What are acceptable times for Boards sending materials to the peer reviewer once a peer review has been requested? What is an acceptable timeframe for the peer reviewer to perform a peer review? What are acceptable costs in performing peer reviews? Should costs differ by specialty? Do the rates of complaints differ by years in practice? Are there acceptable percentages for findings of malpractice for peer reviews ordered? If so, what are they? Do the findings of malpractice vary by the specialty of the peer reviewer? Should they vary?

We hope this study stirs similar research of its kind, which can then be shared between state medical boards and help answer many of the questions raised.

I would like to express my appreciation to the president, executive director, Board members, and the entire staff of NSBME for their help and support in this study. ■

Table 18:
Suggested peer reviewer agreement

1. Agreement on an established hourly reimbursement for time spent in performing the peer review. This may include CME credits in addition to or instead of monetary reimbursement for the time spent in performing the peer review. The physician also can elect not to charge.
2. Agreement to participate in any consultation needed by the Board's attorneys in preparation of the case for a hearing and agreement to testify at a hearing if needed. Agreement on an established hourly hearing preparation and testimony reimbursement including transportation and lodging expenses when applicable.
3. Agreement that there are no conflicts of interest for the peer reviewer in performing the review.
4. Agreement that the peer reviewer will adhere to an established format as much as possible in writing the peer review.
5. Agreement that the peer review will be completed within an established timeframe.
6. A statement in the agreement that the peer reviewer is immunized by the Board from any potential damages and liability in rendering his or her own honest, forthright opinion.



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Canada

Medical Council of Canada helps move ‘Future of Medical Education in Canada’ recommendations forward

The Medical Council of Canada (MCC) has created an Assessment Review Task Force to formally consider all recommendations in Canada’s ambitious “Future of Medical Education in Canada” project, assess aspects of the project related to its examinations, and report back within the next two years on how the Council can best support the changes suggested.

The Future of Medical Education project was launched by the Association of Faculties of Medicine of Canada to change Canada’s approach to medical education in a way that better meets current and future health care needs.

Canada, like many western nations, is experiencing significant demographic and workforce shifts, from an increasingly large number of Canadian students studying medicine abroad, to changing public expectations of the role physicians should play as health care providers, to a new movement in the regulatory community towards common standards for licensure.

As a part of its work, the Task Force will examine these changes and their impact on the assessment of physicians in Canada. It will identify any additional competencies that may require assessment in the future to ensure that physicians meet appropriate standards of care for licensure in Canada.

According to MCC, the Task Force will work closely with Canada’s regulatory community to better understand how it uses MCC’s examinations currently. It will perform literature reviews and interviews with key experts to find out more about other potential physician assessments that might be added to its current assessment structure, and how these assessments might be of value throughout a physician’s education, training and practice. ■

Source: Medical Council of Canada website, June 2010

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Ireland

Minister for Health & Children Launches Maintenance of Professional Competence Components as Part of Medical Practitioners Act

Ireland’s Minister for Health & Children has formally launched Part 11 of the 2007 Medical Practitioners Act, requiring physicians to participate in a new program of maintenance of professional competence.

Ireland’s Medical Council, which regulates physicians and medical practice, called the new program a milestone for the medical profession that will help promote the safety of patients.

Part 11 of the Medical Practitioners Act, which is the final part of the act to be implemented, stipulates that all registered medical practitioners in Ireland must participate in maintenance of professional competence, including a process of engagement in continuing professional development (CPD) and clinical audit. All physicians must be engaged with the new process by 2011.

The Medical Council assured physicians that its new process would not be overly burdensome, with Medical Council President Kieran Murphy saying: “For the majority of doctors this is the formalization in law of a process with which they are already voluntarily engaged.”

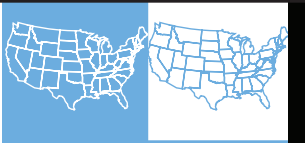
Murphy said that the cost of the new process would not be significant for physicians or for organizations that provide medical education.

“The majority of doctors are already involved in professional development, so I cannot see the introduction of this scheme creating a financial burden for them,” he said.

“It is a very positive development for the profession and for patients who can now be certain that their doctor is maintaining their level of knowledge and skills. This will help to ensure that patients are getting the best possible care,” Murphy said.

More information about Ireland’s new maintenance of professional competence process is available at the Medical Council website at www.medicalcouncil.ie. ■

Source: Medical Council of Ireland news release, May 31, 2010



Colorado

New Rules for Advanced Practice Nurses with Prescriptive Authority

The Colorado State Board of Nursing and the Colorado Medical Board recently began implementing new complementary rules for advanced practice nurses (APNs) with prescriptive authority. These new rules were enacted as part of Senate Bill 09-239 and became effective July 1, 2010.

The new requirements, which are intended to clarify prescribing responsibilities, will affect currently licensed advanced practice nurses with prescriptive authority as well as new applicants for prescriptive authority.

Under the new requirements, a collaborative agreement between an advanced practice nurse with prescriptive authority and a physician is no longer required. An “Articulated Plan for Safe Prescribing” is required instead.

An articulated plan does not require an ongoing involvement of a physician, as the former collaborative agreement did.

Under the new requirements, APNs who wish to obtain prescriptive authority are required to:

- Have national certification
- Hold a graduate or postgraduate nursing degree
- Complete a 1,800-hour preceptorship
- Complete a 1,800-hour mentorship
- Develop an Articulated Plan for safe prescribing

For specific information regarding the role of the physician in the precepting, mentoring and development of the APN’s Articulated Plan to obtain prescriptive authority, visit <http://www.dora.state.co.us/medical/advancedpractice.htm> ■

Source: Colorado State Medical Board website, June 2010

Georgia

Georgia changes policy on graduates from medical schools outside the United States and Canada

The Georgia Composite Medical Board voted earlier this year to use the list titled “Medical Schools Recognized by the Medical Board of California” as its official reference for approval of medical schools located outside the United States and Canada.

Graduates of the schools contained in this list are required to complete one year of postgraduate training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME).

Graduates attending schools not listed in the Medical Schools Recognized by the Medical Board of California must complete three years of postgraduate training in a program accredited by the ACGME. The list Georgia is now using can be viewed online at: <http://www.mbc.ca.gov/applicant/schools.html> ■

Source: “New IMG Policy,” Georgia Composite Medical Board website, June 2010

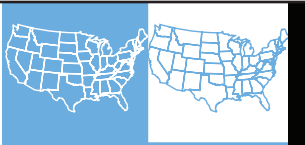
North Carolina

New rules established for ‘sleep techs’ in North Carolina

The North Carolina Medical Board has established new standards for physicians supervising registered polysomnographic technologists (RPSGTs), also known as “sleep techs.”

In 2009 the North Carolina General Assembly passed into law “The Polysomnography Practice Act,” (S.L. 2009-434), which regulates the practice of RPSGTs, who perform and assist in interpreting sleep studies to aid physicians in the diagnosis of sleep disorders.

The Assembly then tasked the North Carolina Medical Board with identifying standards for physicians



supervising RPSGTs with the goal of improving the quality and safety of sleep studies. The Medical Board convened a work group to establish those standards, which were adopted earlier this year.

The new law mandates that the North Carolina Medical Board maintain a registry of RPSGTs that are registered by the Board of Registered Polysomnographic Technologists (BRPT). The Medical Board will now collect the name, full address, date of registration with the BRPT, and proof of registration for RPSGTs in the state. The Medical Board will not be responsible for determining whether registration of a practitioner is appropriate, and it will not discipline RPSGTs for substandard practice. Instead the Board merely acts as the repository for the registry information.

Starting in 2012, RPSGTs cannot practice in North Carolina unless they are a part of the registry and meet a variety of other requirements.

North Carolina’s new law requires that RPSGTs work under the indirect supervision of a physician. The supervising physician is required to have policies and procedures in place for the safe and appropriate completion of RPSGT services and must be readily available to render assistance if needed, but on-site supervision is not required.

The law also mandates that sleep studies may only be performed in a hospital, standalone sleep laboratory or sleep center, or in a patient’s home. The law permits other licensed or registered health care professionals or those working under the supervision of another health care professional to perform sleep studies; however, only those individuals registered with the Medical Board may use the designation “RPSGT.” Violation of the new law is a Class I misdemeanor.

The Medical Board will develop more detailed procedures for RPSGTs who must register under the Act closer to the January 2012 implementation deadline. For more information, visit the Board’s website at www.ncmedboard.org. ■

Source: North Carolina State Medical Board website, June 2010

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West Virginia

Guidelines Help Clarify Working Relationships Between Physicians and Nurses

The West Virginia Board of Medicine has adopted a new position statement: Guidelines for Physicians in Collaborative Relationships with Advanced Nurse Practitioners or Certified Nurse Midwives. The statement provides guidance to physicians clarifying their responsibilities when entering into collaborative work relationships with advanced nurse practitioners and certified nurse midwives.

PHYSICIANS WHO FAIL TO ADHERE TO THE
NEW GUIDELINES ESTABLISHED IN THE POSITION
STATEMENT MAY BE SUBJECT TO DISCIPLINE
BY THE BOARD.

The West Virginia position statement stipulates that physicians entering into such relationships must be fully licensed in West Virginia without practice restrictions or limitations, and that they must create written collaborative agreements with nurses and midwives they work with.

Written collaborative agreements must include a variety of specific provisions outlined in the position statement.

Physicians who fail to adhere to the new guidelines established in the position statement may be subject to discipline by the Board. To learn more, visit the West Virginia Board of Medicine website at <http://www.wvbom.wv.gov/> ■

Source: West Virginia Board of Medicine Policy Statement: “Guidelines for Physicians in Collaborative Relationships with Advanced Nurse Practitioners or Certified Nurse Midwives,” May 2010



By Tim Miller, J.D.
Senior Director, Government Relations and Policy
Federation of State Medical Boards

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The Nexus Necessity: Disciplining Physicians for Non-Clinical Misconduct

The aphorism “primum non nocere,” first I will do no harm,¹ is well known. But Hippocrates recognized there was more to practicing medicine than not harming the patient. In the *Hippocratic Oath*, Hippocrates admonishes physicians to preserve the purity of their life and their arts. Hippocrates realized that beyond competence the physician must be a good person and professional.² His admonishment has not faded or lost relevance over the ensuing 25 centuries.

In the 21st century we find that “in the practice of medicine, the application of knowledge is principally judgmental rather than mechanical. A personal relationship of trust and confidence must exist between a physician and his patient if the patient is to have confidence in the physician’s professional judgment. We believe ‘the public has the right to expect the highest degree of integrity from members of the

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medical profession.”³ The reason for a high level of trust is that “there is no other profession in which one passes so completely within the power and control of another as does the medical patient.”⁴ In *Lawrence v. Board of Registration in Medicine*, the court concluded that “mere intellectual power and scientific achievement without uprightness of character may be more harmful than ignorance. Highly trained intelligence combined with disregard of the fundamental virtues is a menace.”⁵

Regulating this dual standard—quality care and good character—creates a challenge for state medical boards. When disciplining a physician, the state medical boards find it easier to impose discipline when the unprofessional⁶ behavior results

in patient harm, such as wrong patient/wrong site surgery. But it becomes much more difficult when the unprofessional conduct has no affect on patient care, such as billing fraud. Setting aside the practical consideration in investigating claims of unprofessional conduct, this article focuses on legalities of applying the Medical Practice Act to conduct that does not affect patient care.

The Nexus Necessity

When turning to non-clinical misconduct, state legislatures and state medical boards should tread carefully. As demonstrated below, there is no doubt state medical boards can discipline physicians for non-clinical unprofessional conduct, but there are limitations. The initial and most difficult limitation state medical boards encounter in enforcing the Medical Practice Act for non-clinical unprofessional conduct is the constitutionality of the laws authorizing state medical boards’ actions. The courts are clear that the substantive due process clause and the equal protection clause in the 14th amendment to the U.S. Constitution require state laws and actions to be clear so the physician knows what conduct is proscribed. “[T]he due process and equal protection clauses of the United States Constitution apply to disciplinary proceedings, and that no person may be prevented from practicing a profession except for valid reasons.”⁷ Indeed, constitutional considerations require that a statute “bar a person from practicing a lawful profession only for reasons related to his fitness or competence to practice that profession.”⁸ To do this, “there must be a sufficient ‘nexus’ between the asserted grounds for dismissal and the fitness to carry out the responsibilities of employment.”⁹ Therefore, it is necessary for the legislature, state medical boards or the courts to draw the nexus between the conduct and the profession.

The courts are nearly unanimous that “a professional license may be revoked only if the conduct upon which the revocation is based relates to the practice of the particular profession and thereby demonstrates an unfitness to practice such profession.”¹⁰ “[A] statute constitutionally can prohibit an individual from practicing a lawful profession only

for reasons related to his or her fitness or competence to practice that profession.”¹¹ One court held that “there must be a logical connection of licensees’ conduct to their fitness or competence to practice the profession or to the qualifications, functions, or duties of the profession in question.”¹² Thus the state can impose discipline on a professional license only if the conduct upon which the discipline is based relates to the practice of the particular profession and thereby demonstrates an unfitness to practice such profession.

Identifying the Nexus

It is the state medical board’s responsibility to identify the nexus between conduct and the profession. The *Matanky* court held that “with regard to actions that do not directly affect patient care, the state medical board must demonstrate a nexus between the proscribed conduct and the practice of medicine. For a nexus to exist between the unprofessional conduct and the fitness or competence to practice medicine, it is not necessary for the misconduct forming the basis for discipline to have occurred in the actual practice of medicine. “[The medical board] is authorized to discipline physicians who have been convicted of criminal offenses not related to the quality of health care.”¹³ This decision makes it clear that the state medical board can identify the nexus in situations where there is no patient care.

The first place to look for the necessary nexus is the Medical Practice Act and associated rules. The legislature and subsequently the state medical board can establish a nexus through statutory process and rule making. One court concluded that by defining “more than one misdemeanor conviction involving alcohol consumption as unprofessional conduct ... the Legislature has determined that a nexus exists between those convictions and a physician’s fitness or competence to practice medicine. The issue is whether such convictions have a “logical connection” to a physician’s fitness or competence to practice medicine.”¹⁴ Likewise, the *Griffiths* court found that by defining convictions for use, consumption, or self-administration of

alcoholic beverages as unprofessional conduct, the statute satisfies the constitutional requirement that a nexus exist between the disciplined conduct and the physician’s fitness and competence to practice medicine without any additional showing that the convictions or the alcohol consumption impaired Griffiths’ practice of medicine.¹⁵

A California statute provides an example of a statutorily created nexus. In 16 § 1360, the California legislature provides that:

For the purposes of denial, suspension or revocation of a license, certificate or permit pursuant to Division 1.5 (commencing with Section 475) of the code, a crime or act shall be considered to be *substantially related* to the qualifications, functions or duties of a person holding a license, certificate or permit under the Medical Practice Act if to a *substantial degree* it evidences present or potential unfitness of a person holding a license, certificate or permit to perform the functions authorized by the license, certificate or permit in a manner consistent with the public health, safety or welfare. Such crimes or acts shall include but not be limited to the following: Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision of the Medical Practice Act.

Most statutes are not as explicit as California’s, but they can still create the nexus. A good example is Kentucky’s statute KRS 311.597(4), in which the legislature provides that “it is unprofessional for a physician to take any action calculated to or has the effect of bringing the medical profession in disrepute including, but not limited to, violations of AMA/AOA ethics.”¹⁶

The courts are willing to allow the legislature to connect the disconnected. “The Legislature which presumptively legislated in a constitutional fashion . . . has determined that conviction of a doctor for a violation of the laws regulating narcotics and dangerous drugs or a doctor’s personal non-



prescribed use of such substances evidences a sufficient danger to the public that sanctions should be imposed regardless of the availability of evidence that such conduct in fact impaired the doctor's professional skill."¹⁷ This similarly reflects the Federation of State Medical Boards' policy stating it is unprofessional to engage in conduct calculated

‘...IT IS NOT NECESSARY FOR THE MISCONDUCT FORMING THE BASIS FOR DISCIPLINE TO HAVE OCCURRED IN THE ACTUAL PRACTICE OF MEDICINE.’

to or having the effect of bringing the medical profession into disrepute, including but not limited to, violation of any provision of a national code of ethics acknowledged by the board.¹⁸

The Unconnected Connection

Sometimes statutes or rules do not establish the nexus between the prohibited act and the practice of medicine. In these instances, the courts have read into law a nexus where one does not explicitly exist. So, “where a licensing statute does not require a showing of a nexus between the licensee’s conduct and the licensee’s fitness or competence to practice, the statute must be read to include this “nexus” requirement to ensure its constitutionality.¹⁹ Further, “[a] presumption exists that in enacting a statute, the Legislature did not intend it to violate the Constitution, but instead intended to enact a valid statute within the scope of its constitutional powers. Therefore, we frequently have observed that a statute must be interpreted in a manner, consistent with the statute’s language and purpose, which eliminates doubts as to the statute’s constitutionality.”²⁰ The act of dishonesty need not arise out of the practice of medicine to establish the required nexus. “For a nexus to exist between the misconduct and the fitness or competence to practice medicine, it is not necessary for the misconduct forming the basis for discipline to have occurred in the actual practice of medicine.

The Medical Board is authorized to discipline physicians who have been convicted of criminal offenses not related to the quality of health care.”²¹

Not all courts agree that deriving a nexus is necessary. Two courts have held it is unnecessary to establish a nexus. The *Weissbuch* court held “there is no basis, constitutional or otherwise, for the courts to override that legislative determination by imposing a special requirement of ‘nexus’ between the proscribed conduct and professional conduct.”²² Likewise, the *Wilson* court concluded that no basis appears for creating a special requirement of ‘nexus’ where conviction of a crime is considered as a ground for discipline.²³

The Board’s Broad Authority

Some courts require boards to identify the nexus when one is not obvious. The *Kvitka* court noted that “the concerns with protecting the integrity of the profession and protecting the public are not unrelated. As an interest of the state, however, preserving professionalism is not an end in itself. Rather, it is an instrumental end pursued in order to serve the state’s legitimate interest in promoting and protecting the public welfare. To perform their professional duties effectively, physicians must enjoy the trust and confidence of their patients. “Conduct that lowers the public’s esteem for physicians erodes that trust and confidence, and so undermines a necessary condition for the profession’s execution of its vital role in preserving public health through medical treatment and advice.”²⁴ The board has broad authority to regulate the conduct of the medical profession,²⁵ including the ability to sanction physicians for conduct which undermines public confidence in the integrity of the medical profession.²⁶ Likewise, in *Kindschi*, a board had suspended a physician’s license to practice medicine after he was convicted of tax fraud. The court upheld the board’s action, and in doing so it took a broad view of the required relationship between the improper conduct and the practice of the profession. The court pointed out that a medical disciplinary proceeding is taken for two purposes: “to protect the

public, and to protect the standing of the medical profession in the eyes of the public.”²⁷

Not only may state medical boards draw the connection when necessary, they may draw the connection before there is an actual connection. “The protection of the public, the primary purpose of licensing statutes, does not require harm to a client before licensing discipline can take place. “[R]epeated criminal conduct, and the circumstances surrounding it, are indications of alcohol abuse that is adversely affecting petitioner’s private life. We cannot and should not sit back and wait until petitioner’s alcohol abuse problem begins to affect her practice of law.”²⁸

Good Doctor/Bad Person Dilemma

Once the legislature, the state medical board or the court draws the nexus between the non-clinical conduct and the practice of medicine, the state medical board will encounter a “good doctor/bad person dilemma.” When searching to make a connection, boards may encounter a physician who is an excellent clinician or surgeon but has a lack of moral character. To discipline such a physician could result in the loss of a highly skilled, badly needed physician, but failure to discipline could bring the profession into disrepute. “A personal relationship of trust and confidence must exist between a physician and his patient if the patient is to have confidence in the physician’s professional judgment.”²⁹ “The public has the right to expect the highest degree of integrity from members of the medical profession.”³⁰ “Mere intellectual power and scientific achievement without up-rightness of character may be more harmful than ignorance. Highly trained intelligence combined with disregard of the fundamental virtues is a menace.”³¹ *Matanky* bluntly made the same point: “A physician can be subject to disciplinary action notwithstanding his technical competence or skill under circumstances where his moral character is in dispute. Intentional dishonesty, especially involving moral turpitude, demonstrates a lack of moral character and satisfies a finding of unfitness to practice medicine.”³²

The *Griffiths* court held that “driving while under the influence of alcohol also shows an inability or unwillingness to obey the legal prohibition against drinking and driving and constitutes a serious breach of a duty owed to society. Knowledge of such repeated conduct by a physician, and particularly of its propensity to endanger members of the public, tends to undermine public confidence in and respect for the medical profession.”³³

Likewise, the *Burg* court held that “convictions involving alcohol consumption reflect a lack of sound professional and personal judgment that is relevant to a physician’s fitness and competence to practice medicine. Alcohol consumption quickly affects normal driving ability, and driving under the influence of alcohol threatens personal safety and places the safety of the public in jeopardy. It further shows a disregard of medical knowledge concerning the effects of alcohol on vision, reaction time, motor skills, judgment, coordination and memory, and the ability to judge speed, dimensions, and distance.”³⁴

While the repeated excessive off duty use of alcohol demonstrates a clearer nexus, the courts and the state medical boards can identify a nexus in more nebulous situations. For example, the *Windham* court rejected the argument that personal income tax evasion did not reflect upon a doctor’s professional qualifications.³⁵ The *Matanky* court held that an intentional misdeed relating to third-party payors reflects adversely on a physician’s fitness to practice medicine. It is irrelevant that it is a third party, and not a patient, who is being defrauded.³⁶

Conclusion

Broadly put, intentional dishonesty, especially involving moral turpitude, demonstrates a lack of moral character and satisfies a finding of unfitness to practice medicine.³⁷ The public has a right to expect the highest degree of trustworthiness of the members of the medical profession. We believe there is a rational connection between income tax fraud and one’s fitness of character or trustworthiness to practice medicine, so that the legislature can properly make fraudulent conduct in such



instances a ground for revoking or suspending the license of a doctor.³⁸

The U.S. Supreme Court and subsequent court decisions makes it clear there must be a nexus between the physician's conduct and the practice of medicine if the state medical board wants to take disciplinary action. When deciding whether to discipline a physician for non-clinical unprofessional conduct, state medical boards should look to the statutes and rules to see if there is an explicit or implicit nexus. Medical boards should be prepared to demonstrate a nexus between the physician's unprofessional conduct and the practice of medicine. ■

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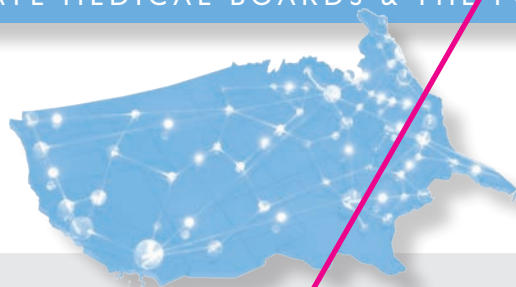
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