Approaching the Issue of the Aging Physician Population

Data and Survey Opinions on Age-Based Physician Competency Screening
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### Approaching the Issue of the Aging Physician Population

Data and Survey Opinions on the Need for Age-Based Physician Competency Screening

Christine Y. Moutier, MD  
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### The Evidence and Rationale for Maintenance of Licensure

Humayun J. Chaudhry, DO, MS  
Frances E. Cain, BA  
Mark L. Staz, MA  
Lance A. Talmage, MD  
Janelle A. Rhyne, MD, MA  
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How old would you be if you didn’t know how old you are?

— Satchel Paige

THE GREAT CLEVELAND INDIANS  Baseball Hall of Famer Satchel Paige certainly knew a thing or two about longevity: He was the oldest rookie of all time when he broke into the major leagues at age 42, and he pitched his last game, as a minor leaguer, just a few days before his 60th birthday. Paige was an outstanding pitcher—called the “hardest thrower in the history of baseball” in 2010 by Sports Illustrated—but it was his folksy ways and homespun philosophy on how to stay young that earned him attention beyond baseball. Among Paige’s pearls of wisdom were “keep the juices flowing by jangling around gently as you move,” “don’t look back — something might be gaining on you” and one of my personal favorites: “avoid running at all times.” Paige taught us that staying young means thinking young—and learning how to adapt as the world around us changes. That’s great advice for the staff of the Journal of Medical Regulation as we begin a very special year in 2013, marking our 100th anniversary of continuous publication. First distributed in 1913 as the Quarterly of the Federation of State Boards of the United States, this publication has provided voluminous information on regulatory issues and trends over the years and has grown to serve thousands of readers around the world. The FSMB has archived every edition, and even the most brittle and yellowed of them shows a remarkable continuity of focus: Many of our most pressing issues today are simply new twists on old themes—from rooting out fraudulent behavior among physicians to seeking better ways of sharing data between state boards and other health care organizations. During this special year, we’ll share historical tidbits from the Journal’s archives and will bring you reflections from guest authors on our history. I’m honored to launch the first of them in this issue, with our “Past and Present” essay on page 6. Throughout our centennial year, we’ll provide the same analysis and reporting you’ve come to expect, including features in this issue on age-based screening of physicians (page 10) and FSMB’s Maintenance of Licensure initiative (page 19). Hopefully we’re following Satchel Paige’s advice—despite our advanced age—and staying young in spirit as we tackle these topics for you, our valued readers.

Susan R. Johnson, MD
Editor-in-Chief
JMR Issues Call for Manuscripts for Special Edition on Workforce Issues

The Journal of Medical Regulation (JMR) is requesting manuscripts on topics related to the health care workforce for inclusion in a special edition scheduled to appear in early 2014.

The special edition will be titled “The Health Care Workforce in Transition: How Will Demographic Trends and Changing Delivery Models Impact Medical Regulation?”

Workforce issues — ranging from physician shortages to the rise of telemedicine and new federal mandates in the Affordable Care Act — bring unique challenges to regulators, which will be explored in content in the edition that will range from commentary to statistical analysis.

Prospective manuscripts for JMR’s special workforce edition may address a wide range of issues under the broad heading of the theme: demographic analyses of the physician and allied health care workforce; undergraduate and graduate enrollment levels; diversity and equity; economic, political and social trends impacting workforce; state and federal policy initiatives; and international factors.

All manuscripts should provide content and analysis that are relevant to the work of the nation’s medical regulatory community, including state medical boards. Content and analysis dealing specifically with the particular workforce challenges faced by state medical boards in this environment are encouraged.

The submission deadline for manuscripts is October 1, 2013. For author information and manuscript guidelines, please visit http://jmr.fsmb.org or call 817-868-4043.

FSMB 2013 Annual Award Winners Announced

The FSMB has announced the recipients of its 2013 awards recognizing outstanding service and leadership in the field of medical regulation. The awards will be presented at the FSMB’s Annual Meeting in Boston in April.

Distinguished Service Award

The Distinguished Service Award recognizes individuals who have demonstrated outstanding service and leadership to the FSMB and to the field of medical licensure and discipline. Recipients of the 2013 award are Martin Crane, MD, and Scott M. Fishman, MD.

Dr. Crane exercised key leadership roles in strategic planning, governance and fiduciary oversight as a member of the FSMB’s Board of Directors from 2004–2011. As chair of the organization from 2009–2010, he led initiatives to open an FSMB Advocacy Office in Washington, D.C., and raised public awareness of the important role of state medical boards in maintaining health care quality and patient safety. During his term, Dr. Crane also led efforts to enhance the FSMB’s data resources, ensuring the continued competence of licensed physicians through the FSMB’s Maintenance of Licensure initiative, and integrating the FSMB’s resources into the national system of emergency preparedness.

From 2000 to 2008, Dr. Crane served on the Massachusetts Board of Registration in Medicine. In addition to leading the board as chair for five years, Dr. Crane chaired several key committees and led significant policy changes for utilizing a state medical board to improve health care quality and access to health care in the state. In 2006, the U.S. Secretary of Education appointed Dr. Crane to the National Committee on Foreign Medical Education and Accreditation, a committee he now chairs.

Dr. Fishman, Chief of the Division of Pain Medicine and Professor of Anesthesia at the University of California, Davis, is well known for his longstanding scholarship and leadership in the area of pain management. He lectures throughout the United States on all aspects of pain control as well as the prevention of prescription drug abuse.
Dr. Fishman is the author of the FSMB Foundation’s 2007 book, “Responsible Opioid Prescribing,” which was widely distributed by medical boards and quickly became a recognized authoritative resource for physicians in confronting problems associated with the evaluation and treatment of chronic pain. An expanded and revised second edition, “Responsible Opioid Prescribing: A Clinician’s Guide,” was released in print and e-book formats in 2012. Dr. Fishman is Past President of the American Academy of Pain Medicine, and is author of “The War on Pain” and “Listening to Pain,” co-author of “Spinal Cord Stimulation,” and co-editor of “Bonica’s Management of Pain” and “Essentials of Pain Medicine and Regional Anesthesia.”

**The John H. Clark, MD Leadership Award**

The John H. Clark, MD Leadership Award recognizes leadership in the field of medical licensure and discipline. This year’s recipient is W. Eugene Musser, Jr., MD.

Dr. Musser has been a member of the Wisconsin Medical Examining Board since 2004. He was elected by his colleagues as board chair for a remarkable three consecutive terms, 2007 to 2009. Under Dr. Musser’s tenure, the board took an active role in initiating legislation that created a duty for physicians to report their colleagues’ unprofessional conduct. Effective in 2010, the new law expanded reporting obligation for providers licensed by the medical board and expanded the definition of unprofessional conduct to include failure by a physician to report such conduct.

Dr. Musser was also the principal architect in securing a separate appropriation for the Medical Examining Board within the Department of Safety and Professional Services, which resulted in 17 dedicated positions for the board’s credentialing and enforcement functions. Dr. Musser has served on the FSMB Education Committee since 2009 and on the FSMB Special Committee on Reentry to Practice from 2010 to 2012.

**Award of Merit**

The Award of Merit recognizes exceptional contributions in the field of medical licensure and discipline, and specifically to state medical boards. This year’s recipient is Carl F. Ameringer, PhD, JD.

Dr. Ameringer, a professor of Government and Public Affairs at Virginia Commonwealth University, has conducted extensive research about state medical boards, the health professions, delivery systems and health care workforce issues. He is the author of “State Medical Boards and the Politics of Public Protection,” “The Health Care Revolution: From Medical Monopoly to Market Competition,” and, most recently, “State-based Licensure of Telemedicine: The Need for Uniformity but Not a National Scheme.”

From 1987 to 1992, Dr. Ameringer served as assistant attorney general and deputy counsel to the Maryland health department where his responsibilities included oversight of disciplinary actions before Maryland’s health licensing boards and commissions. He has served on health policy task forces in Maryland, Wisconsin and Virginia.

**Ray L. Casterline Award for Excellence in Writing**

The 2013 Ray L. Casterline Award for Excellence in Writing is being presented to Gretchen P. Kenagy, PhD, et al., for the outstanding article, “Physician Reentry into Clinical Practice: Regulatory Challenges,” published in the *Journal of Medical Regulation*. Dr. Kenagy is Senior Research Associate, Medical Education Outcomes at the American Medical Association (AMA). Her areas of research include the medical education learning environment and physician reentry. She also supports policy development for the AMA Council on Medical Education.
A Century of ‘Splendid Material’: Why the Journal of Medical Regulation Still Matters
By Susan R. Johnson, MD

“I believe the progressive boards, which now seem to have control of the National Confederation, should make that a really effective organization. Along with this reorganization, arrangements should be made for someone connected with the confederation to edit a national state board bulletin, which would be circulated only among state boards. There is much splendid material which should go into such a bulletin — reports regarding imposters, reports of changes in practice acts, etc. More importantly, however, this bulletin could be used effectively in the campaign for higher and better standards of medical licensure.”

Private letter from James Duncan to Charles Cook
June 3rd, 1911

“Your proposed ‘bulletin,’ as an abstract question, seems desirable. Whether it could be made a practical matter I am not ready to say.”

Private letter from Charles Cook to James Duncan
June 20th, 1911

James Duncan, a medical regulator in Ohio in the early 20th century, had no idea just how much “splendid material” would be available for the pages of a national publication for the regulatory community when he suggested it in 1911.

And his colleague Charles Cook, who later served as the first president of the Federation of State Medical Boards, had no idea just how challenging the “practical” aspects of publishing such a journal would be — and still are.

It turns out they were both quite astute in their observations. Serving as the latest editor of the FSMB’s flagship publication, I know this to be true.

The range of issues facing medical regulators — Duncan’s “splendid material” — is just as wide and thorny a thicket as it has ever been. I am amazed, as are my colleagues, by the complexity of the modern medical environment and all of the conundrums it raises — from the impact of telemedicine on the patient-physician relationship to the ever-shifting landscape of scope of practice and delivery of service. Just as we begin to feel comfortable with one model or mode of practice, another emerges, bringing new questions that regulators often must sort out.

I am perhaps not so amazed by the dark side of the “splendid material.” Duncan’s physician “imposters” can be just as present — and just as reprehensible — today as they were 100 years ago,
from purveyors of pill mills to pedophiles and Medicare cheats. As long as there are humans in medicine, there will be bad apples. It’s the sad reality we regulators know too well.

Can a publication like the *Journal of Medical Regulation* make a difference in such a world?

Cook certainly knew the challenges of production schedules and printing costs, and, as he predicted, the FSMB has grappled with them. The Federation had extremely modest means in its early years, sharing office space and operating with a lean staff, and the printing cost of a nationally distributed publication was a serious financial challenge. The early version of the *Journal*—known as FSMB’s *Bulletin*—survived mostly thanks to the largesse of the American Medical Association, which assumed its printing costs for decades.

The *Journal* changed its shape and publication schedule numerous times over the years, evolving from booklet-size to today’s 8 x 11-inch format and from a quarterly production to monthly and then back again. Along the way, there have been the usual tough questions of what should be covered in its pages and how much space to devote—questions we still face every quarter.

Despite the challenges, the *Journal* has maintained *continuous* publication for 100 years—a record very few publications can claim. And the depth and quality of its coverage of the regulatory profession speaks for itself.

Like most institutions, much of the *Journal*’s credit goes to influential individuals who helped shape it along with way—among them, Walter Bierring, MD, who served as editor for 45 years, from 1915 to 1960—and Ray Casterline, who served for 23 years, from 1969 to 1992. I consider myself lucky to be in their company.

Roughly 1,000 issues after its launch, the *Journal of Medical Regulation* remains a rich resource for more than 3,000 researchers, policy makers, academics and, of course, regulators themselves—the dedicated public servants who work day in and day out to protect patients and families.

As a regulator myself, I’m extremely grateful that James Duncan had a great idea and that men like Charles Cook, who initially had reservations about it, eventually came around to Duncan’s thinking. As a result, the *Journal of Medical Regulation* has become one of the key threads binding together a remarkable community of public service that I’m proud to be a part of.
In Brief Dr. Talmage discusses FSMB efforts to encourage common standards and terminology related to reentry for ill physicians, while raising awareness and understanding of the reentry process among health care stakeholders

Anyone who has practiced medicine knows how demanding and challenging the profession can be. The work can be intense and the pressures high. In order to practice safely and effectively, physicians must be physically and mentally fit.

But physicians, like anyone, may become ill — sometimes with conditions significant enough that their ability to work can be impacted. The unique stressors physicians face can affect practice, patients, career, peers and family.

Illnesses can be both physical and mental, including addictive disease. Factors such as burnout, depression and suicide have been identified as particularly serious challenges within the physician community.

We must be fair: Physicians who have successfully addressed their illness and can demonstrate the ability to practice safely should not feel encumbered or penalized.

At the same time, physicians — like anyone with an illness — can recover. And this sometimes means returning to practice after a long period away.

This raises unique questions for the regulatory community. What can we do in these situations to ensure that the circumstances of the illness, and the time away from practice, don’t put patients in jeopardy?

The community of state medical boards, along with organizations such as the American Medical Association, the Federation of State Physician Health Programs and others, has had policies in place for years to help ensure pathways in and out of practice for physicians who become ill. These may include steps such as licensure restriction and remediation.

But we have also learned over the years that this is a complex, multi-faceted issue — one that doesn’t lend itself to overly broad generalizations, and that can be easily misunderstood by health care stakeholders, ranging from hospitals to insurers. There is a general lack of awareness, and often misperception, about the meaning of terms such as “restricted license.” The reentry process, overall, may not be well understood, and some terms, such as “ill physician” and “impaired physician” may be inaccurately used — sometimes interchangeably.

The result is that physicians who have been ill, and subject to an action by a state medical board, often face unique challenges to reentry to practice — particularly in terms of their ability to obtain or retain specialty board certification, malpractice insurance and employment. They sometimes can be unfairly or inadvertently penalized.

In recent years it has become clear that we need to do more to promote better understanding of the process and terminology used by regulators in cases of reentry for ill physicians, while encouraging common standards and best practices for state boards.

Recognizing the importance of this topic, I convened a Special Committee on Reentry for the Ill Physician in the summer of 2012 to examine trends and to provide recommendations to state boards for their consideration and adoption. I’m delighted to say that the committee, ably chaired by former FSMB President Barbara S. Schneidman, MD, has completed a draft report, which will be considered by the FSMB House of Delegates at its 2013 Annual Meeting in April.

During the course of its work, the committee has established two key facts about reentry for ill physicians.

The first is that the term “restriction” when applied to a physician’s license, does not necessarily imply...
the physician’s scope of practice has been limited in any way, that the physician has displayed a lack of professionalism, or is unsafe when practicing within that scope. License restrictions may or may not include a condition of “restricted practice” — and there is often significant confusion about this among health care stakeholders. The word “restriction” or “restricted” is often misunderstood — to the detriment of physicians who are ill.

The second is that there is a significant difference between the terms “illness” and “impairment,” and that our system would be much better served if there was greater understanding and awareness of these distinctions. The terms are not synonymous, but the distinctions between them have not been emphasized as regulatory policy has evolved over the years.

To give an example, many physicians who enter a Physician Health Program (PHP) are ill but not impaired. They have the potential for impairment. As it examined the difference between “illness” and “impairment,” the committee noted that “illness” is the term used to describe a disease state, whereas “impairment” is a functional classification that implies the inability of the person affected by the disease to perform activities specific to practice.

Because not all physicians who are ill will come to the attention of a state board, and because they may obtain successful treatment before actually becoming impaired, it is critical that “illness” and “impairment” not be used interchangeably.

As the committee has gone about compiling its report, it has discussed a number of potential action steps that could help strengthen systems for reentry in the United States. In general, they include an effort to raise awareness among stakeholders of how the system works, clearer, more consistently used terminology, and the implementation of best practices for physician reentry among boards.

A better system of sharing and review of state medical board orders by entities such as specialty boards, insurers and employers—one which helps eliminate gaps of information or use of confusing nomenclature — could also help improve the reentry process.

Some recommendations under consideration are simple: For example, taking all cases in which a physician is returning to clinical work following an illness on a case-by-case basis and examining evidence holistically. Understanding all of the factors and circumstances of a physician’s case — and the personal and professional support system a physician may have in place as he or she seeks to reenter — will lead to more accurate assessments by state boards and less unwarranted negative impacts.

These are just a few of the pathways to system improvement the committee has considered, and I look forward to a robust discussion of its ideas at the April House of Delegates meeting.

As the health care community continues to address the issue, we must be fair: Physicians who have successfully addressed their illness and can demonstrate the ability to practice safely should not feel encumbered or penalized as a result of license restrictions that are interpreted negatively.

It is especially important to create a reentry process that does not impact the ability of such successful physicians to obtain or maintain specialty board certification, malpractice insurance, medical insurance provider panel membership, hospital privileges or employment.

The goal of the committee’s work has been to ensure the capability of physicians to provide safe, effective patient care. But it also has recognized the value of physicians as a community and public resource, especially in underserved areas and in light of growing concerns about expected physician shortages in years to come.

That means finding a balance when it comes to reentry for ill physicians — one that puts the highest priority on patient safety, as always, while enabling physicians who are capable of practicing safely to reenter under adequate supervision and continued treatment, if necessary for their recovery.

Seeking balance is at the very core of our work as regulators, and I’m pleased that the Federation, through the work of the committee, is well on the way to achieving it with sensible policies on reentry for ill physicians. We will report back to readers of the Journal as the committee’s report goes on now to the House of Delegates for consideration.
Approaching the Issue of the Aging Physician Population

Data from the Coalition for Physician Enhancement Conference “Practicing Medicine Longer: The impact of aging on physician clinical performance and quality of care,” including survey opinions on the need for age-based physician competency screening

By Christine Y. Moutier, MD; David E.J. Bazzo, MD; William A. Norcross, MD

ABSTRACT: In November 2011, the Coalition for Physician Enhancement (CPE) and the University of California, San Diego, Physician Assessment and Clinical Education (PACE) Program held a conference on the issue of physician aging and its potential impact on clinical performance and quality of care. Speakers and attendees from the United States and Canada reviewed a variety of topics and trends related to aging. Data reviewed during the conference reveal that average physician age is increasing, and while a variety of positive aspects of aging can provide a professional benefit, some studies associate a decrease in physician performance with increasing age. Among the factors that can affect physician performance include solo practice, lack of American Board of Medical Specialties (ABMS) Board Certification, practicing outside the scope of training, high clinical volume and health issues. Conference attendees examined Canadian experiences with age-based competency screening and participated in a survey of opinion regarding age-based screening. The majority favored age-based screening beginning at the age of 70, using a system that would include assessments of physical and mental health and a cognitive screen. Competency screening could include peer review and practice evaluation methods. The authors propose further study of age-based screening and encourage physicians to think carefully about the timing of appropriate modifications to and retirement from practice.

Introduction

As our society’s population ages, so do physicians. This has led to increasing numbers of older physicians in practice and new discussions in the health care community about physician competence and the maintenance of skills in older age. Among the topics of growing interest among regulators and other policymakers in this new environment: Should older physicians be the subject of some form of age-based competency screening?

The profession of medicine holds itself to high ideals of caring and competency, the first tenet being primum non nocere, “First, do no harm.”

In a 2011 conference titled “Practicing Medicine Longer: The impact of aging on physician clinical performance and quality of care,” the Coalition for Physician Enhancement (CPE) joined with the University of California, San Diego, Physician Assessment and Clinical Education (PACE) Program to review the current body of knowledge on aging and physician competence, and ascertain views from attendees on a variety of topics—including the question of age-based screening.

International experts in medicine, law and public policy gathered to discuss the multi-faceted impact of aging on physician clinical performance and quality of care during the two-day event. Attendees were surveyed in order to understand their opinions about age-based physician screening—whether or not it should be implemented, and if so, what age, interval and screening methods would be optimal.

The profession of medicine holds itself to high ideals of caring and competency, the first tenet being primum non nocere, “First, do no harm.” While other high-stakes professions—such as aviation—have proactive policies to ensure safety and quality, medicine has relied on self-regulation, in which incident-triggered evaluation is the norm. Policies for addressing the potential for health or age-related impairment of clinical practice are rare. The purpose of this paper is to share the salient data presented at the conference, present the results of the conference survey regarding age-based screening, and propose...
a construct for how an age-based screening agenda could be carried forward.

**Conference Proceedings and Highlights**

**Physician demographic trends:** AMA Physician Masterfile data demonstrates an increase in the aging physician population. In 1985, the number of active physicians in practice was 476,683, with 9.4 percent age 65 or older. In 2005, physicians in active practice numbered 672,531, with 11.7 percent age 65 or older and a mean age of 50. In 2011, physicians in active practice numbered 697,340, with 15.1 percent age 65 or older and with a mean age of 52.5. In addition to the concern about aging physicians, many sources predict an overall shortage of physicians in the future, particularly in primary care, to provide medical services for our aging population and the additional patients who will receive care with the implementation of the Affordable Care Act. Moreover, from the physician’s perspective, the recent economic slow-down in the United States has impacted the retirement plans of many aging physicians, leading them to feel the need to practice medicine longer.

**Healthy aging and the benefits of aging:** Successful aging is an area of current investigation that includes the concepts of wisdom, social cognition and optimal decision making—areas beyond general physical and mental health. Basic neuroscience research provides evidence that aging brains remain plastic, and compensation, neurogenesis and synaptogenesis can continue to occur in enriched environments. From a large population-based study, predictors of successful aging include optimism, resilience, self-efficacy, low perceived stress, low level of depressive symptoms, exercise at any level, writing, computer use, and regular socialization. While there are physical and cognitive declines associated with aging, positive psychological attributes such as optimism, resilience, compassion, and wisdom do not decline, but stay stable or even increase with age.

Physicians are a unique group of professionals with a complex combination of assets, including intelligence, drive, conscientiousness, stamina; and liabilities, including stress, limited time, lack of diversified activities, and lack of planning for retirement activities/life. While there is some evidence of neurocognitive deficits in aging physicians with competence problems, data also demonstrates that older physicians’ ability to cope with stress in improved ways increases and that adaptation occurs with the development of new skills.

**Neuropsychological changes in aging physicians:** A body of literature links aging to cognitive changes, but the association between these potential changes and occupational performance in physicians is a more challenging one to demonstrate. In one systematic review called “Relationship between Clinical Experience and Quality of Healthcare” which reviewed 62 published studies, more than half of the studies found declining clinical performance outcomes with increased age; only one study showed improvements in all outcomes with greater age. There is a well-supported theory that many older physicians draw from prior experience and rely more heavily on non-analytic, crystallized cognition. An example of this is the use of pattern recognition in a clinical presentation, which may be accurate most of the time, but can lead to early and incorrect cognitive closure some of the time. Fluid cognitive abilities, which include novel, spatial manipulation and mental speed, tend to peak in the third decade and decline more steeply in the seventh and eighth decades. Data suggests that older physicians tend to do less well when dealing with novel, complex patient situations: The tendency to rely on crystallized memory and pattern recognition led to incorrect diagnosis in 40 percent of complex presentations in one study, for example. In a neuropsychological evaluation study of physicians being disciplined by the Medical Board of California, Perry and Crean found relative deficits on tests of sequential processing, attention, logical analysis, eye-hand coordination, and verbal and non-verbal learning. These findings revealed that in this cohort of physicians, there is lower than expected performance on tests of intellectual and neuropsychological functioning. It was proposed that doctors can accommodate the cognitive changes associated with aging and mitigate against unsafe practice by shifting their work away from
procedural work, allocating more time to each patient, using memory aids, seeking advice from colleagues, and seeking second opinions.12

**Factors (including age) that can impact physician clinical performance:** When considering age as a possible factor affecting clinical performance, it is imperative to consider the other known risk factors, which can negatively impact clinical competence. These include:

- Poor performance in medical school
- Solo practice
- Lack of hospital privileges
- Lack of ABMS Board Certification
- Practicing outside the scope of training
- High clinical volume
- Fatigue/stress/burnout
- Health issues, both physical and mental
- Organizational, systems problems13

In contrast, in a Rand study,14 factors which were associated with better clinical outcomes and performance were identified and included female gender, board certification in area of practice, and having attended a U.S. medical school.

In a study of 460,000 patients undergoing one of eight types of major operations, Waljee et al. found mortality outcomes were increased for older surgeons (>60 years) for three of the eight types of operations: pancreatectomy, coronary artery bypass graft (CABG), and carotid surgery. Additionally, older surgeons with the lowest volume of cases had the highest mortality rates.15 In another study, physicians with greater years in practice length were more likely to provide inpatient care with longer length-of-stay and higher risk of patient mortality.16

Based on the collective data regarding aging and physician performance, the following suggestions were proposed at the conference:

- Aging results in a wide spectrum of physiological changes which may affect clinical competence. Amongst the most important are the reductions in dexterity and visual-spatial acuity, short-term memory, problem-solving, and ability to adopt new ideas and to re-examine old ideas.
- Aging is but one of several risk factors which may impact clinical competence: The degree and rate of decrement caused by aging do not occur in a linear fashion and the impact upon the clinical competence and performance of any one physician is highly variable.
- Programs exist which can and do assess medical knowledge, historical aspects of patient care and simulations of patient care and interpersonal skills and communication, but generally these assessments take place after the occurrence of an untoward outcome. Physicians are not regularly and routinely assessed.
- Assessment could include evaluation of mental and physical health, review of actual performance of clinical care — either diagnostic or procedural, documentation that learning and behavior change as a result of participation in CME has taken place, and review of quality improvement efforts.
- We should not establish mandatory retirement for physicians based on age alone for many reasons, including the inability to definitively conclude that age, in and of itself, is a risk factor for incompetence or dyscompetence. Establishing mandatory retirement based on age alone would further negatively impact the physician shortage in the United States and would lead to the loss of the wisdom and experience of many capable physicians.

**Assessment of the aging physician:**

**The Quebec and Ontario experiences**

Quebec: The age distribution of physicians in Quebec has also changed rapidly in the past few years, with physicians over 65 years of age reaching new high levels and increasing numbers of physicians now practicing in Quebec past 70 to 75 years of age. In a peer-reviewed study in Quebec from 2001–2010, 1,618 physicians were contacted two to three months in advance of an onsite visit in which their practice would be reviewed.17 Based on a thorough review of documentation, prescribing habits, data from the province’s billing administration and clinical practice outcomes, each physician was placed in one of five categories:
WE SHOULD NOT ESTABLISH MANDATORY RETIREMENT FOR PHYSICIANS BASED ON AGE ALONE FOR MANY REASONS, INCLUDING THE INABILITY TO DEFINITIVELY CONCLUDE THAT AGE, IN AND OF ITSELF, IS A RISK FACTOR FOR INCOMPETENCE OR DYSCOMPETENCE.

physicians age 65 to 69 showed only slightly higher rate of cancellation (13 percent, N=338) but had nearly double the rate of Level 3 recommendation than for the physician group less than 65 years old (18 percent vs. 10 percent). Continuing Professional Development (CPD) was reviewed as an independent factor: poor quality or insufficient CPD was strongly associated with poorer outcomes in the peer review study. Additionally, physicians aged 65 to 97 had a higher percentage of inadequate CPD than the younger physician groups (30 percent vs. 10 percent). Physicians with recommendations were provided clinical training programs or tutorials, and the physicians in the over-70 group had less favorable outcomes even with remediation (22 percent success vs. 45 percent for the 65-to-69 year-old group).

Ontario: The College of Physicians and Surgeons of Ontario (CPSO) Peer Assessment Program offers a rich data set of outcomes based on peer review. The program was initiated in 1977 as a way to identify incompetent physicians. From 1977 to 1980, pilot data was collected; then, in the following five-year period from 1981 to 1986, 920 physicians were formally assessed.\textsuperscript{18} The assessment included four components: 1. Practice questionnaire, 2. A peer site visit to learn about the practice and inspect the physical office, 3. A chart review of 20–30 randomly selected charts, and 4. A chart-stimulated discussion with the physician. Of the 920 physicians in the initial five-year period, 11 percent had grossly deficient records or unsatisfactory care or both, with 10 percent having medical record-keeping deficiencies and five percent with actual clinical performance and patient care problems. This breakdown is consistent with subsequent outcomes from the CPSO program.

By age, the Peer Assessment Program in Ontario found that 22 percent of physicians in the group over 75 years old had gross deficiencies in their practice, 16 percent in the 50-to-74 year-old group had deficiencies, and nine percent of physicians under the age of 49 had deficiencies. When the age categories were split differently, 55-and-older physicians had poorer performance than physicians under age 55, and surprisingly, there was close to no difference in physicians’ performance outcomes between the 55-to-69 year-old group and the group over 70 years old.\textsuperscript{18}

Another focus of Ontario findings was on the relationship between record keeping and patient care. The findings show that good records are associated almost entirely with good care, whereas the existence of poor record keeping can go either way regarding quality of care.

The question of age-based competency screening for physicians

During the 2011 CPE/PACE conference, a special survey was conducted to gather data on the topic of age-based competency screening for physicians. The results of that survey are summarized here.

Methods

The authors obtained Institutional Review Board approval to obtain human subjects data on the opinions of the conference attendees. Two workshops were offered to all course participants: “Individual versus societal right: Point-Counterpoint” and “Creating an assessment battery for the aging physician.” The workshops were offered after the didactic portion of the program. Participants answered questions via an audience response system (ARS) (Turning Technologies, LLP, 2008 Turning Point software) during the course of the workshop. Data was collated and analyzed using the same software.

Results

The total number of attendees for the conference was 110. Of the total, 35 percent were physicians, seven percent were PhDs, 25 percent were Juris Doctors (both judges and attorneys) and 33 percent were self-described as “other.” Thirty-eight percent
had a college or university affiliation, 48 percent had a state, national or other government affiliation, six percent were from private law firms and five percent were from other organizations. Forty-nine percent of the participants were from California, 15 percent from another state in the United States and 36 percent from Canada.

A total of 71 individuals responded to the ARS questions. Not all participants answered all questions. Demographic information, including profession, professional affiliation, gender, age, location and specialty for medical practitioners was obtained. Fifty-two percent of responders were physicians or other healthcare professionals, 13 percent were state medical board members, 26 percent were from the legal profession (judge, attorney), six percent were research scientists, one percent were administrator and one percent self-identified as “other.” Of practitioners, 46 percent were primary care and 54 percent were specialists (see Table 1).

Participants were asked, “Do you believe that there is a need for age-based physician screening?” (Answers were multiple choice: yes, no or maybe.) Sixty-two percent of individuals responded “yes,” 18 percent responded “maybe” and 20 percent responded “no” (Figure 1). When the responses were segregated by the age of the participant (Figure 2), the “yes” response was much greater for those respondents age 60 and younger versus respondents over 60 years old. Regarding participant gender (Figure 3), the number of “yes” responses for men and women were nearly identical. For responses segregated by physician vs. non-physician (Figure 4), responses were nearly equal as well. For responses segregated by United States vs. Canadian resident (Figure 5), Canadians were more likely to respond “yes” than Americans (70 percent vs. 58 percent). Finally, related to physician specialty (Figure 6), there was a slightly higher percentage of “yes” responses from primary care physicians vs. specialists (67 percent vs. 62 percent).

### Table 1
**Participant Responses to Question: “Do you believe that there is a need for age-based physician screening?”**

<table>
<thead>
<tr>
<th>Aggregate Responses</th>
<th>Yes</th>
<th>No</th>
<th>Maybe</th>
</tr>
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<tr>
<td>Under 40</td>
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<td>0</td>
<td>1</td>
</tr>
<tr>
<td>41–50</td>
<td>9</td>
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<td>51–55</td>
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<td>1</td>
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<td>12</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>61–65</td>
<td>7</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>66–70</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>71–75</td>
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<td>1</td>
</tr>
<tr>
<td>76–80</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Over 80</td>
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</table>

<table>
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<th>Age</th>
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<tbody>
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<td>5</td>
<td>7</td>
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<td>22</td>
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<tr>
<td>Specialist</td>
<td>13</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>

### Figure 1
**Total Participant Responses to Question: “Do you believe that there is a need for age-based physician screening?”**
Figure 2
Number of Responses by Respondent Age Groupings

Figure 3
Percentage of Responses by Gender

Figure 4
Percentage of Responses by Physician v. Non-physician
Regarding the components of a possible assessment battery for aging physicians, participants felt strongly about including assessments of physical and mental health and a cognitive screen. Forty-five percent of respondents believed that age-based screening should begin at age 70, 27 percent at age 65, 16 percent at age 60, eight percent at age 75 and one percent each at 80 and 85 years old.

**Discussion**

The majority of respondents agreed that there is a need for age-based screening of physicians. Notably, there were no significant differences across gender and profession, and only a modest difference between primary care physicians and specialists—with primary care physicians more strongly endorsing age-based screening. In the United States it is estimated that 35 percent of physicians are engaged in primary care and 65 percent practice in other specialties, which is similar to the physician cohort of participants in the survey.

The greatest difference in opinion was related to physician-participants age 61 or older, who were less in favor of screening for aging physicians than their younger colleagues. While specific reasons were not queried, the temporal relationship of older physicians’ age to the proposed screening age may have affected their responses. Other notable results from the workshop surveys were that Canadians were more in favor of screening the aging physician than their U.S. counterparts. Perhaps the fact that age-based screening already exists in some Canadian provinces (Quebec and Ontario) influenced their responses. Additionally, responses from participants were gathered after data were presented in the morning didactic sessions, which may have influenced responses either negatively or positively. Another limitation to the findings of the survey was the predominance of participants being from California compared with a broader representation from other regions of the U.S. On the other hand, a strength of the cohort was its bi-national representation.
The information presented during the program, while not definitive, provides compelling evidence that aging is one of several independent risk factors for substandard clinical performance. It is incorrect to state that aging has only negative outcomes with regard to physician performance. Clinical ability does improve with experience; however, the neuropsychological assessment and clinical outcomes literature indicates that with aging, certain abilities begin to diminish. High patient-complexity, performing certain major operations and multitasking confer higher patient risk with older physicians.

The authors believe that there should not be a required retirement age for physicians. Undesirable outcomes from a required retirement age are negative impacts to the physician workforce numbers, poorer access to care and unnecessary loss of experienced and productive physicians. The evidence, however, does point to a need for evaluation of mental and physical health at appropriate junctures throughout a physician’s lifecycle. A call for a process beyond self-regulation is warranted. In one study, 96 percent of physicians agreed that impairment should be reported, but only 55 percent who had encountered such colleagues actually reported their concern to anyone.19

Screening for medical conditions (e.g., cancer, diabetes, hyperlipidemia) in the United States is a well-established practice. An analogous model for screening physician competence based on identified risk factors, such as age, should be considered. Like any screening test, the benefits, costs and risks must be established, but with minimal to no data existing for physician screening, professionalism should guide us initially. Preliminary data from Canada may help to craft policy in the United States and as some U.S. hospitals have instituted age-based screening, an evidence-based answer may be achievable in the near future.

In conclusion, the authors recommend that national discourse continue with regard to age-based screening. The authors recommend studying screening commencing at age 70 with an assessment battery consisting of evaluations of physical health (including vision, hearing and dexterity for proceduralists), mental health and a cognitive screen. In addition, other modalities such as peer review, Ongoing Professional Practice Evaluation (OPPE), Focused Professional Practice Evaluation (FPPE)20 and Maintenance of Certification for ABMS-certified physicians (or a similar process for non-ABMS-certified physicians) should be considered.

Physicians must take the lead in addressing this important issue. Medical professionalism calls for self-evaluation. In reviewing the current body of knowledge about the impact of aging on physician practice and reflecting upon the rationale for screening for conditions that are associated with adverse health outcomes, we are led to the conclusion that age-based screening for competency is an important safety measure. We applaud the hospitals and medical systems that have initiated age-based screening. The medical profession should act now, lest others dictate the direction of this important issue. We believe it should embrace a model that encourages physicians to think carefully about the timing of their retirement from practice — doing so in a way that supports a graceful, non-traumatic exit at the right time.

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The Coalition for Physician Enhancement (CPE) is a consortium of professionals with expertise in quality assurance, medical education, and the assessment, licensing, and accreditation of referred physicians seeking higher levels of performance in patient care with members from the United States and Canada.

The University of California, San Diego, Physician Assessment and Clinical Education (PACE) Program is a physician assessment and remediation program that is dedicated to the education of physicians and other health care professionals; the detection, evaluation, and remediation of deficiencies in medical practice; and assisting the medical profession in its quest to deliver the highest quality of health care to the citizens of the United States.
Presenters at the conference included:

Peter Boal  
Associate Director of the University of California, San Diego, PACE Program

Dilip Jeste, MD  
Distinguished Professor of Psychiatry and Neurosciences at University of California, San Diego; Director of the Stein Institute on Aging

William Perry, PhD  
Professor and Associate Director of the Neuropsychiatry and Behavioral Medicine Service at University of California, San Diego

Stephen Miller, MD  
Clinical Professor of Plastic Surgery and Faculty in the PACE Program

André Jacques, MD  
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The authors would also like to acknowledge the participation of the conference attendees and their willingness to share their thoughts and opinions on this important topic.

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The Evidence and Rationale for Maintenance of Licensure

Humayun J. Chaudhry, DO, MS; Frances E. Cain, BA; Mark L. Staz, MA; Lance A. Talmage, MD; Janelle A. Rhyne, MD, MA; and Jon V. Thomas, MD, MBA

ABSTRACT: Fulfilling a statutory responsibility to protect the public within their jurisdictions, state medical boards have been working with the Federation of State Medical Boards (FSMB) and collaborating organizations to thoughtfully explore pathways and procedures by which Maintenance of Licensure (MOL) may be implemented for physicians in the years ahead. As a better understanding emerges of the types of continuing medical education (CME) and continuous professional development (CPD) activities physicians already engage in, and the resources that may be necessary for state boards to meaningfully implement MOL, questions have sometimes arisen about the value of these activities in contributing to quality health care and improved patient outcomes. Though MOL has not yet been formally implemented, there is a growing body of compelling evidence and rationale for the educational activities that could meet a state board’s requirements for MOL. This article summarizes the recent literature on the subject, including CME and CPD, and recent policy statements of organizations and thought leaders from the house of medicine.

“When I graduated from Cornell University Medical College in 1941, I thought I was brimful of knowledge, ready to be a doctor and to bring my skills to patients. Little did I know that my learning had just begun and, even more important, that much that I had been taught would soon become obsolete if in fact it hadn’t been wrong in the first place.”

—C. Everett Koop, MD (2011)

The quality of health care delivered in the United States has an immediate and long-term impact on the quality of life, livelihood, morbidity and mortality of its residents and on the nation’s economy and national security. There are many stakeholders (e.g., patients, physicians, hospitals, health insurance plans) within our costly health care system. At the most fundamental level of health care delivery, however, what matters most is the interaction that takes place between a licensed and qualified health care provider and a patient seeking health care. As the sole entity charged with overseeing the licensure and regulation of physicians, state medical boards have long recognized their responsibility to protect the public and promote quality health care by ensuring that only qualified individuals receive a license to practice medicine and deliver health care. In further fulfillment of their responsibility to protect the public, most state boards adopted continuing medical education (CME) requirements for physicians beginning in 1971 as part of the license renewal process. Several boards are now considering Maintenance of Licensure (MOL), a system of continuous professional development (CPD) that includes practice-relevant CME, to better assure the public that only those physicians who remain up-to-date in their area of practice retain that privilege.

This article reviews the origins of MOL, highlights some of the recent literature about CME and CPD, and summarizes the evidence and rationale underpinning the foundation for the FSMB’s MOL efforts. It includes references to quality improvement activities of organizations across the continuum of medical education in the United States and abroad.

From Lifelong Licensure to Maintenance of Licensure

In the United States, the practice of medicine has long been considered a privilege granted by the public through their elected representatives. State and territorial medical boards are charged through each

THE QUALITY OF HEALTH CARE DELIVERED IN THE UNITED STATES HAS AN IMMEDIATE AND LONG-TERM IMPACT ON THE QUALITY OF LIFE, LIVELIHOOD, MORBIDITY AND MORTALITY OF ITS RESIDENTS AND ON THE NATION’S ECONOMY AND NATIONAL SECURITY.
of their Medical Practice Acts to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent and deceptive practice of medicine. Every Medical Practice Act is built upon this premise and each state board uses rigorous criteria (e.g., graduation from medical school, training in an accredited graduate medical education program in the United States, and passage of a medical licensure examination such as the USMLE or COMLEX-USA) to assess a physician’s competence and fitness to practice prior to granting initial licensure.

When an applicant for initial licensure provides evidence of successfully meeting such requirements, state medical boards — and by extension, the public — can be confident that the physician has the requisite knowledge and skills to practice medicine competently and safely. Licensure renewal, by contrast, has long been an administrative function that assumes licensees are fit to practice medicine unless adverse events, complaints or negative outcomes indicate otherwise. While the licensure renewal processes carried out by state boards are a central component of public protection, they reflect a reactive, rather than a proactive, evaluation of physicians’ continued fitness to practice.

FSMB Board Chair Henry Cramblett declared in 1980, “The Federation holds firm to the premise not only that a person must show evidence of being thoroughly educated, highly qualified, and staunchly ethical in order to receive a medical license, but that these characteristics must be displayed continuously throughout that physician’s active career.” Over the last quarter century or so there have been increasing calls from outside the state medical regulatory community in support of more robust requirements for renewal of medical licensure and more proactive evaluation of physicians’ continued fitness to practice as part of the license renewal process.

The nature of the physician-patient relationship has also changed, in part because of the public’s awareness that there are limitations of medical knowledge and the availability of multiple, if not conflicting, treatment options and pathways.

In 1994, the Pew Charitable Trust recommended that states “require each licensing board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals.” Similarly, a series of Institute of Medicine (IOM) reports beginning in 2000 addressed the importance of quality health care and patient safety, stressing the need for better regulation (including licensure) across the continuum of medical education, training and practice. The IOM’s 2012 report, Best Care at Lower Cost, recommended an expanded commitment to the goals of a “continuously learning health care system” from leaders in health care, advising them to “incorporate basic concepts and specialized applications of continuous learning and improvement into health professions education; continuing education; and licensing...requirements.”

Recent studies of the quality of health care delivered in the United States and how it may be related to clinical experience and skills lend further support for more proactive evaluation of physicians’ continued fitness to practice as part of the license renewal process.

In a random sampling of adults living in 12 metropolitan areas about their health care experiences, a survey that included a review of these individuals’ medical records, McGlynn and colleagues found that participants received only 55% of recommended health care, a finding that the authors said, “poses serious threats to the health of the American people.” In a widely quoted article from 2005 by Niteesh Choudhry and colleagues, a systematic review of the relationship between clinical experience and quality of health care found that physicians who have been in practice longer may be at risk for providing lower-quality care and that this subgroup of physicians may benefit from quality improvement interventions. Similarly, Epstein and colleagues found that psychiatrists in practice for 11 to 20 years had mean accuracy scores in their ability to diagnose major depression 10.5% points lower than those in practice for 0-5 years, and psychiatrists in practice for more than 20 years had scores 12.5% points lower than those in practice 0-5 years.

In 1994, Paul Cauford and colleagues evaluated physicians referred to the Physician Assessment Center at McMaster University in Hamilton, Ontario. Physicians were evaluated in seven skill areas:
knowledge, communication, interviewing skills, history taking, physical exam, problem solving, management and record-keeping. The results of the study found that age, graduation year, solo versus group practice, reported CME hours and specialty certification status had significant simple correlations with competence in these areas. A multivariate analysis found that the only significant predictors of competence were age and specialty certification status.

Thus, while the conventional wisdom holds that physicians get better at the practice of medicine with age and experience, this is not unequivocally borne out by the evidence. The aforementioned studies instead demonstrate that as the rate of expansion of medical knowledge and advancements in technology continue to increase exponentially, it becomes increasingly critical that physicians actively engage in lifelong learning in their area of practice. Throughout medical school and postgraduate training, the next generation of physicians is being encouraged to embrace lifelong learning as an integral part of professionalism. Such efforts are also becoming commonplace for physicians already in practice. In either case, failure to keep pace with advances in knowledge, skills and technology has the real potential to negatively impact healthcare quality and patient safety.

The Case for Continuing Medical Education (CME)

In order to address the need for physicians to stay abreast of changes in the practice of medicine, most state medical boards in the 1970s and 1980s implemented mandatory continuing education requirements for license renewal. Continuing medical education was first established as a national requirement for physicians by the American Academy of General Practice (now the American Academy of Family Physicians), which has required CME for membership since 1947.14 The organization today notes on its website that “the responsibility for providing comprehensive and continuing health care to patients carries with it the responsibility to continue learning” and that “the need to keep abreast of the rapid expansion of medical knowledge necessitates CME.” Physicians commonly spend an average of 50 hours per year in CME activities, which are required for renewal of medical licensure by nearly all of the state medical boards and are often a requirement for hospital admitting privileges and participation in many health insurance plans. Many state boards also require physicians to obtain a specified number of CME credit hours and/or content-specific CME in particular areas (e.g., Infection Control, Responsible Opioid Prescribing, End-of-Life Care). Few licensing jurisdictions, however, require licensees to take CME that is directly related to their scope or area of practice. The FSMB’s MOL framework, as articulated by an MOL Implementation Group in 2011, recommends that as part of a state’s adoption of MOL it require that a majority (i.e., at least half) of the required CME be in a physician’s area of practice.

Early studies, including a systematic Cochrane review, examining the value of CME found that short courses and conferences have little direct impact on professional practice, though they suggested that more effective methods such as systematic practice-based interventions, interaction with opinion leaders and multifaceted activities could change physician performance.15,16 In the late 1990s, this observation was supported by studies that demonstrated evidence that “interactive CME sessions that enhanced participant activity and provided the opportunity to practice skills can effect change in professional practice and, on occasion, health care outcomes.”17

In a more recent review of more than 130 articles related to the effectiveness of CME — selected from 68,000 citations identified in a comprehensive literature search — Marinopoulos and colleagues determined that while the quality of the evidence was “low” and firm conclusions were not possible, “CME appears to be effective at the acquisition and retention of knowledge, attitudes, skills, behaviors and clinical outcomes.”18 A promising 10-year investigation of evidence-based clinical practice in primary care, utilizing educational materials provided to physicians about lipid-lowering recommendations and an intervention group of physicians who received periodic lectures and case-based training, demonstrated substantially decreased mortality in patients with coronary heart disease among the intervention group (22%) compared with patients whose physicians only received educational materials (44%).19

EARLY STUDIES...EXAMINING THE VALUE OF CME FOUND THAT SHORT COURSES AND CONFERENCES HAVE LITTLE DIRECT IMPACT ON PROFESSIONAL PRACTICE.
Integrating CME into a System of Continuous Professional Development (CPD)

Continuing medical education, especially when it is interactive and directly related to a physician’s practice, is an important part of MOL and will likely remain so in the years ahead, as long as there continues to be evidence in support of its potential and its impact on quality health care delivery and patient outcomes. Maintenance of Licensure programs will rely on efforts by educators and regulators alike to apply evidence-based approaches to new types of CME, such as simulation-based CME, that support translating knowledge into practice. A recent example of such an approach is a randomized controlled study of Internet-based CME that concluded that appropriately designed, evidence-based online CME can produce objectively measured changes in behavior as well as sustained gains in knowledge that are comparable or superior to those realized from effective, live interactive CME workshops.20

There have been recent calls for the further reform of CME. For example, the IOM in its December 2009 report, Redesigning Continuing Education in the Health Professions, endorsed a new vision for CME based on CPD that emphasizes identification of learning needs, development of a learning plan and acquisition of lifelong learning and skills.21 This is consistent with the AMA’s definition of CPD, which incorporates “the wider arena of skills and specialized education, including but not limited to cognitive knowledge, that physicians employ in the delivery of patient care.”22

The National Institutes of Health (NIH) and the Agency for Healthcare Research and Quality (AHRQ) have now also placed greater emphasis on translating scientific knowledge into clinical practice.23 The new models of CME share some of these same basic goals, particularly behavioral change and systems redesign to improve patient outcomes.24 For example, Performance Improvement Continuing Medical Education (PI CME) was introduced about a decade ago as an attempt to address quality-improvement concerns, and the model has expanded significantly since then. In 2011, 44,275 physicians and 7,492 non-physician health professionals participated in more than 500 PI CME activities, according to the Accreditation Council for Continuing Medical Education (ACCMCE).25 The processes for PI CME have been defined by the American Medical Association (AMA) and the American Academy of Family Physicians (AAFP), are recognized by the ACCME, and involve three basic steps: an

assessment of the physician’s practice using nationally identified evidence-based performance measures (benchmarks), implementation of an intervention and reevaluation of those performance measures to gauge improvement. The AMA has since expanded its Physician Recognition Award for Category 1 Credit to include PI CME activities, Internet-based learning and point-of-care learning. As it began to introduce PI CME, the AMA also convened the Physician Consortium for Performance Improvement (PCPI) in order to enhance quality and patient safety and foster accountability. This consortium focuses on the development, testing and implementation of evidence-based performance measures for use at the point of care and aims to advance the science of clinical performance measurement and improvement.26

For osteopathic physicians, the equivalent of PI CME is the American Osteopathic Association’s (AOA) Clinical Assessment Program (CAP), first offered as a CME activity in 2005 and which has the same three-step structure as PI CME. While the FSMB’s MOL framework does not mandate that physicians engage in such activities, it encourages state medical boards to include PI CME and CAP, which it mentions by name, as educational options by which a physician may be able to comply with one or more MOL components.

The interface between physician self-assessment and CME, which was part of the FSMB’s MOL discussions, has also been explored recently. Most CME activities rely on the individual physician to determine gaps in his or her knowledge through a subjective self-assessment and to select the appropriate CME activities to remedy any perceived deficiencies. While physicians may find this type of self-assessment to be of value, research has shown that “physicians have a limited ability to accurately self-assess.”27 Eva and Regehr argue that “it is time to move beyond the rhetoric that self-assessment as a general, personal, unguided judgment of ability should be taught and developed as a valid basis on which to direct performance improvements.”28 Particularly relevant to the
The development of MOL is their conclusion that “for maintenance of competence efforts to be in any way meaningful, external feedback is essential.” The FSMB’s MOL recommendation is consistent with these conclusions and suggests a continuous feedback loop for physicians that helps them select educational activities. Not only will physicians participating in MOL be able to engage in a process of self-assessment that is objective and externally verified, they should be able to receive important practice-related feedback and data as part of their engagement in MOL Components 2 and 3 (Assessment of Knowledge and Skills, and Performance in Practice) that better inform their selection of further educational activities.

Growing Emphasis on Continuous Improvement

The movement toward MOL is consistent with the increasing and ongoing efforts in recent years by organizations throughout the health care system—from those representing hospitals to specialty boards—to develop elaborate and meaningful new systems of quality measurement and improvement. While the MOL framework is also a new system, to the extent that it has not existed before, it differs from the others because it primarily seeks to recognize physicians already engaged in these new systems of quality measurement and improvement activities and to “raise the floor” of clinical competency rather than mandate an entirely new series of measurements. A brief overview of some of these new systems is provided below.

The American Board of Medical Specialties (ABMS) and all of its member specialty boards have now adopted its Maintenance of Certification (MOC) program, which requires specialty-certified physicians to provide evidence of meeting the following criteria on a continual basis in order to maintain their specialty certification status: medical licensure and professional standing, lifelong learning and self-assessment, cognitive expertise and practice performance assessment. The ABMS and its specialty boards are actively conducting research to evaluate the impact of specialty board certification and participation in MOC activities on patient care, with growing evidence of its utility in improving patient outcomes. The AOA’s Bureau of Osteopathic Specialists implemented in January 2013 its Osteopathic Continuous Certification (OCC) program, which requires its specialty-certified physicians to provide evidence of meeting the following criteria on a continual basis in order to maintain specialty certification status: medical licensure, lifelong learning and CME, cognitive assessment, practice performance assessment and improvement and continuous AOA membership.

The FSMB’s framework for MOL recommends to state boards that physicians already engaged in robust CPD and lifelong learning activities in their area of practice, such as the ABMS’s Maintenance of Certification (MOC) program or the AOA Bureau of Osteopathic Specialists’ Osteopathic Continuous Certification (OCC) program, be recognized by state boards as being “substantially in compliance” with any MOL program. It is important to note, however, that state boards have not required specialty certification, or participation in specialty recertification activities, for medical licensure. The MOL framework, likewise, does not recommend that state boards mandate all actively licensed physicians to obtain, or maintain, specialty certification in order to maintain their license. Other CPD and educational activities acceptable to state boards for MOL have been and will continue to be identified, especially for the more than 230,000 actively licensed physicians who never were—or are no longer—specialty certified or who have lifetime specialty certification. The National Commission on Certified Physician Assistants (NCCPA) and the American Academy of Physician Assistants (AAPA) are engaged in defining “certification maintenance” activities that all certified physician assistants (PA-C) will be required to complete every six years to maintain their certification.

The Accreditation Council on Graduate Medical Education (ACGME), as part of its mission to ensure and improve the quality of graduate medical education, began implementation in 1999 of its Outcomes Project. While the accreditation of its GME programs historically focused on the potential of the program to effectively educate and train its residents and fellows, the Outcomes Project focused on the actual accomplishments of the program through an assessment of its outcomes.
In 2008, the Outcomes Project was expanded into a program called Milestone Development, in which each specialty is responsible for identifying its physicians’ milestones of competency development during training. By July 2013, the ACGME plans to also begin a phased implementation of the Next Accreditation System (NAS), which aims to enhance the ability of the peer-review system to prepare physicians for practice in the 21st century, to accelerate the ACGME’s movement toward accreditation on the basis of educational outcomes, and to reduce the burden associated with the current structure and process-based approach.39

The Joint Commission, which accredits hospitals, implemented new credentialing and privileging standards in 2007 and 2008 which were intended to make the credentialing and privileging process more objective and evidence-based by facilitating continuous monitoring of physicians’ performance and by providing a basis for intervening when quality-of-care concerns are identified. The American Hospital Association’s (AHA) Physician Leadership Forum last year released a white paper, “Lifelong Learning—Physician Competency Development,” that examines the core competencies needed to deliver coordinated, team-based, value-driven care and includes recommendations for hospitals and physician-associated organizations to develop these skills in the current and next generation of physicians. “Licensing boards,” the report said, “should also consider stronger focus on the core competencies as part of the licensing process.”40

In 2008, the Council of Medical Specialty Societies (CMSS) released a primer, The Measurement of Health Care Performance, which summarizes recent discussions and interest in quality improvement, outcomes measures, practice measurement and the validity and integrity of physician performance. The National Committee for Quality Assurance (NCQA) has also dedicated itself to measuring, evaluating and improving the quality of health care in the United States through tools such as the Healthcare Effectiveness Data and Information Set (HEDIS) and health plan “report cards.”41

The recent growth of Patient-Centered Medical Homes (PCMH) and Accountable Care Organizations (ACOs) all have at their core a commitment to continuous improvement and evidence-based outcomes, with the ultimate goal of better serving the needs of patients. In addition, the IOM’s To Err Is Human report specifically challenged state medical boards to do their part in making health care safer for patients by periodically assessing providers “based on both competence and knowledge of safety practices.”41 An additional impetus for state medical and osteopathic boards to embrace change and improvement in medical regulation is the concern that if they don’t, others may do so on their behalf or in their place. Medical regulation outside the bounds of state licensing authority could in turn, as one observer notes, lead to damaging effects to patients and society.42

Internationally, the College of Physicians and Surgeons of Ontario (CPSO) evaluates the continuing competence of its licensees through its Peer Assessment Program, which it initiated in 1981. As part of the program, physicians undergo an office-based evaluation of their facilities, medical records and quality of care once every 10 years. The General Medical Council (GMC) of the United Kingdom launched Revalidation, its version of MOL, for all of its physicians in December 2012, becoming the first nation in the world to formally implement such a program. Though Revalidation’s goals are similar to MOL, it includes a very different set of requirements for physicians. Because MOL has not yet been implemented in the United States, and Revalidation has only recently been initiated in the U.K., formal outcomes data are not yet available for either program. However, the FSMB, GMC and medical regulators in other nations contemplating variations of MOL have pledged to share lessons learned alongside the opportunities and challenges that are identified as best practices in licensure renewal.

Finally, efforts by public and consumer-oriented organizations and websites such as Consumers Union, Healthgrades.com and Angieslist.com to disseminate consumer-focused information about physicians also highlight a growing interest on the part of the public for information about their physicians, including the status of their credentials and the quality of care they provide. In 2007 the American Association of Retired Persons (AARP), in collaboration with Citizen Advocacy Center (CAC), conducted a survey of the residents of Virginia
who were 50 years of age or older to assess their understanding and knowledge of Virginia’s existing state medical licensure requirements. More than 95 percent of respondents said they believe that health care professionals should be required to show they have up-to-date knowledge and skills needed to provide quality care as a condition of retaining their medical license.43

MOL As a form of Continuous Professional Development (CPD)
The adoption by the House of Delegates of the FSMB of a framework for MOL in 2010 was an important milestone that recognized emerging research in the area of physician education and professional development, as well as the cultural shift that was already occurring across the house of medicine. The adoption of a framework for MOL set into motion a desire on the part of state medical boards, articulated in a policy statement in 2004, to better support their “obligation to the public” to ensure the continuing competence of physicians as a condition of license renewal.44

The FSMB’s MOL framework recommends that state boards require physicians seeking license renewal to provide evidence of participation in a program of continuous professional development that reflects the three major components of what is known about effective lifelong learning: 1. Reflective self-assessment, 2. Assessment of knowledge and skills, and 3. Performance in practice. By design, the MOL framework does not specify the details of a continuous professional development program, instead suggesting a system that state boards may wish to consider that enables physicians in their jurisdiction to demonstrate through a selection of reasonable educational options in their area of practice that they are meaningfully engaged in these activities. The MOL framework also does not mandate a secure, high-stakes examination for compliance with any of its components, although a physician may elect such an option if desired.

While MOL is still years away from implementation by any state medical board, several state boards have been working with the FSMB and collaborating organizations to look at the operational and logistical aspects of a program that is designed to support a physician’s commitment to lifelong learning and assure multiple stakeholders of the enduring value of the hard-earned license to practice medicine. As MOL advances, state boards, the FSMB and collaborating organizations will need to be mindful of what adult learning theorist Marsha Speck has described as a basic principle to be considered when professional development activities are designed: “Adults will commit to learning when the goals and objectives are considered realistic and important to them. Application in the ‘real world’ is important and relevant to the adult learner’s personal and professional needs.”45

This article was endorsed by the Board of Directors of the Federation of State Medical Boards on February 7, 2013.

Endnotes


Supreme Court Unanimous Ruling in Federal Trade Commission Case Has Implications for Regulators

On February 19, 2013, the U.S. Supreme Court issued a unanimous ruling in favor of the Federal Trade Commission (FTC) in the case, FTC v. Phoebe Putney Health System. The case was on appeal from the U.S. 11th Circuit Court of Appeals, and was the result of the FTC’s complaint against Phoebe Putney Health System’s acquisition of Palmyra Park Hospital in Albany, Georgia.

The FTC argued that the merger of the only two hospitals in Albany would reduce competition, virtually creating a monopoly in the market for acute-care hospital services. The Court held that because Georgia has not clearly articulated and affirmatively expressed a policy allowing hospital authorities to make acquisitions that substantially reduce competition, state-action immunity does not apply.

Federal antitrust laws prohibit private restraints on trade and are not meant “to restrain a state or its officers or agents from the activities directed by its legislatures.” This premise gave rise to the existing articulation of the state action doctrine in the 1943 case, Parker v. Brown. The state action doctrine is interpreted to confer immunity to state actors who engage in anti-competitive conduct under certain conditions.

In general, in order for the state action doctrine to result in immunity to a state entity, the entity must be acting pursuant to a clearly articulated and affirmatively expressed state policy to displace competition. Thus, in FTC v. Phoebe Putney Health System, the Court examined whether the Georgia Legislature, in vesting the state’s hospital authority with general corporate powers to acquire and lease hospitals and other properties, clearly articulated and affirmatively expressed a state policy to displace competition in the hospital services market. In its decision, the Court found that the state had not clearly expressed such a policy.

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Justice Sonia Sotomayor said in her Court opinion that an exception in antitrust law for actions taken by a state or its agencies, which in this case was the hospital authority, did not shield the transaction from having a federal antitrust concern.

“We hold that Georgia has not clearly articulated and affirmatively expressed a policy to allow hospital authorities to make acquisitions that substantially lessen competition,” Justice Sonia Sotomayor wrote for the Court.

The Court’s treatment of the state action doctrine has far-reaching implications for state medical boards and is likely to play a central role in the pending case, North Carolina State Board of Dental Examiners v. Federal Trade Commission.
STATE MEMBER BOARD BRIEFS

Florida

Florida Board of Medicine Launches Interactive Website

The Florida Board of Medicine (BOM) has announced the launch of a new interactive website to improve communication with its constituents. The site will help inform applicants, licensees, and the public about the board’s role and activities in regulating the practice of medicine.

The idea for the website evolved from the BOM’s Communication, Education, and Information Committee, which was formed to identify proactive communications tools to highlight the work of the board. The Florida Department of Health’s Division of Medical Quality Assurance subsequently established a workgroup for designing the website, and board member Brigitte Goersch, chair of the Communication, Education, and Information Committee, spearheaded the project.

“We understand the importance of sharing information with the citizens we serve, and we are committed to providing this as a resource,” Goersch said. “The new website offers clear and direct access to information about who we are and what we do as the Florida Board of Medicine.”

Content for the site was created through direct input from the BOM, along with members of the workgroup. Users will be able to access initial licensing forms, licensure renewal information, an online licensure verification tool to assist Floridians in taking an active role in their health by verifying the license of health care providers and public records of disciplinary history of Florida physicians.

The website also provides information on special licensing tools available to military families living in Florida.

For more information, visit www.flboardofmedicine.gov.

Source: Florida Department of Health news release, Dec. 21, 2012

Iowa

Court Upholds License Suspension for Iowa Physician Who Violated Board Order

A district court judge in Iowa has upheld the Iowa Board of Medicine’s order to suspend the medical license of a physician who was found to have repeatedly violated the terms of a board order.

Robert F. Tobin, MD, a 71-year-old Iowa-licensed physician who formerly practiced ophthalmology in Council Bluffs and Des Moines, asked the court to reverse the board’s decision, dated March 29, 2012, in which he was sanctioned for violating a board order issued in 2010. The board determined he did not complete many terms of the order.

Dr. Tobin contended that he was in substantial compliance with the order, that the board’s sanctions were unreasonable, and his due rights were violated by the deliberative process utilized by the board.

Judge Michael Huppert, in a ruling filed February 8, affirmed the board’s decision and order in its entirety to suspend Dr. Tobin’s medical license for at least six months, to assess a $10,000 civil penalty, and to publicly reprimand him. Dr. Tobin was also ordered to comply with an educational intervention plan, obtain a board-approved worksite monitor, implement a practice monitor and practice monitoring plan, and comply fully with terms of the 2010 order prior to seeking reinstatement of his license.

Source: Iowa Board of Medicine News Release, Feb. 15, 2013
Ohio

State Medical Board of Ohio Report Details Impact of New Prescription Drug Abuse Efforts

A new, comprehensive effort to address prescription drug abuse in Ohio by bolstering the tools available to medical regulators is under way and having an impact in the state, according to the FY12 Annual Report of the State Medical Board of Ohio.

In 2011 and 2012, the board worked closely with Ohio Governor John Kasich on what it called “aggressive efforts to reduce prescription drug abuse.” The passage of HB93 by the state legislature in 2011 gave the board new tools, particularly its ability to address drug diversion by “pill mills” — pain management clinics that improperly prescribe opioids. The legislation made a major change to medical practice in the state by defining “pain management clinics” and requiring that they be owned by licensed physicians.

The opioid prescribing initiative in Ohio included strengthening the state’s prescription monitoring program, requiring pain management clinic inspections, and giving the board new investigative and disciplinary tools. Medical board investigators were authorized to inspect and copy any books, accounts, papers, records or documents in the course of an investigation, for example. The board was also authorized to take disciplinary action based upon administrative actions taken by other licensing boards.

The initiative also created a stronger interdisciplin- ary effort that better coordinated the activities of law enforcement, state agencies and licensing boards as they investigated opioid prescribing abuse. Board investigators, for example, were involved in all active drug task forces in the state. Board members worked closely with dental, pharmacy and nursing boards to prioritize cases and reduce overlapping efforts.

Classifying inappropriate prescribing cases as a high enforcement-priority, the board worked more aggressively to identify and pursue prescription abuses. Of the 190 disciplinary sanctions it issued in fiscal year 2012, 40 sanctions were based on inappropriate prescribing issues. Nineteen of the prescribing-based actions resulted in the revocation or permanent revocation of a physician’s medical license.

Finally, the board’s efforts included expanded educational outreach activities to make licensees more aware of its prescription abuse activities and to ensure they are more aware of proper prescribing practices. During fiscal year 2012 it worked with organizations such as the Ohio State Medical Association and the Ohio Hospital Association to provide educational programs for prescribers.

The report is available at www.med.ohio.gov.

Source: State Medical Board of Ohio FY12 Annual Report
Vermont

**Vermont Supreme Court Says Physician Not Liable for Improper Conduct of His Physician Assistant**

The Vermont Supreme Court has upheld a 2012 decision by the Vermont Board of Medical Practice, which found that if a physician has supervised a physician assistant (PA) properly, the physician shouldn’t be disciplined for the PA’s improper conduct.

The original Vermont case involved a PA who improperly prescribed opiates. The State of Vermont had argued that the physician in the case, Jon Porter, MD, should have been held accountable for the PA’s actions.

The case had caused discussion in the state of whether a ruling against the physician would make it difficult to find physicians willing to supervise PAs.

After discovering that a PA under his supervision was improperly prescribing opiates, Dr. Porter filed a complaint against him with the Vermont Board of Medical Practice. The board disciplined the PA. Later, the State of Vermont filed charges against Dr. Porter, alleging that he had “vicariously engaged” in unprofessional conduct in the case. The board held a hearing in January 2012 and dismissed the charges against Dr. Porter, saying he could not have been expected to be aware of the improper activities of the PA.

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West Virginia

**West Virginia Conference for Health Care Professionals Aimed at Prescribing Abuse**

The West Virginia Board of Medicine partnered recently with the West Virginia Board of Osteopathic Medicine and the state’s medical and osteopathic associations to host a conference aimed at raising awareness among West Virginia health care professionals of opioid prescribing issues.

The Controlled Substances Conference, held in Charleston on November 30, 2012, drew more than 300 physicians and related health care professionals.

Presentations and discussions focused upon the treatment of chronic pain, the issues resulting from the prescribing of opioids for such pain and recently enacted legislation and proposed legislative rules in West Virginia to combat opioid addiction and prescription drug abuse.

West Virginia Governor Earl Ray Tomblin addressed attendees during the conference, encouraging continued action aimed at the state’s opioid-abuse issue. Keynote speaker was Scott Fishman, MD, author of the book “Responsible Opioid Prescribing: A Clinician’s Guide.”

The conference satisfied proposed Continuing Medical Education requirements of both boards, which are mandated by the state’s recently enacted prescription drug-abuse legislation. A second conference is now being considered for 2013.

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Source: West Virginia Board of Medicine Quarterly Newsletter, Volume 16, Issue 4

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Source: American Medical News, Dec. 27, 2012
INFORMATION FOR AUTHORS

The Journal accepts original manuscripts for consideration of publication in the Journal of Medical Regulation. The Journal is a peer-reviewed journal, and all manuscripts are reviewed by Editorial Committee members prior to publication. (The review process can take up to eight weeks.) Manuscripts should focus on issues of medical licensure and discipline or related topics of education, examination, postgraduate training, ethics, peer review, quality assurance and public safety.

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3. The manuscript pages should be numbered, and length should be between 2,750 and 5,000 words, with references and tables attached. Please ensure that references adhere to the AMA Manual of Style. For more information, visit www.amamanualofstyle.com.

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