Disruptive Physician Behavior
Use and Misuse of the Label
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‘The disruptive physician differs from peer physicians in the sense that manifestations of inappropriate behavior represent an ongoing pattern that is pervasive, deep-seated, and resistant to change.’

IT’S NO SECRET THAT THE PRACTICE OF MEDICINE can be intense. For some medical specialties, “intense” may be putting it mildly: When lives are at stake and details are critical— in emergency rooms or high-risk surgeries, for example— working conditions can sometimes be nothing short of harrowing. It only goes to reason that tensions can run high and tempers run short, occasionally leading to emotional outbursts or confrontations between physicians and those around them. For years, this was a tacit reality for those thinking of careers in medicine— conditions can be rough, and if you can’t take the heat you should stay out of the kitchen. But recently, the medical community has begun to assess more thoughtfully the ramifications of interpersonal behavior on our system of care. It has done a much better job of establishing a dividing line between the occasional rough-edged human interactions that occur in any pressure-filled profession and more deep-seated, chronically bad physician-behavior— the kind that can harm both medical staff members and patients. The medical community now calls those who display such behavior “disruptive physicians,” and the scientific literature about what causes them to behave badly and how it impacts care is growing. From yelling and abusive language to psychological intimidation and even physical violence, these physicians can wreak havoc on their staffs and create environments in which clinical performance is impeded. The Federation of State Medical Boards recently addressed the problem in its 2011 Policy on Physician Impairment— recognizing that cases involving disruptive physicians can be difficult for regulators to sort out. In this issue of the Journal of Medical Regulation we bring you an article by Dr. Norman Reynolds— a psychiatrist with expertise in disruptive physician behavior— offering deeper insights into why it occurs and how it can be recognized and managed. Dr. Reynolds’ article begins on page 8...You’ll also find in this issue the first of a series of articles devoted to the FSMB’s 100th anniversary, chronicling how the FSMB evolved and began operations in 1912. Over the course of this Centennial year, we plan to bring you other historical articles. Stay tuned.

Susan R. Johnson, M.D.

Editor-in-Chief
CPE Meeting Features Simulation Technology for Physician Assessment

The spring meeting of the Coalition for Physician Enhancement (CPE) will be held June 7-8, 2012, in Denver, Colo., and will be hosted by the Center for Personalized Education for Physicians (CPEP). The conference, titled “An Idea Whose Time Has Come? Advances in Simulation Technology for Use in Physician Assessment,” will examine the rapidly advancing field of simulation technology and its applications in evaluating clinical skills of physicians currently practicing and those returning to practice.

For registration information on this event, visit www.physicianenhancement.org.

FSMB Offers Enhanced SPEX Exam to State Board Members

To assist state medical boards in learning about the Special Purpose Examination (SPEX), the FSMB is offering one member of each board the opportunity to take the exam at no charge at a local Prometric testing center.

The SPEX is a multiple-choice examination of current knowledge requisite for the general, undifferentiated practice of medicine and is used by medical boards to reexamine a licensed or previously licensed physician’s ongoing level of basic medical knowledge.

An enhanced version of the SPEX was released in 2010. For more information, please contact Frances Cain, FSMB’s Director of Post-Licensure Assessment Services, at fcain@fsmb.org or (817) 868-4022.

FSMB Annual Meeting to Feature Centennial Celebration on Opening Day

The FSMB is planning special recognition of its 100-year anniversary on April 26 during the opening ceremony of its 2012 Annual Meeting in Fort Worth, Texas.

The opening session, scheduled from 8 a.m. to noon, will include a welcoming address from U.S. Surgeon General Regina Benjamin, M.D., and keynote remarks from Aneesh Chopra, former Chief Technology Officer of the United States. Dr. Chopra will discuss the impact of health information technology on medical regulation. Also speaking during the opening session will be Shantanu Agrawal, M.D., Medical Director of the Center for Program Integrity, Centers for Medicare and Medicaid Services.

Opening ceremonies will include introduction of FSMB leaders and a number of dignitaries who will represent other health care organizations during the meeting and the presentation of historical tributes.

The opening session will also feature a panel discussion titled “Standing on the Cusp: Where Will the Next 100 Years Take Us?” Led by FSMB President and CEO Humayun J. Chaudhry, D.O., the panel will examine future challenges in medical regulation. Panelists will include Lyle Kelsey, MBA, Executive Director, Oklahoma State Board of Medical Licensure & Supervision; Janelle Rhyne, M.D., Chair, FSMB Board of Directors; and Barbara Schneidman, M.D., Past President, FSMB Board of Directors.

The morning’s activities will conclude with an FSMB history presentation titled “The FSMB Time Machine: A Decade-by-Decade Tour.” Delivered by David Johnson, MA, FSMB Vice President, Assessment Services, the presentation will include highlights from an upcoming book about FSMB history.

A luncheon following the opening session will feature remarks by R. Gil Kerlikowske, Director of the Office of National Drug Control Policy.

For more information or to register, please visit www.fsmb.org or call the FSMB at 817-868-4000.
IN BRIEF  Dr. Rhyne recaps key action steps and progress on various FSMB initiatives during her year as chair of FSMB’s Board of Directors.

Last spring at the FSMB’s Annual Meeting in Seattle, I outlined an agenda for my year as FSMB Board Chair that put an emphasis on focusing our attention on the fundamentals of our profession: protecting the public’s safety...ensuring the integrity of medical practice...verifying the accuracy of information.

As I said then, one of the most important roles for the FSMB is to identify and develop more efficient and effective ways for our members boards to fulfill these simple goals—which represent our core purpose.

After a year of serving as Board Chair—and traveling extensively to meet with many of our member boards all over the country, at conferences, site visits and at committee meetings—I can confidently report that our Federation is doing an outstanding job, day in and day out, at fulfilling these fundamentals.

At the same time, I can assure you that our Federation is working hard to keep ahead of trends and changes in medicine, so we can continue to accomplish our goals. Over the last year we made great progress in advancing new initiatives that recognize the challenges of today while offering solutions for tomorrow.

As I near the end of my term, here is a brief summary of just a few of our important areas of recent activity on behalf of the public:

Maintenance of Licensure (MOL): Our MOL initiative is moving forward. After the House of Delegates accepted the report last year of the FSMB workgroup tasked with creating an MOL implementation plan, we began the complex task of beginning to address the details of how this new system of licensure renewal would work. There will be much to consider—from statutory language to communications. A key first step is the creation of a series of pilot projects—nine in total in the first phase—which will enable us to try out concepts and glean information that will be critical for more widespread adoption of MOL. We worked closely over the last year with partner organizations such as the American Board of Medical Specialties, the National Board of Medical Examiners, the American Osteopathic Association Bureau of Osteopathic Specialists and the National Board of Osteopathic Medical Examiners to develop these pilot projects, which we are now in the process of matching with state boards and other organizations for implementation. On the horizon is a report on MOL requirements for non-clinical physicians, which will be presented to the 2013 House of Delegates. Many thanks to our MOL Implementation Workgroup and the MOL Workgroup on Non-Clinical Physicians for their continuing efforts.

Composite Action Index (CAI): Last year I announced that a priority during my year as Board Chair would be to advance a discussion of our needs in the regulatory community for a better system of metrics and measurement. While state boards exist to protect and serve the public and, necessarily, undergo public scrutiny, we lack an acceptable standard set of metrics for evaluating how well we fulfill our missions. Even though physicians undergo myriad reporting regimens—from state boards, hospitals, large practices, health care purchasers, and consumer watchdogs, to name a few—there are real questions about the measurement

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data’s fairness to physicians and its usefulness to the public.

As a first step in this effort, I appointed a Workgroup to Examine the Composite Action Index (CAI) and Board Metrics. The Workgroup’s task was to examine the CAI, a weighted average of disciplinary actions taken against physicians practicing in a state as well as all physicians licensed by that state, that FSMB has computed since 1993.

I am pleased to report that the workgroup has completed a report of its findings after evaluating the effectiveness and uses of the CAI — a good starting point for a large-scale effort which the workgroup will embark on shortly to create a fair, accurate and useful system of measurement and comparison for regulators and the public.

**Physician Reentry:** Our Special FSMB Committee on Reentry to Practice completed its work on this important topic in 2012 following two years of thoughtful deliberations and the report has been submitted to the House of Delegates for approval at this Annual Meeting. Reentry to practice, a key workforce issue, should enable the development of a coherent plan to reclaim those qualified physicians who desire to return to the practice of medicine after an absence. We know that physician reentry will become more pressing in the face of projected physician-workforce shortages and thus we continue to keep reentry at the forefront of our policy discussions. At our Annual Meeting this year, a special session has been scheduled to provide regulators with updates on this issue.

**Telemedicine:** We continued our longstanding work on telemedicine in early 2011 with our national symposium in Washington, D.C., titled “Balancing Access, Safety and Quality in a New Era of Telemedicine.” In late 2011 we published a list of recommendations drawn from those proceedings, with the goal of guiding the regulatory community towards innovations to help facilitate telemedicine’s growth in a way that ensures the safety of the public. As telemedicine continues to evolve, the FSMB will review its formal policies to ensure we are continuing to adapt to this fast-changing environment.

**Ethics and Professionalism:** Social Media: As the voice of the regulatory community, the FSMB is in a unique position to have an impact on the promotion of ethical and professional behavior. Last year I appointed a new Special Committee on Ethics and Professionalism, which is submitting its formal recommendations for physicians on the use of social media. The report, titled “Model Policy Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice,” will be on the agenda for adoption by the House of Delegates. A research study that the FSMB co-authored with Yale University, which was published in JAMA last month, demonstrated the need to address this important issue. I am very pleased that the FSMB has been at the forefront of not only the analysis of the issue but also the policy and guidelines necessary to help physicians, physician assistants and member boards better address it.

**Advocacy:** During my year as Chair, the FSMB was an active and vocal participant in the advocacy arena. I was pleased to work with our Washington, D.C., staff on a number of important policy issues, ranging from license portability to promotion of state-based licensing.

We have worked hard over the last year to raise awareness among physicians of pressing health-policy issues. One example is our work on the problem of opioid abuse, misuse and diversion: We are just weeks away from publishing an updated version of our influential book, “Responsible Opioid Prescribing: A Clinician’s Guide.” We continued our leadership on this topic over the last year by convening two workgroups comprised of policy makers and subject matter experts to review and update our “Model Policy for the Use of Controlled Substances for the Treatment of Pain” and our “Model Policy Guidelines for Opioid Addiction Treatment in the Medical Office.”

Our new grassroots advocacy network grew over the last year, and helped make our “Day on the Hill” in Washington, D.C., last October a spectacular success. Throughout the past year, the FSMB Board and Advocacy Office met with more than 50 House and Senate members and staff, raising the visibility of key issues of importance to our state member boards. We continue to work closely with federal agencies on mutually important topics.
We worked closely with a wide range of policy organizations on issues of mutual interest in 2012, including our participation in the Tri-Regulator Collaborative, an alliance of the FSMB, the National Council of State Boards of Nursing and the National Association of Boards of Pharmacy. We advanced our advocacy in international settings as well, through our work as the secretariat of the International Association of Medical Regulatory Authorities (IAMRA). We are working with IAMRA on a set of global best practices for medical regulators.

**Data, Licensing and Credentialing:** The FSMB continued its efforts to streamline and improve the licensing and credentialing process, with significant hardware and software updates to our Federation Credentials Verification Service (FCVS) and additions to the number of states now utilizing our Uniform Application (UA). Our participation with the National Board of Medical Examiners in a multi-year project to review and revise the U.S. Medical Licensing Examination (USMLE) — known as the Comprehensive Review of USMLE (CRU) — made important progress over the last year, with identification of structural changes in the exam that will be implemented over the course of the next several years. Our SMB Advisory Panel to the USMLE made vital contributions to this effort.

Our new Workgroup to Define a Minimal Data Set has begun addressing the need to create a more cohesive system of gathering physician data during the licensing and credentialing process — data that could play a key role in helping the nation understand and better plan for its physician workforce needs. The Workgroup has submitted its report to the House of Delegates for review.

**FSMB Centennial:** It has truly been an honor to serve as the FSMB’s Chair when our Centennial began in January. As the year continues, we will be focusing on the four key themes of FSMB’s mission, which include Service, Partnership, Leadership and Innovation. We will be publishing a history book about the FSMB this summer and will host a gala ceremony recognizing our birthday, along with a special Centennial symposium on regulatory issues with the NCSBN and NABP, in October in Washington, D.C. Congratulations to the Centennial Advisory Panel for its excellent planning of this year’s Centennial events.

As I said during the Chair’s Investiture ceremony at last year’s FSMB Annual Meeting, I believe our organization is a dynamic clearinghouse for robust ideas about the work of state boards — a kind of hub of information and service that can help our profession grow stronger. We help facilitate dissemination of ideas and new ways of connecting among the boards — from the diverse informational sessions at our annual meeting to our monthly roundtable telephone calls, which state board staff members are invited to participate in.

Over the course of the last year I have learned just how true this clearinghouse idea is: As Chair, I spoke with hundreds of people in various capacities from our state member boards — learning that every day they are developing smart, inspirational ideas and solutions to regulatory challenges that we all face. The synergy of relationships in the Federation, and the positive impact of those relationships on the work we do, is remarkable.

I have done my best during my year as Chair to encourage an environment in which this positive synergy can grow, building a strong community for all of us. I pledge to continue that effort as I end my term.

As we celebrate 100 years as a Federation, I believe our state boards are well positioned to protect the public, ensuring the safety and quality of medical care that patients and their families have come to expect and deserve to receive.

It has been a privilege and an honor to serve as Chair and I deeply appreciate the opportunity to have done so. I take great pride in the FSMB and in the amazing dedication of the public servants who make up our member boards and their professional staffs. Many thanks to all of you for your support and encouragement during this very special year.
Disruptive Physician Behavior: Use and Misuse of the Label

Norman T. Reynolds, M.D.

ABSTRACT: Beginning in 2009, The Joint Commission (TJC) requires medical leaders to address disruptive behaviors in accreditation organizations and this includes addressing disruptive physician behaviors. The Federation of State Medical Boards (FSMB) has acknowledged the importance of addressing disruptive physician behavior as reflected in the 2000 Report of the Special Committee on Professional Conduct and Ethics and in the 2011 Policy on Physician Impairment. This article provides in-depth information about disruptive physician behavior, including discussion of the causes and contributing factors, strategies to manage such behavior, formulation of medical staff policies, and appropriate and inappropriate use of the disruptive label. Although not a diagnosis, the disruptive label is useful in screening for disruptive physician behaviors. However, the disruptive label should not be applied to physicians just because they present controversial ideas or offer criticism of the medical system.

Introduction
Beginning in 2009, The Joint Commission (TJC) created a new Leadership standard (LD.03.01.01) that addresses disruptive and inappropriate behaviors in two of its elements of performance:

• EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.

• EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.

TJC also provides 11 suggested actions to serve as guidelines for organizations to address disruptive and inappropriate behaviors. One of the suggested actions states: “Hold all team members accountable for modeling desirable behaviors, and enforce the code consistently and equitably among all staff regardless of seniority or clinical discipline in a positive fashion through reinforcement as well as punishment.” This means that physicians are to be given no exception or special status. This provision is important in light of a finding from a study conducted by the American College of Physician Executives in which a significant number of respondents agreed that “physicians in my organization who generate high amounts of revenue are treated more leniently when it comes to behavior problems than those who bring in less revenue.”

The Federation of State Medical Boards (FSMB) has acknowledged the importance of addressing disruptive physician behavior, as reflected in the 2000 Report of the Special Committee on Professional Conduct and Ethics and in the 2011 Policy on Physician Impairment. This article provides in-depth information about disruptive physician behavior, including discussion of the causes and contributing factors, strategies to manage such behavior, formulation of medical staff policies, and appropriate and inappropriate use of the disruptive label. Although not a diagnosis, the disruptive label is useful in screening for disruptive physician behaviors. However, the term “disruptive” should not be used to label physicians who present controversial ideas or who offer criticism of the medical system.

Definition
Disruptive physician behavior consists of a practice pattern of personality traits that interferes with the physician’s effective clinical performance. Manifestations are behavioral (see Table 1).

The disruptive behaviors negatively impact the persons with whom the physician interacts. The behaviors include inappropriate anger or resentment,
inappropriate words or actions directed toward another person, and inappropriate responses to patients’ needs or staff requests. The behaviors can be expressed directly to patients or indirectly through impeding the health care delivery team, or they may potentially compromise the quality of care of patients. The behaviors can be overtly aggressive, such as yelling, cursing, or throwing objects. Or, they can be indirectly passive-aggressive, such as sarcasm, “joking” at someone else’s expense, or giving them the “cold shoulder.” The disruptive physician may avoid direct expressions and, instead, resort to more disguised expressions, especially when put on notice by a medical executive committee. Insidious behaviors are more difficult to explicate, making it difficult for others to render complaints and for victims to defend themselves. When called to task, the disruptive physician can argue that the behavior in question is a matter of interpretation, the physician meant no harm, and the recipient is overly sensitive and reading things into what was said. The whole matter was just a simple “misunderstanding.”

Horty cites case law that defines disruptive behavior as conduct that “disrupts the operation of the hospital, affects the ability of others to get their jobs done, creates a ‘hostile work environment’ for hospital employees or other physicians on the medical staff, or begins to interfere with the physician’s own ability to practice competently.” In its model medical staff Code of Conduct, the American Medical Association (AMA) offers definitions of the terms inappropriate behavior and disruptive behavior, as well as appropriate behavior (see Table 2).

What Is Not Pure Disruptive Behavior
A single episode of disruptive behavior does not render a physician a disruptive physician. Human beings are complex creatures. No one is perfect. Expecting absolute harmony is unrealistic. The disruptive behavior label should not be applied to the physician who has an occasional bad day or an occasional reaction that

### Table 1
**Disruptive Behaviors**

<table>
<thead>
<tr>
<th>Aggressive behaviors:</th>
</tr>
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<tbody>
<tr>
<td>• Yelling</td>
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<tr>
<td>• Foul and abusive language</td>
</tr>
<tr>
<td>• Threatening gestures</td>
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<tr>
<td>• Public criticism of coworkers</td>
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<tr>
<td>• Insults and shaming others</td>
</tr>
<tr>
<td>• Intimidation</td>
</tr>
<tr>
<td>• Invading one’s space</td>
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<tr>
<td>• Slamming down objects</td>
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<tr>
<td>• Physically aggressive or assaultive behavior</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Passive-aggressive behaviors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hostile avoidance or the “cold shoulder” treatment</td>
</tr>
<tr>
<td>• Intentional miscommunication</td>
</tr>
<tr>
<td>• Unavailability for professional matters, e.g., not answering pages or delays in doing so</td>
</tr>
<tr>
<td>• Speaking in a low or muffled voice</td>
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<tr>
<td>• Condescending language or tone</td>
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<tr>
<td>• Impatience with questions</td>
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<tr>
<td>• Malicious gossip</td>
</tr>
<tr>
<td>• Racial, gender, sexual, or religious slurs or “jokes”</td>
</tr>
<tr>
<td>• “Jokes” about a person’s personal appearance, e.g., fat, skinny, short, ugly</td>
</tr>
<tr>
<td>• Sarcasm</td>
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<tr>
<td>• Implied threats, especially retribution for making complaints</td>
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</tbody>
</table>

### Table 2
**American Medical Association Definition of Terms**

- **Inappropriate behavior** means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as “disruptive behavior.”

- **Disruptive behavior** means any abusive conduct, including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised.

- **Appropriate behavior** means any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized medical staff, or to engage in professional practice, including practice that may be in competition with the hospital. Appropriate behavior is not subject to discipline under these bylaws.
Defining appropriate/good and inappropriate/bad behavior involves making value judgments. What is acceptable behavior in one setting may not be in another. For example, although ad hominem verbal attacks are to be discouraged, allowing heated debates among physicians in closed staff meetings may be appropriate — while having such debates in front of patients is inappropriate.

Human communication involves individual perceptions and feelings. Dealing in the realm of subjectivity is challenging. When it comes to creating medical staff policies and procedures, it is important to get it right. The stakes may be high in terms of the impact of disruptive behavior on patient care. There are risks to the complainant in terms of potential retaliation. There are risks to the physician in terms of potential damage to reputation and viability of career, especially if the complaint is a false one.

Table 3
Positive Physician Behaviors

The American College of Graduate Medical Education (ACGME) has promulgated requirements for residency programs that include interpersonal skills. Among these core competencies are the following:

- Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
- Interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals
- Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds
- Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care

Table 4
AMA Medical Ethics Regarding Collegiality

- Responsibility to other health professionals
- Respect the rights of colleagues and other health professionals
- Make relevant information available to colleagues
- Expose physicians deficient in character or competence
- Avoid engaging in conduct that undermines the public’s confidence in the profession
- Facilitate remedial action for deficiencies

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Human communication involves individual perceptions and feelings. Dealing in the realm of subjectivity is challenging. When it comes to creating medical staff policies and procedures, it is important to get it right. The stakes may be high in terms of the impact of disruptive behavior on patient care. There are risks to the complainant in terms of potential retaliation. There are risks to the physician in terms of potential damage to reputation and viability of career, especially if the complaint is a false one.
Failure to take into consideration the subjective aspect of human communication is to ignore a significant aspect of relating. Common sense, supported by research, shows that a significant component of spoken communication is nonverbal. Body language is a powerful means of communication. It is not simply the words spoken but also the associated facial expressions, gestures, eye contact, body posture, and intonation that convey meaning behind the literal words. Depending on the style of communication, the same words can convey acceptance, appreciation, and understanding or conversely rejection, humiliation, and disparagement.¹⁰

The issue is made more complex by the fact that, although the disruptive behavior is part of a deep-seated pattern, its expression can vary depending on circumstances. Disruptive physicians can thrive when they are in control. In settings that are compatible with the physicians’ likes and needs, they can function quite well, especially where there are no external constraints on them. In positions of power, they can resort to intimidating tactics to accomplish their agendas. Problems arise when disruptive physicians are faced with circumstances that require flexibility to consider the needs of others. They have difficulty collaborating and compromising. Self-centered and inflexible, they resort to rigid defenses. When asked to explain their behavior, disruptive physicians defend the behavior as justified. From their viewpoint, the problem is the negative circumstance that prompted the display of disruptive behavior.

One can refer to theories with greater ease than making determinations about real-life situations. Some disruptive behaviors are obviously inappropriate. But what about subtler cases? Addressing insidious behaviors can be challenging. Medical staff leaders tasked with making determinations about what behavior is appropriate and what is not must be wary of their own tendencies, on the one hand, to be overly moralistic and punitive or, on the other hand, to be overly permissive. Medical staff leaders must be careful not to back down when confronted by an intimidating disruptive physician who refuses to be accountable for inappropriate behaviors or threatens legal retribution. Having empathy for all parties concerned, including the perpetrator, can be challenging for medical staff leaders when involved with specific cases that spark strong emotions.

Magnitude of the Problem
Sound data are lacking for the incidence of disruptive physician behavior. Analyzing information from several sources, Leape and Fromson¹¹ state, “Our best estimate is that 3 percent to 5 percent of physicians present with a problem of disruptive behavior.” According to a 2004 survey of physician executives, more than 95 percent reported regularly encountering disruptive physician behaviors, and 70 percent reported that the disruptive behaviors nearly always involved the same physicians. Disruptive physician behaviors most commonly involved conflict with a nurse or other allied health care staff. Nearly 80 percent of the respondents said that disruptive physician behavior is under-reported because of victim fear of reprisal or is only reported when a serious violation occurs.¹²

In surveys of health care professionals, nurses perceive many physicians as displaying disruptive behaviors. Physicians, when evaluating themselves, are less likely to perceive such problems. Why the difference? One reason is that systemic institutional factors can play a role in selecting for and teaching disruptive behaviors. Abusers often have a past history of having been abused themselves. Although not intended, medical training by its very nature can serve to encourage disruptive physician behavior among those who already have personalities that are so inclined. Studies show that many medical students and house staff experience abuse during their training. Abuse is described as “belittling” or “humiliation” by “malignant” and “egotistical” attending physicians. Some students identify with abusive authority figures who served as role models during training, especially when abuse is common among superiors and condoned by the institution.¹³,¹⁴,¹⁵ Those who survive their hazing experiences can identify with those in power who previously abused them. (In psychological parlance, this is referred to as “identification with the aggressor.”) Having achieved full status as physicians, some physicians, having paid their dues, feel entitled to re-enact abuse on others. As Eckenfels and colleagues warn,
“Today’s abused student is tomorrow’s source of social control as a resident or attending physician.”

**Causes and Contributing Factors**

Disruptive behavior can be manifestations of Axis I psychiatric clinical conditions, or of Axis II personality disorders, or of an occasional incident not stemming from underlying psychopathology. Clarifying these distinctions is important in managing the physician and argues for expert professional evaluation.

Pure disruptive behavior as defined in this article is not caused by substance abuse or an Axis I psychiatric clinical condition such as depression or bipolar disorder. Pure disruptive behavior arises from the physician’s personality or basic character. Typical personality disorder diagnoses among disruptive physicians include paranoid, narcissistic, passive-aggressive, and borderline types that can occur as mixed types (see Table 5).

**Other Contributing Factors**

Many different types of factors can result in interpersonal conflicts. Gender, ethnicity, culture, religion and social factors can contribute to interpersonal conflicts. Differing values and perceptions may result in conflicts. Maladaptive personality or character traits can lead to conflicts. It is the latter that is at issue with pure disruptive physician behavior.

External stressors can provoke disruptive behaviors in physicians predisposed to such behavior. The more external stress—personal or professional—the greater the risk that the physician will express disruptive behaviors. Functioning as a physician places demands on coping skills that are psychologically draining. Krizek writes that the nature of surgical training and the rigors of practicing surgery are impairing.

**Psychological Dynamics**

In some settings, the disruptive physician’s behavior can be adaptive. However, because of inflexibility,

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**Table 5**  
**Differential Diagnosis Associated with Disruptive Behavior**

**Axis I (symptoms disorders):**
- Bipolar Disorder  
- Depressive Disorders  
- Substance Use Disorders  
- Attention Deficit Disorder  
- Intermittent Explosive Disorder  
- Circadian Rhythm Disorder  
- Dementia

**Axis II (personality disorders):**
- Paranoid (pattern of distrust and suspiciousness; such that other’s motives are interpreted as malevolent)  
- Narcissistic (pattern of grandiosity, need for admiration and lack of empathy)  
- Passive-aggressive (pattern of negativistic attitudes and passive resistance to demands for adequate performance in social and occupational situations)  
- Borderline (pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity)

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**Table 6**  
**Personality Traits Associated with Disruptive Physicians**

**Positive traits:**
- Highly-skilled  
- Well-read  
- Intelligent  
- Articulate  
- Hard-working  
- Heavy admitters  
- Confident  
- Persevering  
- High-achieving

**Problem traits:**
- Arrogant  
- Intimidating  
- Controlling; insistence of having things their way  
- Inflexible, uncompromising  
- Self-centered; exaggerated sense of self-importance  
- Entitlement  
- Un-empathic  
- Rationalizing to justify their behavior  
- Blame others  
- Create upset and distress in others; viewed as difficult by others  
- Denial; lacks self-awareness, insight, accurate self-appraisal  
- Lacking in remorse; incapable of genuine apologizing  
- Failure to self-correct behavior  
- Resist help  
- Vindictive  
- Litigious
the same personality traits are maladaptive across a broad variety of settings (see Table 6). Disruptive physicians lack closeness in relationships, lack empathy for others, and lack insight about their problem behaviors. They denigrate and resist mental health treatment.

Pure disruptive behavior is motivated by the physician’s need for power and control in relationships. Disruptive physicians seek to control others through intimidation. They are not team players. Invitations to act collegially meet with rebuffs. Disruptive physicians rebel against limits that are set on them. The DSM-IV description of Passive-Aggressive Personality Disorder is apt: “These individuals habitually resent, oppose, and resist demands to function at a level expected by others.” Disruptive physicians, while dominating others, resent others dominating them. Ironically, the repeated disruptive behaviors ultimately provoke others in positions of authority into scrutinizing and regulating the disruptive physician’s behavior. This results in the very domination the disruptive physician detests.

Complicating matters is the fact that one cannot rely on collaboration from the disruptive physician to arrive at a reasonable consensus position about the occurrence of inappropriate behaviors and even less about how to remedy problems. The disruptive physician has no appreciation of the inappropriate-ness of the behavior. In fact, the opposite is true: The disruptive physician views the behaviors as justified and others as deserving of harsh treatment. There are no pangs of conscience that suggest reconsideration and change; an internal corrective feedback mechanism is absent in the disruptive physician. Disruptive physicians do not collaborate in problem solving to improve their behavior. They disparage and resist mental health approaches. Effective management requires the imposition of strict external controls, which disruptive physicians vehemently resist. They view remediation as punishment. They feel victimized when prevented from victimizing others.

Impact on the Workplace
Disruptive physician behaviors can have a devastating and widespread impact on the health care system. A single physician can create a hostile workplace environment. Demoralization of staff and lawsuits are not uncommon. According to TJC, “Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments” (see Table 7). Accordingly, TJC requires medical systems to create “a code of conduct that defines acceptable, disruptive, and inappropriate behaviors” and to “create and implement a process of managing disruptive and inappropriate behaviors.” In order to implement TJC requirements, medical staffs and health care organizations must collect information and analyze complaint information to determine if there are trends or patterns that suggest disruptive behavior and the need for intervention.

TJC suggests proactive, rather than passive, actions to develop an organizational process to uncover information. Specific suggestions include:

- Soliciting and integrating substantial input from an inter-professional team, including representation of medical and nursing staff, administrators and other employees.
- Developing and implementing a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior.
- Including ombudsman services and patient advocates, both of which provide important feedback from patients and families that may experience intimidating or disruptive behavior from health professionals.
- Monitoring system effectiveness through regular surveys, focus groups and coworker evaluations.

Why Bother to Assist Disruptive Physicians?
Oftentimes, disruptive physicians are successful and accomplished practitioners, who profess high standards of patient care and clinical practice. Aside from their interpersonal problems, they are

| Table 7 |
| Impact of Disruptive Behavior |
| - Lowered staff morale |
| - Increased turnover of staff |
| - Negative reputation of the health care system |
| - Undermined team effectiveness |
| - Poor patient satisfaction |
| - Diminished patient care: medical errors, adverse elements |
| - Increased cost of care |
| - Lawsuits |
valuable members of the medical group because of their knowledge and technical expertise. Whenever possible, efforts should be expended to assist them so that they behave appropriately and can be valuable contributors in the health care setting. Invoking discipline with no option for assistance automatically creates an adversarial relationship in which the physician becomes invested in justifying the disruptive behaviors. A program of assistance allows for constructive change to the benefit of the individual physician, patients, and members of the health care delivery system. There is a win-win result for all parties when a program of assistance is successful.

Strategies to Manage Disruptive Behavior

Keys to success in changing disruptive behavior involve a program of management that is intensive, multimodal, and long-term. “Tough love” is the key phrase/byword. Constructive change in disruptive physicians comes through requiring adherence to expected behaviors while providing educational and other supports to teach the physician new coping skills for achieving the desired behaviors (see Table 8). Expectations should be explicitly crafted into a behavioral management contract to improve functioning and reduce acting out on the part of the physician.

Trying to talk the physician out of being angry is not realistic and is counterproductive. The problem is not in having angry feelings. It is the manner in which the angry feelings are expressed, and whether this expression is disruptive or not. A goal of management is to teach ways of expressing the feelings in order to achieve the desired end rather than expressing them inappropriately with all the problems that subsequently ensue.

Referral to a single anger-management course will not change a long-standing pattern of disruptive behavior that arises because of a personality disorder. Successful management of disruptive physician behavior begins with an in-depth Comprehensive Fitness-for-Duty Evaluation, which should include

Table 8

Elements of a Program of Remediation

Remediation should be tailored to the needs of the individual physician based on psychiatric evaluation. Examples of program elements include the following:

Training sessions:
- Communication skills training:
  - Anger management
  - Negotiation and conflict resolution
  - Sensitivity training
  - Self-assertiveness training
  - Team building
- Impulse control training

Treatment options:
- Focused psychotherapy
- Use of psychotropic medications for select cases
- Professionally led assistance groups for physicians with disruptive behavior
- Behavioral coaching

Ongoing assessment:
- Assessment utilizing the 360-degree tool
- Periodic psychiatric re-evaluation to adjust the participant’s contract based on progress or recurrences of negative behaviors; determinations about danger to patients and coworkers, suitability to practice and limitations that may require practice restrictions (temporary or permanent) or need to terminate well-being committee assistance as ineffective and refer to medical executive committee for discipline

Oversight program resources:
- Participation in physician wellbeing committee
- Participation in state physician assistance program
medical, chemical, and social evaluation in addition to psychiatric evaluation with personality assessment.\textsuperscript{19} The front-end professional evaluation serves as a guide to developing a program of remediation and monitoring and as a benchmark against which to measure future change. A program of remediation and monitoring should be codified into a tightly crafted contract. Expect that the disruptive physician will search for loopholes to slip through. As such, contracts should always be open to revision, based on experience. Vague contracts invite recurrences of inappropriate behavior and a process of protracted negotiations. Medical staffs can become frustrated and worn down by disruptive physicians, who have boundless energy to avoid closure that would result in accountability for their problem behaviors. Of surprise to most medical staffs is the fact that professional evaluations yielding individualized remediation programs can produce amazingly positive results when they are carefully conducted and there is a good follow-through process, supported by a monitoring program.\textsuperscript{20}

The goal of remediation is improved behavioral functioning. Psychological insight, which rarely occurs, would be a bonus. Educational and other remedies that teach the physician positive coping skills are useful. However, they must be applied over a number of years in order to prevent recurrences of disruptive behaviors. Remediation involves a learning curve over time. Expect some recurrences of problem behavior. Improvement consists of fewer occurrences that are less egregious in nature. A brief crash-course may give false hope to a medical staff, while allowing the physician to “get it over with” quickly. With remediation requirements completed quickly, the physician resumes an out-of-sight, out-of-mind mentality and reverts back to disruptive behaviors.

Understanding the psychological underpinnings of disruptive behavior should not serve to excuse disruptive physicians from responsibility for the behavior. In a program of assistance, disruptive physicians must be held accountable for any recurrences of disruptive behavior. Learning to be accountable for creating problems is part of a growth process.

Because disruptive physicians lack internal motivation to improve behavior, it is the threat of external consequences that incentivizes compliance with behavioral expectations. Imposition of sanctions meets with opposition from the disruptive physician, and medical staffs must be prepared for a fight. Fierce adversaries, disruptive physicians are confident they will prevail and triumph in legal proceedings. Prone to be litigious, many disruptive physicians are self-educated in the law. Some even have law degrees. Black and white legalistic thinking appeals to them. The prospect of proving others wrong and making them pay appeals to the mentality of the disruptive physician.

Effective monitoring takes genuine commitment on the part of a medical staff. There must be long-term follow-through in order to change deeply imbedded behavior patterns. Sometimes monitoring is best accomplished by referral to an external professional monitoring agency that is experienced in dealing evenhandedly with the resistances of this population and guarantees impartiality to the physician. For some physicians with hardcore resistance to constructive change, there is no easy way out for medical staffs. Ignoring the behavior, hoping it will go away, only serves to enable continuation of it. Early intervention is best. Allowing one physician to engage in disruptive behavior serves to encourage others to express similar behaviors, and the whole system can become dysfunctional.

At all stages of intervention, treatment, and monitoring, physician due process rights should be respected. If assistance from a well-being committee fails and a process of reasonable “progressive discipline” fails, termination can be considered. Such cases must be reported to the medical board which may result in action against the physician’s license if the board determines that complaints are valid.

Construction of Medical Staff Policies
In accordance with TJC, medical staffs and hospitals must develop behavioral standards. Medical staff bylaws, policies and procedures should be consistent with hospital regulations and with the federal, state, and local laws. Behavioral expectations should be reinforced through initial medical staff privilege screening, re-credentialing, and periodic education of the medical staff. Systems
should be established to identify problem physicians. Disruptive physician behavior can be identified utilizing patient complaints and surveys, peer assessments, and 360-degree reviews that utilize feedback from coworkers, including physician peers, nursing staff, and administrators.

In developing bylaws, medical staffs must define appropriate and disruptive behaviors. Where does one draw the line between acceptable versus unacceptable behaviors? On the one hand, care should be taken not to be overly restrictive which can be unrealistic in terms of human behavior. Doing so can have a chilling effect on open communication. On the other hand, being too lax and ignoring inappropriate behavior can create problems. Doing so can enable the perpetrator to persist in expressing unacceptable behavior and serve as a role model for others to do likewise. What to include and what to exclude can be a difficult balancing act.

Medical staff bylaws should include a due process component because false accusations can be made. Complaints should not be considered valid without a complaint verification process. Bylaws should include an appeals process with an option for a fair hearing.

Also, physicians should be permitted an avenue to report individuals whom they perceive to be incompetent. Typically, nursing administrations provide a process for nurses to submit complaints, including complaints about physicians. Medical staffs should formalize a similar process for physicians to lodge complaints. Periodically, individual complaints should be reviewed collectively to uncover patterns in the system that can be constructively addressed.

Resources are available to guide medical staffs in developing bylaws. Pfifferling provides guidelines for developing an equitable system for managing disruptive behavior. The policy guidelines can assist medical staffs to ensure that policies address such key areas as behavioral expectations, method of confrontation, grievance process, assessment, treatment, sanctions and work re-entry. The College of Physicians and Surgeons of Ontario, Canada provides a Guidebook for Managing Disruptive Physician Behaviour that includes a “Sample Code of Conduct” and a “Sample Complaints Procedure” that can be adapted by medical staffs in developing bylaws. The American Medical Association’s detailed “Code of Conduct” can serve to guide medical staffs in developing policies and procedures that are consistent with TJC standards. The California Medical Association (CMA) has developed sample guidelines for developing medical staff bylaws regarding a physician code of conduct.

The CMA has expressed concern that the 2009 Joint Commission Leadership Standard allows hospitals, as opposed to medical staffs, to define disruptive behavior. According to the CMA, California law does not condone this type of hospital control over the self-governing medical staff: “Medical staffs, not hospitals, determine when, under what circumstances, and how disruptive behavior should be managed.”

TJC suggests, but does not require, that leaders “Conduct all interventions...with adequate resources to support individuals whose behavior is caused or influenced by physical or mental health pathologies.” That would include Axis I psychiatric conditions. But does this include disruptive behavior caused exclusively by Axis II personality disorders? Some medical staffs may choose to invoke discipline without an option for assistance to disruptive physicians whose behavior is rooted in a personality disorder. The AMA and the CMA both recommend assistance as an option. Medical staffs that wish to create an assistance option for physicians with disruptive behavior should create a policy and procedure for referral for professional psychiatric evaluation to determine the root cause and to determine if an assistance approach is feasible. Medical staffs may refer the disruptive physician to their state physician health program to develop and oversee a program of assistance and monitoring. Referral to the state medical board will be required in cases in which a physician declines assistance and the behavior poses a danger to patient care. Some physicians may be more inclined to accept assistance knowing that they face potential discipline with referral to the medical board.

Given the complexities of crafting bylaws, medical staffs should seek counsel from an experienced health-law attorney. In crafting bylaws regarding
disruptive behavior, medical staffs can also benefit from consultation with a psychiatrist experienced in evaluating and managing disruptive behavior. Likewise, in addressing specific cases that come before the medical staff, consultation with a health-law attorney as well as a psychiatrist experienced in behavioral issues can help avoid pitfalls (see Table 9).

**Appropriate vs. Inappropriate Use of the Disruptive Label**

The disruptive physician label can be misused in several ways. The label is not a diagnosis. The label should not be applied to physicians whose disruptive behaviors are symptoms of a psychiatric clinical condition (Axis I psychiatric disorder). A number of psychiatric conditions can present with symptoms that include agitated, angry and inappropriate behaviors. For example, Axis I psychiatric disorders such as Bipolar Disorder, Depression and Substance Use Disorders can present with symptoms of agitation, mania, poor judgment, and poor impulse control that present as disruptive behaviors. Medical staff committees should not diagnose conditions. Instead, committees should act in a case management or oversight capacity and refer the physician to appropriate resources. Referral for professional evaluation can establish whether diagnosable psychiatric conditions are present. When Axis I psychiatric disorders are present, such individuals should be assisted by physician well-being committees in accordance with TJC standards for assisting impaired physicians. Treatment can alleviate the disruptive symptoms and allow the physician to return to normal baseline functioning.

Anyone can have a bad day. The disruptive label should not be applied to a physician who has a one-time or occasional disruptive episode that is otherwise out of character for the physician. Pure disruptive behavior is rooted in personality; it is deep-seated and pervasive.

The label “disruptive” should not be used to silence physicians who criticize the health care system. When physician voice is ignored, patient care suffers. The CMA has prepared a statement cautioning medical staffs to guard against vague codes of conduct. Physicians should not be labeled “disruptive” if they violate onerous and overbroad codes of conduct designed to squelch medical advocacy or target competitors. In a similar vein, the AMA advises, “Criticisms that are offered in good faith with the aim of improving patient care should not be construed as disruptive behavior.”

Furthermore, judgments about a physician’s behavior should be fair and unbiased, “not based on personal friendships, dislikes, antagonisms, jurisdictional disagreements or competitiveness among members of the staff.” Individual whistleblowers with good ideas, even when well presented, may be falsely labeled disruptive as a tactic to silence them.

Although disruptive physicians can be right, a good message can be destroyed by a bad delivery. Unfortunately, key issues become lost because of poor delivery. The focus becomes the objectionable delivery rather than the issues that caused the physician to express anger. In today’s world, physicians must learn appropriate ways of expressing complaints. A good system provides a mechanism for physicians to express complaints. Failure to include physician voice creates fertile ground for disruptive behaviors.

**What Can be Done to Prevent Disruptive Behavior?**

Consistent with recommendations from TJC, preventive approaches require a proactive stance to uncover existing or ongoing problem physicians. Sensitizing medical staffs to the issues requires regular educational sessions. Recommendations offered in Table 9 of this article address systems issues. For example, medical staffs can require applicants to endorse their compliance with a behavioral policy during the initial application and credentialing process, and subsequently as part of recredentialing.

As part of the application process for medical staff privileges, applicants can be screened for unprofessional behavior. Medical staffs can solicit, from those individuals who write letters of reference, information about unprofessional behavior. To simplify matters, letters of reference can be appended with checklist forms. For example, has the applicant manifested undesirable behaviors (as listed in Table 1 of this article)? Conversely, questions can be asked about positive behaviors. For example, does the applicant possess the core competences as defined by the ACGME (as listed in Table 3 of this article)?

Can prevention of disruptive behavior be applied to the medical school application process? There is accumulating evidence that performance in medical school and beyond is related to personality. Five factors of personality have been identified as important to success. “Agreeableness” has been
identified as one of the “big five personality factors.” As such, some medical schools are utilizing instruments such as the “multiple mini interview” (MMI) to assess character of students in the application process. Some MMI stations aim to assess behaviors that evidence whether or not an applicant is caring, empathic and collaborative. In addition, should education of students in training include learning modules to teach skill sets that promote desired behaviors? Further research could be done to determine how effective such efforts may be in reducing the incidence of disruptive physician behaviors.

**Summary**

Physicians, like all human beings, manifest with a wide range of behaviors and means of relating to others stemming from their individual personalities and environmental influences. Anyone can have an occasional expression of

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**Table 9**

**Elements of a Policy to Manage Disruptive Physician Behavior**

**Behavioral standards and identification of disruptive behavior:**
- Definition of disruptive behavior
- Definition of desired behavior
- Endorsement of behavioral policy during initial credentialing and also subsequent re-credentialing
- Mechanism for identifying disruptive behavior
- Mechanism for reporting complaints and concerns about disruptive behavior

**Infrastructures for addressing incidents:**
- Review or verification process to ascertain the validity of each complaint
- Process to notify the physician of a complaint
- Mechanism for conducting interventions
- Process for making referrals to a well-being committee for assistance in terms of case management and oversight
- Process for making referrals for psychiatric evaluations to determine fitness for duty, diagnosis, recommendations for treatment, and monitoring plan
- Model corrective action plans/contracts commensurate with the behavior
- Monitoring system to determine whether disruptive physician behavior recurs or improves
- Process for disciplinary actions in cases not appropriate for remediation (suspensions, termination, loss of clinical privileges, reporting to professional licensure bodies)
- Understanding of who will be involved at various stages of the process
- Guidelines for confidentiality
- Protection of the physician’s due process rights under the law
- Protection against retaliation for individuals who file complaints

**Systems issues to include the voices of all stakeholders:**
- Organizational process that solicits and integrates substantial input from an inter-professional team including representation of medical and nursing staff, administrators and other employees
- Skills-based training and coaching for all leaders and managers in relationship-building, collaborative practice (including skills for giving feedback on unprofessional behavior) and conflict resolution
- With the goal of making systemic improvements so as to reduce occurrences,
  - develop a mechanism for analyzing complaint data with regard to patterns and trends within a system
  - develop a system for assessing staff perceptions of the seriousness and extent of instances of unprofessional behaviors and the risk of harm to patients
- Mechanism for physicians to report complaints about coworkers
- Mechanism for physicians to report complaints about the health care system

**Primary prevention:**
- Ongoing education of the medical staff regarding acceptable and disruptive behaviors and resources to obtain assistance
inappropriate behavior. The disruptive physician differs from peer physicians in the sense that manifestations of inappropriate behavior represent an ongoing pattern that is pervasive, deep-seated, and resistant to change. Expected behavioral standards have been established by the professional organizations and, when incorporated in medical staff policy, may prevent and/or redress disruptive physician incidents. When pervasive violations of behavioral and interpersonal norms persist and medical staff attempts to mediate are met with physician resistance, denial, and even aggressive responses, consideration should be given to referral for in-depth professional evaluation of the physician. The feasibility of offering assistance should be considered before automatically invoking discipline. The goal of professional evaluation is to determine a diagnosis, identify contributing causes, and formulate a specific treatment and monitoring plan for the individual physician. In all cases, a balanced, respectful, and compassionate perspective toward both perpetrators and their targets should guide the work of medical staff committees. The disruptive label should not be applied to physicians just because they present controversial ideas or who offer criticism of the medical system.

About the author

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References

The History of the Federation of State Medical Boards: Part One — 19th Century Origins of FSMB and Modern Medical Regulation

David Johnson, M.A., and Humayun J. Chaudhry, D.O.

ABSTRACT: The Federation of State Medical Boards celebrates its centennial anniversary in 2012. In honor of this milestone, the *Journal of Medical Regulation* offers the first in a series of articles presenting the history of the FSMB within the context of the growth of America’s medical regulatory system. These articles are adapted from *Medical Licensing and Discipline in America: A History of the Federation of State Medical Boards*, set for release later this year by Lexington Books, a subsidiary of Rowan and Littlefield Publishing Group.

Keywords: Federation of State Medical Boards, centennial, state medical boards, medical regulation

The roots of the Federation of State Medical Boards (FSMB) stretch more than 20 years prior to its formal establishment in 1912. They extend into the last decades of the 19th century when America’s system for medical licensure developed into the broad framework characterizing it to this day. In constructing this state-based system, state legislatures reflected the growing importance of two critical forces: public expectations and professional interests. The laissez-faire milieu of late 19th century America did not prevent public sentiment from slowly coalescing around the need for modest measures of governmental protection against unqualified practitioners. Even stronger was the desire of a medical profession striving for greater autonomy and prestige — a desire that manifested itself directly in support of the creation of state medical boards. Many individuals familiar with the work of state medical boards know of their origins in the last quarter of the 19th century. Less commonly known, however, is that the establishment of medical licensing boards throughout much of the United States beginning in the 1870’s constituted the rebirth of a system that had first taken hold in the late 18th and early 19th centuries. In order to fully appreciate the impetus for this rebirth — as well as the fundamental tensions inherent to the system and which galvanized the predecessor organizations from which the FSMB arose — it is necessary to first briefly review the collapse of this earlier licensing system.

Colonial and Early National Antecedents
After the Revolutionary War, individual states perpetuated the common practice of colonial authorities to invest their respective medical societies with the authority to regulate the practice of medicine. Such legislation was largely exclusionary as it used medical societies to control entry into the profession.¹ This regulatory model predicated upon localized control by non-governmental bodies comprised of a physician’s peers made sense for many reasons. The questionable diagnostic and therapeutic value of almost all medicine at the time meant the profession was truly more akin to an art than a science. As such, direct experiences with, and supervision by, an experienced physician represented a reasonable attempt to ensure a modicum of expertise. Furthermore, in the overwhelmingly rural America of that time, this decentralized approach represented the only practical model for oversight. At the dawn of the 19th century, the practice of medicine remained largely an empirical and experiential art, often passed on through an apprenticeship model of training. Increasingly, however, a burgeoning number of medical schools offered another means for presenting a credible alternative to this model.²

The emerging question this posed for individual states was, “Who would take the lead in regulating or
licensing physicians—the medical societies or medical schools?” The medical societies had already received the power to license physicians from many of the colonies prior to Independence, though some had also exempted medical school graduates from their licensing requirement. Yet, medical societies increasingly felt they should require all physicians, even those trained at the newest medical schools, to obtain licenses. The schools, in turn, asserted that their diplomas should be adequate for the lifelong practice of medicine. This underlying tension remained largely unresolved when the antebellum framework for medical licensing collapsed.3

In the first decades of the 19th century, inadequate knowledge of the science underpinning medicine helped promote a notion that popular knowledge was perhaps as accurate as that of experts. Such a proposal found a receptive climate during the Jacksonian Era (1828–1840) when the long political shadow of President Andrew Jackson inculcated a reverence for the wisdom of the common man and cast a skeptical eye on experts and authorities who they deemed more likely to protect their own interests than those of the average citizen. Concurrent to this anti-intellectual trend, others began to explore alternative methods for understanding the laws of nature, founding philosophies and professions that would ultimately find their place alongside mainstream medicine. These alternative approaches rejected the “heroic” philosophy of medicine often characterized by harsh treatments (e.g., bloodletting, purgatives) in favor of minimalist approaches based often upon herbal treatments, diet and fresh air. Such a philosophy struck many people as an appeal to the laws of nature, founding philosophies and professions that they sensed the wisdom behind the adage of the doctor taking the fee while nature made the cure.4

The significance of these medical philosophies, whose adherents were often characterized as sectarian or “irregular” practitioners in the 1800s, was their subsequent success in establishing strong challenges to traditional medicine. These challengers included the followers of Samuel Thomson’s populistsecular or “irregular” practitioners in the 1800s, was their subsequent success in establishing strong challenges to traditional medicine. These challengers included the followers of Samuel Thomson’s populist herbal approach to medicine; Samuel Hahnemann’s homeopathic philosophy and various “eclectic” practitioners blending elements of all strands of medicine. The individualism and anti-regulatory climate of the Jacksonian Era, combined with the democratization of medicine as espoused by Thomsonians and others, contributed to the wholesale collapse of medical regulation in the first half of the 19th century. Nearly every state repealed its penalties for the unlicensed practice of medicine, with Illinois leading the way in 1826, followed over the next quarter century or so by Alabama, Ohio, Mississippi, Georgia, Massachusetts, Maine, South Carolina, the District of Columbia, Maryland, Vermont, Connecticut, New York, Texas, Michigan and, in 1852, Louisiana.5 As the governmental basis behind medical regulation disappeared in most states in the second quarter of the 19th century, many physicians simply pursued their vocation as best they could and were generally free to ply their trade in whatever fashion they chose. Others, however, sought to mobilize colleagues to action in fields where they believed progress could be made, particularly as a means for establishing medicine as a profession.6 One of the major examples of this was the establishment of the American Medical Association (AMA) in 1847. The organization’s early adoption of a consultative clause prohibiting its members from consulting with “sectarian” practitioners (i.e., Thomsonian, homeopathic, eclectic) created a schism within the medical profession. The growing lines of division separating regular from so-called irregular or sectarian practitioners later spawned a vigorous counterattack from adherents of alternative philosophies. When licensing laws returned in the 1870s, these practitioners waged successful legislative battles establishing separate licensing boards for homeopathic, eclectic (and later osteopathic) physicians.7

**The Second Wave of Licensing Laws**

In post-Civil War America, the proliferation of medical schools having few requirements for admission contributed to an increasing number of physicians of varying philosophies possessing medical degrees. With the general collapse of the legislative structures that had supported medical regulation, the physician holding a medical degree or a license possessed a credential of limited utility.8 Where an earlier generation of the profession understandably viewed the medical degree as a path to socio-economic prestige and financial advantage, this was no longer a given. As for the public, they seemed uninterested in physicians’ intraprofessional debates. As one historian described it, the public “remained indifferent to progress in pathology, new germ theories of disease,
or...primitive ideas that ascribed ills to the influence of the stars, provided they were relieved of their pain and freed from the bonds of sickness.”¹³ Much of the public had come to view the credential of a physician (medical degree or medical license) as irrelevant; this disinterest continued as long as the diagnostics and therapeutics of medicine remained poorly understood and largely ineffective.¹⁰

The reinstitution of a medical licensing system in America can be traced to many factors, though perhaps the greatest of these was a general reassessment of what government regulation in the guise of licensing represented. Where once the licensing of physicians had been equated with “power and privilege,” the concept now became more closely linked to a genuine effort at protecting the public and the interests of independent educated professionals, both of which now seemed vulnerable in the emerging age of industrial titans like Rockefeller and Carnegie. The post-Civil War era witnessed the birth of large corporations that seemed to threaten the idealized vision of American as a nation driven by the economic engines of the yeoman farmer, artisan and small businessman. Recognizing the value of qualified physicians to help promote the public’s health, not to mention the value of qualified engineers and architects, occupational licensing developed anew. The basic idea was hardly new as colonial officials had licensed multiple trades from physicians to auctioneers to peddlers. The type of licensure familiar to us today for doctors, nurses, pharmacists and lawyers took root in the latter 19th century. While the justification was the same for almost all of the occupations (ostensibly to protect the public) this was perhaps the most obvious and persuasive argument in the case of doctors.¹¹

North Carolina was one of the first states to emerge out of the professional and regulatory dark ages of the Jacksonian Era with the establishment of its medical board in 1859. Texas adopted its medical licensing authority in 1873 (its State Board of Medical Examiners was created in 1907), Nevada in 1875 (its State Board of Medical Examiners was created in 1899), Alabama and California in 1876, Illinois in 1877, Minnesota in 1883, Colorado and Washington in 1881, New Mexico in 1882, Virginia in 1884 and Oklahoma in 1890. Nearly all states had established licensing boards and independent examinations of their own by 1910.*

And once states began insisting upon an examination as a prerequisite for medical licensure, proprietary schools—many of which were little more than diploma mills—could no longer blatantly exploit state law with abandon.¹²

One of the most comprehensive efforts to curb the blatant excesses ongoing in medical education took place in Illinois. That state’s 1877 legislation created a Board of Health under the leadership of John Rauch, who launched a vigorous campaign to verify physician credentials, assess their qualifications, identify bogus credentials and eliminate fraudulent practitioners. Additionally, the Illinois board introduced a classification system for medical schools that predated later national efforts. By 1883, Rauch and the board identified 24 schools whose graduates were not eligible for licensure. Illinois’ efforts soon constituted a de facto “authoritative” listing for all medical licensing boards.¹³ Additional pressure to standardize the quality of medical education occurred almost simultaneously with the creation in 1876 of a voluntary organization dedicated to improving medical education, the Association of American Medical Colleges (AAMC). Though the group’s aspirations proved untenable early on—the organization disappeared

STATE MEDICAL BOARDS FACED AN ARRAY OF ISSUES: MEDICAL EDUCATION STANDARDS, ASSESSING INDIVIDUALS’ QUALIFICATIONS FOR PRACTICE, THE MEDICAL PROFESSION’S SOCIO-ECONOMIC INTEREST IN FOSTERING A STRONG IDENTITY, ETC.

from 1882–1890 when its members fell out over a proposal concerning the duration of a medical education curriculum—the momentum toward a more meaningful medical education was clearly building. A good deal of impetus derived from progressive schools like Johns Hopkins, Harvard and the Universities of Pennsylvania and Michigan. State medical boards like those in Illinois provided a strong complementary force, especially in forcing proprietary schools to meet higher standards or shut down.¹⁴

Looking back, a narrative explaining the rebirth of medical licensing laws in the late 1800s in America might reasonably draw upon several factors: professional aspirations of physicians for greater prestige, competing schools of medicine striving for recognition, a growing number of medical schools, advances in medical science and growing public awareness of (and perhaps impatience with) the
ramifications of a purely laissez-faire economic system upon individual consumers. Quality goods or services should, in theory, have driven out bad ones in the market, or forced lower prices. But many people, including the producers of quality goods and the providers of health care services (physicians), were not always willing to wait for the hidden hand of the marketplace. Indeed, the scientific and medical advancements characterizing the late 19th century created almost a moral imperative to some. According to at least one legal scholar, licensing laws and state medical boards reappeared beginning in the 1870s with the ostensible intent of correcting what the hidden hand of the marketplace had failed to resolve.15

The Federation’s Predecessor Organizations

The newly reconstituted state medical boards faced an array of challenging issues: medical education standards, assessing individuals’ qualifications for practice, the medical profession’s socio-economic interest in fostering a strong identity, etc. This soon prompted individual state medical boards and their leaders to seek opportunities for collective action among the licensing community. The deeper origins of the Federation rest with the regional and national licensing efforts that began in the 1890’s.

When addressing the Federation’s establishment in 1912, published histories of medical licensure and regulation in the United States have pointed correctly to the merger of two predecessor organizations as the genesis of the Federation: the National Confederation of State Medical Examining and Licensing Boards and the American Confederation of Reciprocating Examining and Licensing Boards.16 However, these accounts have not gone beyond referencing the merger to look more closely into the history of these organizations and the larger issues they confronted which prompted not only their creation, but that of the Federation itself. Their history, and particularly the key issues spurring their genesis (principally medical education and license reciprocity), reflected the multiple priorities and tensions at work within the medical profession and the emerging licensing community near the end of the 19th century.

The National Confederation of State Medical Examining and Licensing Boards

The National Confederation of State Medical Examining and Licensing Boards represented the elder of the Federation’s two predecessor organizations. The National Confederation was established in 1890 and held its first annual conference the following year in conjunction with the annual gathering of the American Medical Association (AMA). John Rauch provided the initial impetus for the National Confederation and served as its president until his death in 1894.17 The selection of Rauch signaled the unwavering emphasis of the organization “to establish a uniform standard of requirements” for both medical schools and the state medical licensing boards who would subsequently be evaluating their graduates. Previously, Rauch served as a catalyst in the early efforts of state medical boards to raise the educational standards of medical schools, starting with Illinois’ 1878 legislation restricting the issuance of a medical license to graduates of approved schools with clear standards for pre-medical and medical education.18

Because medicine was only just acquiring valid scientific underpinnings for its study and practice, the field was rife with practitioners with minimal or no qualifications for practice.

Upon Rauch’s death, leadership of the organization passed to William Warren Potter, a New York physician and former Civil War surgeon.** Potter continued the National Confederation’s focus on educational reform. That Potter and other early leaders of state-based medical licensure placed so much emphasis upon common standards for medical education is not surprising as influential physicians for medical licensure. This emphasis—specifically the insistence upon raising educational standards as the best long-term means for achieving uniformity of the standards for licensure—ultimately created a fundamental disagreement within the physician and licensing communities among those pressing for more immediate progress on practical issues such as license reciprocity, i.e., the prerogative of one state board to recognize and authorize for their jurisdiction the licensure decisions made by another state.

** Potter’s reminiscences of his Civil War experience were reprinted in 1996 as One Surgeon’s Private War: Doctor William W. Potter of the 57th New York (John Michael Priest, Editor). A shorter reminiscence by Potter appeared as “Three Years with the Army of the Potomac—A Personal Military History,” Buffalo Medical Journal LXVII (July 1912): 678-683.
medical educators shared their concerns. It seems telling that the National Confederation arose in the same year (1890) as the reorganized AAMC. That organization had essentially disappeared for several years when its earliest members withdrew their membership in protest over the “too rapid” application of higher standards for medical entrance requirements and curricula. The problems inherent to the largely unregulated practice of medicine in mid-19th century America provided a natural intersection of interests later between state medical boards and medical educators on the issue of educational standards. These complementary efforts can be seen in the curriculum standards adopted by the National Confederation which mirrored those set by the AAMC. The written summaries of National Confederation meetings reflect its growing alignment with the AAMC and later the AMA Council of Medical Education.19

In retrospect, the efforts of the National Confederation to facilitate “uniform standards” in the requirements set forth by both state medical boards and medical schools appear to reflect a strategic approach to resolving a seemingly intractable issue.20 The period of the mid-to-late-19th century witnessed a proliferation of medical schools, many of which were dedicated to specific philosophies of medicine. Because medicine was only just acquiring valid scientific underpinnings for its study and practice, the field was rife with practitioners with minimal or no qualifications for practice and a dubious knowledge base. Consequently, the medical profession struggled to acquire the gravitas necessary to set even minimum standards without accusations of “protectionism” — an updated version of the Jacksonian Era anti-privilege accusations that destroyed earlier legislative attempts at medical regulation.21 Voluntary associations such as the AMA and the AAMC, while potentially influential, lacked the authority to drive needed change. The only recourse was legislative. As the duly constituted legal authority regulating the practice of medicine within each state or territory, the state medical boards were poised to accomplish what others could not: establish or strengthen standards that protected the public from incompetent and unsafe practitioners and create a foundation for medicine as a legitimate profession. This fact was not lost upon advocates for medical education reform such as Abraham Flexner who in his 1910 report on the state of medical education in America dedicated an entire chapter to the critical role of state boards in fostering reform. By the mid-1890’s, 27 states had established (or re-established) state oversight of the practice of medicine through the creation of a medical licensing and examining board. According to one source, in 16 of these 27 states the requirement for a diploma from a “recognized medical college” was mandated for the issuance of a license.22 The National Confederation’s twin priorities of uniform standards for both medical education and licensure reflected not merely the vision of its early leaders but the reality of state medical boards actively weighing in on the educational standards of the day.

Potter and the leadership of the National Confederation applied a long-term strategy to achieve higher uniform licensure standards by raising medical education standards nationally, a laudable commitment serving the best interests of the public and patient care. But in playing such a long endgame dependent upon statutory changes among the various states, the organization risked sacrificing short-term victories that might address the more immediate concerns of all licensees. The key issue for many was license reciprocity and the failure to address this more vigorously fractured the organization in 1902.

The American Confederation of Reciprocating Examining and Licensing Boards

The genesis of the Federation’s other predecessor organization — the American Confederation of Reciprocating Examining and Licensing Boards — can be found in countless stories like that of Edwin Klebs. This German physician had achieved a considerable measure of professional success and in 1895 relocated to North Carolina. State law required every physician entering the state to sit for the medical board’s examination and provided the board with no discretion for exceptions. Similarly, no allowances were provided to the board for establishing reciprocal relations with other states that might have precluded the need for an examination. This minor contretemps involving a prominent physician exposed the board to criticism despite Klebs’ willingness, and subsequent
success, in passing the board’s examination. Licensed physicians less sanguine than Klebs often balked at mandated examinations and pressed state medical boards and legislatures for license reciprocity.²³

The immediate impetus for the American Confederation arose from a meeting of the Wayne County (Michigan) Medical Society whose members voiced frustration with real and perceived barriers for interstate physician licensure. Their conversations led directly to efforts by the state medical boards in Michigan, Wisconsin, Illinois and Indiana to address license reciprocity on a regional basis for their respective boards.²⁴ In June 1900, Emil Amberg of Michigan and William Spurgeon of Indiana made a forceful push on the issue of license reciprocity at the National Confederation’s annual meeting. They argued that such an initiative could move forward in parallel with the organization’s ongoing efforts to support higher standards in medical education. Amberg also called for an aggressive media campaign to mobilize the profession and draw in the “lay press” as an ally in the “improvement of medical progress.”²⁵ Written accounts of the meeting reflect that many National Confederation leaders were less than enthusiastic on the subject but grudgingly agreed to establish a committee to investigate the topic.²⁶

The committee reported back at its June 1901 meeting. The published transactions of the organization for that year appeared in the Bulletin of the American Academy of Medicine, the National Confederation’s official publication, and appear to show a seemingly terse treatment of license reciprocity as an issue for consideration by the organization’s membership. The report was “received and filed,” the committee thanked for its work and then formally “discharged.” While the transactions did not convey any of the prior year’s contentious tone, the treatment of the committee and its report clearly ranked. Representatives from the same four boards that brought the issue forward originally gathered seven months later in January 1902 at a meeting that culminated in the formation of the American Confederation. Looking back at this development, the National Confederation’s Secretary (A. Walter Suiter) admitted the causal chain of events leading to the American Confederation’s genesis. He acknowledged that the National Confederation “summarily disposed” of the reciprocity topic in a manner leading directly to the formation of the American Confederation. He further regretted the creation of a second “association” drawn from the state medical board community; and particularly one whose name was sure to create confusion as it mirrored the older organization so closely. Suiter’s overall assessment proved telling when he asserted the issue (license reciprocity) had received more “attention…than its importance really deserves” and that interstate legislation was premature. Such sentiments reflected a fundamental disagreement over the utility of a national organization attempting to resolve an issue arising from state-specific circumstances.²⁷

The American Confederation may have received an additional boost from an abortive contemporary effort to establish a national examining board whose credential might bridge varying state standards and thus foster license portability. Proponents of such a body argued that this represented the best means for resolving the difficult practical issues stemming from the varying standards for licensure among the states and territories. They chafed at the “inelastic” nature of the U.S. Constitution, which seemed more reflective of 18th century socio-political values and mores that feared placing trust in the people, as opposed to the progressive American spirit at the dawn of the 20th century.²⁸ Inevitably, opponents of such a national licensing board forestalled these proposals by playing their Constitutional trump card (i.e., the 10th Amendment reserving rights not otherwise elucidated to the individual states) and generally arguing that a voluntary national board was unlikely to gain traction among the states. The collapse of this initiative only served to invigorate the efforts of the American Confederation on the license reciprocity front. If a national examining body was not imminent,⁹ then state boards would have to create their own mechanisms for facilitating license portability.²⁹

The American Confederation’s leadership — J.R. Currens, James Dinnen, Beverly Drake Harrison — moved quickly to formulate a series of “qualifications”
that might serve as the basis for license reciprocity. These qualifications centered upon a medical diploma and either examination or recommendation by a state board.

**Qualification 1:** Possession (for at least one year) of a medical license presented by virtue of a “satisfactory” medical diploma and an examination by a state medical board; or

**Qualification 2:** Possession (for at least one year) of a medical license presented by virtue of a “satisfactory” medical diploma and upon the “recommendation” of that state medical board in lieu of an examination.30

Some critics pointed to Qualification 2 as a pathway for graduates of substandard schools and/or sectarian schools to gain further recognition. The concern that this allegation might gain traction led the American Confederation to ultimately adopt a Qualification 3, requiring evidence of “moral and professional character” through an attestation by a medical society. While not a panacea, it represented a good faith effort to flag “charlatans” and practitioners of questionable ethics.31

The American Confederation’s efforts appear to have come at a propitious time. Between 1905 and 1908, more than 2,500 “reciprocal registrations” were issued by 21 reporting state boards. The detailed statistics for 1905–1906 reveal that the vast majority of physicians (938 out of 1,187) were issued reciprocal licenses under Qualification 1.32 Thus, it appears that younger physicians who had been licensed in part based upon an examination were finding fewer barriers than their older colleagues.

As the parallel work of the American and National Confederations unfolded, distinct perceptions developed regarding the nature of both organizations. Because several leaders of the National Confederation

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**Original Charter Member Boards of the Federation of State Medical Boards of the United States**

<table>
<thead>
<tr>
<th>Board</th>
<th>Date Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas Eclectic Medical Board</td>
<td>January 23, 1913</td>
</tr>
<tr>
<td>Arkansas Regular Medical Board</td>
<td>February 13, 1913</td>
</tr>
<tr>
<td>Illinois State Board of Health</td>
<td>July 10, 1913</td>
</tr>
<tr>
<td>Iowa State Board of Health</td>
<td>March 5, 1913</td>
</tr>
<tr>
<td>Louisiana Board of Medical Examiners</td>
<td>February 7, 1913</td>
</tr>
<tr>
<td>Maryland Regular Board of Medical Examiners</td>
<td>January 29, 1913</td>
</tr>
<tr>
<td>Massachusetts Board of Registration in Medicine</td>
<td>February 20, 1913</td>
</tr>
<tr>
<td>Michigan State Board of Registration in Medicine</td>
<td>July 24, 1913</td>
</tr>
<tr>
<td>Minnesota State Board of Medical Examiners</td>
<td>July 17, 1913</td>
</tr>
<tr>
<td>Montana State Board of Medical Examiners</td>
<td>July 30, 1913</td>
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<tr>
<td>New Jersey State Board of Medical Examiners</td>
<td>May 1, 1913</td>
</tr>
<tr>
<td>New York State Board of Medical Examiners</td>
<td>February 17, 1913</td>
</tr>
<tr>
<td>North Dakota State Board of Medical Examiners</td>
<td>February 19, 1913</td>
</tr>
<tr>
<td>Ohio State Board of Medical Examiners</td>
<td>February 7, 1913</td>
</tr>
<tr>
<td>Oregon State Board of Medical Examiners</td>
<td>March 13, 1913</td>
</tr>
<tr>
<td>Pennsylvania Bureau of Medical Education and Licensure</td>
<td>March 25, 1913</td>
</tr>
<tr>
<td>Rhode Island State Board of Health</td>
<td>February 17, 1913</td>
</tr>
<tr>
<td>South Carolina State Board of Medical Examiners</td>
<td>July 30, 1913</td>
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<tr>
<td>Utah State Board of Medical Examiners</td>
<td>February 5, 1913</td>
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<tr>
<td>Vermont State Board of Medical Registration</td>
<td>February 7, 1913</td>
</tr>
<tr>
<td>Virginia State Board of Medical Examiners</td>
<td>July 30, 1913</td>
</tr>
<tr>
<td>Wisconsin State Board of Medical Examiners</td>
<td>July 26, 1913</td>
</tr>
</tbody>
</table>

Source: Quarterly of the Federation of State Medical Boards of the United States, October 1913
(T. J. Happel, J. N. McCormack, George Webster) held leadership positions with the AMA, the perception took hold of a pro-AMA bias on the part of the National Confederation. This view deepened after 1904 when the AMA established its Council on Medical Education, which moved quickly to adopt minimum standards for medical education (i.e., four years of high school; four years of medical school) consistent with those advocated by the National Confederation and the AAMC. Not surprisingly, the harshest criticism of the National Confederation arose within the medical profession along sectarian lines, especially among physicians graduated from homeopathic and eclectic medical schools who had long been wary of the AMA and took umbrage at the organization’s consultative clause.33

The strongest support for the American Confederation arose from the ranks of these irregular practitioners.34 This support is not surprising given the ‘Qualification’ model set forth by the American Confederation as the basis for reciprocal licensing. In essence, the examination and recommendation components removed all issues of the relative merits of a given school of medicine from the equation. Practitioners educated in homeopathic or eclectic medical schools had already experienced considerable success legislatively in either gaining representation on state medical boards or having a separate board constituted for their practitioners.11 Consequently, they looked favorably upon the American Confederation’s efforts at reciprocal licensing agreements among state boards as this would only serve to further legitimate these practitioners and offer additional practice opportunities. In addition, the American Confederation’s vigorous program for having state licensing boards inspect the medical schools within their state seemed less threatening than a process under the control of the AAMC and the AMA Council on Medical Education.35

The Merger Creating the Federation

Despite outward appearances of viability for both organizations continuing as separate entities, forces were at work moving them toward what many perceived as an inevitable and desirable merger. First, neither organization possessed significant financial resources or the infrastructure for a truly sustainable national organization. Second, there was a clear understanding that the interests of the public and medical regulation were not well-served by two national organizations operating within this realm and sometimes directly at cross purposes. Third, by 1911, half of the National Confederation’s officers and executive committee were drawn from the Arkansas, Illinois and Ohio state boards — all of which were members of the American Confederation.36 One might reasonably speculate that these individuals’ exposure to the American Confederation through their respective boards’ participation created a familiarity that may have transcended philosophical differences between the two organizations. Finally, there seems to have been a clear push from the AAMC and AMA acting as mediators to bring about a union of the American and National Confederations. Indeed, as early as 1908 one hears a gentle, but direct, chiding of both organizations from speakers at the AMA Council on Medical Education. “You gentlemen…ought to organize a body that will bring together all states….”37

Exploratory discussions between the two organizations took place starting in 1910 though the critical meetings did not occur until February-March 1911 at the Congress Hotel in Chicago. Representatives from the American Confederation (William Spurgeon, Beverly Drake Harrison), the National Confederation (Charles Tuttle, George Matson); the AAMC (William Harlow, Fred Zapffe); the AMA Council on Medical Education (Nathan P. Colwell, Arthur Dean Bevan); and the Carnegie Foundation for the Advancement of Teaching (Abraham Flexner) met and concluded that a merger of the two organizations was “desirable” and in the best interests of the nation’s state medical boards. A session on March 2 identified a proposed name for the new organization as put forth by George Matson of the Ohio medical board — the National Federation of State Medical Boards. (The word “national” was soon dropped without explanation though one might speculate this represented an attempt to avoid overt reference

†† Independent licensing for osteopathic physicians gathered momentum only after 1903. By the end of the 1920s, approximately 15 states had legislation in place guaranteeing full practice rights for osteopathic physicians.
to either predecessor’s name.) The following day the American Confederation met for apparently the last time.38

A draft Constitution and Bylaws for the Federation were adopted on February 28, 1912. Within the first year, there were 22 original charter member boards to the Federation (see table on page 26). Looking back, one senses that the National Confederation held considerable sway in the nascent Federation. Most of the Federation’s early leadership had prior links to the National Confederation and, with the exception of Beverly Drake Harrison, few of the American Confederation’s leaders assumed comparable roles with the Federation. However, the American Confederation seemed to have achieved its primary purpose as the Federation’s bylaws contained a section on “minimum standards” that its member boards were required to uphold specific to educational standards for licensing physicians. More importantly, the subsequent description of “qualifications for indorsement (sic) of state licenses” drew almost verbatim from the qualifications criteria set forth previously by the American Confederation.39

Despite the apparent success of the merger, some within the licensing community could not help but wonder what the future held for the Federation. With the notable presence of representatives from the AMA Council on Medical Education and AAMC in establishing the Federation, and the dearth of medical education issues on the program of the first Federation annual meeting in 1913, it is not hard to see why some individuals were unsure just what the future might hold for this new body representing America’s medical licensing community.39

### About the authors
David Johnson, M.A., is the FSMB’s Vice President, Assessment Services.

Humayun J. Chaudhry, D.O., is the FSMB’s President and CEO.

### Endnotes
7. Duffy, Humors to Medical Science, 85; Haller, American Medicine, 237.
9. Haller, American Medicine, 192.

20. 18th Annual Report of the State Board of Health of the State of Illinois, xii.


23. Emil Amberg, “The Cooperation of the Medical Profession of the United States with the National Confederation of State Medical Examining and Licensing Boards in Establishing Interstate Reciprocity for the License to Practice Medicine,” *Medical Record* 58 (July 7, 1900): 493.


34. “A Medical Comedy,” 122.


Federal Legislative Update

• Rep. Lois Capps (D-CA-23) and Rep. Todd Young (R-IN-09) introduced H.R. 3884, The Emergency Medic Transition Act of 2012, which provides for grants to states to assist veterans with military emergency medical training to become, upon discharge or release from active duty service, state-licensed or certified emergency medical technicians. The grants allow for expedited training and licensing of veterans with prior medical training.

• Rep. Cathy McMorris Rodgers (R-WA-5) and Rep. Mike Thompson (D-CA-1), Co-Chairs of the Congressional Rural Health Coalition, introduced H.R. 3859, The Rural Hospital and Provider Equity Act of 2012, or “R-HOPE.” Among its provisions to increase access for Medicare beneficiaries in rural communities, the bill directs the Secretary of HHS, in consultation with representatives of states, physicians, health care practitioners, and patient advocates, to encourage and facilitate the adoption of provisions allowing for multi-state practice across state lines for expediting telehealth services.

• Rep. Kathy Hochul (D-NY-26) and Rep. Phil Roe (R-TN-01) introduced H.R. 4023, The Veterans’ Telehealth & Telemedicine Improvement Act, which seeks to improve the use of teleconsultation, teleretinal imaging, telemedicine, and telehealth coordination services to provide care to veterans, especially in rural communities. Moreover, the legislation directs the Secretary of Veterans Affairs to promulgate technical and clinical care standards for the use of teleconsultation services within VA facilities, as well as requires each facility involved in the training of medical residents to work with each relevant university to develop an elective rotation in telemedicine for residents.

• Rep. Bill Cassidy, M.D. (R-LA-6) and Rep. Mike Ross (D-AR-4) introduced H.R. 4095, The Online Pharmacy Safety Act. The bill seeks to protect patients from illegal and unsafe online pharmacies by updating federal law to clearly define what constitutes a “legitimate online pharmacy” as well as a “valid prescription.” The legislation also requires the FDA to establish a consumer-friendly registry of legitimate online pharmacy websites. A Senate companion bill (S. 2002) was introduced in December 2011.

For further information on the FSMB’s federal advocacy activities, please contact Jonathan Jagoda, FSMB Director of Federal Government Relations, at jjagoda@fsmb.org or (202) 530-4526.

State Legislative Update

Prescription Drug Abuse, Misuse and Diversion

Of all the legislative activity occurring in the 2012 Session, no legislative measures feature more prominently than those measures intended to curb prescription drug abuse, misuse and diversion. The FSMB is currently tracking more than 50 bills regulating pain management and pain clinics alone.
Other trending issues include continuing medical education, prescription take-back programs, prescription monitoring programs (PMPs) and expedited licensure programs for military spouses.

**Kentucky: HB 4**
HB 4 includes major amendments to existing law and would require the Attorney General, the Department of Kentucky State Police and licensing boards to share information and take action to prevent drug diversion and improper prescribing. The bill would also move the prescription monitoring program (KASPER) to the Attorney General’s office where agents would be authorized to review reports in order to identify improper prescribing and potential abuse. In the case of an overdose death, the measure would require the coroner to report the death to the proper state entity, including, in cases when the prescriber’s identity is known, the Kentucky Board of Medical Examiners. The comprehensive measure also addresses ownership requirements for pain clinics, proper investigation procedures and reporting standards.

**West Virginia: SB 437**
SB 437, which recently passed the West Virginia Legislature and is awaiting the Governor’s signature, allows a prescribing practitioner who reasonably believes a patient is abusing or diverting his or her prescriptions to notify the appropriate law enforcement authorities. The bill also requires that all law enforcement personnel who have access to the controlled substances monitoring database successfully complete US DEA Diversion and National Association of Drug Diversion Investigation Training. Like KY HB 4, WV SB 437 also provides that in the instance of an overdose death, the chief medical officer may provide notice of the death to the appropriate entity as well as disclose the name of the prescribing practitioner.

**Continuing Medical Education (CME)**
- Washington: HB 2366 requires an applicant seeking to obtain licensure to practice allopathic or osteopathic medicine who intends to practice psychiatry to complete at least 15 hours of coursework in suicide assessment, treatment and management.
- Washington, DC: B19 510 requires that practitioners receive three credits of instruction on HIV and AIDS covering one or more of the following topics: 1) the impact of HIV/AIDS on populations of differing ages, particularly the senior population; 2) the impact of HIV/AIDS on populations of different racial and ethnic backgrounds; 3) general risk to all individuals in the District of HIV infection; and 4) how to inform all patients about HIV/AIDS.
- New Jersey: A 1148 requires licensed physicians to complete ten hours of continuing education credits in suicide prevention.
- New York: AB 9102 and NY SB 6160 require doctors, nurses and pharmacists to complete three hours of training on the prevention, treatment and mitigation of opiate analgesics and psychotropic drug addiction.

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SB 437 allows a prescribing practitioner who reasonably believes a patient is abusing or diverting prescriptions to notify law enforcement authorities.

how to discuss HIV/AIDS with all patients, and how to appropriately monitor all patients for potential exposure to HIV and AIDS.

- New Jersey: A 1148 requires licensed physicians to complete ten hours of continuing education credits in suicide prevention.
- New York: AB 9102 and NY SB 6160 require doctors, nurses and pharmacists to complete three hours of training on the prevention, treatment and mitigation of opiate analgesics and psychotropic drug addiction.
**Take Back Programs**

- Colorado: HB 1122 creates a locally run medication take-back program to divert waste from water disposal to minimize the inadvertent or inappropriate use of medications.

- Maryland: HB 531 proclaims October 29th as prescription take back day.

- Massachusetts: HB 2356 directs the department of public health to study and report on the issue of pharmaceutical drug waste and its effect on the environment, including the feasibility of a take-back program.


- Utah: HB 306 amends the Pharmacy Practice Act to require the pharmacy board to adopt rules regarding the disposal of unused prescription drugs.

- Washington has introduced three complementary measures, HB 1370, HB 2006 and SB 5234, to create a stewardship program for the collection, transportation and disposal of unwanted and unused medicines.

**Prescription Monitoring Programs (PMPs)**

Passage of New Hampshire HB 332 and Missouri HB 1193, measures currently pending in the New Hampshire and Missouri legislatures, would bring all 50 states into uniformity with respect to prescription monitoring programs. HB 1193 passed the Missouri House and was referred to the Senate on March 8, 2012. New Hampshire and Missouri are the only states that have not yet implemented a prescription monitoring program.

**Expedited Licensure for Military Spouses**

Colorado HB 1059, Delaware HB 238, and Kansas HB 2178 seek to simplify the process for a military spouse applying for initial licensure or reinstatement of a professional license or permit. Louisiana HB 732 attempts to expedite the licensure process for both military-trained applicants and military spouses. All four measures condition expedited licensure upon an applicant’s completion of substantially similar licensure requirements in the jurisdiction issuing his or her previous license and an applicant’s demonstration of proper character and competence.

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Arkansas

Arkansas Board Publishes Annual Report with Licensing Statistics and Actions

The Arkansas State Medical Board has published its 2011 Annual Report, showing its licensing statistics and a summary of Board proceedings in 2011.

A total of 8,918 physicians are licensed in Arkansas, including both medical doctors (M.D.) and doctors of osteopathy (D.O.). The state licensed 530 new physicians in 2011. It also licensed a number of other health care professionals, including 73 new occupational therapists, 46 occupational therapy assistants, 39 physician assistants, 111 respiratory care therapists, and 1 radiologist assistant. A total of 1,187 occupational therapists are licensed in the state, along with 295 occupational therapy assistants, 217 physician assistants, 1,844 respiratory care therapists, 2 radiologist assistants and 4 radiology practitioner assistants.

In 2011 the Board handled 480 individual discussions and issues, broken down into 354 complaints (including investigation and other issues involving licensed practitioners) and 126 other issues.

The Board levied nine license suspensions, two license revocations, five reprimands and seven consent orders during the year.

Source: Arkansas State Medical Board Newsletter, Winter 2012

Oklahoma

Oklahoma Board Promotes Subscriber Services to Expedite Credentialing

In an effort to streamline the process of applying for hospital and/or clinic privileges, membership on insurance panels and managed care entities and other health care settings, the Oklahoma Medical Board is promoting its OSBMLS Subscriber Services.

Oklahoma physicians can streamline the application and/or credentialing process if the entity they wish to join is affiliated with OSBMLS Subscriber Services. Currently more than 60 hospitals, clinics, insurers, pharmaceutical companies, government agencies and others pay a nominal fee of $60 a month to access, with physician approval, the Board’s Subscriber Services database, according to the Board.

Some organizations use OSBMLS Subscriber Services as a primary credentialing source, others to supplement existing programs.

To learn more about how the Board structures its Board’s Subscriber Services, visit www.okmedical-board.org.

Source: Oklahoma Board of Medical Licensure and Supervision Issues and Answers, Winter 2012

West Virginia

Rule Change Regarding Use of Stimulants in Treating Obesity Proposed

The West Virginia Board of Osteopathy, recognizing that obesity is a significant health concern for an increasing number of West Virginia citizens, has proposed rule modifications in an effort to give physicians new “tools and methods” to deal with the issue.

The current Osteopathy Rule, §24-1-18.1.30, prohibits the use of certain stimulant drugs in West Virginia for the treatment of obesity or for the goal of weight loss.

Source: West Virginia Board of Osteopathic Examiners, Winter 2012
loss for more than two weeks at a time. The description of the rule only addresses Schedule II controlled substances, but the drugs most commonly used for this purpose are listed on Schedule IV in the West Virginia Controlled Substances Act. The Board moved forward to change the rule to include all sympathomimetic amine drugs, which are controlled substances.

Based upon comments received, comparison of rules from other states and publications in medical literature, the Board said it “chooses to modify its rule to require careful screening of prospective patients, establishment of comprehensive weight loss plans, regular monitoring of patients’ health and weight, and limited periods of use to prevent the patients’ tolerance to the drugs involved. Drugs approved by the FDA, such as Phentermine, may only be used for the treatment of obesity when they are a component of the treatment regimen listed above. The patient’s chart must clearly document that the patient has had no adverse effects from the drug and that they continue to lose weight and remain healthy for a period of sustained use longer than twelve weeks.”

The rule is scheduled to be presented for approval during the 2012 Legislative Session.

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Wisconsin

**Wisconsin Revising Administrative Rules This Year**

The Wisconsin Medical Examining Board has announced that during the course of the coming year it will be revising Wis. Admin. Code Chapter 10, which includes the administrative rules relating to professional conduct.

According to the Board Chair Sheldon A. Wasserman, M.D., “this chapter of the rules has not been revised or updated in decades.” The process of making changes to Wis. Admin. Code Chapter 8, which deals with physician assistants, has also been launched, according to the Board.

One of the most significant changes expected during the upcoming year, according to the Board, is an increase in the number of physician assistants a physician may concurrently supervise from two to four. Work on revisions to both rules is under way.

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Source: Wisconsin Medical Examining Board Med Board Newsletter, February 2012
INFORMATION FOR AUTHORS

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

Queries and manuscripts should be sent by email to editor@fsmb.org or by mail to:
Editor
Journal of Medical Regulation
Federation of State Medical Boards
400 Fuller Wiser Rd., Suite 300,
Euless, TX 76039

Manuscripts should be prepared according to the following guidelines:

1. An email or letter should introduce the manuscript, name a corresponding author and include full address, phone, fax and email information. The email 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.
Help us commemorate FSMB’s Centennial in 2012!

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  
Federation of State Medical Boards  
400 Fuller Wiser Road, Suite 300  
Euless, TX 76039  
or by email to ljordan@fsmb.org.

For more information about the FSMB Centennial Project, please contact: David Johnson, djohnson@fsmb.org or (817) 868-4081.
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