Characteristics of Physicians Referred for a Competence Assessment

A Comparison of State Medical Board and Hospital Referred Physicians

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WHAT ARE THE KEY CHARACTERISTICS OF PHYSICIANS REFERRED FOR COMPETENCE ASSESSMENT BY STATE MEDICAL BOARDS AND HOSPITALS?

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COMPETENCE ASSESSMENT is a fundamental part of medical education, starting from the earliest moments of medical school and extending in different forms throughout the licensure and specialty credentialing process for physicians. Thankfully, most physicians are never deemed to be lacking in competence—but when they are, we as regulators must ask ourselves: What happened? The creation of special programs in recent decades that help practicing physicians understand and address their competency issues through remedial education has given us an important tool for state medical boards as we seek to protect patients from substandard care. In this issue of *JMR*, one such program—the Center for Personalized Education for Physicians (CPEP)—examines the characteristics of physicians referred for competency evaluation by medical boards and hospitals to learn if there are differences in the kinds of physicians who are referred in these two settings (page 8). By better understanding who is being referred, we can better understand the risk factors for referral and thus build strategies for earlier intervention as we seek to protect patients from harm. Beyond the obvious improvements that this knowledge could bring to our current system of competency referrals, we could also learn much that might be relevant as initiatives such as FSMB’s competency-oriented Maintenance of Licensure (MOL) concept begin to take hold nationally. The journey towards safer medicine and higher quality outcomes is one that all sectors of our health care system must embark upon, and support, together. The CPEP study is an excellent contribution to that effort…

On another topic, you will notice that there is a new name at the bottom of this month’s Notes from the Editor page—mine. I’m both humbled and honored by this new assignment: humbled to be following in the footsteps of our excellent former editor, Bill Wargo; and honored that FSMB and the *JMR* Editorial Committee have extended their vote of confidence. I look forward to serving as your editor and hope you will feel free to send me your thoughts and ideas for future issues of *JMR*. You can reach me at editor@fsmb.org.

*Susan R. Johnson, M.D.*

*Editor in Chief*
Journal of Medical Regulation Seeks Historical Articles for FSMB Centennial

To help commemorate the FSMB’s Centennial year in 2012, JMR is seeking manuscripts that highlight and celebrate the history and accomplishments of the FSMB and the important work of state medical boards during the last century.

Published continuously since 1915, JMR is a quarterly peer-reviewed journal featuring a wide topical range of original articles of interest to state medical boards and organizations and individuals interested in medical licensing and regulation. Interested writers should send manuscript ideas and queries to editor@fsmb.org.

FSMB Plans Telemedicine Symposium in Washington, D.C.

In an effort to raise awareness of telemedicine and its growing impact on the medical profession, FSMB will host a multi-stakeholder invitational symposium in Washington, D.C. in March 2011, titled “Balancing Access, Quality and Safety in a New Era of Telemedicine.”

The event is scheduled for March 10 at the Westin Washington, D.C. City Center Hotel.

FSMB will convene a diverse mix of participants—ranging from state medical and osteopathic board members and government policymakers to physicians, payers and consumers—for a full day of panel presentations and small-group discussions to examine the opportunities and challenges in telemedicine.

The conference will identify gaps in knowledge, policy and structural resources that must be addressed in order to facilitate telemedicine’s adoption and expansion—while ensuring patient safety and medical quality as key priorities.

Lisa Robin, FSMB’s senior vice president of Advocacy and Member Services, said the key focus of the symposium will be to bring leaders together from many areas within the health care system to encourage a more effective, cross-sector approach to telemedicine.

FSMB has played an active role in helping establish policies for telemedicine, dating back to the 1990s. It recently surveyed its member boards on the topic and found wide interest in telemedicine and a belief among the boards that telemedicine will continue to rank as an important policy item on their agendas.

Robin said findings and conclusions from the symposium will be shared widely with the health care community. To learn more, visit FSMB’s website at www.fsmb.org.

FSMB Annual Meeting Moves to Seattle in 2011

FSMB’s Annual Meeting will be held April 28–30, 2011, in Seattle, Washington, at the Sheraton Seattle Hotel.

The meeting will include a broad variety of workshops and seminars for medical regulators, plus a variety of special-topic sessions devoted to this year’s theme, “The New Face of Medicine: A Workforce in Transition.” Special content is being developed for attendees that will focus on a variety of workforce-related issues of relevance to state medical and osteopathic boards, ranging from medical training to scope of practice.

Attendees can make hotel reservations online at discounted conference rates by visiting www.fsmb.org. Please reference the FSMB Annual Meeting when booking reservations to secure the conference rate. The number of discounted rooms available is limited and reservation cutoff date is April 4, 2011.

Correction

A table in the article titled “Pediatricians Over 50 Reentering Clinical Practice: Implications for Physicians and the Regulatory Community,” which ran in the last issue of JMR (Vol. 96, Number 2), contained inaccuracies. In the column titled “Degrees of Freedom,” the first four rows should all contain the number “1.” In the column titled “OR,” the number for female pediatricians should be 4.672, not 4.670. The authors of the article have noted that none of the table errors change the substance or conclusions of the article itself.
Message from the CEO

2010: A Year of Change and Progress for FSMB

Humayun J. Chaudhry, D.O., M.S., FACP, FACOI
President and CEO
Federation of State Medical Boards

IN BRIEF Dr. Chaudhry highlights FSMB’s advocacy and initiatives over the last year, noting the increasing need for leadership among health care organizations.

The year 2010 brought with it a number of significant accomplishments and highlights for FSMB that will help propel our organization forward as we begin a new year of advocacy and service. We are more committed than ever to our goals of supporting our state/territorial medical and osteopathic boards in their efforts to protect the public and enhance the quality of medical care.

In 2011 we find ourselves on the cusp of great change in health care in the United States. Despite an intense national debate about the future of our health care system in 2010 and passage of health reform legislation, many huge issues still remain to be sorted out. The one thing that we can all probably agree on is that the time for inaction is over: The problems in our health system are simply too serious to ignore.

In this environment, every health care organization must carefully consider what contribution it can make to our national debate and then take an active role in the advocacy arena. The regulatory community must have a voice as we shape the future of our medical system.

Recognizing the unique health care challenges we face as a nation, FSMB has over the last year embarked on a number of exciting new initiatives that we believe will strengthen our ability to serve in this capacity—as the national voice for state medical and osteopathic boards. Our efforts range from the adoption of a new strategic plan to a variety of programmatic, service and personnel changes—all designed to serve our stakeholders better.

A Renewed Focus on Advocacy
At the top of our priority list in 2010 were enhanced advocacy efforts—starting with the launch of our new Washington, D.C. office in January. The office now serves as the hub of our work with national legislators and policymakers on behalf of the state medical and osteopathic board community.

By maintaining an ongoing presence in Washington, FSMB can be a more effective champion and advocate for the needs of state medical and osteopathic boards, while helping raise awareness and public understanding at a national level of the important work boards do.

Over the last year, staff in our new office have created a grassroots advocacy network, coordinated office visits with legislators and key policy makers, launched an online advocacy newsletter, and provided input and advice on pressing policy matters.

Among the Washington, D.C. policy forums we participated in this year was a special session on Electronic Health Records, titled “Advancing Electronic Health Records Adoption and Meaningful Use,” which was hosted by the Health Industry Forum of Brandeis University and Health Affairs. During this session we announced our recognition of the value of the effective adoption of health information technology to improve patient outcomes and promote higher quality care.

In just a few short weeks — on March 10 — our Washington, D.C. office will host its own major event—a national symposium on the future of telemedicine, titled “Balancing Access, Quality and Safety in a New Era of Telemedicine.” A news item about the symposium is included on page 4 of this issue of JMR.

Our advocacy extends globally as well, via our role as Secretariat of the International Association of Medical Regulatory Authorities (IAMRA). In September, we served as co-host for the biennial meeting of IAMRA members in Philadelphia, Pa. FSMB is playing an active role in helping IAMRA shape the first-ever set of global best practices for the use of medical regulators throughout the world. A story about this project is featured on page 24 of this issue of JMR.
New Milestones for Maintenance of Licensure (MOL)

2010 proved a seminal year for our Maintenance of Licensure (MOL) initiative, which reached a milestone in April when the FSMB House of Delegates approved a framework for MOL that has now been passed on to the states and territories for their consideration. There is a growing consensus that physicians should periodically attest to engaging in some activities that promote lifelong learning and maintenance of medical skills. It is now up to us, as regulators, to help move MOL to fruition for those states ready and willing to do so.

MOL will move one step closer to wider adoption in early 2011, when our Implementation Work Group distributes its first phase of recommendations intended to help the nation’s state medical and osteopathic boards make MOL operational and as interested states begin to pilot the MOL framework.

Paving the Way for Reentry to Practice

In June 2010, Board Chair Freda Bush, M.D., appointed a Special Committee on Reentry to Practice, with a mandate to develop specific recommendations for use by state boards in their licensure processes. Ensuring physicians are qualified to reenter practice after a period of clinical inactivity is a complex undertaking, with implications for educational testing, monitoring and regulatory process. We believe this will be an important issue for medicine going forward as demographic shifts and economic trends create more “churn” in the physician workforce than we have experienced in the past. In early 2011, the American Medical Association released new guidelines on physician reentry, which were based in part on a collaborative effort between the AMA, FSMB and the American Academy of Pediatrics.

A New Era for FCVS

There is much exciting news to report from FSMB’s licensure, credentialing and assessment division, where our products and services have recently been significantly improved. Our credentialing services, in particular, have been the focus of important upgrades. Early in 2011 our new and improved Federation Credentials Verification Service (FCVS) will be available to physicians and health care organizations everywhere, with new features that make the credential verification process faster and more effective than ever before. More than 126,000 physicians and physician assistants have used FCVS since its inception in 1996, and we expect that number to continue to grow with our new advanced services. Other features, such as GME Connect and MedEd Connect, have increased in popularity among graduate and undergraduate medical education programs, respectively—in some cases improving verification response times for these groups by as much as 30 percent.

In October, the Wyoming Board of Medicine became the 14th state to require all applicants for medical licensure to use FCVS.

Uniform Application (UA) and License Portability Progress

We continued to make progress on our long term advocacy goal of enhanced license portability in 2010, with our Uniform Application for Physician State Licensure (UA) project. So far, nearly 20 states are either using the UA or in the process of implementing the application into their licensure processes. Most of these states have initiated implementation of the UA since late 2008.

In August, we hosted a meeting of 21 state medical and osteopathic boards to help move the UA project forward toward greater national adoption. Our major partner in this effort, the U.S. Department of Health and Human Services, has extended our funding to help us achieve our goals.

Enhancements to USMLE and SPEX

We continue to work closely with the National Board of Medical Examiners (NBME) in enhancing the United States Medical Licensing Examination (USMLE) and our Special Purpose Examination (SPEX) — aimed at physicians for whom there is a question regarding clinical competence. A newly enhanced SPEX debuted in April, with a stronger focus on patient care. The SPEX blueprint and content was completely overhauled to make it more relevant to current medical practice.

Educational Innovation

On the educational front, FSMB offered innovations in 2010, including our first-ever “virtual” educational session from the Annual Meeting in Chicago. Participants nationwide were able to log in to an online session that featured a live forum on health reform. We plan to continue exploring online technology as a means of widening our engagement with stakeholder audiences.

We released our Emergency Preparedness Workgroup template in April — a tool that helps state medical and osteopathic boards develop their own customized emergency and disaster preparedness plans.
Our educational division hosted another installment of its influential Board Attorneys Workshop series, and is planning new content for 2011. Our Certified Investigator Training seminar, co-hosted with Administrators in Medicine (AIM), provided new tools to help state boards implement more effective investigations.

A Revitalized Brand
Raising our visibility as an advocacy organization remains a key goal, and in 2010 we revitalized our brand with a new visual identity and new communications tools. Our new electronic newsletter, FSMB eNews, launched in February and has been well-received by subscribers. In November, we rolled out our new web design, intended to make the site more visually appealing and improve navigation. As a part of our overall re-branding, we also redesigned and renamed the scholarly publication you are reading—the Journal of Medical Regulation.

New Directions for the FSMB Foundation
This has been an important time of re-branding for the FSMB Foundation, as well, which was re-launched in April 2009 with a new mission, strategic plan and governance structure. The newly configured Foundation continued to provide much needed physician education services in 2010 via the book it helped us develop, “Responsible Opioid Prescribing: A Physician’s Guide,” and its Online Prescriber Education Network (OPEN). More than 160,000 copies of the book have been distributed via state medical and osteopathic boards to health care practitioners in 21 states, and OPEN—which educates physicians about drug industry marketing techniques and their impact on prescribing practices—now features more than 30 CME modules.

The Foundation recently launched a new project aimed at helping raise awareness of the important role public members play on state medical and osteopathic boards. The Public Members Initiative will eventually include a guidebook for public members, video and other resources.

A New Leadership Team
2010 marked my first full year serving in the position of FSMB’s chief executive officer. Working closely with the FSMB Board, we created a new management structure for FSMB that now includes a chief operating officer, Sandra Waters, MEM; a chief financial officer, Todd Phillips, MBA; and a chief information officer, Michael Dugan, MBA; the designation of Lisa Robin, MLA, in our Washington, D.C. office, as our Senior Vice President for Advocacy and Member Services; and the appointment of Starr Stelivan, MBA, as our new Director of Human Resources. I’m delighted to be working with this team of highly respected and capable individuals, alongside the hard-working vice presidents, managers, directors, supervisors and other individuals we employ in Euless, Texas and Washington, D.C. It has also been my honor and privilege to work with FSMB’s Board, House of Delegates, state executives and staff from throughout the Federation. I look forward to meeting more of you in 2011.

Leadership Meetings and Collaboration
The year 2010 saw important visits by health care leaders who were invited to formally meet with FSMB’s Board of Directors. These included visits by Darrell Kirch, M.D., President and CEO of the Association of American Medical Colleges, and by Emmanuel Cassimatis, M.D., President and CEO of the Educational Commission for Foreign Medical Graduates (ECFMG). Last year we also had the first ever joint meeting between the Executive Committee of FSMB’s Board and the Executive Committee of the National Board of Osteopathic Medical Examiners, at their offices in Pennsylvania. In February, Karen Nichols, D.O., the first woman to be elected President of the American Osteopathic Association, visited with FSMB’s Board, becoming the first leader of the AOA to address our Board. In December of 2011, the full Boards of the FSMB, NBME and ECFMG will have a meeting in Philadelphia, a collaborative meeting the three organizations hold periodically to discuss issues of mutual interest and concern. Throughout the year, in fact, Dr. Bush and I held direct and indirect meetings with leaders from across the continuum of medical education and with leaders representing practicing physicians, both here and abroad.

These are just a few highlights of an exciting year for FSMB. In March you will be able to view a much more comprehensive report at FSMB’s website, www.fsmb.org.
Characteristics of Physicians Referred for a Competence Assessment: A Comparison of State Medical Board and Hospital Referred Physicians

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Elizabeth J. Korinek, M.P.H.
Executive Director, CPEP

Zung V. Tran, Ph.D.
Research Professor of Biostatistics and Informatics, University of Colorado, Anschutz Medical Campus

ABSTRACT: This study compares key characteristics and performance of physicians referred to a clinical competence assessment and education program by state medical boards (boards) and hospitals. Physicians referred by boards (400) and by hospitals (102) completed a CPEP clinical competence assessment between July 2002 and June 2010. Key characteristics, self-reported specialty, and average performance rating for each group are reported and compared. Results show that, compared with hospital-referred physicians, board-referred physicians were more likely to be male (75.5% versus 88.3%), older (average age 54.1 versus 50.3 years), and less likely to be currently specialty board certified (80.4% versus 61.8%). On a scale of 1 (best) to 4 (worst), average performance was 2.62 for board referrals and 2.36 for hospital referrals. There were no significant differences between board and hospital referrals in the percentage of physicians who graduated from U.S. and Canadian medical schools. The most common specialties referred differed for boards and hospitals. Conclusion: Characteristics of physicians referred to a clinical competence program by boards and hospitals differ in important respects. The authors consider the potential reasons for these differences and whether boards and hospitals are dealing with different subsets of physicians with different types of performance problems. Further study is warranted.

Keywords: clinical competence, competence assessment, state medical licensing board, physician performance

Introduction
Competence assessment and remedial education programs are important tools for state medical boards (boards) and hospitals. CPEP, the Center for Personalized Education for Physicians, offers such programs. CPEP was founded as an independent not-for-profit organization in 1990 through the collaboration of several Colorado healthcare organizations, including the Colorado Foundation for Medical Care, COPIC Insurance Company, Colorado Hospital Association, Colorado Medical Society, University of Colorado School of Medicine, Colorado Society of Osteopathic Medicine and others. CPEP’s founders were responding to a recognized need to remediate underperforming physicians and were inspired by the 1989 Planning Conference on Focused/Prescribed/Remedial Medical Education for Enhanced Clinical Competence.

Though it was originally envisioned as a resource for Colorado, CPEP quickly became a national center, receiving its first out-of-state referral in 1991. Boards have referred physicians to the program since its inception, with the first Colorado Board of Medical Examiners (now the Colorado Medical Board) referral in March 1991, and other boards referring soon thereafter. In 2009, CPEP completed its 1,000th competence assessment, and in 2010 celebrated its 20th anniversary.

Only limited information has been published about physicians who have presented for competence assessment. A recent survey provides information about both U.S. and international assessment programs. Several programs in Canadian provinces have described their programs and experiences. In the United Kingdom, the National Clinical Assessment Service (NCAS) published a comprehensive overview of its first four years of operation. However, significant differences in the structure and operation of medical practice, medical regulation and physician assessment in Canada and the United Kingdom make it problematic
to attempt to generalize and compare the experience and processes of those countries to the U.S.

Previous papers about CPEP have described the program and its development1 or have discussed limited characteristics of participants.11 Cerda et al described the University of Florida Comprehensive Assessment and Remedial Education Services (CARES) program and provided the specialties of 30 physicians who completed that program in its first two years.12 The most comprehensive information published about any U.S. program has been from the University of California, San Diego, Physician Assessment and Clinical Education (PACE) program.13 By 2009, that program had evaluated close to 900 physicians; in the article the authors discussed their process for physician assessment and described a cohort of 298 physicians assessed between 2002 and 2005. The experience of the CPEP program adds substantively to the information currently available about physicians referred to a competence assessment center.

A total of 588 physicians participated in a CPEP competence assessment between 2002 and 2010. Of this total, 502 were referred to CPEP by boards (n=400) and by hospitals (n=102). An additional 86 physicians were referred by other types of organizations or indicated that they were self-referred. In this paper, the focus is on the comparison of key characteristics of and assessment performance between board- and hospital-referred physicians. Based on CPEP’s experience and knowledge of the circumstances surrounding the referral of these physicians, the authors hypothesized that physicians who are referred by boards might differ in important ways from those referred by hospitals.

Methods

Participant selection

The participants in this study included all physicians (M.D. or D.O.) who were referred for assessment by a board or hospital and who completed a CPEP assessment between July 2002 and June 2010.

Some of the 502 physicians included in this study were referred for and completed more than one assessment during this time; 13 physicians presented twice for competence assessments, and one presented three times during this eight-year period. Repeat enrollees were sometimes referred by different parties and generally were referred for different incidents or concerns; typically the enrollments were separated by a period of several years. Since some of the characteristics evaluated in this study would generally not change (gender, country of training, specialty), the authors decided that each participant should only be represented once in the calculations. Therefore, the data from the most recent assessment were included for those physicians who enrolled in the assessment process more than once. Data on reentry physicians (physicians returning to practice after a voluntary break from practice) were not included because the authors believe that the characteristics of reentry physicians may differ significantly from physicians referred for competence assessment.

Assessment process

Typically, physicians have enrolled in the CPEP assessment program for a clinical competence evaluation after the physician’s skills or abilities have been questioned by a board or hospital. The evaluation is often part of a disciplinary agreement or part of an investigation. The assessment consists of an evaluation of competence in the physician’s current, previous or prospective practice.

At the time of enrollment, the 502 participants included in this study completed a self-report form to provide demographic information such as gender and age, location (country) of medical school, specialty, years of post-graduate training and other information about their professional status; if information in this form was unclear or missing, CPEP staff clarified the information through discussion with the participant.

The participants completed an assessment that included 90-minute interviews with specialty-matched board-certified physician consultants who also reviewed charts from the physician’s current or previous practice, if available. Depending on the scope of the assessment and areas of practice/specialty(ies) to be covered, two to four interviews were conducted. Participants also completed simulated patient encounters—two encounters for psychiatry or three for all other specialties that involve patient contact. The assessment also included a documentation exercise, a cognitive function screen and, depending on the physician specialty, written testing.

CPEP staff assigned an overall rating of the participant’s performance on the assessment. Factors considered in determining the performance ratings were the extent and characteristics of educational needs identified and the level of supervision required to ensure patient safety while the physician addressed the educational needs. Two CPEP physician reviewers and the Executive Director reviewed the data for each participant and reached agreement regarding the factors and level of educational needs.
Physicians who demonstrated no to minimal educational needs were assigned a performance rating of 1; physicians with global educational deficits were rated a 4. Physicians rated 2 and 3 demonstrated moderate to extensive educational needs, with the latter having more extensive educational needs warranting a recommendation for more intensive education, such as initial practice in a supervised setting with gradually increasing independence.

Data calculated and presented
Characteristics and assessment performance of the physicians referred by boards and hospitals who completed assessments at CPEP from July 2002 through June 2010 are reported. The characteristics reported are gender, average age, degree (M.D., D.O.), location of medical school (U.S. and Canadian LCME-approved schools, international medical schools), specialty and proportion with current board certification by an American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Bureau of Osteopathic Specialists. The average performance rating on the assessment for each group was reported.

Statistical analyses
Prior to any analyses, data were checked for possible outliers and inconsistencies in the data fields. As needed, queries were generated and resolved. Initial analyses consisted of calculating descriptive statistics for continuous variables and frequency distributions for categorical variables. Variables with highly skewed distributions were considered for log transformations; none of the variables analyzed fell into this category.

TABLE 1
Source of referral
CPEP participants July 2002 through June 2010

<table>
<thead>
<tr>
<th>Referral source</th>
<th>Number (n)</th>
</tr>
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<tbody>
<tr>
<td>State medical or osteopathic board</td>
<td>400</td>
</tr>
<tr>
<td>Hospital</td>
<td>102</td>
</tr>
<tr>
<td>Self</td>
<td>26</td>
</tr>
<tr>
<td>Other</td>
<td>24</td>
</tr>
<tr>
<td>Attorney</td>
<td>13</td>
</tr>
<tr>
<td>Medical clinic</td>
<td>12</td>
</tr>
<tr>
<td>Physician health program</td>
<td>8</td>
</tr>
<tr>
<td>Disability insurance carrier</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>588</td>
</tr>
</tbody>
</table>

Of the board-referred group, 89% (356) completed their degree at an allopathic medical school while 11% (44) completed osteopathic training; for the hospital-referred group, type of degree was 88.2% (90) allopathic versus 11.8% (12) osteopathic.

Table 2 presents key characteristics of the participants including gender, average age, medical school (U.S./Canadian schools compared to other international schools), specialty board certification status (for boards approved by the ABMS or AOA Bureau of Osteopathic Specialists) and average performance of the board and hospital groups. The five most common specialties represented in each group are presented in Table 3.

Comparison of physicians referred by boards versus hospitals
Gender, average age at the time of assessment, medical school (international medical school graduate status), specialty board certification status, and performance rating for board-referred physicians and hospital-referred physicians were compared.
Statistical analysis shows significant differences between the two groups regarding the gender, specialty board certification status and average age at the time of the assessment. Board referrals were more likely to be male (p<0.001), and older (p<0.001) than their hospital-referred peers. Board referrals were less likely to be specialty board certified (p<0.001). To explore whether the age difference between board and hospital referrals might be responsible for this finding, comparison of the average age at the time of the assessment and specialty board certification status was made. There was no statistically significant difference in the average age at the time of the assessment of those specialty board certified (52.74 years) and those who were never board certified (52.66 years) (p=0.99).

There was no statistically significant difference between board- and hospital-referred physicians in the proportion of physicians who were international medical school graduates. The mean performance rating for board referrals was 2.62, which was slightly worse than that of hospital referrals, whose ratings averaged 2.36 (p=0.007).

**Discussion**

These data identify significant differences in the characteristics of physicians referred by boards and those referred by hospitals. In the discussion of these findings, we present factors in the hospital setting that could contribute to the differences noted. While the board-referred group also includes physicians who practice in the hospital setting, we believe that the relative pertinence of these factors is greater for the hospital-referred physician group.

**Gender**

A majority (88.3%) of the physicians referred by boards were male. The proportion of male physicians who were referred by boards appears disproportionate to the general physician population, based on American Medical Association (AMA) Physician Masterfile data that indicate that 71.6% of physicians in the U.S. were male in 2007. CPEP enrollments

<table>
<thead>
<tr>
<th>Total number (percentage)</th>
<th>Board-referred physicians</th>
<th>Hospital-referred physicians</th>
<th>p value</th>
</tr>
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<tbody>
<tr>
<td>Male gender</td>
<td>353 (88.3%)</td>
<td>77 (75.5%)</td>
<td>p&lt;0.001</td>
</tr>
<tr>
<td>Average age, years</td>
<td>54.1</td>
<td>50.3</td>
<td>p&lt;0.001</td>
</tr>
<tr>
<td>Medical school</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>US, Canada</td>
<td>319 (79.8%)</td>
<td>85 (83.3%)</td>
<td>p=0.415</td>
</tr>
<tr>
<td>International</td>
<td>81 (20.3%)</td>
<td>17 (16.7%)</td>
<td>(NSS)</td>
</tr>
<tr>
<td>Currently board certified</td>
<td>247 (61.8%)</td>
<td>82 (80.4%)</td>
<td>p&lt;0.001</td>
</tr>
<tr>
<td>Assessment performance rating (mean)</td>
<td>2.62</td>
<td>2.36</td>
<td>p=0.007</td>
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**Table 2**

**Characteristics of physicians referred by state boards and those referred by hospitals**

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Board-referred physicians</th>
<th>Hospital-referred physicians</th>
<th>p value</th>
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<tbody>
<tr>
<td>Specialty Number (percentage)</td>
<td>Specialty Number (percentage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 FM 102 (25.5%)</td>
<td>OBG 31 (30.4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 IM 62 (15.5%)</td>
<td>FM 18 (15.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 GP 35 (8.8%)</td>
<td>GS 13 (12.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 GS 31 (7.8%)</td>
<td>IM 8 (7.8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 P 24 (6%)</td>
<td>ANE 6 (5.9%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FM=family medicine, IM=internal medicine, GP=general practice, GS=general surgery, P=pediatrics, OBG=obstetrics and gynecology, ANE=anesthesiology

**Table 3**

**Most frequent specialties of physicians referred by boards and by hospitals**

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Board-referred physicians</th>
<th>Hospital-referred physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Number (percentage)</td>
<td>Specialty Number (percentage)</td>
<td></td>
</tr>
<tr>
<td>1 FM 102 (25.5%)</td>
<td>OBG 31 (30.4%)</td>
<td></td>
</tr>
<tr>
<td>2 IM 62 (15.5%)</td>
<td>FM 18 (15.6%)</td>
<td></td>
</tr>
<tr>
<td>3 GP 35 (8.8%)</td>
<td>GS 13 (12.7%)</td>
<td></td>
</tr>
<tr>
<td>4 GS 31 (7.8%)</td>
<td>IM 8 (7.8%)</td>
<td></td>
</tr>
<tr>
<td>5 P 24 (6%)</td>
<td>ANE 6 (5.9%)</td>
<td></td>
</tr>
</tbody>
</table>
over time have reflected an overall disproportionate preponderance of males. A male preponderance in board referrals to the CPEP program is consistent with data previously published about U.S. physicians referred for competence assessments. Male gender was also more common in NCAS referrals (U.K.) than would be expected, and this did not appear to be related to gender-specific choices in practice specialty. Data on U.S. licensure board discipline also show a disproportionate representation of males. The reasons for males being over-represented in these settings are not readily apparent, but may involve legitimate differences in performance between genders or other unrelated factors. Firth-Cozens proposed some potential reasons for the male preponderance in the NCAS data, including different communication skills of women and men and greater leniency of supervisors for women. Thus, though the reasons are unknown, the gender distribution for board referrals is not surprising.

The proportion of males referred by hospitals (75.5%) more closely approximates the proportion of males in the physician population at large, again based on the AMA Masterfile data. As we consider the reason why males seem to be overrepresented in board referrals, an equally compelling question is why this referral pattern does not hold true for hospitals. A study of hospitalists showed that 74% of hospitalists (defined in this reference as a physician who works at least 50% of the time in the hospital setting) that responded to a survey were male, making it unlikely that the demographics of the hospital physician are responsible for a difference in this study between hospital referrals and board referrals (which would include inpatient and outpatient physicians). The factors that Firth-Cozens considers as potentially responsible for a disproportionate number of males referred to NCAS (communication skills, leniency toward women), if present, would seem to be relevant in the hospital setting.

We cannot definitively answer the question of why there is a higher rate of referral of males by boards compared with hospitals. The events that lead to questions about a physician’s clinical competence are complicated and multifaceted; thus, so are the reasons for referral for clinical competence evaluations. It may be that boards and hospitals refer physicians for very different reasons, and that these differences lead to different gender proportions.

**Age**

Physicians referred by boards were older (54.1 years) than hospital-referred physicians (50.3 years) (statistically significant, p<0.001). Again, though interesting to note, the reasons this might be true can only be hypothesized. Though the characteristics of hospitalists do not necessarily represent the overall characteristics of physicians who work in the hospital setting, the reported average age of hospitalists is fairly young at 40 years, possibly contributing to a younger average age of the hospital-referred physician. CPEP envisions physician dyscompetence and incompetence as developing gradually over time (see Figure 1), and there are some data to support that increasing age is associated with decreased performance and with increased risk of board discipline. Hospitals are local resources proximate in both time and location to a physician’s practice. It is logical and appropriate that local resources might identify concerns about physician competence earlier (when the physician is younger).

**Practice specialty**

Primary care specialties, specifically family medicine and internal medicine, are common self-reported specialties of physicians referred for CPEP assessments, and they are among the top five specialties for both board-referred and
hospital-referred physicians. Other assessment programs have also reported a preponderance of primary care physicians. CPEP data regarding specialty distribution of referred physicians should be a relatively accurate reflection of the actual referral patterns because CPEP accepts physicians into its assessment program from all specialties. However, CPEP has encountered misunderstanding by some referring organizations that assessment programs can only evaluate physicians in primary care; such organizations may not be referring physicians of all specialties to assessment programs, potentially resulting in an underrepresentation of some specialties.

The differences in types of specialists referred by hospitals and boards are particularly interesting, with obstetrics and gynecology ranking sixth for boards but first for hospitals, and anesthesiology ranking ninth for boards and fifth for hospitals. Possible explanations for this may include types of patients cared for by these two specialties, the impact of hospital peer review processes and the medico-legal risks for the hospital related to labor and delivery and to surgical patients.

**Specialty board certification**
Current specialty board certification was more common among hospital-referred physicians (80.4%) than board-referred physicians (61.8%), and this difference reached statistical significance (p<0.001). CPEP determined through statistical analysis that age difference between board and hospital referrals was not likely to be responsible for this observation. The difference in specialty board certification status is logical given the general trends towards board certification as a requirement for hospital privileges, though these requirements are far from universal. Another possible contributor to this observation could be the requirements for certification established by specialty boards. Some specialty boards require that the physician hold a full and unrestricted license to maintain certification. Some (but not all) of the board-referred physicians would have already been subject to a board order, and therefore not eligible to maintain certification. For those physicians who reported they were not currently certified, there may be different implications for those who lost certification on the basis of their license status alone compared with those who never certified or those who allowed certification to lapse.

**Performance**
Hospital-referred physicians performed slightly better on the CPEP assessment than board-referred physicians, and this difference is statistically significant. While it is not possible to explain the basis for this with certainty, the authors propose some reasons that the performance of board-referred physicians would be worse than their hospital-referred peers.

To a large degree, this consideration echoes the factors discussed above regarding physician age: hospitals, as a local resource, may have the opportunity to identify concerns sooner, earlier on the line of progression from competence through dyscompetence to incompetence. Routine peer review processes might identify problems at an earlier stage. In the typical progression of reporting, problematic behavior or results that occur at a hospital may be reported to and evaluated by the hospital, and this can be a prolonged process. When these processes do not resolve the issue or when the issues are of great enough concern initially, the concern may be passed along to the board. This could result in more egregious cases being presented to the board. In addition, if a hospital becomes aware of but does not address a concern about a physician’s care, the problem may progress and may then ultimately be reported to the board after significant time has passed and after further decline has occurred. Furthermore, the significant medico-legal risks faced by hospitals may prompt hospitals to address questions about a physician’s quality of care at an earlier stage. Lastly, the observation that hospital-referred physicians were statistically more likely to have current specialty board certification may be a factor in the better relative performance of the hospital-referred physician.

**Limitations**
Many of the data elements used for this study were based on self-reported information. Though CPEP staff made every effort to clarify ambiguous or inconsistent responses, either through questioning the physician participant at the time of assessment or through review of relevant documents during the assessment process or during the preparation of
this study, inaccuracies in self-reported data are not uncommon. The potential exists for confusion about one’s own specialty board certification status, as an unencumbered and active license is typically a requirement to maintain specialty board certification, and CPEP is aware of at least some participants who had been subject to a board action against their licenses but were not aware that their specialty board certification had been lost as a result.

Concluding Thoughts
Clinical competence assessment programs are useful tools for boards and hospitals in their quest to address questions about quality of care and patient safety. The data in this study highlight differences in characteristics of physicians referred from these two types of organizations.

It is possible that the different demographic data of the two groups indicate that physicians in very different circumstances come to the attention of a board versus a hospital, demonstrating the complementary and overlapping nature of these two entities in the safety net of self-regulation of the medical profession. In some cases, the findings herein may reflect that hospitals have the opportunity to intervene at an earlier phase in a physician’s decline from competence to incompetence. Currently in the U.S., board investigations into competency and discipline are largely complaint-driven.26 Hospital also rely on complaint- or critical incident-driven investigation, though there is some degree of proactive screening for quality-of-care concerns in the hospital setting that might raise concerns about a physician’s competence at an earlier stage. Identification of patterns for referral that are related to or found to be based on actual differences in competence could provide additional opportunities for early, proactive intervention prior to an adverse event or complaint.

Earlier intervention represents an opportunity for the physician to remediate his or her deficits when educational needs are more contained in scope, and remediation can be accomplished more quickly, cost effectively and safely. Short of employing routine random screenings for quality-of-care concerns, as is done in some Canadian provinces, understanding risk factors for referral to competence assessment programs and risk factors for poorer performance will help the medical profession move toward preventive strategies for the benefit of patients as well as the physician involved.

These data answer some questions about who gets referred for a competence assessment, and raise many exciting points for future research about risk factors for referral to a competence assessment program as well as risk factors for declining performance and clinical dyscompetence.

References


LEGAL BRIEFS

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Federation of State Medical Boards

Informed Consent: A Medical Board Analysis

Occasionally, boards must investigate a complaint of a physician’s failure to obtain informed consent. This article examines the development of informed consent, and the manner in which the courts currently handle informed consent cases. Suggestions are offered here to help boards handle informed consent investigations.

Informed consent, in the practice of medicine, has a long history that stems from the right to bodily integrity. Understanding informed consent begins with an analysis of consent in general and what it means for consent to be informed.

General Consent

In general, consent is the permission to be touched by another.1 Before a physician may touch a patient in any manner, the physician must have the patient’s general consent. Consent can be either explicit or implicit. If a physician asks, “May I touch you?” and the patient replies, “Yes,” then the physician has obtained explicit general consent for the touching. Much consent, however, is implied. If a physician asks a patient to raise his or her shirt to listen to the heart and the patient complies, then the physician has obtained implied general consent for the touching that follows. In the medical setting, most minor touchings are general and implied.2

Why is general consent important? Any non-consensual touching that results in compensable damages to the patient can form the foundation for the intentional tort of battery. A battery is any intentional, unlawful and harmful contact by one person with another person. The elements of a civil battery include:

- Defendant intentionally committed an act that resulted in a harmful or offensive contact with the plaintiff’s person.
- Plaintiff did not consent to the contact.
- The harmful or offensive contact caused injury, damage, loss or harm to the plaintiff.3

Even without harm, a patient may be entitled to nominal damages,4 which opens up the possibility of punitive damages.5

General consent also includes limited or conditional consent. Patients can limit or condition their consent to a particular treatment or medication.6 Besides setting conditions on treatments, patients can set conditions who will perform the procedures.7 Ashcraft v. King established that “[t]he rule of conditional consent has been applied in battery actions against physicians and surgeons.”8 Thus, “if the physician exceeds the patient’s limitations or conditions, the general consent does not protect the physician from liability for the excessive act.”9

General consent differs from informed consent. General consent is the patient’s basic permission for the physician to touch him or her in a specific manner. Obtaining general consent alone is not sufficient to avoid a battery claim. The physician must obtain informed consent to secure the validity of the consent. Perna v. Pirozzi concluded that “[i]f the patient succeeds in proving that the surgeon did not comply with the applicable standard for disclosure, the consent is vitiated.”10 If the consent is vitiated, then the physician may be liable for a battery.11 The battery theory of liability is not confined to cases of a deviated operation but extends to cover the simple failure to advise adequately a patient of the potential ramifications of a certain course of treatment.

General Consent Forms as Adequate Disclosure

Courts have found that general consent forms do not adequately inform patients about the risks and
benefits of the anticipated procedures. Conditions-of-admission forms, however, are not merely informational, but rather provide general consent to treatment, and therefore encompass administration of drugs and treatments as necessary for proper care. In general, as established in *Siegel v. Mt. Sinai Hospital*, “a written consent form will be considered as evidence that the patient’s informed consent was obtained, but generally it is not conclusive.”

**Informed Consent**

Some courts limit the battery theory to those circumstances when a doctor performs a procedure to which the patient has not consented. Instead, when the patient consents to certain treatment and the doctor performs that treatment but an undiscovered inherent complication with a low probability occurs, no intentional deviation from the consent given appears; rather, in obtaining consent the doctor may have failed to meet his due care duty to disclose pertinent information.

To understand informed consent and the way it differs from general consent, it is important to remember that informed consent is a legal and ethical concept, not a medical concept. As noted in *Keogan v. Holy Family Hospital*:

> The phrase “informed consent” refers generally to legal theories of recovery in medical tort cases that depend, not on the appropriateness or inappropriateness of the doctor’s diagnosis and treatment of the patient’s condition, but on the patient’s right to know the condition of his body and to make a decision regarding his medical care. In his fiduciary relationship with the patient, the physician has a duty to disclose relevant facts about the patient’s condition and care. If the physician has not given the patient all the information necessary for the patient to make a knowledgeable decision regarding his medical care, the patient’s “consent” to the course of action taken by the physician is not “informed.” The doctor’s breach of his fiduciary duty to the patient may make him liable if damages result because the patient, if apprised of all of the material facts, would not have agreed to the physician’s course of action.

The AMA Code of Medical Ethics provides that “the patient has the right to receive information from physicians and to discuss the benefits, risks and costs of appropriate treatment options.” *Alswanger v. Mego* noted that informed consent involves four specific factors:

1. The nature of the procedure.
2. The risks and hazards of the procedure.
3. The alternatives to the procedure [including no treatment].
4. The anticipated benefits of the procedure.

In general, a physician must obtain a patient’s informed consent prior to performing a medical procedure upon the patient. As noted above, a physician’s performance of a medical procedure without the patient’s informed consent may constitute a battery. Failure to obtain informed consent may trigger a negligence claim when the treatment or procedure was authorized but the consent was uninformed. For a negligent failure of informed consent claim, the patient must prove the same elements as a malpractice case, as noted in *Willis v. Bender*:

1. The physician owed a duty to the plaintiff.
2. The physician breached that duty.
3. The breach proximately caused injury to the plaintiff.

The physician has a duty to disclose all known risks and benefits of the recommended treatment, alternative treatments and no treatment. Additionally, according to *Keogan*, “[b]ecause the doctrine of informed consent is based on the patient’s right to self-determination, particularly with regard to the treatment of medical abnormalities of his condition, ‘(t)he physician’s duty of disclosure arises ...
whenever the doctor becomes aware of an abnormality which may indicate risk or danger.”21 As noted in 
Duffy v. Flag, a physician must disclose who will perform the procedure and “details of his or her 
professional experience even if this experience [does] not increase the risk to the patient.”22 Physicians, 
however, need not discuss the risks inherent in common procedures that very rarely result in serious ill effects.23 Thus, not only must the physician disclose the general information, the physician 
also must disclose sufficient information to obtain informed consent.24

Disclosure and Informed Consent
There are two embedded concepts in informed consent. The first relates to the word “disclosure.” 
The physician must disclose relevant facts regarding treatment. The second relates to the word 
“informed.” The patient must adequately understand the disclosed facts to make an informed decision. 
It is possible, and is not unusual, for a physician to disclose facts to a patient regarding a procedure 
but fail to inform the patient fully. This disconnect can happen for several reasons. The patient might 
be medically illiterate and may not fully comprehend what the physician is explaining. The physician 
might disclose only those facts that the physician believes are relevant to the patient. The physician and patient 
may misunderstand each other.

Standards to Determine Sufficiency of 
Disclosed Information
Jurisdictions differ as to the standard the court applies when judging the adequacy of disclosures 
for informed consent purposes. A majority of courts have ruled that the appropriate standard is that of 
the “reasonably prudent medical practitioner acting under the same or similar circumstances.”25 Others 
use the more recently developed standard of the reasonably prudent patient faced with making the 
decision to consent to or forego treatment.26 Also used is the less well-defined standard of the 
subjective patient need.

Reasonably Prudent Physician Standard
A majority of the courts have adopted the reasonably prudent physician standard.27 Prior to 1972,
most jurisdictions recognizing the informed consent doctrine used the reasonably prudent physician 
standard.28 The prudent physician standard holds that “[a] physician is required to disclose only such 
risks that a reasonable practitioner of like training would have disclosed in the same or similar circumstances.”29 This standard looks to the community of similar physicians to determine what information the physicians disclose to patients regarding a particular procedure.

Reasonably Prudent Patient Standard
In 1972, two cases adopted the reasonably prudent patient standard in measuring the physician’s duty 
to disclose.30 This is because, as established in Keogan, “the patient’s rights to self-determination cannot be solely dependent on expert medical testimony.”31 Under this standard, “a physician 
must disclose all information which a reasonable person in the patient’s position would consider 
material to her decision as to whether to allow the physician to perform the contemplated treatment 
or procedure upon her.”32 Sard v. Hardy established that “[u]nlike the subjective test, which ‘considers 
what the plaintiff would have done if the risks had been properly disclosed,’ the objective test ‘focuses 
on what a reasonable person in the plaintiff’s position would have done if the risks had been 
adequately disclosed.’”33 Causation must also be shown: i.e., that the reasonably prudent person in 
the patient’s position would have decided differently if adequately informed.

Subjective Patient Need Standard
Cross ruled that “[w]hether a particular medical risk should be disclosed by the physician to the patient 
under the patient need standard ordinarily depends upon the existence and materiality of that risk 
with respect to the patient’s decision relating to medical treatment.”34 Under this analysis, the court 
determines whether the patient, if the physician provided the specific disclosure of information, 
would have chosen to go forward with a medical procedure. This arises in two circumstances. First, 
the court finds that the patient requested certain information, but the physician denied the information 
or misinformed the patient.35 As noted in Moore v.
Regents of the University of California, “[p]hysician-specific information such as experience is relevant to the informed consent issue and physicians have a duty to voluntarily disclose such information prior to obtaining a patient’s consent.” Likewise, the subjective duty arises when the physician becomes aware of a specific abnormality that may indicate risks not present in the average patient.

The second instance is when a patient specifically limits or conditions the treatment to a specific medication or provider. Patients may limit their consent to certain conditions that, if not adhered to, may lead to liability for a battery. In such a case, general consent does not necessarily defeat a battery claim. As noted in Duncan v. Scottsdale Medical Imaging, “[w]hen a patient gives limited or conditional consent, a health care provider has committed a battery if the evidence shows the provider acted with willful disregard of the consent given.”

Experts or No Experts
Just as there is a split in the courts as to which standard to apply, there is also a split in the courts as to whether expert testimony is needed. Smith v. Weaver concluded that “expert testimony is required to establish what a reasonable practitioner would disclose in the same or similar circumstances.” In Willis, “[t]he expert is required to state the standard of care with specificity sufficient to enable the court to determine if [the doctor] properly disclosed the risks and alternatives in conformance with the standard.” Canterbury v. Spence held that “[a] causal connection exists when, but only when, disclosure of significant risks incidental to treatment would have resulted in a decision against it.”

Authors David Louisell and Harold Williams have written that “[u]nlike the [reasonably prudent physician standard], expert testimony is not required under the prudent patient standard.” Thus, those following the reasonably prudent physician standard rule require an expert to establish causation, while those using the reasonably prudent patient standard or subjective standard do not necessarily require an expert.

Misrepresentation
Besides battery and negligence, a third theory of liability is based upon the contract concept of misrepresentation. In this manner, the court looks to determine if the physician breached his or her fiduciary duty to disclose completely and accurately all relevant information. Some courts recognize that the relationship between a patient and a physician is contractual in nature and that the physician owes a duty of full disclosure to the patient. Even when a battery claim and a malpractice claim fails, the patient can recover under the theory of misrepresentation. The elements of a negligent misrepresentation claim are:

1. False information supplied in the course of one’s business for the guidance of others in their business.
2. Failure to exercise reasonable care in obtaining or relating the information.
3. Pecuniary loss resulting from justifiable reliance thereon.

The Restatement (Second) of Torts recognizes a claim for negligent misrepresentation resulting in physical harm. Section 311 provides “[o]ne who negligently gives false information to another is subject to liability for physical harm caused by action taken by the other in reasonable reliance upon such information, where such harm results to the other [person]....” Comment (b) states:

The rule stated in this Section finds particular application where it is a part of the actor’s business or profession to give information upon which the safety of the recipient or a third person depends. Thus, it is as much a part of the professional duty of a physician to give correct information as to the character of the disease from which his patient is suffering, where such
knowledge is necessary to the safety of the
patient or others, as it is to make a correct diag-
nosis or to prescribe the appropriate medicine...

Even here, if the physician obtains the patient’s
consent through misrepresentation, the patient may
have a claim for battery.48

Conclusion
As shown, the courts are divided on how to proceed
with informed consent cases. The courts have
identified three theories of liability — battery, neg-
ligence and misrepresentation. The courts have
equivocated on whether information must be specific
or general, and are at odds on whether a patient
needs expert testimony to establish a deviation from

the standard. Finally, the courts have used three
different standards — prudent physician, prudent
patient and subjective patient — to determine if the
physician adequately informed the patient.

How can medical boards proceed on informal
consent cases in the face of this environment? As
the courts are divided upon the correct standard,
a reasonable approach may be to use all three
standards rather than just one. The board can first
ask, “What would a reasonably prudent patient want
to know?” This question can be followed with, “What
is the community standard for disclosing sufficient
information to meet the disclosure requirements for
the reasonably prudent patient?” Finally, the board
can ask, “Did the disclosed information take into
account the specific subjective needs and concerns
of the patient and did the patient place any restric-
tion or conditions on the care provided by the
physician?” In this way, the medical board can
ensure that it has gathered all relevant information
in determining whether a physician provided adequate
information in obtaining the patient’s consent.

When investigating a lack-of-informed-consent case,
a medical board can first look to see if the state
has adopted statutory provisions; then it should
look at the essential components, including the
who, what, where, when, why and how of the case.
What elements should be in place? The physi-
cian should:

• Disclose all people who will be involved in the
procedure including other surgeons, anesthesiologist,
residents, etc.

• Disclose which procedure he or she will perform
and its risks and benefits, alternative procedures
and their risks and benefits, and the risks and
benefits of no treatment.

• Disclose where the procedure will take place
(office-based surgery versus hospital, for example)
and the risks and benefits of the options.

• Disclose when the procedure needs to take place
(expedited or elective, for example).

• Disclose why he or she is recommending one
procedure above others.

• Disclose how he or she will perform the procedure.

After determining the presence or absence of these
elements, the medical board then could determine
if the patient gave general consent for the procedure
and involved health care providers. After this, the
board could determine if the physician disclosed
sufficient information to allow the patient to give
informed consent. Finally, the board could determine
if the patient placed any specific limitations or condi-
tions on the care and whether the physician complied
with the patient’s limitations and conditions. With all
these steps complete, the board can determine if
the physician breached a duty, and if so, whether any
discipline is necessary.

As informed consent is a nebulous concept,
and because the courts have rendered divided
approaches to it, medical boards should exercise
great care as they undertake their investigations.
Endnotes

1. Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129, 105 N.E. 92, 93 (N.Y. 1914), overruled on other grounds (Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.).

2. Bonner v. Moran, 126 F.2d 121, 123, 75 U.S.App.D.C. 156, 158, (App.D.C. 1941) (We think there can be no doubt that a surgical operation is a technical battery, regardless of its results, and is excusable only when there is express or implied consent by the patient; or, stated somewhat differently, the surgeon is liable in damages if the operation is unauthorized.); see also Schloendorff at 129, 93; Bing v. Thunig, 2 N.Y.2d 656, 163 N.Y.S.2d 3, 143 N.E.2d 3 (N.Y. 1957); Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (Ill. 1906).


5. Perna at 461, 439.

6. Piedra v. Dugan, 123 Cal.App.4th 1483, 1497, 21 Cal. Rptr.3d 36, 49, (Cal.App. 4 Dist. 2004) (Even if a patient consents to treatment, if the patient places conditions on that consent, the physician may be liable for battery if he or she exceeds those conditions.). see also, Ashcraft v. King, 228 Cal.App.3d 604, 610, 278 Cal.Rptr. 900, 902, (Cal. App. 2 Dist., 1991).

7. AMA Code of Ethics 8.087 “Patients should be informed of the identity and training status of individuals involved in their care and all health care professionals share the responsibility for properly identifying themselves.”

“Patients are free to choose from whom they receive treatment. - AMA Code of Ethics 8.088 ‘Residents’ and fellows’ interactions with patients must be based upon honesty.”


11. Trogun v. Fruchman, 58 Wis.2d 569, 595, 207 N.W.2d 297, 311 (Wis. 1973) (A physician who violates his duty to adequately apprise his patients of the dangers of a proposed treatment is liable for an assault and battery).


17. AMA Code of Ethics section 10.01, 2010-2011.


22. Duffy v. Flag, 279 Conn. 682, 687, 905 A.2d 15, 18, (Conn. 2006).


24. Marsingill v. O’Malley, 58 P3d. 495, 499, 504-505, (Alaska 2002) (The quantity and specificity of this information should be tailored to meet the preferences and needs of the individual patient.).

LEGAL BRIEFS


27. See, e.g., Culbertson v. Mermitt, 602 N.E.2d. 98, 103, 106, (Ind. 1992) (citing AMA Code of Medical Ethics 8.08 in establishing the reasonably prudent physician standard).


29. Willis at 1255.

30. Canterbury at 786; see Cobbs v. Grant, 8 Cal.3d 229, 104 Cal.Rptr. 505, 502 P.2d 1, 10-11 (1972).

31. Keogan at 318, 1254.

32. David W. Louisell & Harold Williams, Medical Malpractice § 22.05[3], [4] [B] (2009).


34. Cross at 455.

35. Johnson by Adler v. Kokemoo, 199 Wis.2d 615, 545 N.W.2d 495 (Wis. 1996) (According to the record the plaintiff had made inquiry of the defendant’s experience with surgery like hers. In response to her direct question about his experience he [misrepresented] that he had operated on aneurysms “dozens” of times).

36. Moore v. Regents of the Univ. of Cal., 51 Cal.3d 120, 271 Cal.Rptr. 146, 151-52, 793 P.2d 479 (Cal. 1990) (failure to inform patient of physician’s research and economic interests in procedure prior to conducting it); Barriocanal v. Gibbs, 697 A.2d 1169, 1170, 1173 (Del.Supr. 1997) (failure to disclose that physician had not recently performed aneurism surgery and there were other nearby hospitals that specialized in aneurism surgery); Hidding v. Williams, 578 So.2d 1192, 1198 (La.Ct.App. 1991) (failure to inform patient that physician suffered from alcohol abuse at the time of the proposed surgery); Goldberg v. Boone, 396 Md. 94, 912 A.2d 698, 717 (Md. 2006) (failure to inform patient there were other, more experienced surgeons in the region that could perform the proposed procedure); Johnson ex rel. Adler v. Kokemoo, 199 Wis.2d 615, 545 N.W.2d 495, 504-08 (Wis. 1996) (failure to disclose to patient there are substantially different morbidity and mortality rates of the proposed procedure depending on the physician’s experience), but see Willis v. Bender, 596 F.3d 1244 (10th Cir.Wyo. 2010) (not adopting requiring physician to disclose limitations).


39. Duncan at 311, 440 (Her general authorization of an injection does not defeat her battery claim because her consent was limited to certain drugs. Duncan explicitly conditioned her consent on the use of morphine or Demerol and rejected the use of any other drug, Conduct involving the use of a sedative other than morphine or Demerol, contrary to explicit instruction and understanding, cannot be viewed as consensual.).

40. Duncan at 311, 440; see Ashcraft v. King, 228 Cal.App.3d 604, 278 Cal.Rptr. 900, 904 (1991) (surgeon committed battery when patient’s consent to operation was conditioned on use of family-donated blood only, and surgeon intentionally violated condition.).


42. Willis at 1254.

43. Canterbury at 790, 281.

44. David W. Louisell & Harold Williams, Medical Malpractice § 22.05[3], [4] [B] (2009).

45. Willis at 1258 (The court said nothing in its ruling prevented the physician from being held liable for misrepresentation.).


47. Restatement (Second) Of Torts § 311(1) (1965).

48. Duncan at 311, 440 (if a patient’s consent is obtained by a health care provider’s fraud or misrepresentation, a cause of action for battery is appropriate), see 6 Am.Jur.2d Assault and Battery § 127 (1999).
United Kingdom

Office of the Health Professions Adjudicator Will Not Go Forward As Planned

The United Kingdom’s (U.K.) Department of Health has announced that its proposed system of separating investigation and prosecution from adjudication in cases of medical wrongdoing will not go forward as planned.

The department made the official announcement less than a year after it opened its Office of the Health Professions Adjudicator (OHPA) in January 2010.

When concerns are raised about the competence of a health professional in the U.K., it is currently the responsibility of the organization that regulates the profession to both investigate and adjudicate the case. But proponents of OHPA had argued that separating the functions of investigation and adjudication would lower costs by creating more efficient mechanisms and processes across the various regulatory bodies.

In ensuing months, the government concluded that the creation of another administrative body would not be the best way to improve the investigation/adjudication process in the U.K. Rather, it has signaled that it believes that strengthening the current adjudication process within the U.K.’s medical regulatory bodies— the General Medical Council (GMC) and the General Optical Council (GOC)—would deliver similar benefits to implementing a new administrative body.

The decision came in an environment in which deep cuts to social services are being considered in the U.K. Cuts of 45 percent to the administrative costs of the country’s National Health Service (NHS) have been proposed.

Adjudication will now continue under the system currently in place— with some changes anticipated. Niall Dickson, GMC's Chief Executive, said his agency is committed to reforming the current process of investigation and adjudication within GMC.

“We welcome the government’s decision,” he said. “We are committed to taking forward a program of major reform to create an efficient and modern adjudication function which operates independently from our other work.”

According to Dickson, GMC will separate its investigation activity and the presentation of cases from adjudication by creating what he called a new “tribunal service.” A chair, reporting directly to Parliament on an annual basis, will be appointed to oversee the service.

OHPA will remain in existence until the legislation under which it was set up is formally repealed.

The establishment of OHPA was a key proposal made by the Government following recommendations by Dame Janet Smith, who recommended that there should be clear separation between the power to investigate and the power to adjudicate concerns about health professionals. The establishment of a separate agency was approved under the Health and Social Care Act in 2008. Walter Merricks, CBE, was appointed as the new agency’s chair and Stephen Shaw, CBE, joined as chief executive in May 2010.

Had the proposal moved forward, OHPA would have taken over responsibility for hearing cases of fitness to practice from the GMC and the GOC sometime in 2011 or 2012.

To learn more, visit www.gmc-uk.org.

Source: United Kingdom General Medical Council website, December 2010
The collaborative agreement between the two countries includes a framework for:

- Jointly agreed accreditation standards.
- Collaboration in the assessment and accreditation of medical programs leading to general registration and specialist registration.
- Sharing of best practices in the assessment of international medical graduates who want to practice medicine in either Australia or New Zealand.
- Collaboration on the recognition of new medical specialties and addressing professional scope-of-practice issues.

To learn more, visit the Medical Council of New Zealand website at http://www.mcnz.org.nz/.

Source: Australian Medical Council and Medical Council of New Zealand websites, January 2011

Global Organizations

IAMRA Meeting Kicks Off Project for Global Best Practices in Medical Regulation

Representatives of the International Association of Medical Regulatory Authorities (IAMRA) took the first step toward the establishment of a set of best practices in medical regulation during the group’s most recent Biennial Conference on Medical Regulation, held in the United States last fall.

More than two hundred participants, representing 90 organizations from 32 countries, worked together in interactive, small-group sessions to identify issues and principles related to global best practices in medical regulation during the meeting, held in Philadelphia, Pa.

“IAMRA members face quite different challenges in medical regulation,” said John Hillery, MB, FRCPsych, FRCPI, immediate past chair of IAMRA. “As a resource for all members, IAMRA must focus on core aspects of medical regulation.”

Source: IAMRA website, January 2011

Australian and New Zealand Medical Councils Signal Shared Future

The Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ) have signed an agreement signaling a new stage in their 20-year history of collaboration.

Since 1992, the two Councils have worked together to assess and accredit Australian and New Zealand medical schools. Nominees of the MCNZ participate in the accreditation process managed by the AMC. Officials from the two systems say this has served to benefit both Australia and New Zealand — strengthening the assessments and making possible the sharing of best practices between medical schools in both countries.

Source: Australian Medical Council website, January 2011
of regulation that can be implemented anywhere in the world.”

The Educational Commission for Foreign Medical Graduates, the National Board of Medical Examiners and the FSMB were co-hosts of the IAMRA 2010 Conference.

Small-group sessions allowed participants to share their own experiences and stories related to specific issues in medical regulation and licensure. The groups narrowed the wide-ranging discussions to identify 153 basic principles for further development.

The IAMRA Management Committee is now in the process of reviewing the principles and will eliminate areas of redundancy. Work groups will then shape further key principles. The goal is to present results for review and adoption by IAMRA at the 2012 conference on best practices.

Parameters established by IAMRA to help shape the eventual global best practices in medical regulation stipulate that they must be:

- Feasible; realistic
- Acceptable to sovereign authorities
- Accountable to the public, physicians and fellow regulators
- Affordable
- Fair
- Evidence-based
- Portable
- Transparent in their processes
- Open relative to the public
- Relevant
- Collaborative
- Innovative and leading edge
- Geared toward putting safety first; excellence later
- Proactive

“Our 2010 working conference was highly productive and generated a lot of good commentary,” said Fleur-Ange Lefebvre, executive director and CEO of the Federation of Medical Regulatory Authorities of Canada and the new chair of IAMRA. “The number of principles identified is indicative of the level of engagement reached at the conference.”

“With the increasing number of global interconnections in health, it’s more important than ever for medical regulators around the world to regularly communicate with each other and share ideas and learning,” she added. “It’s an exciting time to be part of IAMRA.”

On the last day of the conference, elections were held for the IAMRA Management Committee. Philip Pigou, chief executive officer of the Medical Council of New Zealand, was elected to a two-year term as chair-elect to be followed by a two-year term as chair.

More information on IAMRA and the results of the 2010 IAMRA Conference can be found online at www.iamra.com or by contacting IAMRA Secretariat Roxanne Huff at (817) 868-4006 or secretariat@iamra.com.

Source: FSMB website and Newsline, November 2010
STATE MEMBER BOARD BRIEFS

Alabama

**Board of Medical Examiners and MASA Raise Awareness of Prescribing and Pharmacology Issues**

The Alabama State Board of Medical Examiners and Medical Association of the State of Alabama are working together to raise physician awareness of issues related to prescribing and pharmacology via a series of educational sessions to be held in 2011.

An educational program titled “Prescribing and Pharmacology of Controlled Drugs — Critical Issues and Common Pitfalls” will be held three times during the year, in several locations.

The prescription of controlled substances that help patients cope with pain, insomnia, anxiety, depression, obesity and other health problems is on the rise in the United States. Studies show great variation in prescribing practices among physicians.

In addition, many of these controlled prescription medications are falling into the hands of prescription drug abusers, and new issues related to addiction among people with chronic conditions are being increasingly reported.

The Alabama sessions will help physicians better understand the pharmacologic profiles for controlled drugs, identify diagnostic criteria for appropriate prescribing and consider the therapeutic implications of specific substance use by individual patients. The goal, according to organizers, is to “enhance the physician’s ability to effectively prescribe controlled medications, while minimizing their misuse whenever possible.”

The Medical Foundation of Alabama has approved the educational sessions for a maximum of 12 AMA PRA Category 1 Credits™. The Medical Foundation of Alabama is accredited by the Medical Association of the State of Alabama to provide continuing medical education to physicians.

Sessions will be held March 12–13 at the Renaissance Montgomery Hotel & Spa at the Convention Center in Montgomery; July 15–17 at the Battle House Renaissance Mobile Hotel & Spa in Mobile; and November 19–20 at a location in Birmingham to be announced later.

For more information, visit the Alabama State Board of Medical Examiners at www.albme.org.

Source: Alabama State Board of Medical Examiners website, January 2011.

California

**New Changes Made to State Physician Assistant (PA) Scope-of-Practice Regulations**

New regulations for physicians who supervise physician assistants went into effect in California January 1, 2011.

The legislation, SB 1069, was sponsored by the California Academy of Physician Assistants. Among its stipulations, the law permits PAs to:

- Order durable medical equipment.
- Approve, sign, modify, or add to a plan of treatment—or plan of care—for home health services (PAs are not allowed to order home health and hospice care for Medicare beneficiaries.)
• Certify that certain school district employees, including educators at community colleges, are free from communicable diseases for purposes of employment.

• Provide the statement attesting to the need of an Epi-pen to be carried by pupils while at school.

• Order medications and provide the statement attesting to the need for medications to be available to a student during school hours.

• Certify the parent’s request to waive a school-based visual acuity test.

• Perform physical examinations required for participation in interscholastic athletic programs.

• Certify the needs of an individual who has been diagnosed by a physician as being deaf or hearing impaired to retain a telecommunications device for the deaf or hearing impaired.

To read the new regulations in their entirety, please visit www.capanet.org/pdfs/SB1069Chaptered.pdf.

Source: Medical Board of California Newsletter, January 2011

New Vendor will be Responsible for Substance Prescription Data Collection and Monitoring of State Program

The California Department of Justice (DOJ) has contracted with a new company for the collection of the state’s controlled substance prescription data. Atlantic Associates, Inc. (AAI) has begun incorporating several new features in the state’s data collection process, which officials say will provide “significant benefits to pharmacies, physicians, and the Bureau of Narcotic Enforcement.”

In California, all controlled substance prescription data must now be submitted in the American Society for Automation in Pharmacy (ASAP) standards, ASAP 2009 version 4.1 format. All pharmacies and dispensing prescribers/clinics are required to submit their controlled substance prescription data electronically using this format; however, AAI will also continue to accept controlled substance prescription data in ASAP 2005 version 3.0 format until July 1.

California’s DOJ has provided AAI with a set of requirements for validating the controlled substance prescription data submitted by individual pharmacies and dispensing prescribers/clinics. AAI will perform the validations and has announced that it will only accept files that meet the established criteria. Other files will be rejected. Pharmacies will be notified when controlled substance prescription data has been validated, accepted or rejected.

AAI also announced that in the near future, it will be possible to submit direct-dispense controlled substance data using an electronic application.

Source: Medical Board of California Newsletter, January 2011

Maryland

New Cosmetic Medical Procedure Regulations Approved in Maryland

In Maryland, as in other parts of the nation, cosmetic medical procedures are now being offered by a wider range of physicians than just dermatologists and plastic surgeons. Many other specialties have begun offering procedures such as laser hair removal, and the “medical spa” concept is growing in popularity.

Recognizing these trends, the Maryland Board of Physicians has adopted regulations clarifying the parameters for the performance of cosmetic medical procedures by physicians. Included are guidelines for the appropriate training of physicians; qualifications and training for persons to whom a physician might delegate performance of the procedures; and clarification of the physician’s responsibilities, including adopting written protocols for each procedure, as well as the responsibilities of non-physicians who may be involved.
Under Maryland’s regulations, physicians are responsible for evaluating the patient and prescribing the treatment to be provided and obtaining informed consent. In general, physicians must be present when procedures are performed, but the regulations do allow delegation or assignment of procedures to another licensed health care provider. Delegation may be made to an individual whose licensing board has determined that performing the procedures is within the scope of practice of a health care provider. Typical health care workers who may be eligible for delegated responsibilities include physician assistants and nurses. The Maryland Board of Nursing is adopting its own regulations, which will allow licensed nurses to accept assignment of these procedures.

In Maryland, procedures such as laser hair removal and Botox injections are considered “medical” in nature. Because many of these procedures are performed in “medical spas,” the Maryland Board of Physicians is cautioning the public to be aware of the procedures that can’t be performed by the estheticians who work in these spas. An esthetician is not a health care provider in Maryland, and a physician may not delegate performance of cosmetic medical procedures to them. Regardless of setting, a physician must evaluate each patient and write an order for the procedure.

For more information about Maryland’s regulations, visit the Maryland Board of Physicians website at www.mbp.state.md.us.

Montana

Montana Board of Medical Examiners Bans Online Medical Marijuana Exams

The Montana Board of Medical Examiners ruled recently that physicians may not use Internet-based video examinations as a basis for determining when to dispense medical marijuana in that state.

The board has decided that medical doctors must conduct in-person physical examinations before determining whether patients may receive medical marijuana.

Individuals seeking medical marijuana in Montana had increasingly been using web video teleconference services to establish their need for the substance; in some cases this was attributed to their inability to travel.

In an addendum to its regulations on medical marijuana, the board said physicians must use “hands-on” examinations when determining whether patients are eligible for medical marijuana. The board wrote that “the exclusive use of teleconference methods to certify individuals does not meet this level of standard of care.”

Montana passed Initiative 148 in November 2004, allowing certain patients with specific medical conditions to alleviate their symptoms through the limited use of marijuana under medical supervision.
The new law also allows qualified patients and their caregivers to grow and/or possess a restricted number of marijuana plants.

Montana was the 10th state to pass a medical marijuana law. The new laws have created a wide range of practices from state to state; under federal law, it is still illegal to grow, sell, purchase, or use marijuana, even for health-related reasons.

To use or grow marijuana under the Montana law, patients and caregivers must first register with the Quality Assurance Division of the Department of Public Health and Human Services.

According to the Associated Press, the number of medical marijuana patients registered with the state Department of Public Health and Human Services tripled in one year — from 7,339 in December 2009 to 27,292 in December 2010.

Source: Montana Department of Public Health and Human Services website; Associated Press

Texas

New Medical Director Joins TMB

The Texas Medical Board (TMB) has announced the appointment of Linda Gage-White, M.D., as medical director.

Dr. Gage-White is an ear, nose and throat specialist who formerly served on the Louisiana State Board of Medical Examiners from 2002 to 2010 as president, vice president and as a member of the Licensure Committee and the Board’s Malpractice Committee.

She is a graduate of Duke University and received her medical degree from the University of Miami School of Medicine. She was an intern at Mount Sinai Medical Center in Miami and completed her residency in otolaryngology at the University of Iowa Hospital and Clinics. She is board certified in otolaryngology and has taken part in charitable medical missions throughout the world.

Dr. Gage-White fills a position that was vacated by Alan T. Moore, M.D., TMB’s previous medical director. Texas state law requires that if the TMB’s executive director is a non-physician, a medical director be hired.

“We’re very pleased to have someone of this caliber join the agency,” said TMB Executive Director Mari Robinson, J.D., in Texas Medical Board News. “Dr. Gage-White’s extensive, relevant experience and her passion for public safety will help fulfill the Board’s mission of public protection.”

Source: Texas Medical Board News, January 2011
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.

Queries and manuscripts should be sent by e-mail to editor@fsmb.org or by mail to:
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Manuscripts should be prepared according to the following guidelines:

1. An e-mail or letter should introduce the manuscript, name a corresponding author and include full address, phone, fax and e-mail information. The e-mail or letter should disclose any financial obligations or conflicts of interest related to the information to be published.

2. The title page should contain only the title of the manuscript. A separate list of all authors should include full names, degrees, titles and affiliations.

3. The manuscript pages should be numbered, and length should be between 2,750 and 5,000 words, with references (in Associated Press style) and tables attached.

4. The manuscript should include an abstract of 200 words or less that describes the purpose of the article, the main finding(s) and conclusion. Footnotes or references should not be included in the abstract.

5. Any table or figure from another source must be referenced. Any photos should be marked by label on the reverse side and “up” direction noted. Tables and figures can be supplied in EPS, TIF, Illustrator, Photoshop (300 dpi or better) or Microsoft PowerPoint format.

6. The number of references should be appropriate to the length of the text, and references should appear as endnotes, rather than footnotes.

7. Commentary, letters to the editor and reviews are accepted for publication. Such submissions and references should be concise and conform to the format of longer submissions.

8. If sent by mail, a PC- or Mac OS-compatible CD-ROM should accompany a printed copy of the manuscript. Microsoft Word format is the preferred file format.

9. Manuscripts are reviewed in confidence. Only major editorial changes will be submitted to the corresponding author for approval. The original manuscript and CD-ROM will be returned if the submission is not accepted for publication only if a SASE is supplied with sufficient postage.
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Preparations are under way to celebrate the Federation of State Medical Boards’ Centennial year in 2012. The year-long celebration of the FSMB and all state medical boards will include:

- A written history of the FSMB
- Historical highlights of each state medical board
- Special events at the 2012 FSMB Annual Meeting in Fort Worth, Texas
- Website content commemorating medical regulation over the last century

The FSMB welcomes the submission of any historical materials that could help document and celebrate the accomplishments of the FSMB and the important work of state medical boards. Materials could include photographs, copies of key archival documents, articles, personal memoirs and previously written medical board histories. **Your contributions are greatly appreciated.**

Historical materials may be sent to: **Linda Jordan, Librarian**
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For more information about the FSMB Centennial Project, please contact: **David Johnson**, djohnson@fsmb.org or (817) 868-4081; or **Drew Carlson**, dcarlson@fsmb.org or (817) 868-4043.
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