Insightful Practice
A Method to Address a Gap in Medical Regulation
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"The ideal is for an integrated system, which would identify medical professionals who are at risk before patients are harmed — and the associated human and material costs are incurred."

From the article “Insightful Practice: A Method to Address a Gap in Medical Regulation,” page 16.
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The universe of discourse...makes possible the bringing together...of organized attitudes which represent the life of these different communities into such relationship that they lead to a higher organization.1

—George Herbert Mead

IT IS IMPORTANT FOR US, according to George Herbert Mead, to broaden our perspectives about how to resolve social issues by examining how other groups or nations do so. Sometimes that may mean looking at the way other nations are instituting new means of ensuring medical competencies over the life course. Other times, it may be useful to examine the nature of medical regulation from a broader perspective than just focusing on licensing and disciplinary boards. Our first article in this issue, from Richard E. Burney, MD, former Chair of the Michigan Board of Medicine (page 8), explores the various systems within which physicians are regulated today. It provokes us to think about who does not fall under any of these systems—where the gaps are—and also to think about where there may be too much overlap of regulatory systems. Our second article, from Douglas James Murphy, MD, FRCGP, and his colleagues in Scotland (page 16), examines what in the United Kingdom is referred to as “revalidation” and which is similar to the U.S. concept of continuing competency. The authors see a need for assessing some weak practitioners before they get into trouble, and they have data to support their system of assessment. Examining how those in the U.K. are exploring these issues allows us to think more broadly about how we might do this for maintenance of licensure and competency. We need to think very hard about these issues and I hope that these articles will provide some new ideas.

Ruth Horowitz, PhD
Editor-in-Chief

USMLE Management Committee Raises Minimum Passing Score for Step 3

The United States Medical Licensing Examination (USMLE) Management Committee reviewed the minimum passing score for USMLE Step 3 during its recent meeting in Philadelphia and has raised the minimum pass score. The committee’s review was informed by several informational and data elements: results from a survey of key stakeholders (medical boards, educators and examinees), examinee performance data trends, data on measurement precision and results from feedback by several expert panels. Taking this into consideration, the committee raised the minimum pass score from 190 to 196, effective for all examinees beginning testing on or after Jan. 1, 2016.

Registration for FSMB 2016 Annual Meeting is Open

The Federation of State Medical Boards will host its next Annual Meeting April 28-30, 2016 at the Manchester Grand Hyatt Hotel in San Diego, California. The theme for this year’s meeting is “New Horizons in Medical Regulation: Successful strategies for a changing health care environment.”

The 2016 meeting will feature a number of new innovations, including increased audience participation during general sessions and more opportunities for networking and information exchange.

Significant discounts are available for those who register for the meeting before the Early Bird Registration deadline of March 17, 2016.

To learn more, call 817-868-5160 or visit www.fsmb.org/annual-meeting/registration.

FSMB Foundation Announces Grants to Support Interstate Medical Licensure Compact

The FSMB Foundation has begun accepting applications for grants to support projects in support of the Interstate Medical Licensure Compact. Multiple grants will be awarded, from a total fund of $60,000.

The Interstate Medical Licensure Compact is a new licensing pathway for physicians that enables them to gain licensure in multiple states using a new, streamlined process. Twelve states have joined the Compact so far, and soon, physicians in these states will be able apply for multiple licenses using the new, expedited licensing process.

Grants can be used for a wide array of activities related to the Interstate Medical Licensure Compact. Examples include education of stakeholders interested in the Compact, implementation of Compact administrative requirements, staff training, technical enhancements, and more.

Those interested in applying should provide the name of their organization, contact information, a narrative to include the purpose and description of the proposed project, a budget estimate (how the funds will be used), and a timeline for completion.

Applicants may apply for more than one grant if seeking funding for multiple projects.

Grant applications may be submitted to Kelly Alfred at KAlfred@fsmb.org. For more information, please call 817-868-5160.

Volunteers needed for Post-Licensure Assessment System project

The Post-Licensure Assessment System (PLAS), a joint program of the FSMB and National Board of Medical Examiners, is seeking state medical board members and physicians who are not teaching and who have been in practice for at least ten years to form a task force to review PLAS exams designed to assist in assessing physicians’ clinical competence.

The intent of the project is to develop performance guidelines to assist users of the exams in evaluating physicians’ exam performance and making recommendations regarding medical knowledge.

Individuals interested in participating should contact Frances Cain, Assistant Vice President for FSMB Assessment Services, at fcain@fsmb.org or (817) 868-4022.
FSMB’s Docinfo Tool Now Providing Consumers Free Physician Licensure, Disciplinary Data

The FSMB recently launched a new free online resource to provide consumers with important background information on the more than 900,000 actively licensed physicians in the United States, including whether or not a physician has been disciplined by a state medical board.

The Docinfo physician search tool (www.docinfo.org) draws data from the FSMB’s Physician Data Center, the nation’s most comprehensive database of physician licensure and disciplinary information. The Data Center is regularly updated with information provided to the FSMB by its membership of 70 state medical and osteopathic boards, which license all U.S. physicians, and discipline several thousand physicians each year for unprofessional conduct, incompetence and other issues. The tool also includes data on thousands of physician assistants regulated by state medical boards.

“The FSMB has supported state medical boards for more than a century in their mission to protect the public,” said Michael Dugan, FSMB Senior Vice President and Chief Information Officer. “The Docinfo tool provides a valuable public service by providing consumers important information about their physicians.”

Originally launched by the FSMB more than 10 years ago, Docinfo was revamped during 2015 with a modernized technical platform and simplified navigation. The tool is easy to use — consumers simply enter their physician’s name and state to receive a report including this information:

- Whether or not the physician has been disciplined by a state medical board
- States in which the physician is actively licensed
- Medical school
- Location information (city, state)
- Specialty Certification information (provided by the American Board of Medical Specialties and the American Osteopathic Association)

If a medical board has sanctioned a physician, the report will provide a link to the appropriate state medical board website for specific details about the disciplinary action.

Docinfo also features helpful information about the 70 medical boards within the United States and its territories that license and discipline allopathic and osteopathic physicians and, in some jurisdictions, other health care professionals.

NABP Announces Re-launch of Prescription Drug Safety Website

The AWARxE® Prescription Drug Safety Program, sponsored by the National Association of Boards of Pharmacy Foundation™, has re-launched its website to provide health professionals and the public with an easier way to find timely and relevant information on preventing the misuse and abuse of prescription drugs.

In addition to a new look and easier navigation, the site has a new address: www.awarerx.pharmacy.

The redesigned website has a streamlined navigation, including icons that direct visitors to key drug safety categories.

The website’s Drug Disposal Locator Tool has been updated with maps that are easier to navigate and more detailed search results for permanent drug disposal site in the United States. The site also includes information on safe drug disposal sites, and educational resources on safe prescribing.
Message from the CEO

Celebrating A Momentous Year For Medical Regulators

Humayun J. Chaudhry, DO, MACP

IN BRIEF Dr. Chaudhry provides highlights of FSMB activity in 2015

As we look forward to a new year of service to the nation’s state medical and osteopathic boards in 2016, the FSMB has much to be grateful for and to celebrate.

We have just completed one of the most momentous years in our history as an organization, embarking in new directions that are exciting, fulfilling and impactful.

Topping the list is the formal adoption and implementation in 2015 of the Interstate Medical Licensure Compact — a historic achievement that is the culmination of more than two years of dedicated, grassroots organizing by state medical and osteopathic boards.

On May 19, 2015, when Alabama became the seventh state to adopt it, the Interstate Compact achieved a historic milestone and became a reality, creating a new pathway to medical licensure that will significantly streamline the process for physicians who wish to practice in multiple states.

As of January 2016, 12 states have joined the Compact, and its administrative body — the Interstate Medical Compact Commission — has begun formal meetings to establish operational policies.

We expect several more states to join the Compact very soon, and momentum for adoption continues across the nation. The Compact has now been endorsed by 30 state medical and osteopathic boards.

What makes the Compact truly impressive is the speed and passion with which grassroots organizers from state boards developed and implemented it — in response to the pressing need for greater access to medical care in the United States. A dedicated group of state board leaders rose to the occasion, pledging to change substantively their existing licensure processes with a new and innovative partnership — and the FSMB was pleased to provide support for their efforts. As the year 2016 begins, we continue to make FSMB resources available to help this effort grow and succeed.

A second highlight of the past year was the adoption in April of the FSMB’s new five-year strategic plan, which will guide us through 2020. The plan’s six areas of strategic emphasis include advocacy and policy leadership, collaboration, education, data and research services and organizational strength and excellence.

At the very core of our new strategic plan is an emphasis on partnership and working with others to leverage our impact — which is certainly embodied by the formal launch of the Interstate Medical Licensure Compact.

Another excellent example of our focus on partnership and collaboration is our participation in the Tri-Regulator Collaborative, which unites the nation’s medical, nursing and pharmacy regulators and is entering its fifth year as an organization. Working with our partners, the National Council of State Boards of Nursing and the National Association of Boards of Pharmacy, we convened the second Tri-Regulator Symposium in Washington, D.C., in October 2015. Themed “Team-Based Care — Collaborative Regulation,” the two-day symposium brought together representatives of our three organizations for fruitful discussions on a variety of topics, ranging from team-based care and new practice models to regulatory strategies and stakeholder communications.

With a combined scope that impacts regulation of more than 5 million physicians, physician assistants, pharmacists and nurses in the United States, the Tri-Regulator Collaborative is a significant force for
advocacy and we remain firmly committed to it as a partner.

In 2015, J. Daniel Gifford, MD, of Alabama assumed the Chairmanship of FSMB, following a successful year of leadership under Donald H. Polk, DO, of Tennessee. Under Dr. Gifford’s inspiring leadership, the FSMB established several new workgroups intended to study the implications of a new era of team-based regulation, develop new ideas for the education of medical students about medical regulation, and to review policies on telemmedicine consultations and the regulation of marijuana for medical purposes.

This ambitious undertaking moved forward quickly in 2015 and the workgroups have made strong progress in advancing our understanding of these topics of key importance to medical regulation’s future. Reports and updates are expected at the 2016 Annual Meeting in San Diego, California.

From a personal perspective, another highlight of 2015 is the time I spent working with international regulators as a part of the FSMB’s increased emphasis on outreach to the global regulatory community.

The FSMB continues to serve as the Secretariat of the International Association of Medical Regulatory Authorities (IAMRA), and in late 2016 I will begin a two-year term as Chair of IAMRA during the organization’s biennial meeting in Melbourne, Australia.

We are making wonderful progress in our new efforts to make IAMRA more inclusive and valuable to the world’s medical regulators as we seek ways to help them voluntarily share licensure and disciplinary information globally about physicians.

Here in the United States, the FSMB completed a busy year of upgrades to its Federation Credentials Verification Service (FCVS), which is entering its 20th year of service to the medical community. By the end of 2015, 96% of state medical boards had begun utilizing electronic FCVS profiles, and the service’s approval rating had topped 90% — the highest in its history.

We continued to make progress in 2015 with our Uniform Application for Physician State Licensure (UA) project, an effort to help physicians save time on licensure applications by standardizing information required across state borders. Well over 50,000 physician applications have been submitted since the UA’s launch, and, combined with our efforts to support the Interstate Medical Licensure Compact, the UA is helping us move forward in our long-term goal of speeding up physician licensing.

2015 also marked the distribution of the FSMB’s third Census of Actively Licensed Physicians in the United States, which provides the most accurate assessment available of key data about U.S. physicians — ranging from gender and age to specialty certification. Information for the Census is derived from our Physician Data Center, which in 2015 began offering for the first time free online searches of physician data for the public through its DocInfo service.

A commitment to quality data also drove our efforts in 2015 with the United States Medical Licensing Examination (USMLE) program, which the FSMB offers in partnership with the National Board of Medical Examiners. Over the last year we continued to make improvements and upgrades to this key component of the U.S. health care system.

Finally, it is important to note the contributions of FSMB staff in 2015. Our Washington D.C. advocacy team—which has expanded to include a staff of six—had a banner year representing the interests of the medical regulatory community, including vital support of state boards participating in the Interstate Medical Licensure Compact.

In an environment of ever-accelerating change that brings new challenges every day, the FSMB’s staff in Euless, Texas, also had an outstanding year of contribution in support of state boards. Meeting the needs of state boards is our highest priority, and in 2015 we succeeded in making our work spaces and organizational structure more functional and responsive to those we serve.

As we end one year of activity and begin another, I can confidently report that the FSMB is well positioned to help all of our 70 member boards in their ongoing quest to promote patient safety and the delivery of quality health care in the United States. It is our honor and privilege to serve in that capacity.

...THE FSMB IS WELL POSITIONED TO HELP ALL OF OUR 70 MEMBER BOARDS IN THEIR ONGOING QUEST TO PROMOTE PATIENT SAFETY AND THE DELIVERY OF QUALITY HEALTH CARE...
Oversight of Medical Care Quality: Origins and Evolution

Richard E. Burney, MD

ABSTRACT: Not long after physicians began to gather in organized groups and form professional societies in the 19th century, it became clear that education, training and practices were highly variable and that oversight to prevent outright quackery was needed. Although the situation is quite different today, experience has shown that continued oversight of medical care is still necessary. Some modern physicians may allow their knowledge, skills, and practices to become out of date, resulting in ineffective, unnecessary and expensive care. They may engage in any number of unprofessional behaviors, ranging from substance abuse to billing and insurance fraud, leading to disciplinary actions by external agencies. That said, providing oversight in today’s highly complex health care delivery system is not a simple task to accomplish. Many rules, regulations, structures and processes have been put into place, all trying to ensure that medical care is safe, affordable and of high quality. This essay briefly describes the history and evolution of medical oversight—from its relatively simple beginnings in licensing and accreditation initiated over a century ago to the multiplex of oversight programs currently in place—including a look at some of the new, innovative and data-driven approaches being used today.

Introduction

Consider for a moment this question: how can members of the public know that the physicians they are seeing are good physicians? How can patients know that their physicians have the requisite knowledge and the skills to care for them competently, using up-to-date, effective methods? How can they be assured that their physicians are of “good moral character” and practice in a professional manner? These are important questions, because not all physicians live up to expected standards. Physicians can and do fall behind in their knowledge and skills, practicing in an outdated fashion. They may abuse drugs, become alcoholic, act dishonestly, fail to abide by agreements, abuse employees, engage in sexual improprieties, sell drugs illegally, commit billing and insurance fraud, invent dangerous and ineffective treatments, dishonor their profession by cheating, stealing and lying, and go to jail.

I have been engaged in the oversight of medical care quality for more than 35 years in hospitals, in a Professional Standards Review Organization, in a Medicare Quality Improvement Organization, and for the past seven years as a member of the Michigan Board of Medicine. I have seen all of these failings occur and understand that oversight of medical care is necessary. But if oversight of quality is necessary, who should be responsible for it? How should it be accomplished—fairly and consistently? What follows is an attempt to summarize efforts past and present to achieve the goal of affordable, high quality health care.

The Definition of “Quality”

The father of quality in health care, the late Avedis Donabedian, defined the essential attributes or domains of quality in terms of structure, process and outcome in a groundbreaking 1989 essay, which remains the foundation document for all studies of health care quality.1,2 The term “health outcome” was defined by Donabedian as “the end results of medical care measures by health status and patient satisfaction.”1 This definition was advanced further by Paul Ellwood, who introduced the concept of the patient-reported health outcome,3 while at about the same time, John Ware and others at the Rand Corporation—under government contract—developed the SF-36, the first valid, reliable and functional health-status measurement tool.4 The Institute of Medicine, merging these ideas, has defined “medical quality” as “the degree to which health services for individuals and populations increase the likelihood of desired
health outcomes and are consistent with current professional knowledge.\textsuperscript{5} The purpose of oversight should be to ensure that proper structures in health care delivery are in place, as well as processes that ensure good quality and measure patient outcomes in ways that enhance improvement efforts. Table 1 shows how present oversight practices relate to structure and process.

### Basic Quality Oversight: Education and Certification

At the national level, three levels of professional achievement are required and accepted that offer the public assurance of competence. The first level of assurance is provided by successful graduation from medical school, which requires the student to have completed a high level of education, training and testing. Medical school graduation also implies that graduates are of good moral character and that as professionals they embody a desire to care for people. Further proof of students’ abilities is provided by having successfully completed Steps I and II of the United States Medical Licensing Examination (USMLE), which medical graduates are required to pass before entering post-graduate training.

The next level of assurance is provided by successful completion of residency training in an area of medical specialization. One year of internship may have sufficed many years ago, but it is no longer considered even remotely sufficient to ensure competence in patient care.\textsuperscript{6} All medical graduates must now enter a post-graduate training

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**Table 1**

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<th>Structural Elements</th>
<th>Applicable Attribute</th>
<th>Relevant Processes</th>
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<td>Graduation</td>
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<td>PQRI*<em>, SCIP*</em></td>
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<td>Commercial insurers</td>
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<td>Utilization Review</td>
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\* OPPE: ongoing professional practice evaluation; FPPE: focused professional practice evaluation
\** PQRI: Practice Quality Reporting Initiative; SCIP: Surgical Care Improvement Program
program in either a direct patient care specialty, such as Internal Medicine, Pediatrics, or Family Medicine; or a supporting specialty, such as Radiology or Pathology/Laboratory Medicine.

Minimum training in any medical field generally takes three to five years. During that period, the Accreditation Council for Graduate Medical Education (ACGME) requires all trainees to be evaluated during their training in six “core competencies”: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice. Safeguards for the public are thus implied by completion of residency. Endorsement of successful residency program completion by the program director implies competence, professionalism, honesty and good moral character. Additional safeguards are offered by specialty board certification, which requires successful completion of stringent written and oral examinations and may involve practical testing as well.

A third level of assurance is offered by completion of post-residency fellowship training and certification, such as Cardiology, Gastroenterology, Cardiothoracic Surgery, or Neonatology. Successful achievement of subspecialty certification suggests a higher level of competence in a particular field and should provide additional assurance of competence.

Maintenance of Certification in a Medical or Surgical Specialty

Almost all specialties now award only time-limited certification, ranging from five to ten years. To maintain certification, physicians must demonstrate competence by passing an examination at prescribed intervals. The requirements for recertification (or “maintenance of certification”) vary by specialty, but in keeping with ACGME recommendations, usually include:

- Demonstration of active practice
- Skill and knowledge assessment
- Demonstration of professionalism
- Evidence of reflective self-assessment
- Proof of continuing education or life-long learning

These levels of assurance, which utilize education, specialty training and certification, should provide a foundation for quality, but as experience has shown, they are not always sufficient to achieve broad health care goals or to protect the public.

Fellowship in a national organization

Large national medical specialty organizations, such as the American College of Surgeons, the American College of Physicians, and the American College of Obstetrics and Gynecology, play important roles in setting standards for training and education for their members. The American College of Surgeons, for example, offers the Fellow, American College of Surgeons (FACS) certificate as emblematic of high quality practice and good moral character — but it cannot possibly oversee patient-level quality of care by those who have earned the FACS distinction.

Oversight by State Boards

Licensing of physicians and other professionals, as we now know it, began in the last half of the 19th century when the quality of medical education, in the absence of regulation, was highly variable, mostly unscientific, and often blatantly commercial.

There were many “schools” of medicine at that time, ranging from homeopathic and eclectic to allopathic, Thompsonian, and dozens more. The threat to public health of widespread quackery led to the drive within the profession to improve medical training and to license physicians.

Influenced by medical societies, which existed in almost every state, states began to pass legislation regulating medical practice in the early 19th century. Although quite weak, these laws nevertheless came under attack by physicians as an infringement on free enterprise and an illegal restriction of liberty. They were also seen as an effort by MDs, the largest group, to eliminate competition from alternative practitioners. This led to the repeal of all of these laws prior to the Civil War.

After the Civil War, states — once again encouraged by state medical societies — established medical oversight boards. These acts once again came under attack. This time, however, the right of states to...
enact medical licensing laws was confirmed by the U.S. Supreme court in the 1889 decision, Dent v. West Virginia. The dispute leading to this case arose when Frank Dent, a graduate of the American Medical Eclectic College of Cincinnati, who had been in practice for six years, was denied a license by the West Virginia board for not having met state-licensing requirements, which included graduation from a reputable medical school or having passed a licensing examination. He sued and lost, which led to the appeal to the Supreme Court. In a separate case, the Supreme Court held that states could require physicians to be “of good moral character” in order to be licensed. In 1910 the court held it was reasonable for physicians to be required to register with the state in order to practice medicine. In these cases, the health of the public was found to have primacy over the individual rights of physicians (whether competent or incompetent) to practice.

State Licensing Standards

The requirements for obtaining a medical license do not raise the bar very high. Most depend almost entirely on the first two levels of assurance or competence described above — namely graduation from an accredited medical school and passage of the first two parts of the USMLE (or its counterpart osteopathic examination), followed by a period of post-graduate training and experience. USMLE Step 3 can be taken after six months of post-graduate training in an accredited program, and must be passed within five years. There is no requirement that an applicant have completed a residency program in an accredited hospital or institution. There is no limitation of practice by specialty. There is no special privilege for board certification.

Oversight Functions of State Boards of Medicine

Boards of medicine play an important role in regulation and oversight, even though the information they work with is limited to patient complaints, limited retrospective record review and interviews. Moreover, they have only blunt instruments at their disposal as remedies. They can take actions at the licensing level, such as limiting, revoking or suspending a license, or requiring treatment for alcoholism or drug addiction. Boards are effective in suspending, revoking, or limiting licenses and in refusing to grant or renew licenses of physicians who are obviously incompetent, convicted of fraud or other felony, alcoholic or impaired by substance abuse. Boards are also reasonably effective in limiting the practices of physicians who have engaged in improper sexual conduct involving patients or trainees. Prescribing practices can be monitored, supervisor reports requested, and monitoring visits set up. State boards thus play an important role in protecting the public. But removing bad apples, although necessary, is not sufficient to ensure good quality medical care.

Oversight at the Hospital or Health Care Organization Level

The hospital or health care organization is arguably the most important and effective locus of responsibility for overseeing the quality of medical care. Membership on a hospital staff in and of itself conveys some measure of assurance, because of the presumption that hospitals must exercise some degree of selectivity in whom they bring on staff. Thus the initial recruitment, credentialing and privileging of physicians by hospitals or large integrated health care systems, done properly, plays a critical role in ensuring quality.

The effectiveness of any quality oversight program at the hospital or health care organization level depends on its leadership, structure and organization. Where there is formal organizational structure there is the possibility of effective quality oversight. By formal organizational structure, I mean a departmental structure of the type usually seen in teaching hospitals, in which real, tangible authority is vested in a director/service chief/department chair, whose income does not depend entirely on the goodwill of those he or she oversees. In the community hospital model, service chiefs elected by the medical staff to serve for a year or two voluntarily will have a difficult time if they wish to bring about change or impose discipline. In either structure, change or improvement will not occur without strong support from the leadership at the hospital board level.
Hospital Quality Processes

Historically, the mechanisms by which hospitals exercised quality oversight on medical practice fell under the general heading of “peer review.” The most familiar, time-honored ones are “death and complications,” “morbidity and mortality,” and “clinicopathologic conference,” which is based on autopsy findings. These have traditionally been regular occasions at which complications and errors in medical care are reported (or confessed) before one’s colleagues, and unusual or difficult medical problems can be presented for discussion. Optimally, they create an opportunity for physicians to set consensus standards of care, to be held accountable for their care, and to learn from the experience of others so that needed changes in practice are brought to light and errors are not repeated.

Traditional peer review was found wanting in the early 1970s when it became obvious that only a few years after Medicare’s implementation in 1965, its costs were increasing far more rapidly than anticipated. The government response was to try to reduce costs by paying only for care that was deemed “reasonable and necessary” as stipulated in Section 1862(a) of the Social Security Act.

This led to two initiatives, both endorsed by the medical profession. One was called quality assurance, or QA, which was intended to oversee and improve the quality of care. The other was Utilization Review (UR), which was intended to reduce costs by eliminating unnecessary hospital days and procedures. (These initiatives were begun prior to the advent of the “diagnosis related groups” method of payment, in which a fixed rate for hospital admission was paid based on “diagnosis related group” or DRG.) Quality assurance required chart review of samples of records and application of clinical judgments with regard to the appropriateness of care, compared to agreed-upon standards. Included within UR parameters that could be examined were such factors as length of stay, frequency of test ordering, admissions lasting less than 24 hours, and justification for admission based on parameters such as “severity of illness or intensity of service.” These assessments were unavoidably subjective and reviewers found that charts rarely recorded the necessary data on which to base judgments. In the end, neither QA nor UR programs had a discernible effect on cost. In spite of this, UR persists among many insurance companies, who use it to screen admissions, monitor length of stay and deny payment for hospital services.

The failure of the initial attempts at peer review made it clear that something better was needed, paving the way for both “patient outcome” measurements in the 1980s and “quality improvement” in the 1990s—an approach that was adapted from industry and focuses on improving inefficient and ineffective processes in patient care. These forms of peer-review based oversight remain important alternatives in improving health care quality.

Professional Practice Evaluation

There is today a demand for newer, more quantitative and objective metrics to assess competence. Advances in health information technology (HIT) have made these more available (if not always well understood). The Joint Commission now requires medical staffs to carry out Ongoing Professional Practice Evaluations (OPPEs) quarterly on all physicians on a hospital staff. If there is suspicion of a competence problem, a “focused” PPE (FPPE) is called for. Compiling meaningful data without burdensome chart review is not easy, and hospitals increasingly look to electronic health record (EHR)-derived data analysis and manipulation to do the bulk of this work. Statistical methods can also be applied to non-direct patient care, examining rates of correct radiographic interpretation, for example. Fully electronic health record systems are expected to expand this kind of medical care oversight more widely.

There is also new emphasis on looking at physician behavior, particularly disruptive, uncooperative or insensitive behavior toward patients, co-workers or employees, arising out of the recognition that these behaviors contribute to errors in patient care.

Oversight by Payers

Organizations that pay the bills for medical care provide oversight through economic credentialing. The rapid expansion of innovation in the medical marketplace in the past 30 years has led to an amazing explosion of new drugs, devices, procedures,
and treatments, some of which are useful and cost-effective, many of which are not. While FDA approval of a new device is evidence of safety, it says nothing about utility. Unopposed, the heavy marketing and aggressive pricing of these products could potentially lead to intolerable increases in medical costs. It has fallen to payers to be the countervailing force to prevent this from happening. Medicare, Medicaid, large managed care organizations and Blue Cross plans have all established mechanisms for reviewing and approving new devices, drugs, and treatments for reimbursement. Whenever possible, these decisions should be “evidence based”—that is, based on scientific evidence of improved patient outcome.

Oversight by the Legal Profession

Although physicians are rarely willing to acknowledge it, malpractice litigation plays a role both in compensating patients for medical injury and in maintaining and possibly improving the quality of medical care. Malpractice litigation is usually perceived as a threat and is blamed for excesses in testing, documentation, and cost of medical care. There is undoubtedly some truth underlying this perception, but at the same time physicians cannot reasonably disregard the potential for their errors and complications to cause harm. There is therefore a legitimate and proper role for litigation to compensate patients for injuries that have occurred as a result of negligence, thoughtlessness, ignorance, and failure of duty. Moreover, the malpractice system is able to discipline physicians and others who might otherwise fall between the cracks of other quality oversight processes, and who would otherwise not have to acknowledge their responsibility for poor practices nor be held accountable for them.

National Practitioner Data Bank

The National Practitioner Data Bank (NPDB) was established in Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986. The act was amended in 2013 to combine the National Practitioner Data Bank, which reported on physicians, and the Healthcare Integrity and Protection Data Bank, which provided reports on the rest of the health care system. The NPDB receives and compiles reports of any adverse actions taken on the credentials or license of a physician. These include both substantiated malpractice claims and adverse actions taken with regard to hospital privileges, such as dismissal from a hospital staff. If a malpractice claim is settled, the named physician is reported. If, however, a settlement is made prior to a claim being filed, no report is made.

There are gaps in the NPDB data. Most instances of medical error or negligence do not result in the filing of a claim. If a physician is dismissed from a hospital staff or his or her privileges are restricted, the action is reported. However, if a physician resigns under threat of loss of privileges, the action may not necessarily be reported. It is hard to know the extent to which listing in the NPDB actually offers useful information about the quality of a physician’s care. The actual data are sparse and don’t describe in detail what happened and why. Thus, even though it has been in existence for over 20 years, questions persist regarding the utility of the NPDB’s data.

Online Resources

Individuals can now seek out oversight-like information through online resources that compare hospitals (e.g., www.medicare.gov/hospitalcompare) and physicians (e.g., www.healthgrades.com). According to Wikipedia, “Healthgrades Inc. is a U.S. company that develops and markets quality and safety ratings of health care providers, including hospitals, nursing homes, physicians and dentists.” Large administrative data sets, primarily the Medicare data set, are used as the basis for comparison. Other websites offer the opportunity for patients to rate their doctors and health care experiences. The effectiveness of these online resources in assuring quality is unknown.

Continuous Professional Development

All good physicians know that in order to practice effectively in the rapidly changing environment of medical practice, they must continuously expand and refresh their knowledge and learn new skills. In the ideal, physicians regularly read the medical literature, attend conferences, and seek out courses that keep them current. The process of doing this comes under the general headings of continuous
professional development, life-long learning, or continuing medical education (CME). It is necessary, but not always sufficient, to ensure quality.

In 1968, the American Medical Association effectively mandated CME for physicians by advocating that all of its members engage in 150 hours of approved educational activities over a three-year period.\(^{17}\) State licensing boards soon followed suit, mandating the same or a similar amount of CME as a requirement for license renewal. This led to a rapid expansion of a CME industry, the offerings of which did not always meet the initial goals of the program. Attempts to reconfigure and redesign CME to be more effective began 30 years ago, when evidence emerged that traditional CME was not bringing about actual improvements in practice.\(^{18}\) Since then, newer methods have been proposed in which process is linked more closely to actual practice.\(^{19}\)

**Newer Initiatives to Measure and Improve Quality**

The past two decades have seen the development of a variety of quality improvement entities and “lean” initiatives that are intended to make health care delivery more efficient or effective. This concept has been most visibly promoted nationwide by the Institute for Healthcare Improvement (IHI) and was adopted in the 1990s in the Medicare program, which made the transition from “quality assurance” to “quality improvement” when it had become clear that imposing punitive measures for errors and failures was not achieving the desired goals of improved quality and reduced cost.\(^{20}\) Other initiatives have been made possible by the ability to collect, aggregate, analyze and compare large amounts of health care data by provider. Regional comparisons using Medicare data began showing wide geographic variations in care in the early 1970s.\(^{21}\) Compliance with evidence-based protocols for treatment of common conditions linked with outcomes data, for example, can now be examined using analysis of the electronic health record. The hope is that sharing such data regarding adherence to evidence-based guidelines and sharing of best practices will be effective in improving health care delivery.

Medicare, through its network of state-based Quality Improvement Organizations, has promoted a number of evidence-based practices in the treatment of acute myocardial infarction and pneumonia, prevention of deep venous thrombosis and venous thromboembolism, reduction in urinary tract infections, prevention of central line-related sepsis, and reduction in surgical site infections, to name a few.

Other initiatives are contemplated or under way, using large amounts of data on health services that have become available through the National Center for Health Statistics, the National Cancer Institute (specifically, its Surveillance, Epidemiology and End Results database), Medicare, the National Trauma Data Bank and the National Surgical Quality Improvement Project (NSQIP). Some of these are based on administrative data sets, while others are based on survey data, hospital discharge data sets or actual case reviews. So far, none of these have been linked in a meaningful way to structure or process change and outcome improvement — but experiments are under way.

**The Physician Quality Reporting System (PQRS)**

PQRS is a Medicare program aimed at gathering and making available to the public data on quality of health care in a way that promotes comparison and competition. This process is described as “a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).”\(^{22}\)

In support of this approach, the American College of Surgeons offers a service that allows surgeons to record their cases and compare their outcomes to those of others in a way that meets the requirements of the American Board of Surgery for maintenance of certification — while also meeting federal requirements for the Physician Quality Reporting System (PQRS) demonstrating the “meaningful use” of electronic health records.

**Surgical Care Improvement Program (SCIP)**

The SCIP has been one of the first attempts to enforce evidence-based practices in surgery. Started by Medicare, the SCIP calls for proper antimicrobial selection prior to surgery, proper dosage and timing of antimicrobial administration, and the discontinuation of prophylactic antimicrobials. It has been adopted by insurers, such as Blue Cross/Blue Shield of Michigan, which imposed monetary penalties for imperfect
adherence. This initiative has been a major test of whether findings in clinical research studies can be transferred to community practice that results in improvements in outcomes. The program has led to a number of changes in care-processes having to do with the ordering, administration and documentation of antibiotic administration in the operating room, possibly with some improvement in infection rates. 

The National Surgical Quality Improvement Project (NSQIP)
The NSQIP began in the Veterans Administration (VA) system as a way to measure and improve quality across the all VA hospitals. Nurses abstract data taken from a sample of surgical charts, which allows comparison of surgical results among hospitals. This project shined a bright light on wide variations in rates of complications and deaths after surgery in VA hospitals, and led to major changes in both structure and process among them. The American College of Surgeons adopted the model and has made it available on a voluntary basis to hospitals across the country.

Conclusion
In an ideal world, the character, motivation and personal desire of the caring physician to provide the best patient care possible would ensure quality. If all physicians had sufficient levels of these attributes, oversight might be superfluous. Unfortunately, this is not the case. Regulation and oversight are necessary and in our highly complex health care delivery system there is no simple way to do it. As a result, external agents, including state and national government, insurers, professional organizations, and the Joint Commission, have put many structures and processes into place with the intent of ensuring and improving medical care quality. Today, oversight of medical care is now carried out at many levels, by many different entities. Most, if not all, of these levels of oversight appear to be necessary, but all have their weaknesses and limitations. None is sufficient on its own. Oversight is, and will continue to be, necessary; and we should hope for continued innovation in how to accomplish it. Done wisely, it has the potential to improve health care quality. ■

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**Insightful Practice:**
A Method to Address a Gap in Medical Regulation

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**ABSTRACT:** Risk from sub-optimal medical practice remains a perennial international problem. While regulatory efforts for improvement have been significant, new thinking and innovation is needed. In an ideal world, professional career paths would be enhanced, supported and successfully maintained from medical school to retirement. Regulatory outcomes would be made resilient to public and professional challenge. Professional development, with quality improvement at its heart, would be maximized, and concerns about medical competency would be highlighted and acted upon at an early stage – before they become “a fitness to practice” matter. At this early stage, referred to in this paper as the “amber zone,” concerns about an individual's ability to practice medicine competently may emerge, but they are not considered of sufficient severity to warrant a referral to a fitness to practice inquiry by medical regulators. The introduction of a concept called Insightful Practice is one attempt to address the unmet challenge of the amber zone. A surrogate measure of professionalism, Insightful Practice is a method that assesses medical professionals’ engagement with the system within which they work and with feedback on their performance for any given work role. In addition and crucially, the method considers medical professionals’ insight into what they need to change and their plans for improvement. Potential problems are identified early, increasing the likelihood that remediation measures will be successful. An application using Insightful Practice is described here, examples of its use given, and a discussion is provided of the concept’s advantages, limitations and potential to help regulatory authorities and other health care agencies address the challenge for regulatory systems to identify and remediate medical professionals who find themselves in an early amber zone of concern. The application described is based on humans’ long understood struggle “to see ourselves as others see us,” and is an attempt to support and channel medical professionals’ integrity and drive for improvement in order to protect patients. While the Insightful Practice concept is discussed in this paper in the context of the UK’s regulatory system, its principles are applicable to other medical regulatory systems around the world.

**Introduction**

The practice of medicine is a privilege. Public trust, while it may be enduring, is rooted in the expectation of the best possible professional care available. Medical regulators are charged with ensuring standards are maintained, unprofessional practice dealt with and patients protected by encouraging the raising of overall standards of professional practice.1,2 “Putting patients first” is a key principle of the regulation of physicians that both the public and profession would agree is unarguable. While the goal seems simple, the process is complicated.

In addition to having adverse impact on patients and their families, failings in medical professionalism have significant adverse impact and costs for health care providers, professional organization bodies and medical defense agencies. In preventing these costs, and to minimize risk, potential ambiguity around roles and responsibilities of these multi-agency interests may need clarification. For example, it is accepted that medical regulation needs to become involved when physicians do not engage with their organizations’ systems of appraisal, or when a serious adverse event or complaint emerges. But should regulators also take a proactive interest when tacit information within the system suggests a physician’s performance may be sub-optimal? Or is that the responsibility of health care employers alone? Arguably, medical regulators should keep a wide sphere of influence and interest in order to ensure that different efforts dovetail to offer a robust and comprehensive system.

* In the UK, medical defense is provided by not-for-profit organizations that indemnify and provide legal representation for members for incidents arising from their clinical care of patients.
In recent years, a new, comprehensive system for continuous professional development has been introduced in an effort to strengthen the ongoing competency of physicians in the UK. The GMC’s “revalidation” system requires all medical practitioners to undertake an annual appraisal by a trained peer appraiser with formal review every five years in order to remain on the GMC’s specialist registers as being “fit for practice.”

UK revalidation aims to reassure the public through positive affirmation of physicians’ performance and skills, and by checking that physicians are making appropriate efforts to keep their knowledge and skills up to date. The system involves a collection of information based on a portfolio that includes specified categories: peer feedback, patient feedback, complaints, significant-event analysis and evidence of self-directed continuous professional development (CPD) activities. This evidence is discussed and learning is facilitated through the peer appraisal. Post appraisal, the health employers’ Responsible Officers (ROs)** confirm satisfactory completion or flag concerns to the GMC, following which, the GMC decides on physicians’ revalidation.

While comprehensive, the UK’s system still requires no formal knowledge-testing of physicians. After the tragedy caused by Harold Shipman — a general practitioner and the U.K.’s most prolific serial murderer, who killed his own patients — an inquiry was launched to establish what lessons should be learned and make recommendations for actions to prevent future risk to patients. One of the inquiry’s recommendations was that an “open book” knowledge test should be a minimal requirement of doctors for their future revalidation. While this option has since been piloted with general practitioners as part of a research study, it has not been instituted by the current system.

In 2014, the GMC commissioned a group of independent researchers to undertake a long-term independent evaluation of UK revalidation, based on an agreed evaluative framework. A final report is expected in 2018 and the evaluation’s outcomes and recommendations are eagerly awaited.

Two outcomes of the evaluation are of particular interest, with no weak links. Failure to do so creates the risk of unprofessional health care workers gaming their way around the system, or moving on before their behaviors are identified and acted upon. The ideal is for an integrated system, which would identify medical professionals who are at risk before patients are harmed — and the associated human and material costs are incurred.

Many agencies have an interest. Medical schools seek to recruit good students and to promote standards of professional behavior. Health care employers and professional and accreditation bodies seek high standards of quality improvement. Medical defense agencies seek methods by which potential litigation and risks can be identified early and their impact minimized.

In addition to taking responsibility for “fitness to practice” cases (i.e., formal inquiries into the competency of a physician to practice medicine), regulatory authorities in some countries play other important roles. These include: 1) participating in the monitoring of medical schools’ efforts to support the development of professionalism and deal with problems, 2) enhancing established medical professionals’ personal development and, importantly, 3) identifying those medical professionals who are starting to lose their way and becoming a risk to the system — before serious harm results.

Current initiatives

While there has been considerable global effort by regulatory authorities to achieve quality improvement in their systems, and some of these efforts continue to progress, problems persist and opportunities for improvement remain.

In the United Kingdom (UK), practicing physicians are licensed and registered with the General Medical Council (GMC) after completing a lengthy educational process (in general, anywhere from four to nine years of total medical training). Continuing medical education is mandatory, and the GMC has the authority to sanction physicians who put patients at risk.

**UK Responsible officers (ROs), usually a senior clinician, are accountable for the local clinical governance processes in their NHS health care organization with a focus on the conduct and performance of doctors. Duties include evaluating a doctor’s fitness to practice, and liaising with the GMC over relevant procedures. The ROs’ role is to make recommendations, but the decision on whether a doctor should be revalidated belongs to the GMC, as the regulator.
interest. First, the effectiveness of face-to-face appraisal as a reliable component of revalidation will be of key importance, as its reliability has been previously questioned. Second, whether physicians whose practice may be falling into an “amber zone” (i.e., tacit knowledge in the system has identified concerns with their medical practice, but these are not considered sufficiently severe to warrant a referral to a fitness to practice inquiry) are being identified by the process. If physicians in an early amber zone of concern are being successfully identified, it will then be important to establish if the future trajectory in standards of their practice is being effectively tracked and supported to protect patients before harm can occur. Last, the tracking of progress of any cohort of such amber-zone physicians will need to be based on a valid, reliable and feasible system which is clear around the roles, responsibilities and accountabilities of involved agencies. This raises a number of challenges.

Challenges

Self-assessment

While self-assessment has an important role in helping medical professionals’ identify their learning needs, the accuracy of self-assessment, without the benefit of calibration by the comparison with individuals’ peer assessment, is known to be poor. A systematic review of the physician literature found the majority of studies demonstrated little or even an inverse relationship between self and external assessments. Individuals’ self-assessment skills seem related to levels of competence and the accuracy of self-assessment seems poorest at the extremes of performance. High-achievers, as individuals with high levels of competence, tend to be over-critical of themselves, while individuals with the lowest competence, and whose practice is likely of immediate concern, tend to overestimate their abilities and seem relatively unable to amend their opinion effectively, even when provided with independent external assessment. On the other hand, individuals in the mid-level of competence are most accurate in assessing their own performance and this insight is maintained following independent external assessment feedback.

Reflective practice

In a review paper, Eva and Regehr argued that “the route to self-improvement is not through becoming a more accurate self-assessor, but through seeking out feedback from reliable and valid external sources, and then making a special effort to take the resulting feedback seriously rather than discounting it.” They argued that safe practice requires an on-going dynamic process of “reflection-in-practice,” aimed at continuously monitoring one’s ability by addressing emerging difficulties. They recommended that external feedback be reflected upon to support effective self-awareness.

Is there a “regulatory gap”?

High achievers’ standards of practice are unlikely to be of concern to the public. Physicians whose practice is known to be of serious concern are likely to be already dealt with by regulatory systems’ fitness-to-practice procedures. It is therefore professionals in the amber zone of performance, rather than the high achievers, or those of immediate concern that pose particular difficulty. Physicians within this amber zone risk becoming caught in a regulatory gap, where there may be tacit knowledge suggesting poor performance, but not enough concern to trigger current action by employers or regulators. In addition, those within this amber zone might challenge the validity and reliability of assessments which identify them and resist their classification as being in potential difficulty, so preventing engagement with monitoring or early remediation. Arguably, the development of a feasible system that is valid and reliable could act as a second tier of increased support and scrutiny. This would offer advantages to all parties. Enactment of a second tier process could be triggered by peer appraisers or other concerned bodies. The further clarification of a physician’s progress, through an additional valid and reliable system, would help protect the status of both the physician and the physician’s appraiser as a supporter and educational mentor, while

THE ACCURACY OF SELF-ASSESSMENT, WITHOUT THE BENEFIT OF CALIBRATION BY THE COMPARISON WITH INDIVIDUALS’ PEER ASSESSMENT, IS KNOWN TO BE POOR.
providing the background and rationale for regulatory outcomes that are open to challenge by both medical professionals and public.

**Keeping professionalism “on-track”**

If we are to meet the challenge of the regulatory gap, it is important to understand the risks that can threaten to derail medical professionalism. Maintaining professional standards throughout any career is a significant challenge, given the pressures generated by changing expectations of best practice. Over the lifetime of a medical career, changes in practice context, social circumstances, personal health issues and disaffection are risks that can impact any practitioner. Given that at the start of a career one is “on track” for a successful professional working life, there is a strong argument that monitoring satisfactory progress throughout a career is desirable and offers practitioners confirmation of their ongoing professionalism, self-worth and standing with their patients. Medical professionals need to be given a reliable early warning that they may be wandering “off track” and given support and opportunity, if needed, to correct and change direction. While human-factor science and error theory point to systems as the main cause of error, the quality improvement movement has recently observed that medically adverse events can be more than uniquely a system problem. Some individuals repeatedly display incompetent or grossly unprofessional behaviour. Evidence exists that a minority of physicians account for the vast majority of complaints. As a result, addressing the problem of those practitioners labelled as “bad apples” has been suggested to augment the quality improvement field’s still crucial efforts to improve the design of organizational systems and suffer harm. Rather than searching for a system to find the “bad apples,” should we view the problem from an alternative standpoint, where any professional, when challenged by life events, has the potential of losing his or her way and putting patients and colleagues at unnecessary risk?

**Assessment, performance and criminality**

Criminality and serious complaints bring public concerns to the forefront and demand action from regulators. Many quality improvement systems in use by regulators rely on health professionals’ self-assessment of their CPD activities. If not triangulated by other independent methods, this approach can be flawed and open to the manipulation of evidence. For example, Harold Shipman was complimented on his personal submission of audits just nine months before his arrest. His feedback at his medical appraisal read: “Great to see a single-handed enthusiastic GP with a rolling program of audit — keep up the good work.” Such cases of murder of patients by clinicians can be used to resist or criticize innovation in regulatory monitoring systems as unlikely to protect against criminal events.

**Why measuring professionalism could be the key**

Despite various international efforts, current assessment systems are often viewed by physicians as hoops to jump through with no connection to their everyday work-roles. While agreeing on the importance of identifying and dealing with clearly unprofessional behaviour, we would argue that this view is too simplistic. We would assert that some medical professionals in difficulty may not be “bad,” but unwell or poorly advised or supported — and still potentially remediable if identified and encouraged back into the professional fold before patients...
who are engaged with their continuous professional development (CPD). Repeated evidence of poor performance over time, serious adverse events, and complaints will result in action by medical regulators. This simple standpoint is attractive. It proffers reassurance that the majority of professionals are of good standing and supports employment needs. But it offers little protection for patients by exposing them to the risk of experiencing random negative outcomes before action is taken and the harm has already been done (Figure 1).

The Concept of Insightful Practice: A Proposed Way Forward

In this paper, we put forward Insightful Practice as a new concept to act as a surrogate measure of physicians’ professionalism in maintaining an appropriate response to independent feedback on their career progress. Insightful Practice is defined as professionals demonstrating appropriate levels of engagement, insight and action when presented with credible and independent feedback on their individual and/or team performance. This alternative system is based on the view that we begin our careers from a professional position on entry to medical school. The challenge is to help practitioners maintain this position throughout their careers in order to maximize their competence and performance to protect patients. Use of Insightful Practice is based on professionals’ appropriate response to independent feedback on performance, testing professional integrity and offering a basis

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**Figure 1**

**Professionalism and Risk**

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[Diagram showing the process of gathering evidence, submission of evidence, local recommendation of licensing, and the outcomes of serious complaints, mistakes, non-engagement, and no concerns leading to unacceptable risk.]

Courtesy of University of Dundee School of Medicine
for monitoring and improvement. The method is designed to facilitate effective reflection on professional performance, give early warning of any problems and, where required, monitor successful remediation to maintain a professional career path. Insightful Practice requires physicians to engage with the system within which they work, show insight into the messages conveyed by credible and independent feedback on their performance and set meaningful personal objectives for improvement. Insightful Practice is cyclical and aimed at continuous improvement and maintenance of professional standards (Figure 2).8,19

The proposed system of Insightful Practice requires further consideration with respect to the literature on physicians’ reflection and self-assessment. Insightful Practice can bolster individuals’ self-assessment and reflection on their practice. We believe it meets the call described earlier, by Eva and Regehr, for a fresh approach that can monitor the dynamic and more forward-looking process of physicians’ reflection-in-practice to make any required quality improvement. Insightful Practice explicitly acknowledges that all professionals have areas of need, beyond their self-assessment, that could, if addressed, benefit patients. For the minority of medical professionals in the amber zone who fail to engage, demonstrate insight, or alter course, despite support and facilitation, the system would provide regulators and employers an early warning of risk of sub-optimal care. Reassuringly, two previous and separate studies, conducted in Scotland, have shown the proposed concept of Insightful Practice to offer regulators and medical schools a valid and highly reliable measure to differentiate between family doctors and medical students on their levels of professionalism.8,19

Insightful Practice: Family practitioners’ study
The original study investigating the concept of Insightful Practice involved 60 family practitioners and 12 peer appraisers in Tayside in Scotland. In this study, face-to-face assessment of physicians’ levels of Insightful Practice following their statutory medical appraisal by a peer appraiser proved unreliable as a method of assessment. However, anonymous global assessment by three blinded web-based appraiser assessors of the physicians’ levels of Insightful Practice was highly reliable (G=0.85), as were revalidation decisions using four anonymous assessors (G=0.83). Unlike face-to-face appraisal, anonymous assessment of Insightful Practice was shown to offer a valid and reliable method to decide recommendations on the revalidation of family practitioners.8

Insightful Practice: Medical students’ study
Following the family practitioner study, a similar study was conducted at University of Dundee’s Medical School. This study involved 28 fourth-year medical students divided into two equal groups (n=14). Both levels of Insightful Practice was highly reliable (G=0.85), as were revalidation decisions using four anonymous assessors (G=0.83). Unlike face-to-face appraisal, anonymous assessment of Insightful Practice was shown to offer a valid and reliable method to decide recommendations on the revalidation of family practitioners.8

Figure 2
Cycle of Insightful Practice

groups were assessed by medical school staff web-based assessors for levels of Insightful Practice in response to their available assessment feedback. One group was assessed by blinded and calibrated assessors, and the other group was assessed by blinded and uncalibrated assessors. Calibration of assessors involved a single one-hour meeting to discuss the concept and share experience of making assessments of “virtual examples” of possible students’ portfolios. Insightful Practice offered a feasible and highly reliable global assessment for calibrated anonymous assessors, $G$ (inter-rater reliability) $> 0.8$ (two assessors). Assessment by uncalibrated assessors, however, showed low reliability ($G < 0.31$). This study concluded that calibrated assessment proved an acceptable basis to enhance feedback and identify concern in students’ professionalism. Students reported increased awareness in teamwork and in the importance of heeding advice. Students’ staff coaches (appraisers) reported improvement in their feedback skills and commitment to improving the quality of student feedback.19

**What about high achievers and amber-zone physicians who lack insight?**
Insightful Practice appears to offer possibilities for high achievers and amber-zone physicians. For the context of Insightful Practice, physicians’ self-assessment involves reflection on a valid, credible and independent suite of feedback rather than limiting its scope to physicians’ own personal

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**UNLIKE FACE-TO-FACE APPRAISAL, ANONYMOUS ASSESSMENT OF INSIGHTFUL PRACTICE WAS SHOWN TO OFFER A VALID AND RELIABLE METHOD TO DECIDE RECOMMENDATIONS ON THE REVALIDATION OF FAMILY PRACTITIONERS.**

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**Figure 3**
**Professionalism and Risk**

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Courtesy of University of Dundee School of Medicine
perceptions of their performance. In high-achiever cases, the patient benefits from the high achiever’s continuous striving for excellence, and the high achiever, in turn, is reassured and validated. On the other hand, in the case of amber-zone or “bad apple” physicians, both would need careful support and recording of progress. Those who are unable to engage with feedback, make improvements and get back on track are arguably buying out of their professional responsibilities and, if a risk to patients, need to be referred to a fitness-to-practice hearing.

It is important to stress that all of the above scenarios concern insight, or its absence. Criminality is another matter entirely. It is unlikely that any fixed assessment system could be relied upon to address this.

**How would a system based on Insightful Practice work?**

We believe the measure of Insightful Practice could bolster and stabilize existing regulatory and monitoring systems. Figure 3, by the addition of a second triangle to the earlier Figure 1, illustrates how additional scrutiny could be provided by incorporating Insightful Practice into the overall system (Figure 3). This additional scrutiny could be used to cross-check the validity of outcomes for a sample of those assessed by current systems. It could also help to identify, monitor and support those showing early signs of difficulty. In addition, a system based on Insightful Practice could help support the current shift in the governance processes of medical regulatory systems. It could increase opportunities for lay public involvement in future developments by, for example, including the use of lay assessment. Insightful Practice is not proposed as a replacement for existing systems of professional appraisal or fitness-to-practice systems. It is proposed to fill the regulatory gap mentioned earlier. It could help address a difficult group of practitioners who are in the amber zone of early concern and in danger of being consigned to a “limbo status,” waiting for the calamity that triggers serious action after the avoidable harm has occurred. The system could be adopted and molded to any given work-role or context to give valid feedback. Robust and efficient, the system could help...

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**THOSE WHO ARE UNABLE TO ENGAGE WITH FEEDBACK, MAKE IMPROVEMENTS AND GET BACK ON TRACK ARE ARGUABLY BUYING OUT OF THEIR PROFESSIONAL RESPONSIBILITIES...**

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**Figure 4**

**Step 1: Time to Reflect on Your Feedback**

The purpose of this form is to capture your opinion of this exercise in helping engage, show insight and act on the data provided.

**Please rate your level of agreement using the rating scale 1–7 along with free text comments against each question:**

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<th>Question</th>
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<td>b. This feedback highlighted concern in my performance</td>
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<td>c. This feedback highlighted planned change</td>
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<td>d. This feedback was valuable</td>
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avoid escalating concern resulting in future fitness-to-practice cases. In doing so, the system would help regulators, higher educational institutions, deaneries, indemnity organizations, medical schools, and other groups to meet their shared aim of helping ensure robust outcomes to underpin safe and effective patient care.

Using Insightful Practice to Measure Professional Reflection: Four Steps

Blank templates of the four steps are provided in Figures 4–7. For examples, visit this link: www.tipportfolio.co.uk/InsightfulPractice.htm

**Step 1** (Figure 4)
Professional participants are asked to reflect on each component from their agreed suite of credible independent feedback data by replying on the web to four-question prompts to each component. Components making up the suite of feedback can be contextualized to the work-role being considered. For example, in the examples provided (www.tipportfolio.co.uk/InsightfulPractice.htm) different suites of data are used. In the undergraduate medical school application section, the feedback is based on identified examples of what are considered lapses in professionalism by the medical school. In this case, the purpose of the exercise is to assess and monitor longitudinally an appropriate response by the student to get their professionalism on track.

In the post-graduate section, feedback sources include peer and patient feedback tools as well as complaints. The purpose of this post-graduate application is to enhance the participants’ response to feedback to improve the care they provide as well as identify those who are failing to address important opportunities for improvement, or worse, are possibly practicing in a manner that appears unprofessional. Participant responses to question (c) — “This feedback highlighted planned change” — are automatically harvested by the web system from each entry against each source of feedback to populate a “box of ideas” on the website for the participant to subsequently fashion into objectives for improvement at Step 2.

**Step 2** (Figure 5)
Participants use their “box of ideas” for change to develop Specific, Measurable, Achievable, Relevant and Time-based (SMART) objectives for any areas of identified improvement or further development. A drop-down menu allows participants to allocate a relevant regulatory domain for each of their objectives. The drop-down template uses the UK General Medical Council’s current domains for appraisal and revalidation, but this can clearly be specified appropriately by the system to any given context. The purpose is to underpin the importance of personal reflection, engaging with the system within which the participant professional works.

**Figure 5**
**Step 2: Now Set Your Objectives for Improvement**

Set your SMART objectives based on your suite of feedback. We suggest that each objective is best completed as: Specific, Measurable, Achievable, Relevant to your work and to a Timeline

Match your objectives to the GMC Good Medical Practice Domains.

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**Step 3 (Figure 6)**

In Step 3, participants are asked to rate the quality of their reflection and whether best use of it has been achieved. This is facilitated by asking them to self-assess whether they have shown engagement with all of their feedback, shown insight into its content and taken required appropriate action for any needed improvement/development. By asking them to do this, Step 3 acts as a final cross-check and opportunity to reconsider their reaction and plans.

**Step 4 (Figure 7)**

Step 4 is optional and repeats the same questions as at Step 3. On this occasion, however, the assessment of Insightful Practice can be made by an independent reviewer or multiple reviewers. The purpose of this step is to offer involved organizations and/or regulators opportunities to decide priorities for placing any additional resources. For example, as facilitation is known to be important to encourage insight and help deliver required change, Step 4 could allow input and support to be given, perhaps following an existing system’s planned coaching or appraisal interview, to encourage participants’ successful engagement, insight and action with the process. Facilitation by coaching or appraisal systems is expensive, however, and agencies may wish to integrate the application of the method into their existing systems or use it to help target unmet areas of interest. Importantly, in addition to helping facilitate reflection (Steps 1–3), an additional Step 4 can provide a highly reliable overall surrogate assessment of professionalism by independent web-based assessors to provide challenge-resistant high-stakes decisions on progress if it be required. Given the human basis of an independent assessment of Insightful Practice at Step 4, future research into the validity, reliability and acceptability of including lay assessors would be interesting and widen the potential role of patients in regulatory processes.

**Applications to date**

The measurement of Insightful Practice has been successfully piloted in Tayside, Scotland in the context of general (family) practitioners and medical students.

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**Figure 6**

**Step 3: Reflect on Your Insightful Practice**

Insightful Practice is defined as your engagement with, insight into and appropriate action for quality improvement following reflection on credible and independent feedback.

To ensure that you have made best use of feedback, in order to continue to improve, you should ask the following questions and rate their response:

**Please rate your level of agreement using the rating scale 1–7 along with free text comments against each question:**

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<tr>
<td>a. Have you engaged with all of the feedback?</td>
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<td>b. Have you shown insight into the messages contained within the feedback?</td>
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<td>c. Have you taken appropriate action and set any necessary objectives for improvement?</td>
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Potential applications

Potential benefits

Potential applications

While accurate self-reflection can be difficult when we are challenged by adversity, stress, complaints, or health and social matters, it can be all the more difficult at a time when we need to see problems clearly and strategically to help get our careers back on track. Many of us will be able to recall “a word in your ear” by a trusted professional confidant that was important at some key time of our careers. The system formalizes the process and allows its use at a number of levels. It can be used to maximize the benefit of credible, independent feedback and monitor those who, while not “bad apples,” may be showing signs of becoming of concern and in need of support. This system can build on and add value to regulatory authorities and other agencies’ current systems to support physicians in difficulty. In cases where all efforts have been exhausted, measurement of Insightful Practice by blinded and independent assessors offers robust additional evidence to help inform decisions on continued fitness to practice.8,19

Potential benefits

Professional reflection based on self-driven assessment of needs and current standing is not enough. It risks the high achievers’ collecting ever more data to meet unrealistic targets and those with poor insight into their needs collecting confirmatory evidence of their perception of their standing. Reflection based on credible and independent evidence of performance is of key importance and offers physicians a cross-check on their self-assessment of progress. In addition, physicians’ adequate and appropriate response to independent feedback to highlight opportunities for quality improvement may well highlight deficiencies unobtainable by other means. The system is adaptable to work context and roles and so can offer support to existing regulation methods and associated systems — including professional appraisal, examinations and professional accreditation — to maximize performance and quality of health care. Measurement of Insightful Practice offers a reliable means by which regulatory...
systems could cross-check the validity of their existing regulatory decisions. In addition, it offers a practical method to scrutinize individual medical professionals identified as being of some concern, provide an audit trail of their progress and help inform decisions on professional outcomes. Insightful Practice offers a basis for the surrogate monitoring of professionalism from outset to end of career. It offers medical schools a system to monitor and highlight professional behaviour problems upstream of adverse impact on patients. This is of particular importance, given increasing calls for medical schools to record an audit trail of their input to any decisions on licensure for practice at the end of training.

**Potential limitations**
Professionals are capable people and gaming a way around any system can be a problem for its durability. Ironically, from our studies to date with both family practitioners and medical students, lack of insight into problems can appear to preclude the capacity to recognize that it would be prudent to change course. Where insight is lacking and when feeling threatened by what they perceive as unwelcome and unfair scrutiny, physicians could “agree on the face of it” with their feedback without intending to engage with change in any meaningful way. If so, the longitudinal monitoring of progress would reveal future difficulties. Future experience will be important to establish if these early experiences are valid. The presented method of assessment is designed to encourage and focus on needed change and log progress in performance. It is not designed to facilitate an interactive one-to-one conversation with subjects for the purpose of wider personal support—for example, the discussion of health issues. This would have to be provided separately by alternative methods, such as the services of an occupational health organization. However, a twin-track approach may sometimes be needed, when both occupational health support and the early monitoring of provided standards of care are needed if risks are to be successfully managed and patients protected.

**Implications for medical regulation**
For medical regulation, suggesting to physicians that they “keep up the good work” is not enough. At the same time, suggesting that new regulatory systems should not be implemented because they cannot be guaranteed to catch potentially harmful physicians is also not good enough. Agencies need to work together and be clear of their agreed responsibilities and boundaries or health professionals who put patients at risk will be able to game their way onwards, unchecked, until their behavior finally catches up with them, patients are actually harmed and significant costs are incurred. An applied system based on the measurement of Insightful Practice offers a useful and simple basis to help national systems develop their future plans, meet their contextual needs and provide robust and reliable systems to keep health care professionals on track and to maintain public protection.

**Conclusion**
The measurement of Insightful Practice is a simple concept. It is based on a long-recognized human observation that it can be difficult to see ourselves as others see us. The authors assert that the measurement of Insightful Practice is practical, flexible, and can be adapted to any given context, or professional work role. The system can help support those amber-zone physicians whose practice falls into the regulatory gap of being neither good nor bad enough for either revalidation programs or fitness-to-practice systems. It offers a reliable surrogate assessment of professionalism that could hold valuable application for health care organizations, regulatory authorities, higher educational institutions, professional organizations and professional defense organizations, all of whom have a shared interest in achieving quality and safety in the provision of international health care. If it were adopted, agencies could develop their own system based on the concept of Insightful Practice, consider involvement with an external resource to meet their requirements, or develop an alternative robust system. The status quo is not an option. The challenge will be ensuring that risk within the current regulatory gap does not prevail by being allowed to fall between ill-defined areas of responsibility, for we are all accountable and pay the cost. We will all be patients one day.

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Data Sharing Statement

The concept of Insightful Practice was invented and first described by Douglas J. Murphy, MD, FRCGP as were all the materials and figures contained in this paper. Anyone wishing to use any of the materials in this paper should contact Dr. Murphy at douglasmurphy27@gmail.com or douglas.murphy@nhs.net.

Dr. Murphy was funded in the development of all the ideas and concepts described in this paper by a Primary Care Research Career Award provided by Chief Scientist Office, Scottish Government.

References


Appendix

A workbook of illustrative examples of Insightful Practice is available at: https://www.tipportfolio.co.uk/InsightfulPractice.htm.
Illinois

Illinois Hosts First Meeting of Interstate Medical Licensure Compact Commission

The State of Illinois and Illinois Department of Financial and Professional Regulation (DFPR) hosted the first meeting of the Interstate Medical Licensure Compact Commission on October 27–28 in Chicago. During the two-day meeting, the new Commission established an administrative framework for the Interstate Medical Licensure Compact, which offers a streamlined licensing process for physicians interested in practicing medicine in multiple states.

Illinois is among twelve states that have enacted the Compact, while several additional states have introduced legislation authorizing it. The Commission consists of two voting representatives from each state that has enacted the Compact. As additional states enact the compact, new representatives will be added to the Commission.

During its inaugural meeting in Chicago, Commission members adopted temporary bylaws, appointed committees and elected the following officers:

• Chair: Ian Marquand (Montana)
• Vice Chair: Jon Thomas, MD (Minnesota)
• Secretary: Diana Shepard, CMBE (West Virginia)
• Treasurer: Brian Zachariah, MD (Illinois)

The Compact establishes a voluntary licensing pathway for physicians, eliminating the need to apply separately for a license in more than one state. By significantly streamlining the licensure process, the Compact is expected to expand access to health care—especially to patients in underserved areas of the country—and facilitate new modes of health care delivery, such as telemedicine.

“As physician shortages persist in Illinois, and throughout the nation, it is important that we utilize new methods to foster the sharing of our most vital resources,” said Bryan Schneider, DFPR Secretary. “The Interstate Medical Licensure Compact creates a new avenue to advance the licensing of physicians who seek to practice medicine in multiple states. The compact also bolsters our ability to protect the public through the sharing of investigative and discipline information, something that is currently not allowed.”

For more information on Interstate Compact, please call (202) 463-4000 or visit www.licenseportability.org.

Sources: Illinois Department of Financial and Professional Regulation (DFPR) news release, October 8, 2015; Federation of State Medical Boards news release, October 30, 2015

North Carolina

New North Carolina Law Requires Continuing Education in Controlled Substances

The recently approved North Carolina budget appropriations act includes a new requirement for licensed physicians and physician assistants and other licensed medical professionals to complete at least one hour of the total continuing education hours required in controlled substances prescribing. The North Carolina Medical Board will consider the new law and discuss how to implement it at its January 2016 meeting.

Among the health professionals impacted by the new ruling are dentists, nurses, physicians and podiatrists. The newly required continuing education in North Carolina must include, but not be limited to, instruction on controlled substance prescribing.
practices and controlled substance prescribing for chronic pain management.

Ohio Medical Board Publishes ‘Red Flag’ Signs of Prescription Drug Abuse

The State Medical Board of Ohio has created a list of “Red Flag” signs of prescription drug abuse and is urging health professionals in the state to be on the lookout for what it calls “potential drug-seeking behavior.” The signs are separated into three categories: Look, Listen and Check.

In the “Look” category, the Board suggests health professionals look for signs in patients such as appearing impaired or overly sedated during an office visit or exam, traveling with a group of other patients to the physician’s office where all or most of the patients request controlled substance prescriptions, or traveling an abnormally long distance to the physician’s office.

In the “Listen” category, the Board suggests health professionals listen for certain red flags when speaking with patients. Examples include comments that indicate they may be taking medication that was not prescribed to them, comments about sharing their prescription medications with friends or family members, or references to drugs by street name, color, or identifying marks.

In the “Check” category, the Board suggests that during their review of patient charts, medical histories and other information, health professionals should check for red flags, such as drug screen results that are inconsistent with drugs on the treatment plan, receiving abused drugs from multiple prescribers without clinical basis, and recurring visits to non-coordinated sites of care, such as emergency departments, urgent care facilities, or walk-in clinics to obtain reported drugs.

For the full list of prescription drug abuse red flags, and for more information on the State of Ohio’s efforts to curb drug abuse, please visit the State Medical Board of Ohio’s website at www.med.ohio.gov.

Rhode Island
Stimulant Policy Statement for ADD and ADHD Adopted By Rhode Island Board

The Rhode Island Board of Medical Licensure and Discipline has adopted a policy statement to provide guidance for physicians who treat older adolescents or adults with Attention Deficit Disorders (ADD) or Attention Deficit Hyperactivity Disorder (ADHD).

Titled “Considerations Regarding Pharmaceutical Stimulant Prescribing for Attention Deficit Disorders (ADD)/Attention Deficit Hyperactivity Disorder (ADHD) in Adolescents and Adults,” the statement provides information regarding diversion of pharmaceutical stimulants and their misuse, as well as guidelines for prudent and thoughtful prescribing.

Prescribing stimulants for ADD/ADHD in Rhode Island’s adolescent and adult populations is common. According to the Board, pharmaceutical stimulants prescriptions currently account for...
Wisconsin is Latest State to Enact Interstate Medical Licensure Compact

Wisconsin became the 12th state to enact the Interstate Medical Licensure Compact after Governor Scott Walker signed the legislation into law December 14, joining a growing coalition of states across the nation that have joined the Compact.

Introduced as model legislation last fall by a group of state medical boards, the Compact is intended to expedite the licensing process for qualified physicians who want to obtain licenses in multiple states and jurisdictions.

Legislation in Wisconsin was authored by Wisconsin Representative Nancy VanderMeer (R–Tomah) and Senator Sheila Harsdorf (R–River Falls). The new law passed the Assembly by a vote of 95-1 and was passed by the Senate by a vote of 31-1. Gundersen Health System, Mayo Clinic Health System, Wisconsin Medical Society, and Wisconsin Hospital Association were among the many advocates for the Compact in Wisconsin.

By significantly streamlining the licensure process, the Compact is expected to expand access to health care and facilitate new modes of health care delivery, such as telemedicine. Wisconsin joins 11 other states in enacting the Compact this year, including Alabama, Idaho, Illinois, Iowa, Minnesota, Montana, Nevada, South Dakota, Utah, West Virginia and Wyoming.

“We are proud that Wisconsin has joined the Interstate Medical Licensure Compact to ensure that all its patients have access to quality health care, while maintaining the highest level of patient protections,” said Dr. Kenneth B. Simons, Chairperson of the Wisconsin Medical Examining Board. “By facilitating medical license portability, the Compact will benefit both physicians and patients in Wisconsin and across the nation.”

For more information about the Interstate Medical Licensure Compact, please visit www.licenseportability.org.

Source: Federation of State Medical Boards news release, Dec. 14, 2015
INTERNATIONAL BRIEFS

AMCOA

African Medical Councils Gather for 19th Annual Conference

The Association of Medical Councils of Africa (AMCOA) recently concluded its 19th Annual Conference in Mombasa, Kenya. During the five-day conference, held August 31–September 4, 2015, regional regulators gathered to discuss a wide range of topics related to medical and dental licensure. The event was hosted by the Kenya Medical Practitioners and Dentists Board.

Among key issues for discussion were mutual recognition and reciprocal licensing, Continuous Professional Development (CPD), licensure of foreign trained medical and dental practitioners, certification programs and fitness to practice.

Guests included keynote speaker Niall Dickson, President of the International Association of Medical Regulatory Authorities (IAMRA) and CEO of the United Kingdom’s General Medical Council, and James Macharia, Cabinet Secretary in the Ministry of Health, Kenya.

Former University of Nairobi Vice Chancellor George Magoha was named President of AMCOA during the event.

Member nations of AMCOA include Botswana, Ghana, Kenya, Lesotho, Malawi, Mauritius, Namibia, Rwanda, Sierra Leone, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

To learn more about AMCOA, visit www.amcoa.org.

Source: Association of Medical Councils of Africa website

 IAMRA

Plans Under Way for 2016 International Conference on Medical Regulation

The International Association of Medical Regulatory Authorities (IAMRA) has begun planning for the 12th International Conference on Medical Regulation, which will be held September 20–23, 2016 in Melbourne, Australia.

The IAMRA 2016 Conference will be hosted by the Medical Board of Australia and the Australian Health Practitioner Regulation Agency (AHPRA) — the lead agencies in regulating medical practitioners in Australia.

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A global forum for international medical regulators, policy makers and academics, the IAMRA Conference is held biennially. In recent years it has attracted hundreds of delegates, representing more than 30 countries.

According to IAMRA, the diverse program being planned will “underpin IAMRA’s purpose — to

Denmark

Danish Regulatory Responsibility to Be Spread Over Several Agencies

The Danish Health and Medicines Authority has announced that, starting in 2016, it will be reorganized into four agencies with responsibility for regulation and oversight of various aspects of the Danish health care.

The four new agencies will include:

- A health agency, which will focus on disease prevention, health planning and radiation protection.
- A medicines agency, which will focus on clinical trial authorizations and the marketing of new medicines in Denmark.
- A patient safety agency, which will handle the supervision and registration of health care professionals and deal with complaints.
- A health data agency, which will make health data available to researchers and authorities and strengthen the overall digitization development in the health care system.

The health data agency is a new organization intended to better integrate health care information in Denmark, with a focus on helping regions and municipalities better share health data with national organizations in order to raise the quality of health care.

Source: Danish Health and Medicines Authority website announcement, August 11, 2015

To learn more about AMCOA, visit www.amcoa.org.

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All abstracts must be prepared according to guidelines provided by IAMRA. To view the guidelines, visit www.iamra2016.org/call-for-abstracts.

Ireland

_Irish Medical Council Publishes ‘Your Training Counts’ 2015 Report_

The Irish Medical Council has published its “Your Training Counts” 2015 report, intended to provide data and insights about the quality of the clinical learning environment for Irish medical trainees. The report, published December 7, found that there has been a slight increase in the perception of the quality of learning environments for medical trainees in 2015, but that bullying persists within the training system in Ireland.

According to the report, 50% of trainees reported physicians as being the main sources of bullying, while 36% of trainees reported nurses and midwives as being the main sources of bullying. Almost 70% of trainees who experienced bullying in their learning environment did not report their experience to anyone in authority. Of those trainees that reported their experience of bullying to someone in authority, almost 40% felt no action was taken.

While the bullying problem persists, according to the report, medical trainees also rated teamwork and peer collaboration significantly improved over the previous year.

Source: Irish Medical Society website, Dec. 7, 2015

NBME

_NBME Reports on International Projects in China, Kazakhstan and Brazil_

The National Board of Medical Examiners (NBME) announced recently progress on international programs aimed at improving medical education and health in China, Kazakhstan and Brazil.
INTERNATIONAL BRIEFS

Highlights of the programs include:

**China: Health Coach Examination**

NBME is working on a pilot project that will develop a certification examination for a new health care professional in China, designated a “health coach.” The Chinese government issued a request for proposals for an assessment to ensure the competency of health care professionals in China and to address the knowledge and skills needed to motivate people in that country to take responsibility for their improved health and wellness.

NBME staff has been working for the past year to develop a framework for the Professional Examination of Health Coach, or PEHC, in China. Though health coaches currently exist in the United States, the responsibilities of the health coach in China will differ somewhat, according to NBME, and development of the proposed examination will ethical and cultural topics unique to China.

Staff conducted three item writing workshops (IWWs) with medical school faculty, including physicians, nurses, U.S. health coaches, and several Chinese nationals to develop items for the examination. Individuals involved in the IWWs helped to shape the definition for the health coach in China and how this new health profession will work within the current Chinese health care system.

The new examination is part of a larger initiative of the Smart Healthy Cities Alliance (SHCA). The goal of the SHCA is to combine world class capabilities to provide integrated solutions that focus on the elderly and aging population in China, on chronic diseases, and on promoting health and wellness in the Chinese population. The second annual SHCA conference was held in Hangzhou, China on September 23–25, 2015 and representatives from NBME were in attendance.

**Kazakhstan: Medical Education Improvements**

The NBME has been engaged over the last year in an effort to work with the Ministry of Health of the Republic of Kazakhstan to bring improvements to Kazakhstan’s medical education system—including establishing a licensure/certification framework for health specialists.

NBME staff traveled to Astana, Kazakhstan in December 2014 to work with staff of the newly established Republic of Kazakhstan Center for Knowledge and Skills Assessment (RCKSA). Team members worked with RCKSA on blueprint design, standards for health specialists according to the International Organization for Standardization, National Council for Measurement in Education, and American Psychological Association, and score reporting and equating. NBME staff also conducted workshops on item writing and standard setting.

Following that meeting, representatives from Kazakhstan visited NBME headquarters in Philadelphia and the NBME sent a team for a second visit to Kazakhstan in August of this year. Progress on the new standards development process continues, according to NBME.

**Brazil: Performance Evaluation of Medical Students**

A test committee comprising faculty from medical schools throughout Brazil worked with NBME staff recently to contribute more than 50 new questions to Brazil’s Performance Evaluation of Medical Students examination, which was introduced in Brazil in 2013.

The length of the exam has grown over the years, from 80 items the first year to 100 items in 2014; it now has 120 items. According to the NBME, the goal is to have the examination used throughout Brazil to measure progress of medical students before they graduate from medical school.

In addition to its overall work on questions for the Performance Evaluation, the NBME is also engaged in a joint project committee with the Hospital Sírio Libanês (HSL) in São Paulo, which has repurposed and used the Performance Evaluation exam as a residency selection examination.

Source: NBME Examiner, Fall/Winter 2015
**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 and tables attached. Please ensure that references adhere to the AMA Manual of Style. For more information, visit www.amamanualofstyle.com.

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.
Bring the Interstate Medical Licensure Compact to YOUR State

Implementation grants available from the FSMB Foundation

The Interstate Medical Licensure Compact is a new licensing pathway for physicians that enables them to gain licensure in multiple states. Eleven states have joined the Compact so far. Soon, physicians in these states will be able apply for multiple licenses faster and more efficiently than ever before.

About the Grants

The FSMB Foundation is pleased to begin accepting applications for grants to support projects associated with the Interstate Medical Licensure Compact. Multiple grants will be awarded, from a total fund of $60,000.

Grants can be used for a wide array of activities. Examples include education of stakeholders interested in the Interstate Medical Licensure Compact, implementation of Compact administrative requirements, staff training, technical enhancements, and more.

Application Information

Grant applications are now being accepted. Applications should include the name of the applicant organization, contact information, a narrative to include the purpose and description of the proposed project, a budget estimate (how the funds will be used), and a timeline for completion. Applicants may apply for more than one grant if seeking funding for multiple projects.

Grant applications may be submitted to Kelly Alfred at KAlfred@fsmb.org.

Help us bring health care faster and more efficiently to patients in need—join the Interstate Medical Licensure Compact!
FSC promotes well-managed forests through credible certification that is environmentally responsible and economically viable.

Paper used for this journal is certified to be environmentally friendly and 100% recyclable.