Supporting Physician Lifelong Learning
Through Effective Continuing Medical Education and Professional Development

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Medical Regulation: Ten Key Trends Emerging from an International Review

State Board News

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HOW HAS OUR SYSTEM OF CONTINUING MEDICAL EDUCATION AND PROFESSIONAL DEVELOPMENT EVOLVED?

“...that certified CME is not the only way physicians learn and improve; other professional activities can also help.”

From the article “Supporting Physician Lifelong Learning Through Effective Continuing Medical Education and Professional Development,” page 7.
If one does have a genuine superiority it is a superiority which rests on the performance of definite functions...We change things by the capacities which we have that others do not have.  

— George Herbert Mead

As Mead reminds us, it is not our innate skills, but our learning and performance that make any of us important. That means these “capacities” need to be kept up to date for any “superiorities of function” to be maintained and to develop. For physicians, this means that they keep learning—and practicing what they have learned. For state medical board members and staff, this means that they are obliged to find improved ways of ensuring that every physician under their jurisdiction keeps current. The two articles in this issue provide interesting ideas of how state boards can improve the ways they ensure that the public is receiving improved health care. “Medical Regulation: Ten Key Trends Emerging from an International Review” (page 16) shows how other nations deal with the licensing and discipline of physicians. According to data from the article, many countries require life-long learning and performance improvement activities. This may help us think about ways that may improve our U.S. system of regulation. How can it be that some states do not require continuing medical education for relicensure? How are they ensuring that all physicians are maintaining competencies over the life course? “Supporting Physician Lifelong Learning Through Effective Continuing Medical Education and Professional Development” (page 7) shows how improvements in the delivery and form of continuing medical education better serve to maintain competencies, but that is just a beginning of the process. It may be a bit easier than it should be to hold on to “this is the way I have always practiced medicine” and “my board has always done it this way.” It’s food for thought—for all of us.

Ruth Horowitz, PhD

Editor-in-Chief

Tips Help State Boards Handle Inquiries from Physicians Reentering the Workforce

Working in collaboration with the Physician Reentry into the Workforce Project, the FSMB is offering a guide for the staff of state medical boards to facilitate conversations with physicians who are either considering leaving medical practice or reentering clinical practice after some time away for non-disciplinary reasons. Titled “Reentry into Clinical Practice: Tips for Handling Inquiries from Physicians,” the guide provides advice on how boards can go about developing reentry policies, how to help physicians prepare for reentry, and answers to common questions reentering physicians may have about returning to the workforce.

In 2012 the FSMB adopted the Report of its Special Committee on Reentry to Practice, which identified key reentry issues for state medical boards to consider as they develop reentry policies. Since then, it has continued to provide educational resources for state boards on the topic.

The Physician Reentry into the Workforce Project is an initiative of the American Academy of Pediatrics, working in collaboration with several organizations. To learn more about the project, visit www.aap.org.

The FSMB’s tip sheet for reentry is available at: www.fsmb.org/Media/Default/PDF/Publications/TipsforHandlingInquiriesFINAL.pdf

UA Moves to New Online Platform, Enhancing User Functions

The Uniform Application for Physician State Licensure (UA), an FSMB service designed to streamline physician licensure, has transitioned to a new online platform, providing new features and enhancements for state medical boards. The new platform provides increased data accuracy through pre-populated data fields and enhanced security measures for online payment for those who use the UA.

The core section of the UA, which includes data fields required by all boards — such as education, training and work experience — will now be pre-filled with data if the physician’s information already exists in the FSMB system through his or her use of another FSMB service. Applicants will not be required to re-key data twice.

Now used by 25 state medical and osteopathic boards and more than 62,000 physicians, the UA uses a common license application between participating states, saving steps in the compilation of educational and training experience documentation required for licensure. A customized addendum in the application allows participating boards to capture unique state-level requirements — and is now transferable via the UA’s new online platform.

For more information about the UA, please visit www.fsmb.org.

FSMB Offers Free REMS CME activity on ER/LA opioids

The FSMB is co-sponsoring a free CME Risk Evaluation and Mitigation Strategy (REMS) activity, “Extended-Release and Long-Acting Opioids: Assessing Risks, Safe Prescribing,” which is designed to educate health care professionals on the safe and responsible prescribing of ER/LA opioid analgesics for patients with chronic pain.

The free CME activity is part of the FSMB’s overall effort to educate physicians, state medical boards and the public about potential risks in prescribing of opioids. The FSMB makes available a wide range of learning activities, offered free of charge, on this topic.

For more information about the ER/LA opioids educational activity, please visit https://rems.community360.net.

For more information about the FSMB’s other opioid-related educational activities, please contact Kelly Alfred at kalfred@fsmb.org or visit www.fsmb.org/policy-and-education/education-meetings/pain-policies.
IN BRIEF Dr. Gifford offers highlights of his year as Chair of the FSMB Board of Directors.

During a busy and momentous year, the FSMB advanced all of its key strategic goals, and in the course of much travel during the year I was able to see firsthand how our activities, services and products are providing great benefit to our member boards, the public, and other stakeholder organizations. We are making great progress on our various strategic imperatives. Here are just a few examples:

Interstate Medical Licensure Compact

A summary of my year as Chair must begin with a discussion of the Interstate Medical Licensure Compact, an exciting new concept in physician licensure that has fundamentally changed the landscape of medical regulation in the United States. The Compact, which was formally launched last spring, is one of the most significant developments in medical regulation in many decades. Since its launch, 12 states have enacted the Compact and many more are actively considering it. Expedited licensure via the Compact will become available very soon, and a major step toward that goal was the launch last year of the Compact’s administrative body—the Interstate Medical Licensure Compact Commission.

Workgroups and Task Forces

In recent years the FSMB has been growing in its visibility and influence as a stakeholder in health care. It continues to be important for us to take a visible leadership position on issues that are vital to medical quality and patient safety. With that in mind, several new FSMB workgroups have begun examining issues of emerging importance. They include:

Telemedicine Consultations

Chaired by Dr. Kenneth B. Simons, the Workgroup on Telemedicine Consultations is seeking common definitions for physician-to-physician consultations, and how telemedicine technologies/devices might be used in that context. Its work includes a comprehensive literature review of telemedicine services and an examination of models for the regulation of physician-to-physician consultations.

Team-based Regulation

Chaired by Dr. Ralph C. Loomis, the Workgroup on Team-Based Regulation identified best state-based practices and is developing recommendations for regulatory strategies that could achieve greater cooperation and collaboration among health professional boards in carrying out their shared responsibility to protect the public. The workgroup is closely studying delivery models that utilize interdisciplinary collaboration and a team-based approach to patient care, and how regulation could be conducted in this environment.

Education about Medical Regulation

Chaired by Dr. Patricia A. King, the Workgroup on Education about Medical Regulation studied and developed methods and delivery models that could be used to educate medical students and residents on medical licensing and regulation, including critical issues/problems relevant to young physicians. The workgroup focused on tools and resources that could be shared with medical schools, residency programs and state medical boards.

Marijuana and Medical Regulation

Chaired by Dr. Gregory B. Snyder, the Workgroup on Marijuana and Medical Regulation developed model policy guidelines regarding the use of marijuana in patient care, including best practices when recommending marijuana. The workgroup also developed a policy statement regarding the regulation of licensees who use marijuana recreationally.

Opioid Treatment Guidelines

I served as the Chair of the Workgroup on FSMB’s “Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain,” which reviewed the...
current science for treating chronic pain with opioid analgesics and began development of recommenda-
tions to revise the Model Policy as appropriate.

Physician Burnout
Last year I asked FSMB’s Ethics and Professionalism Committee, chaired by FSMB Chair-elect Dr. Arthur S. Hengerer, to begin a new effort to review policy and examine trends in physician burnout—which surveys show is an increasing issue for the medical profession. The committee is now examining various aspects of physician burnout, including causes, diagnosis, treatment, early intervention, and prevention.

State Medical Board Support
The FSMB’s new Strategic Plan places a particularly strong emphasis on supporting the work of state medical and osteopathic boards, and over the course of the last year we made excellent progress in fulfilling this mandate.

North Carolina State Board of Dental Examiners v. Federal Trade Commission
In 2015 a new issue took center stage for medical regulators when the U.S. Supreme Court ruled in favor of the Federal Trade Commission in North Carolina State Board of Dental Examiners v. Federal Trade Commission (FTC). In the wake of the Court’s ruling in favor of the FTC, the FSMB hosted a symposium in March 2016 to discuss the implications of the decision for state medical boards. State board leaders from all over the country joined together in Texas for the symposium, discussing best practices as states consider how to respond to the ruling.

Advocacy Team Support
Our Washington, D.C. advocacy team continues to serve as an outstanding resource for state boards. Over the course of the year the team helped boards in a variety of ways, from tracking and monitoring state and federal legislation to helping develop policy documents and researching issues. The team helped us organize an outstanding Interstate Compact briefing June 24, 2015 at the National Press Club for policy makers and the media that was very well attended.

Research and Data
The FSMB’s Information Technology (IT) improvements continued to deliver strong results over the last year in terms of service to state boards. The FCVS 2020 project has significantly improved response times and introduced new services and features for boards, and the new State Medical Board Portal is allowing boards to do more “one-stop shopping” when they visit the FSMB website. The user experience has been streamlined. The FSMB updated its DocInfo service in 2015 and made it free for the public for the first time.

Education
In a development that brings great benefit to state medical boards, the FSMB became an accredited Continuing Medical Education (CME) provider in 2015. With its new status, provided by the Accreditation Council for Continuing Medical Education (ACCME), the FSMB will be able to provide free CME hosting for members of the Federation.

Tri-Regulator Collaborative
Through the Collaborative, the FSMB works closely with the National Council of State Boards of Nursing and the National Association of Boards of Pharmacy to address issues of mutual concern for the nation’s state boards of medicine, nursing and pharmacy. The Collaborative held its second symposium in the fall of 2015, and a third event is planned for 2017. Our work together is strengthening advocacy resources for the medical regulatory community.

International Efforts
The FSMB continued to expand its efforts to engage in new ways with the international medical regulatory community in 2015–16. We are a founding member of the International Association of Medical Regulatory Authorities (IAMRA), which has grown to include 95 member organizations from 44 countries. FSMB CEO and President Humayun J. Chaudhry, DO, MACP, is the Chair-elect and Secretary of IAMRA.

As I close out my term as Board Chair, I can say with confidence that the medical regulatory community is strong and well positioned to meet the challenges of a fast-changing health care environment. It has been an honor and a privilege to serve as Chair during this exciting time in our history.
Supporting Physician Lifelong Learning Through Effective Continuing Medical Education and Professional Development

Alejandro Aparicio, MD, FACP; Humayun J. Chaudhry, DO, MACP; Mark Staz, MA; Frances Cain, MPA; William S. Mayo, DO; Ann Karty, MD, FAAFP; Sherry McAuliffe, MBA; Delores Rodgers

ABSTRACT: The medical profession has seen significant advancement in the availability of a variety of educational activities, across a range of formats and processes, to help physicians remain current and improve professional performance. The objectivity and quality of continuing medical education (CME) activities has been enhanced by the credit recognition systems of the American Academy of Family Physicians (AAFP), the American Medical Association (AMA), and the American Osteopathic Association (AOA). These credit systems also provide a metric for tracking compliance with a variety of regulatory requirements such as state medical licensure, hospital staff privileges, and health insurance plan participation, and are increasingly used as criteria for voluntarily obtaining and maintaining specialty certification and fulfilling requirements for membership in medical specialty societies.

This article reviews the history of CME, the research that supports its value, and the opportunities that exist to address its challenges. It also explains how the Federation of State Medical Boards (FSMB) Maintenance of Licensure (MOL) framework incorporates and builds upon the research involving the effectiveness of CME for physician learning and improvement. Special focus is given to the CME credit systems and their features, the synergies among them, and the way in which various learning formats that can be certified for CME credit are aligned with the three recommended components of MOL.

Introduction

When the American Medical Association (AMA), in 1906, endorsed a plan to encourage the nation’s county medical societies to offer weekly educational programs for practicing physicians, significant scientific advances such as the use of insulin to manage diabetes or the discovery of penicillin were many years away.¹

Over the decades that followed, these educational programs became widely accepted by physicians for lifelong learning and evolved into the continuing medical education (CME) activities that frequently became a requirement for membership in medical specialty societies and county medical societies, as well as for state medical license renewal, hospital staff privileges, and health insurance plan participation. Continuing medical education has been shown to improve patient outcomes, though some doubt persists about the impact and extent of these improvements. To ensure the objectivity of CME, certification of these activities is now strictly enforced: proscriptions limit pharmaceutical industry influence, and disclosures of conflicts of interest are mandatory for activity sponsors and faculty.

Today, CME is delivered in live and online formats by a variety of approved entities, increasingly incorporates Performance Improvement (PI) activities, and is part of a global movement supporting Continuing Professional Development (CPD). An example of that support is the framework for Maintenance of Licensure (MOL) that was adopted by the House of Delegates of the Federation of State Medical Boards (FSMB) in 2010. Other examples of CPD activities include the Maintenance of Certification (MOC) program of the American Board of Medical Specialties (ABMS) and the Osteopathic Continuous Certification (OCC) program of the American Osteopathic Association (AOA) Bureau of Osteopathic Specialists. For example, the ABMS has recently...
updated its program standards for MOC with aims of promoting innovation in CPD and increasing the degree to which the assessment components of the program are meaningful and helpful to more than 500,000 participating physicians. It continues to support its member boards and physician diplomates by collecting evidence for the value of MOC, and CPD generally, in its Evidence Library and through the development of initiatives such as the Multi-Specialty Portfolio Approval Program which allows hospitals to sponsor their Quality Improvement activities for MOC Part IV credit. These and other initiatives vary in terms of their rationale and requirements but all recognize the value of participation in CME as a central component of CPD.

There are challenges associated with continuing education programs. At best, lifelong learning through CME and CPD fosters information sharing among physicians, enables quality improvement, promotes public safety at the individual and population levels, and supports innovation and implementation of leading edge approaches to patient care. At other times, however, CME and CPD activities may constitute passive learning, be overly costly and onerous, or devolve into “checkbox” exercises to preserve hospital privileges or medical licensure.

The Evolution of Lifelong Learning and CPD

The value of physicians engaging in lifelong learning has been recognized since the earliest days of the medical profession. The first of the aphorisms of Hippocrates states, in part: “Life is short, and Art long.” Those sentiments have echoed throughout the centuries and some countries that recognized that need brought about formalized structures to address it. In the United States, the current structure was created in the 1900s when three major medical professional organizations, the AAFP in 1947, the AMA in 1968, and the AOA in 1973, created CME credit systems that provided definitions and educational requirements necessary to certify educational activities for CME credit as well as a metric to quantify their value. Their purpose was to ensure educational quality, encourage participation by physicians, and enhance the physician’s ability to provide services for patients, the public, and the profession. An example of the codification of this need by the medical profession is the AMA’s Code of Medical Ethics, which includes in its Principles of Medical Ethics, “A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.”

The importance of CME has been emphasized by many institutions and groups interested in physician competence and patient care, such as the vast majority of licensing boards, specialty boards and hospitals. CME credit has been accepted by those organizations as proof of CME engagement by physicians, and implicitly as a surrogate marker of physician learning and improvement. It is widely recognized, however, that certified CME is not the only way physicians learn and improve; other professional activities can also help physicians improve services they provide to patients, the public, and the profession. CPD is a broad term that includes certified CME and other activities that have educational value for physicians but may not be formally certified for credit. The three credit systems acknowledge and include among their newer learning formats some types of CPD activities not previously considered eligible for certification, such as participation in quality and PI activities, learning to enhance engagement in the clinical education of students and residents, and searching for the answers to clinical questions at the point-of-care in a database designed for that purpose.

Research and Patient Outcomes in Support of CME

Because of the time, cost, and effort entailed in physicians’ engagement in CME activities, research about its effectiveness is valued by physicians and CME providers. But research about CME, particularly those activities and settings that are most common, such as lecture-style presentations using PowerPoint slides, is challenging to construct because of multiple variables. Physicians generally self-select when attending a CME activity, have different ways of learning optimally, and may not always be aware of which activity format is most effective for them. In any audience, there is often a range of learners, from novices to masters, whose knowledge and skills vary widely. Despite these challenges, research has shown evidence for the effectiveness of CME.
Robertson and colleagues, in an article published in 2003, describe how they “identified 15 research syntheses published after 1993 in which primary CE studies were reviewed and the performance (behavior) of health professionals and/or patient health outcomes were examined.” They went on to write in the discussion: “Wave One findings confirm previous research that CE can improve knowledge, skills, attitudes, behavior, and patient health outcomes. Wave Two syntheses show that CE, which is ongoing, interactive, contextually relevant, and based on needs assessment, can improve knowledge, skills, attitudes, behavior, and health care outcomes.”4 These statements were essentially repeated by Marinopoulos and colleagues writing in 2007, “Despite the low quality of the evidence, CME appears to be effective at the acquisition and retention of knowledge, attitudes, skills, behaviors and clinical outcomes.”5 They based their statements on research they conducted as part of the Johns Hopkins University Evidence-based Practice Center (EPC) under contract to the Agency for Healthcare Research and Quality. They identified 68,000 citations by searching the literature. Of those, 136 articles and 9 systematic reviews ultimately met their eligibility criteria and were used in developing this 560 page Evidence Report/Technology Assessment.

In a Cochrane review published in 2009, Forsetlund and colleagues reviewed 81 trials and concluded that “educational meetings alone or combined with other interventions can improve professional practice and the achievement of treatment goals by patients.”6 And in 2014, Cervero and colleagues wrote that “of the 220 articles in the ABMS Evidence Library supporting the Maintenance of Certification program, 129 demonstrate a positive impact of CME on physician performance and patient health outcomes.”7

In 2009, evidence-based educational guidelines were published in an attempt to connect research and practice.8 However, more research is needed on how to best use the different learning formats when physicians have different types of educational needs. For example, in addition to developing a closer alignment with adult learning theory, research should be conducted on the impact of individual preferences and personal characteristics associated with learning, the use of technology to better align activities with learners’ educational needs in real time, and support systems and tools that facilitate an environment more conducive to physicians performing optimally.

As the Vollan Report suggests, “The continuing education of a physician throughout his professional life is absolutely essential if he is to use judiciously and effectively the new developments in the diagnosis, treatment, and prevention of disease that are necessary for adequate medical care.”9 That statement is as true today — maybe even more so — as when it was first written in 1955.

**Maintenance of Licensure**

When the research on the effectiveness of CME is coupled with rapid changes in medicine, an environment is created whereby CME plays an increasingly important role in improving physician performance and patient care, and ensuring patient safety.

In 2003, the FSMB convened members of state medical boards for a Special Committee on Maintenance of Licensure to study the role that medical boards should play in ensuring the ongoing competence of physicians and to develop recommendations for use by state medical boards in considering implementation of maintenance of licensure initiatives. This Special Committee’s work led to the adoption in 2004 by the FSMB’s House of Delegates of a policy statement that state medical boards are responsible to the public for ensuring the ongoing competence of physicians as a condition of license renewal, as well as a set of guiding principles for the development of a framework for implementation of MOL by state medical boards.

The FSMB MOL framework adopted in 2010 is built upon and incorporates extensive research on the effectiveness of CME. Specifically, MOL asks that physicians, as a condition of license renewal, participate in activities that are practice-relevant, informed by objective data sources, and aimed at improving performance. Physicians should have significant freedom in choosing the educational activities that they want to engage in for purposes of license renewal, the MOL framework says, to guide physicians toward
appropriate activities to maximize the impact of their efforts. This guidance is articulated in the framework’s three components (Table 1).¹⁰

In 2011, the FSMB’s MOL Implementation Group recommended that participation in commonly available CPD activities (e.g., PI initiatives, quality improvement projects, specialty certification) should allow the physician to comply with the MOL requirements of any state medical board.¹¹ Compliance with MOL in this way, as suggested by the MOL framework, should engender minimal to no additional burden to physicians. Further detail related to the types of activities that may constitute participation in MOL activities was iterated in a 2014 report of the FSMB’s MOL Task Force on CPD Activities.¹² It is noteworthy that the MOL framework does not require a high-stakes, secure examination for a physician to demonstrate ongoing knowledge and skills in their area of practice. The most likely change for physicians is a periodic requirement to attest on a state medical license renewal application that they have participated in educational activities that meet their licensing board’s MOL requirements.

The CME requirements set by state medical boards for license renewal have evolved over the last half-century since they were first implemented. Historically, state boards have adjusted their requirements to include content-specific CME to better address state-specific issues or legislative priorities (e.g., opioid prescribing, end-of-life care). More recently, state medical boards have strengthened requirements by mandating that a proportion of the CME in which a physician participates be practice-relevant. Currently, 15 boards have such a requirement. For example, the Arkansas State Medical Board requires that 50% of the required CME be in subjects pertaining to the physician’s primary area of current practice, while the West Virginia Board of Medicine and the West Virginia Board of Osteopathic Medicine require that 30 hours be in the physician’s designated specialty.¹³ MOL represents the next step in this evolution and aligns with recent ongoing efforts by the CME community to ensure that educational activities by physicians improve their knowledge and their practice performance, patient care, and patient outcomes. As with other changes in the CME system, MOL is designed according to best practices in physician education and adult learning theory and is intended to increase the degree to which patients are protected as a result of physician participation in CPD activities.

To date, the FSMB has engaged state medical boards and cohorts of practicing physicians in discussions about how best to implement MOL in an effective, non-burdensome, and non-duplicative way. Specifically, these boards have provided feedback regarding legislative issues, the need for ongoing communication with licensees and the public, and potential challenges to implementation of MOL as perceived by board members and board staff. Subsequent surveys of practicing physicians in Colorado and Iowa were aimed at gathering information from licensed physicians about the types of professional development activities they find most useful.

Table 1
Components of Maintenance of Licensure¹⁰

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<tr>
<th>MOL Components</th>
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<td>1. Reflective Self-Assessment (What improvements can I make?)</td>
<td>Physicians must participate in an ongoing process of reflective self-evaluation, self-assessment, and practice assessment, with subsequent successful completion of appropriate educational or improvement activities.</td>
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<td>2. Assessment of Knowledge and Skills (What do I need to know and be able to do?)</td>
<td>Physicians must demonstrate the knowledge, skills, and abilities necessary to provide safe and effective patient care within the framework of the six general competencies as they apply to their individual practice.</td>
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<tr>
<td>3. Performance in Practice (How am I doing?)</td>
<td>Physicians must demonstrate accountability for performance in their practice using methods that incorporate reference data to assess their performance in practice and guide improvement.</td>
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Further research should focus on the availability of appropriate educational activities for participation in MOL, especially for physicians with lower levels of access to educational opportunities and activities due to geographic location, lack of specialty certification, or hospital affiliation.

A notable hallmark of the MOL framework is that it recognizes the value of self-directed learning and supports physician autonomy in the self-selection of relevant professional education activities. Those activities have a long and rich history that is embodied in the three credit systems that have evolved under the direction of the AAFP, the AMA, and the AOA.

**American Academy of Family Physicians**

Soon after the AAFP was established in 1947, it became the first medical specialty society to require CME of its members. It established the nation’s first CME credit system as a way of ensuring appropriateness and quality of CME activities for family physicians engaging in lifelong learning. Desire to encourage practicing physicians to stay current with medical advances and improve patient care was considered a professional responsibility and an ethical imperative. Continued advancement of the specialty meant ongoing acquisition of knowledge and skills, and lifelong learning.

Over time, different categories of CME credit were introduced into the AAFP system. AAFP Prescribed Credit is planned with the involvement of an Active/Life AAFP member to ensure family physician content relevance to patient care, health care delivery, and certain nonclinical topics. AAFP Elective Credit, while still focused on health care professionals, does not require the involvement of an Active/Life AAFP member during the planning stages; however, content must be relevant to the professional development of the physician. Enduring (print) materials and live meetings initially cornerstones of educational planning for AAFP members evolved integrating home study programs, video, and online activities, all to provide opportunities for learners with varied educational preferences. Evidence-based sources for CME, Point-of-Care, PI CME, and Translation to Practice CME (t2p) all utilize innovative designs to highlight areas of highest impact for physicians and for patient outcomes.

AAFP members are currently required to report a minimum of 150 CME credits per three-year cycle. The AAFP Credit System, under the guidance of its Commission on Continuing Professional Development, applies established eligibility requirements to review more than 3,000 CME activities each year. The AAFP Credit System also awards credit for informal CME activities, such as those related to specialty board certification, teaching, advanced training, scholarly work, and other enrichment activities as additional opportunities to enhance professional acumen.

While the AAFP Credit System is unique in its activity-level reviews and family physician involvement requirement, intended to ensure content validity, relevance, and demonstrate improved patient care and health care delivery, the AAFP also is committed to collaborating with other key credit system stakeholders to establish consistent expectations within the CME community. Content must be designed and created independent of commercial support. Post-evaluation random audits are built into processes that review documentation, assess compliance, advise providers, and provide education as feedback to individuals seeking credit.

The AAFP has equivalency agreements with the AMA, the AOA, and the College of Family Physicians of Canada. AAFP Prescribed Credit is accepted as AMA PRA Category 1 Credit™ towards the Physician’s Recognition Award (PRA) and the AAFP accepts AMA PRA Category 1 Credit™ as Elective Credit. The AAFP Credit System also has credit conversion agreements with several nursing and medical assistant organizations, meaning non-physician learners participating in AAFP activities that have been awarded Prescribed Credit are able to claim credit through their respective organizations towards continuing education requirements.

The AAFP, throughout its history, has designed meaningful educational interventions, established equivalency agreements, and assisted in the development of the Accreditation Council for Continuing Medical Education (ACCME) Standards for Commercial Support. It continues to create a collaborative approach to evidence-based CME, the Physician Payments Sunshine Act (Open Payments), and alignment of CME with MOL and MOC.
American Medical Association

The AMA has been committed to medical education since its inception in 1847. Decades later, that commitment to education was focused on medical schools, as evidenced by the work related to the Flexner Report of 1910. But even in the early 20th century interest and effort were devoted to postgraduate medical education. A 1955 report commissioned by the AMA Council on Medical Education (Council) found that almost one-third of physicians surveyed had not engaged in formal medical education courses in the previous five years.

By 1967 the AMA had created a formal system to accredit organizations as providers of CME activities. In 1968, it introduced the PRA to encourage voluntary engagement in 150 hours of CME every three years. In support of this award, it created the AMA PRA CME credit system, which includes two types of CME credit: **AMA PRA Category 1 Credit™** and **AMA PRA Category 2 Credit™**.

The AMA and six other national organizations (ABMS, American Hospital Association, Association of American Medical Colleges, Association for Hospital Medical Education, Council of Medical Specialty Societies and FSMB) created the ACCME in 1981. Since then, **AMA PRA Category 1 Credit™** can be awarded by US organizations that have met the CME accreditation requirements of the ACCME. The AMA grants accredited CME providers the privilege of certifying for CME credit those activities that meet the educational requirements of any of seven AMA learning formats (live activities, enduring materials, journal-based CME, test item writing, manuscript review, PI CME, and Internet point of care learning/Internet PoC) conditional on continued compliance with AMA PRA standards.

The Council has evolved the AMA PRA CME credit system significantly. The advances, particularly in the last 10 years, have taken advantage of the ubiquity of technology, trends in the approach to quality care, and feedback from physicians and the CME community. Additionally, pilot programs have been used extensively, particularly for PI CME and Internet PoC, that have brought CME closer to the clinical encounter. Working closely with the AAFP and AOA credit systems, the AMA has been involved in the evolution of CME in the United States from a time metric to a value metric as the means to quantify the effect of certified CME activities. In addition, the three credit systems have evolved from just requiring participation in an activity to claim CME credit to requiring demonstration of achievement of the objectives of the educational activity. However, the evolution is not yet complete, because credit for live activities continues to be measured on the basis of time and the credit earned on the basis of attendance.

For accredited providers’ activities to be certified for CME credit they must meet the 10 AMA PRA core requirements as well as format-specific requirements, including those for learner performance. These requirements are listed in the standards for the PRA and credit system document.

There are also educational activities for which the AMA, as steward of the credit system, awards **AMA PRA Category 1 Credit™** directly. “Direct” credit activities include publishing (as lead author) a peer-reviewed article in a journal indexed in MEDLINE (10 credits), preparing a poster presentation (as first author) included in the abstracts of an activity certified for **AMA PRA Category 1 Credit™** (5 credits), obtaining a medically related advance degree (25 credits), completing an ABMS board certification or MOC© process (60 credits), and participation in an ACGME-approved residency or fellowship (20 credits/year). **AMA PRA Category 1 Credit™** activities are accepted by most state medical boards for purposes of meeting CME requirements for license renewal. Given that all of these activities are educationally robust, they may also be considered for meeting one or more of the components of MOL.

American Osteopathic Association

The AOA was founded in 1887 with the goal of advancing the osteopathic medical profession through the collective efforts of individual osteopathic physicians and colleges of osteopathic medicine. Today, its mission is to advance the distinctive philosophy and practice of osteopathic medicine, and it serves more than 110,000 osteopathic physicians.
physicians and medical students. The AOA promotes public health, encourages scientific research, and works to maintain and improve the high standards of osteopathic medical education. It is the primary certifying body for doctors of osteopathic medicine (DO) and is the accrediting agency for osteopathic medical schools in the United States. Osteopathic physicians take the whole person approach to treating patients, focusing on prevention and wellness as the keys to maintaining health. Osteopathic physicians train in community settings and more than 60% practice in primary care settings, including in rural and underserved areas. Currently, one of four medical students in the United States is enrolled in an osteopathic medical school. With an expected 25% growth every five years, osteopathic physicians—across multiple specialties—comprise one of the fastest growing medical professions in the country.17

Through its commitment to lifelong learning, the AOA is dedicated to ensuring that osteopathic physicians meet the highest standards of care necessary to protect patients and ensure high quality care. The guiding principles and format of the AOA CME program date back to the establishment of the “Committee on CME” in 1973, known today as the Council on CME. The AOA Board of Trustees accredits organizations to provide osteopathic CME, which involves CME delivered through didactic sessions with an osteopathic focus.

The Committee on CME initially defined the purpose of the AOA CME program as fostering the growth of knowledge, the refinement of clinical skills, and the deepening of understanding about the osteopathic profession. The Committee recognized that the ultimate goals of CME are continued excellence in patient care and improving the health and well-being of individual patients and the public. Currently, AOA members are required to earn 120 CME credits in a three-year cycle, of which 30 are Category 1-A credits (formal didactic education programs).

The AOA Clinical Assessment Program (CAP) is a web-based performance measurement tool that analyzes data abstracted from patient medical records to evaluate clinical practices against evidence-based guidelines. The overarching purpose of CAP is to improve patient outcomes and increase the quality of patient care. CAP meets the three-stage design of PI CME and is an example of a CPD program that includes (1) an initial assessment of a physician’s practice of medicine using identified evidence-based performance measures; (2) an intervention based on the performance measures that were assessed in practice; and (3) a re-evaluation of the physician’s performance. An enrollment option within CAP enables osteopathic physicians to participate in the Centers for Medicare & Medicaid Services Physician Quality Reporting System (PQRS), which offers incentive payments to physicians for reporting data on specific quality measures.

Since 2013, the AOA’s medical specialty boards require participation in the osteopathic continuous certification (OCC) process, which includes ongoing practice assessment and performance improvement, to maintain certification status. The AOA grants 20 category 1-B CME credits for completion of a CAP module. For the 2010-2012 CME cycle, the AOA recorded a total of 17.6 million CME credits earned by learners, and this number is expected to increase exponentially for the cycle ending on December 31, 2015.

To ensure quality CME programming that meets the needs of osteopathic physicians, in 2009 the AOA began requiring a formal needs assessment process as a condition of certification for Category 1-A activities. The needs assessment is intended to ensure that the educational experiences are relevant and assist osteopathic physicians in developing competency or additional expertise in their respective areas of practice. Sponsors are audited through a document survey process every three years, which includes a review of learning objectives and instructional design specifications to ensure adherence to the standards.

In 2012, the AOA approved a policy that requires sponsors’ programs to be outcomes-based using published criteria. CME providers are expected to structure learning activities so that the physician’s current performance is measured or evaluated. These changes create greater accountability for both the individual osteopathic physician and the organiza-
tions that provide CME programming by placing more emphasis on the core competencies and on patient care and safety. All CME credit earned by osteopathic physicians, including AOA CME credit, is recorded on a CME Activity Report available to AOA members.

The AOA Council on CME, since its inception, has encouraged CME requirements as a condition of licensure renewal. In consultation with the AOA, state osteopathic organizations are encouraged to advocate for state licensing laws that attempt to verify lifelong competency. Together the AOA and state organizations recommend appropriate strategies and legislative language to support the passage of general CME requirements for license renewal and recognition of OCC as substantially meeting state CME requirements for AOA board certified physicians.

The certification of CME is a dynamic and evolving process. As such, the AOA continues to study the changing environment of medicine and licensure, and re-engineers its CME policies and practices as needed. The AOA encourages effective program design and delivery channels that provide a quality CME educational experience with demonstrated outcomes-based measures that improve diagnostic accuracy and practice efficiency for patient care and health care delivery.

Summary and Conclusions

Continuing education as a component of ongoing professional development is commonplace and supports professionals in maintaining competency in numerous professional fields. Certified CME activities harmonize requirements for providing quality care, ensuring independence from commercial influence, sharing expertise, and measuring patient outcomes through consistent collaboration between and among CME credit systems. Certified activities are designed to ensure that education meets learners’ expectations of acquiring knowledge about medical advancements, providing cost-effective treatments, practicing evidence-based medicine, and staying abreast of changes within the health care system. For physicians, ongoing professional development to maintain competency is an ethical imperative and a moral responsibility.

There is broad agreement across the medical education-practice continuum that synergy needs to continue from the point at which physicians first obtain a medical license to maintenance of that license through participation in a variety of activities, including CME. For the majority of physicians who voluntarily obtain and maintain specialty certification, their activities should be recognized by state medical and osteopathic boards as substantially compliant with any licensure renewal requirements, such as MOL. Generally, physicians are altruistic and have the same goal in mind: improved health care for all individuals. Continuing medical education has value, but lack of familiarity with CME/CPD research has propagated doubt about its value and confusion about its utility within the complex U.S. health care system.

Educational activities must be meaningful and, through quality improvement initiatives provide physicians with the opportunity to be involved in interventions that benefit populations of patients as well as individual patients. Individualized, self-directed, relevant education need not be restricted by format.

As the expectation for ongoing professional development for physicians has evolved over the past 10 to 15 years, so have the CME systems. Adult education theory posits that self-identified need, repetitive review of materials, and integration of components of interactivity help to sustain new knowledge. Technology can be used as a tool to reinforce components of what is known as “just-in-time” study and assimilation of patient data utilized to highlight areas for personalized improvement or practice-wide areas of potential intervention, both of which could qualify for components of CME and for both MOL and MOC/OCC. While knowledge acquisition may occur with use of enduring materials, there is also educational value in reflective self-assessment through anticipated practice change that may not have occurred during the post-CME intervention implementation phase.

The organizations that sponsor CME credit systems recognize this is an important step in implementing and using information from this educational design to identify additional barriers and design new activities and educational formats to meet those new needs. There continues to be broad alignment among the systems, and innovative educational formats are acceptable (and often preferred). Educators design activities and use ideal formats to meet needs related to improved patient outcomes and physicians caring for those patients in an optimal way. That, ultimately, is what every state medical and osteopathic board seeks and is consistent with their primary mission — to protect the public and ensure that only individuals who are qualified and fit to practice medicine do so.18 ■
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Disclaimer

The opinions expressed in this article represent those of the authors and are not necessarily the views or policies of any organization with which they are affiliated.

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References


Medical Regulation
Ten Key Trends Emerging from an International Review

Carrie H.K. Yam, MPhil; Sian M. Griffiths, FFPH, FRCP; S. Liu, PhD; Eliza L.Y. Wong, PhD, RN; Vincent C.H. Chung, PhD, BCM; E.K. Yeoh, FHKCP, FFPH

ABSTRACT: The licensing and regulation of physicians is an important topic worldwide and is often tied to discussions in various countries of health care system reform. We conducted a review of current practices for regulating physicians as a key group of health care professionals in eight jurisdictions in Asia and other parts of the world in order to draw implications for the development of future regulatory policies in Hong Kong. Jurisdictions studied included Australia, Canada, China, Malaysia, New Zealand, Singapore, the United Kingdom and the United States. A literature search, supplemented by interviews, was conducted. In analyzing information gathered about global regulatory systems, we used a framework for comparing regulatory typology, developed by the RAND Europe research institute. Our review found that the jurisdictions studied exhibited both similarities and differences in terms of how physicians are regulated and by whom. As a result of our search, we were able to identify 10 key trends in international medical regulation of importance to Hong Kong as it considers reforms to its health care system overall:

1. Changes in medical regulation are seen as a way of improving the quality of patient care.
2. Reform of medical regulation often requires government legislation.
3. The creation of common principles for policies, structures and the organization of regulation between professions is an emerging practice.
4. The involvement of lay people on boards and in inquiries is increasingly common.
5. Medical regulation is moving away from models of self-regulation and toward regulatory models that emphasize partnership between professions and the public, physicians and patients.
6. Health care providers and institutional regulators play complementary roles in medical regulation.
7. Regulation impacts the quality of care—not just the detection and remediation of poor performance.
8. Investigatory and disciplinary functions are increasingly separated and organized independently of each other.
9. Continuous Professional Development (CPD) is compulsory for physicians in many jurisdictions.
10. Overseas medical graduates are admitted into practice in different ways from country to country.

These trends are important for regulators in all countries to note as they assess the basic structure and effectiveness of their own medical regulatory systems.

Introduction
Regulation can be defined as “sustained and focused control exercised by a public agency over activities which are valued by a community.”¹ In the health care context, it is “any set of influences or rules exterior to the practice or administration of medical care that imposes rules of behaviors.”² There are two important linked concepts of regulation that are considered “oversight” by an external party using a specific set of commands/rules to “shape/influence the behavior” of health professionals.³ Because of the requirement for higher levels of relevant expertise and technical knowledge in medical regulation, the first, more restricted, definition of regulation—which is limited to the commands/rules exercised by public agencies with powers from legislation, administrative decrees and judicial orders—is not sufficient. In order to ensure the quality of care provided by health care profes-

AT ITS BEST, REGULATION PROVIDES GUIDANCE FOR ESTABLISHING BEST PRACTICES AND FOSTERS PERFORMANCE IMPROVEMENT THROUGH CONTINUOUS MEASUREMENT AND FEEDBACK PROCESSES.

sionals—particularly physicians—the second, broader definition of regulation in the healthcare context is used in this study. According to the United Kingdom’s Department of Health, this broader
approach to regulation includes voluntary self-regulation and employer-led regulation in addition to statutory regulation, in which professionals or providers collaborate and agree to a set of standards and code of practices independent of the statutory framework.\textsuperscript{4} Taken together, these broad regulatory strategies represent a kind of “regulatory pyramid” that begins with persuasion via more cooperative strategies at its base and moves progressively upward to more punitive approaches.\textsuperscript{5} Incentives are sometimes used to encourage or discourage certain institutional and individual behavior.\textsuperscript{5} Viewed in this broad context, the basic purposes of professional regulation, including medical regulation, are to ensure quality of care through the provision and monitoring of minimally acceptable standards of care and to provide public assurance about the quality and safety of care provided to patients.\textsuperscript{5} At its best, regulation provides guidance for establishing best practices and fosters performance improvement through continuous measurement and feedback processes.

However, there are global challenges for medical regulators, due mainly to the changing environment of medical practice—which is continuously influenced by developments in technology and scientific knowledge and the definition of the physician-patient relationship.\textsuperscript{7} The public’s trust in physicians has also changed,\textsuperscript{8} partly because of examples of malpractice highlighted by the media. Access to electronic information and increased consumer empowerment has also contributed to changes in professional governance, reflected in an increasing desire for greater public accountability and transparency and greater lay representation on professional governing bodies.\textsuperscript{6}

Aware of these global challenges, and their impact on the practice of medicine, the Food and Health Bureau (FHB) of the Government of the Hong Kong Special Administrative Region (HKSAR) commissioned our team to provide an updated international review of health care professional regulation—including medical regulation—in order to help identify any areas in which Hong Kong’s approach to professional regulation could be updated to strengthen the oversight of health care professionals. A full report, including international comparisons across six health professional groups in eight jurisdictions has been presented to the FHB.\textsuperscript{9} In this paper we present ten key global trends in medical regulation, derived from the policy review that forms the basis of our recommendations to the HKSAR.

### Medical Regulation in Hong Kong

Medical regulation in Hong Kong is characterized by a high degree of professional autonomy—an environment in which physicians effectively self-regulate. Physicians must register with and become licensed by the Medical Council of Hong Kong (which is a statutory body under the Medical Registration Ordinance) before they can practice. Hong Kong does not have a structured, ongoing assessment and monitoring system for physician performance. Only specialists, who are members of specialist Colleges collected under the Hong Kong Academy of Medicine, are mandated to participate in Continuing Professional Development (CPD) programs. For non-specialists, CPD is undertaken on a voluntary basis. Poor performance and professional misconduct is detected primarily through public/patient complaints.

Of the 28 members that make up the Medical Council, four are lay members appointed by the Chief Executive (14%), whereas the others are appointed or elected professional members.

Hong Kong has a strict entry requirement for physicians who have been trained outside the country, requiring them to pass a licensing examination administered by the Medical Council as well as participate in a supervised one-year internship before they are allowed to practice in Hong Kong with a full license. To tackle the acute manpower shortage in the public sector, Hong Kong’s public hospitals have begun to recruit these internationally-trained physicians to practice in the public sector...
under the Limited Registration Scheme for a fixed period of time under restricted circumstances.

**Methods**

In commissioning our team for its review of global regulatory trends, the FHB defined the target health professionals as those six health professional groups which were currently under statutory regulation in the Hong Kong Special Administrative Region (HKSAR) of China (see Appendix 1). Eight jurisdictions were chosen. Three jurisdictions were located in Asia (China, Malaysia, Singapore) with the remainder located in the West (Australia, Canada, New Zealand, United Kingdom, and the United States). The UK, Australia, New Zealand, Singapore, and Malaysia were chosen because they shared historical roots in the evolution of their medical education and framework for regulation of the health professions. The United States and Canada, representing regulatory systems in North America—were chosen to provide perspectives from a different system of medical education and regulation and to enable greater insight for analysis and synthesis. China was chosen for its relevance to HKSAR—since sovereignty over Hong Kong was transferred back to mainland China in 1997—and because the regulatory system in China is of more recent origin and still developing.

The six groups of health professions targeted for our broad study included physicians, nurses, dentists, Chinese Medicine practitioners, pharmacists, and a group that included a range of other health care professionals—including occupational therapists, physiotherapists, medical laboratory technologists, optometrists, radiographers and chiropractors, which are under statutory regulation in Hong Kong (see Appendix 1). For the purposes of this paper, we have targeted our findings impacting the regulation of physicians.

Data were collected using a “4Ps” analytical framework, taking account the perspectives of policymakers, providers, professionals, and public/patients. This framework has been adopted in other research projects conducted by our team.10 While we analyzed and described current regulatory practices from the perspective of each of these groups in our broader study, for the purposes of this paper our work is limited primarily to the policy aspects of medical regulation.

To identify relevant policies as we compared international regulatory systems, we reviewed available scholarly literature in Medline, documents and reports from government sources, national institutions, regulatory/professional bodies and other relevant organizations in the eight jurisdictions targeted. We cross-referenced bibliographies during our search to ensure comprehensiveness.

In addition, to enhance our understanding of the policymaker perspectives in the UK, Australia, Singapore and Malaysia, we conducted interviews with government officials and leaders of professional organizations in these countries to clarify information and to supplement our online search efforts.

**Comparative Data Analysis**

Content analysis was conducted to analyze the qualitative data collected.11 We adopted the typology of medical regulation developed by RAND Europe as a framework to guide our comparative data analysis.12 This RAND Europe review was commissioned by the General Medical Council of the UK to study the medical regulatory systems in 10 countries in Europe, Africa and South Asia—aiming to provide evidence on the registration of these non-UK qualified doctors to practice in the UK. We included six major areas in the typology of medical regulatory systems for the purposes of our study: (i) structure and nature of regulation and regulatory body (bodies), (ii) the registration process and requirements, (iii) medical education (iv) standards and ethics, (v) revalidation/competence assurance/recertification, (vi) fitness to practice and related disciplinary procedures and sanctions. Content analysis was performed by our primary researcher, with documents being independently reviewed by a second researcher. Results were compared to ensure their validity.

**Ethics Approval**

Ethics approval was obtained for the study from the Survey and Behavioral Research Ethics Committee at the Chinese University of Hong Kong.
Results and Discussion

Analysis of the policy literature, supplemented with semi-structured interviews, enabled the synthesis of 10 key medical regulatory trends for the FHB, which could be mapped onto the RAND analytical framework (Table 1). Table 1 shows that there were six key trends related to the structure and nature of medical regulation, including the purpose of medical regulation and interaction between different regulatory bodies; two trends related to professional standards and the mechanisms to detect and deal with poor performance; one trend referring to investigatory and disciplinary features; and one trend related to the registration requirements for internationally-trained medical graduates.

Structure and Nature of Medical Regulation

1. Changes in medical regulation are seen as a way of improving quality of patient care.

Amidst growing demand by both public and patients for transparency about standards of care and medical practice, many jurisdictions are adopting regulatory reforms of their health care professions—including their medical professions. These changes are often triggered by scandals and political interests. The driving force behind most reform of medical regulation is the concern for ensuring better standards of care for patients and protecting the public from harmful medical practice. A good example is the case of Dr. Harold Shipman, the general practitioner who was convicted of murdering more than 200 of his older patients over a 20-year period. Dr. Shipman’s case was one of the triggers for significant reforms of the regulation of doctors in the UK. A series of white papers was published following the Shipman Inquiry, the Bristol pediatric surgery scandal and other events, and these developments led to significant changes in the regulation of physicians’ professional practice in the UK. More recently, the investigation in 2015 into excess maternal and perinatal deaths in the Morecombe Bay hospitals in the UK found that the clinical competence of a proportion of staff fell significantly below the standard for a safe, effective service. Essential knowledge was lacking, guidelines were not followed and warning signs in pregnancy were sometimes not recognized or acted on appropriately. As a result, regulatory practice for the relevant institutions and professions has been reviewed by the UK Department of Health.

In Hong Kong, the trend recently has been for the beauty industry to incorporate medical personnel

<table>
<thead>
<tr>
<th>Typology (RAND Europe, 2009)</th>
<th>Key Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure and nature of medical regulation</td>
<td>1. Changes in medical regulation are seen as a way of improving quality of patient care.</td>
</tr>
<tr>
<td></td>
<td>2. Reform of medical regulation often requires government legislation.</td>
</tr>
<tr>
<td></td>
<td>3. The creation of common principles for policies, structures and organization of regulation between professions is an emerging trend.</td>
</tr>
<tr>
<td></td>
<td>4. Involvement of lay people on boards and in inquiries is increasingly common.</td>
</tr>
<tr>
<td></td>
<td>5. Medical regulation is moving away from models of self-regulation and toward regulatory models that emphasize partnership between professions and the public, physicians and patients.</td>
</tr>
<tr>
<td></td>
<td>6. Health care providers and institutional regulators play complementary roles in medical regulation.</td>
</tr>
<tr>
<td>Revalidation/competence and assurance/recertification</td>
<td>7. Regulation impacts the quality of care—not just the detection and remediation of poor performance.</td>
</tr>
<tr>
<td>Fitness to practice and related disciplinary procedures and sanctions</td>
<td>8. Investigatory and disciplinary functions are increasingly separated and organized independently of each other.</td>
</tr>
<tr>
<td>Standards and ethics</td>
<td>9. Continuous Professional Development (CPD) is compulsory for physicians in many jurisdictions.</td>
</tr>
<tr>
<td>Medical education; registration process and requirements</td>
<td>10. Overseas medical graduates are admitted into practice in different ways from country to country.</td>
</tr>
</tbody>
</table>
into businesses in order to attract consumers. In 2012, a woman died in a beauty salon after undergoing a high-risk procedure undertaken by a medical practitioner that included auto blood transfusion with contaminated blood for the purpose of rejuvenating the woman’s appearance. This raised issues of standards and scope of practice of physicians, prompting the government to propose a series of regulatory changes to improve the quality and safety of care.\textsuperscript{17,18}

In another example of regulatory policy being used to improve the quality of care, Malaysia’s efforts to encourage medical tourism have stimulated reform of the regulatory structures there, including the need to embrace both public and private sectors with common standards for quality assurance and regulatory governance.\textsuperscript{19}

All of these examples help underscore that medical regulatory processes and policies exist on a developmental continuum, affected by a wide range of factors—from economic interests to public opinion and changing public expectations.

### Table 2

**Legislative Models Across the Jurisdictions**

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Structure of Legislation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia*</td>
<td>✓</td>
<td>• Health Practitioner Regulation National Law Act (2010)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Australian Health Practitioner Regulation Agency (Overarching body)</td>
</tr>
<tr>
<td>Canada</td>
<td>✓ (In six provinces/</td>
<td>• British Columbia: Health Professions Act (1996); Alberta: Health</td>
</tr>
<tr>
<td></td>
<td>territories only)</td>
<td>Professions Act (2000); Manitoba: The Regulated Health Professions</td>
</tr>
<tr>
<td></td>
<td>✓ (For the other</td>
<td>Act (2009), Ontario: Regulated Health Professions Act (1991);</td>
</tr>
<tr>
<td></td>
<td>provinces/</td>
<td>Newfoundland and Labrador: Health Professions Act (2010); and Yukon</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Umbrella health profession legislation co-exists alongside</td>
</tr>
<tr>
<td></td>
<td></td>
<td>individual statutes that regulate professions</td>
</tr>
<tr>
<td>China (Mainland)</td>
<td>—</td>
<td>Single act for each profession</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>✓ (For allied health</td>
<td>Supplementary Medical Professions Ordinance (Cap 359) to regulate</td>
</tr>
<tr>
<td></td>
<td>professions only)</td>
<td>five allied health professions</td>
</tr>
<tr>
<td>Malaysia</td>
<td>—</td>
<td>Single act for each profession</td>
</tr>
<tr>
<td>New Zealand</td>
<td>✓</td>
<td>Health Practitioners Competence Assurance Act (2003)</td>
</tr>
<tr>
<td>Singapore</td>
<td>✓ (For allied health</td>
<td>Allied Health Professions Act (2011) to regulate three allied</td>
</tr>
<tr>
<td></td>
<td>professions only)</td>
<td>health professions</td>
</tr>
<tr>
<td>United Kingdom*</td>
<td>✓ (For allied health</td>
<td>• Health Professions Order (2001) to regulate 15 health professions.</td>
</tr>
<tr>
<td></td>
<td>professions only)</td>
<td>• Professional Standards Authority for Health and Social Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(overarching body)</td>
</tr>
<tr>
<td>United States</td>
<td>—</td>
<td>Single act for each profession, but varies state to state for physicians</td>
</tr>
</tbody>
</table>

Notes: *Australia and United Kingdom have overarching bodies to bring commonality to values and processes between professions, following the same procedures for registration, administration of the governing broad, and complaints resolution and professional discipline processes.

Sources: medical council/board of the relevant jurisdictions

2. Reform of medical regulation often requires government legislation.

Regulatory systems may impose legal restrictions on, or controls over, physicians’ practices through legislation, administrative decrees and/or judicial orders. Reform of medical regulation has required governments to take action either by creating new legislation or amending existing legislation. For example, the General Medical Council of the UK was reconstituted to reduce its membership from 35 to 24 in 2009, and further decreased to 12 in 2013 to simplify its governance arrangements and to focus on strategy and the management of its executives.\textsuperscript{20}

Another example of regulation reform through legislative change is the creation of umbrella legislation to ensure regulatory consistency. Table 2 shows the different legislative models used across the jurisdictions highlighted in this paper. Australia, New Zealand and six provinces/territories in Canada have enacted umbrella health profession legislation; that is, the use of a single overarching statute that makes procedures uniform across professions in order to ensure the...
complaints resolution and professional disciplinary processes. The Agency supports the 14 National Boards that are responsible for regulating the health care professional groups in managing the registration of health practitioners and investigations into professional conduct and performance. The UK’s Professional Standards Authority of Health and Social Care is another example of an overarching body that oversees diverse regulators as a form of meta-regulation.

The decision on whether to have an overarching body, separate regulatory bodies or self-accreditation generally involves a combination of history, lobbying and the desire of individual professions to have greater control over their own regulations.

3. The creation of common principles for policies, structures and the organization of regulation between professions is an emerging trend.

Increasingly, consideration is being given to including medical regulation within broader umbrella legislation in order to ensure nationally consistent legislation across professions. In Australia, for example, the Australian Health Practitioner Regulation Agency was established in 2010 to bring commonality to the values and processes between health care professions, who now follow similar procedures for registration, administration of their governing body, and complaints resolution and professional disciplinary processes. The Agency supports the 14 National Boards that are responsible for regulating the health care professional groups in managing the registration of health practitioners and investigations into professional conduct and performance. The UK’s Professional Standards Authority of Health and Social Care is another example of an overarching body that oversees diverse regulators as a form of meta-regulation.

3. Involvement of lay people on boards and in inquiries is increasingly common.

Along with the demand for greater public accountability and transparency, lay representation is becoming the norm globally in medical regulation. Table 3 shows the current structure of medical

### Table 3

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Composition</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lay (%)</td>
<td>Professional Members (%)</td>
</tr>
<tr>
<td><strong>Australia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Medical Board of Australia)</td>
<td>36%</td>
<td>67%</td>
</tr>
<tr>
<td><strong>Canada — varies across provinces</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>British Columbia</td>
<td>33%</td>
<td>67%</td>
</tr>
<tr>
<td>Ontario</td>
<td>42%</td>
<td>58%</td>
</tr>
<tr>
<td><strong>Hong Kong</strong> (Medical Council of Hong Kong)</td>
<td>14%</td>
<td>86%</td>
</tr>
<tr>
<td><strong>Malaysia</strong> (Malaysian Medical Council)</td>
<td>0%</td>
<td>100% (with government officials)</td>
</tr>
<tr>
<td><strong>New Zealand</strong> (Medical Council of New Zealand)</td>
<td>33%</td>
<td>67%</td>
</tr>
<tr>
<td><strong>Singapore</strong> (Singapore Medical Council)</td>
<td>0%</td>
<td>100% (with government officials)</td>
</tr>
<tr>
<td><strong>United Kingdom</strong> (General Medical Council)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>United States — varies across states</strong></td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>Florida</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>Texas</td>
<td>37%</td>
<td>63%</td>
</tr>
</tbody>
</table>

* With strong government oversight.

Note: The Ministry of Health in China (mainland) is the center of health professional regulation, and there is no lay involvement.

Sources: medical council/board of the relevant jurisdictions

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regulatory bodies in our study, including membership composition. The degree of public/patient involvement in medical regulation varies from jurisdiction to jurisdiction. Lay representation on medical councils/boards in our study varied from a high of 50% in the UK to 0% in Singapore, Malaysia and mainland China, where there is greater government oversight –highlighting significant differences between jurisdictions in some of Asia compared with the West. The general global trend, however, is toward an increase of involvement of lay people on boards, review panels and inquiries in medical regulation. A UK study found that the public preferred a mix of qualified medical professionals and knowledgeable people without medical qualifications to assess physicians’ performance.24

The importance of public and patient involvement in the physician revalidation program has been emphasized in the UK.26 However, providing proper training and support to lay people who serve as regulators is also considered necessary, with training provided on an ongoing basis in order to keep lay people up to date with developments in the field and to help ensure that physicians understand the aims of lay involvement.26

5. Medical regulation is moving away from self-regulation and towards regulatory models that emphasize partnership between professions and the public, physicians and patients.

Self-regulation is rooted in the concept of professionalism, which grants the professions the right to regulate themselves.27 In part due to the change in societal expectations resulting from scandals and poor professional practices, there has been a significant shift away from the concept of the right to self-regulation for physicians and towards a greater openness, accountability, and engagement of lay representatives. Differing models of government oversight of self-regulation exist in the jurisdictions highlighted in our study. There is relatively strong government oversight and direct engagement in Asian jurisdictions, for example, such as in Singapore, Malaysia and mainland China. The UK, Australia and New Zealand engage in co-regulation and emphasize partnership between the government and the public. In the U.S., providers and insurers, who may require physicians to participate in credentialing or certification, are a de-facto element of the regulatory structure. Professions in Canada are self-regulated through professional colleges or associations that perform comprehensive regulatory functions. In the laissez-faire free market of Hong Kong, a high degree of professional autonomy has been retained, and physicians are largely self-regulated by the medical council and the Hong Kong Academy of Medicine, which was established by statute.

Our review suggests that health care professional regulation is moving from the current premise of self-regulation, which is often viewed as protecting its own interests, to one of partnership between professions, regulators and the public (“co-regulation”).

6. Health care providers and institutional regulators play complementary roles in medical regulation

Health care providers and institutional regulators play a greater role in external oversight in the Western jurisdictions in our study, compared with China, Singapore or Malaysia, where medical regulation is under greater governmental control. For example, in addition to the General Medical Council (GMC) in the UK, “arms-length” organizations such as the Care Quality Commission operate as institutional regulators, acting as an external party to regulate the quality and safety of care provided by professionals employed within their institutions. The health care financing system in United States includes government assistance, through such programs as Medicare for older adults and Medicaid for those lacking the ability to pay; private health insurance, which is predominantly employer-based; and via out-of-pocket payment by those who do not have insurance or qualify for government programs. As noted previously, insurance companies/employers may require that the insured consult a physician who has been credentialed and certified in a specialty for reimbursement, thereby playing a role in medical regulation. In these settings, it makes sense for professional and provider regulators to work in partnership and to agree on standards to ensure good quality patient care — and this partnership should be open and transparent if it is to reassure the public. Hong Kong has yet to address such a partnership model.
Revalidation/Competence and Assurance/Recertification

7. Regulation impacts the quality of care — not just the detection and remediation of poor performance.

In addition to upholding professional standards, there has been an emerging emphasis amongst regulators on improving the quality of care through early intervention and remediation to address poor performance amongst physicians. Most jurisdictions have systems for identifying poor performance, but methods of detection and intervention differ. A set of standards usually determines competent practice as a starting point for assessing good/poor performance, providing a threshold against which poor practice can be assessed. For example, “Good Medical Practice” in the UK provides a basis for the principles and values on which competent practice is founded.29

Varying assessment approaches are used in the jurisdictions we studied, including not only assessing health care professionals who have received complaints about their practice, but also periodically assessing and screening all physicians, or at least those who pose a high risk.29 For example, revalidation in the UK uses a periodic-assessment approach through its revalidation system to ensure physician competence, while Canada uses a screening-assessment approach — identifying specific groups (e.g. physicians over 70 years old in Quebec) for assessment using a set of screening indicators.

Mechanisms such as recertification and revalidation are in place in the United States and the UK to assess and monitor physicians’ continuing competence. A large amount of evidence has shown that recertification is related to improved performance.6,30 In the United States, physicians can choose to be certified by the American Board of Medical Specialties and its 24 member boards to show that they have achieved more than the minimum standards required for licensure. They can be recertified through the Maintenance of Certification (MOC) program, which was initiated in 2000 and requires most certified specialists to periodically seek recertification based on four-part assessment tests of their medical knowledge, clinical competence and communication skills with patients. However, physicians have criticized the MOC as an expensive and time-consuming exercise, particularly in terms of the examinations it requires.31 Practicing physicians are not required to be specialty certified. In the UK, the General Medical Council (GMC) launched a revalidation effort in December 2012 after nearly 15 years of discussion with the profession. For the first time, revalidation now asks physicians to demonstrate that they are up to date and fit to practice on a five-year cycle informed by annual appraisals. Revalidation is espoused to be a process that will identify poor practice and benefit all physicians. However, it initially received strong objections from some individuals in the medical profession, who criticized the proposal as impractical and too costly and called it a breach of self-regulation.28

In Asia, there has been little movement toward individual recertification or revalidation. This may in part be due to the greater levels of private provision of care, itself a challenge to medical regulation. In Hong Kong, for example, it is difficult to assess primary care practitioners when they work alone and regulatory structures are lacking. This leads to the question of how best to regulate providers in the out-of-pocket payment system of primary care commonly found in Asia.

Fitness to Practice and Related Disciplinary Procedures and Sanctions

8. Investigatory and disciplinary functions are increasingly separated and organized independently of each other.

All of the jurisdictions we studied have systems in place to detect and deal with professional misconduct by physicians, usually based on complaints or referrals. The power of regulators to investigate
leading to an international shift away from CME and toward CPD, which includes the development of medical, managerial, social and personal skills. Numerous studies have demonstrated that CPD can improve patient health outcomes. CPD programs focus mainly on professional development to keep physicians’ knowledge up to date.

Table 4 shows the CPD requirements for physicians in the jurisdictions we studied. Nearly all of the jurisdictions require physicians to undertake compulsory continuing education programs to maintain their professional competences. CPD is not compulsory for all physicians in Hong Kong, although the Hong Kong Academy of Medicine requires specialists to engage in CPD. Malaysia has passed a law to require compulsory CPD, but it has not been implemented.

### Standards and Ethics

9. **Continuous Professional Development (CPD) is compulsory for doctors in many jurisdictions.**

There is an increasing trend toward implementing CPD for all doctors to enable them to maintain their professional competence and demonstrate that their practices meet professionally agreed-upon standards. Until now, continuing medical education (CME) in the form of formal lectures or seminars with time-based credit points has traditionally been used to signify the maintenance of one’s professional competence. However, CME is increasingly considered to be a more passive form of learning, leading to an international shift away from CME and toward CPD, which includes the development of medical, managerial, social and personal skills.

![Table 4](image-url)

**Table 4:** Legislative Models Across the Jurisdictions

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>CPD Requirements (mandatory)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>✓</td>
<td>—</td>
</tr>
<tr>
<td>Canada</td>
<td>✓</td>
<td>—</td>
</tr>
<tr>
<td>China (Mainland)</td>
<td>✓</td>
<td>—</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>Mandatory for specialist only</td>
<td>—</td>
</tr>
<tr>
<td>Malaysia</td>
<td>—</td>
<td>Passed the law to require compulsory CPD which is yet to be implemented</td>
</tr>
<tr>
<td>New Zealand</td>
<td>✓</td>
<td>—</td>
</tr>
<tr>
<td>Singapore</td>
<td>✓</td>
<td>—</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>✓</td>
<td>Revalidation started for physicians in December 2012</td>
</tr>
<tr>
<td>United States</td>
<td>✓</td>
<td>Certification and recertification in place — only of specialists</td>
</tr>
</tbody>
</table>

Sources: medical council/board of the relevant jurisdictions
Medical Education, Registration Process and Requirements

10. Overseas medical graduates are admitted into practice in different ways from country to country.

The importation of physicians, trained outside the country in which they practice, is often related to physician shortages in particular specialist areas, often in more developed jurisdictions. Western jurisdictions such as the UK, United States, Australia and Canada have histories of physician shortages that have led to the development of a variety of systems that allow foreign medical graduates to practice. Requirements for these medical graduates vary, though language proficiency assessment is necessary for all of the jurisdictions. The United States, Canada, and Hong Kong also require licensing examinations as one form of competency verification.

Some other jurisdictions, such as Malaysia and Singapore, have a recognized list of qualified overseas institutions from which overseas-trained physicians may be accepted. However, these graduates may still need some form of professional supervision before working in health care institutions. Some jurisdictions, such as Australia and New Zealand have different pathways for internationally trained physicians — depending on their qualifications — and might require them to complete a specified period of supervised training in lieu of, or in addition to, qualifying/licensing examinations or internships.

### Implications for Asia and Hong Kong

The regulation of medically qualified professionals is a significant topic of discussion for many global jurisdictions for a variety of reasons — ranging from political, financial, legal, professional pressures to emerging concerns about medical quality and patient safety. This can make medical regulation a key factor in discussions of overall health care reform. The global network of those involved in reviewing and changing medical regulatory processes is growing and rapidly changing the terrain for discussion of these issues worldwide.

Jurisdictions vary in how they are regulated and by whom. Regulatory practices are culturally defined within each jurisdiction and there is no one-size-fits-all solution. Levels of regulatory autonomy, for example, vary from jurisdiction to jurisdiction, based on historical context, socio-political environment and public interests. Other factors, such as a government’s regulatory objectives, the incentives for and behavior of those regulated, and the costs...
In general, government oversight of regulation is greater in the Asian jurisdictions (e.g., China, Singapore, and Malaysia) and there has been little movement toward individual recertification or revalidation in these countries. Hong Kong remains an outlier as it retains medical self-regulation.

Our review of the regulatory frameworks for physicians in several jurisdictions provides an important insight for Hong Kong and its efforts to reform current health care professional regulation, while taking into account local context and values. Compared with the British and North American regulatory models, medical regulation in Hong Kong is characterized by a high degree of professional autonomy. The ten key trends we have identified highlight the emerging challenges to be addressed in Hong Kong as it considers its future regulatory structure. Given the global trend of moving away from depending on self-regulation, Hong Kong policy makers should consider enhancing the role of lay representatives in medical regulation, and they should revisit the appropriate degree of lay representation in the regulatory process to increase accountability and transparency and to account for the views of diverse stakeholders. Consideration of compulsory CPD programs for all physicians should be discussed with the medical profession and the public, and further ways to enhance the detection and management of poor performance should be considered in order to improve the quality of care, particularly in the private primary-care sector. Hong Kong also needs to consider how to better engage internationally trained medical graduates to address its health manpower shortages—a step that could also promote internationalism and enrich professional experiences. Our study provides a framework and context for further discussion of an effective system of medical regulation in Hong Kong.

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Appendix

Jurisdictions and health care professionals included in the analysis:

Eight jurisdictions: Australia, China (Mainland), Canada, Malaysia, New Zealand, Singapore, United Kingdom, United States.

Six types of health professions: (a) Western medical doctors, (b) nurses, (c) dentists, (d) Chinese Medicine practitioners, (e) pharmacists, and (f) other health care professionals, including occupational therapists, physiotherapists, medical laboratory technologists, optometrists, radiographers and chiropractors, which are under statutory regulation in Hong Kong.
Arkansas

Use of Prescription Monitoring Program in Arkansas on the Rise

The Arkansas State Medical Board (ASMB) announced recently that participation in the Arkansas Prescription Monitoring Program (APMP) has reached approximately 2,250 physicians, representing roughly 35% of physicians in the state who write prescriptions for controlled substances.

In an article in the ASMB’s quarterly newsletter, a representative of the APMP Advisory Committee said that like state medical boards in many states, the ASMB is becoming more engaged with the APMP as a useful tool on many levels.

“The Arkansas State Medical Board is increasingly using the PMP as a part of their investigations of complaints against physicians,” said Gene Shelby, MD, Chair of the APMP Advisory Committee. He added that the ASMB is also “actively looking at ways to increase the registration and use of the PMP” as well as “looking at tying the registration for the PMP with the license renewal process for physicians who write controlled medications.”

In 2015, the state legislature in Arkansas passed a number of modifications to increase the effectiveness of the APMP including making it possible for prescribers to delegate to other individuals the ability to access the PMP on their behalf. This makes it possible for a nurse to print out a patient’s APMP record before the physician sees the patient, for example.

The 2015 legislation also makes it possible for the state’s health department to review information in the APMP that might indicate misuse of controlled medications and pass that information to the appropriate state licensing board.

The legislation also stipulates measures that physicians must take when treating chronic non-malignant pain, including checking the APMP, random drug checks, and creating a pain contract with patients, and it requires a two-hour prescribing course of all new licensees within two years of licensure.

Source: Arkansas State Medical Board Newsletter, Winter 2016

Arkansas Releases Summary of 2015 Licensure and Disciplinary Activities

Nearly 10,000 physicians are now licensed to practice in Arkansas, according to statistics released recently by the Arkansas State Medical Board (ASMB) as a part of its 2015 Year End Report.

A total of 9,683 medical doctors (MDs) and doctors of osteopathy (DOs) are licensed by ASMB, with 6,488 of these physicians being residents of the state. During 2015, the state licensed 577 new MDs and DOs. After physicians, the next largest category of health care professionals licensed by the state in 2015 was respiratory therapists, at 1,997, followed by occupational therapists, at 1,416.

In summarizing its disciplinary proceedings in 2015, the Board noted that it suspended 16 licenses in 2015, issued 13 consent orders, and ordered three license revocations, two license surrenders and two reprimands.

Source: Arkansas State Medical Board Newsletter, Winter 2016

California

Medical Board of California Launches Verify a License Campaign

In an effort to educate the public about the importance of verifying a physician’s license, the Medical Board of California has launched the Verify a License Campaign. The campaign encourages patients “to be proactive regarding their physician and health care”—taking steps to check physician credentialing.

As a part of the campaign, Board staff will be passing out brochures and providing consumer tips about the importance of checking physicians’ credentials and disciplinary history, visiting health fairs, town hall meetings and shopping malls to raise awareness.

Source: Medical Board of California Newsletter, Fall 2015
Florida

Florida Board Revises State’s Telemedicine Practice Rules for Physicians

The Florida Board of Medicine has revised Florida’s Telemedicine Rule. The revised rule, implemented March 7, 2016, includes a number of key provisions and definitions, among them:

**Use of telephone:** The revised rule stipulates that telemedicine “shall not include the provision of health care services only through an audio-only telephone, email messages, text messages, facsimile transmission, U.S. Mail or other parcel service, or any combination thereof.”

**Controlled substances:** Prescriptions of controlled substances may not be written using telemedicine, with the exception of treatment of psychiatric disorders.

**Electronic medical questionnaires:** Prescribing medications based solely on an electronic medical questionnaire constitutes “the failure to practice medicine with that level of care, skill, and treatment which is recognized by reasonably prudent physicians as being acceptable under similar conditions and circumstances” under the revised rule.

The Board’s revised rule also states that “a physician-patient relationship may be established through telemedicine.”

Georgia

Georgia Composite Medical Board Releases Annual Regulatory Statistics

In Fiscal Year 2015, the Georgia Composite Medical Board issued 4,652 new licenses to various health professionals in the state, an increase of more than 20% over Fiscal Year 2014.

Between July 2014 and June 2015, the Board issued the licenses in the following major categories:

- Physician: 2,321
- Temporary residency training permit: 724
- Assistant laser practitioner: 469
- Physician assistant: 448
- Respiratory care professional: 396
- Senior laser practitioner: 113
- Pain management clinic: 109
- Acupuncturist: 25

The Board also reported its enforcement and discipline actions for the year. In Fiscal Year 2015, it received 1,550 complaints (of which 1,202 were within the Board’s jurisdiction) and issued 50 sanctions against 48 licensees through various dispositions (public reprimand, probation, revocation, public fine, etc.).

The number of complaints received by the Board was down in 2015, compared to 1,771 in 2014, 1,729 in 2013 and 2,061 in 2012.

The Board also reported that in Fiscal Year 2015, its total budget was $2,402,124, appropriated by the General Assembly. During the year, the Board collected nearly three times that amount in fees, which were turned over to the state’s treasury.

Source: Georgia Composite Medical Board Annual News and Report, 2015

Georgia Board and Public Health Department Create ‘THC Registry’

The Georgia Composite Medical Board and the Georgia Department of Public Health partnered recently to develop a “Low THC Oil Registry” for patients and caregivers who qualify to carry an identification card under Georgia’s new medical cannabis law.

Under the new law, patients and caregivers of patients who believe they may be eligible can consult with their physician about the possibility of obtaining a card allowing them to possess 20 fluid ounces of low THC oil within the state of Georgia. If approved by the physician, the patient or patient’s caregivers’...
information will be entered into DPH’s secure Low THC Oil Registry, and a card will be issued.

Source: Georgia Composite Medical Board Annual News and Report, 2015

Maine

Maine Board Website Has New Look and Features

The Maine Board of Licensure in Medicine has redesigned its website, offering a new look and feel, improved navigation and new features.

To make it easier for licensees to access information quickly, the new website features “What’s Happening” and “Laws/Rules Updates” features on its homepages — which provide up-to-date information on general Board news and emerging topics of interest.

The “Laws/Rules Updates” feature will include legislative information while Maine’s state legislature is in session and information about current and upcoming Board rules.

The new website also contains updated versions of all MD applications under the heading “Apply for MD License,” and the Board is strongly encouraging licensees to use its online renewal system, easily accessible via the website’s new navigation. Also new at the website is a “Jurisprudence Exam Study Guide,” which has updated and condensed previous study materials for licensees.

To view the website, please visit www.maine.gov/md.

Source: Maine Board of Licensure in Medicine Newsletter, Winter 2015

Minnesota

Regulatory Boards Adopt Updated Joint Statement on Pain Management

Minnesota’s regulatory boards of medicine, nursing, and pharmacy recently updated their Joint Statement on Pain Management. The boards adopted the first Joint Statement on Pain Management in 2004, which was reaffirmed in 2009, to give guidance regarding untreated or inadequately-treated pain.

The boards recently reviewed the issue of pain management again in order to offer added guidance regarding appropriate prescribing with emphasis on the critical balance between pain management and the potential misuse of controlled substance medications.

Recognizing that pain management and opioid prescription drug abuse are significant issues in health care, the new joint statement seeks a critical balance between preventing opioid misuse while managing pain — and puts an emphasis on the need for education and awareness among physicians and other health care professionals.

The Joint Statement offers guidance to health care providers in the management of pain and to provide resources where practitioners can obtain additional information.

“Adequate knowledge of pain management and pharmacotherapeutics, effective communication with patients, family members and other health care providers, and a commitment to ethical, compassionate patient care are essential to responsible opioid prescribing,” said Ruth Martinez, MA, Executive Director of the Minnesota Board of Medical Practice.

The Boards will continue to jointly promote appropriate prescribing, dispensing, and administration of controlled substance medications and are encouraging Minnesota health care providers to “work cooperatively and effectively to manage the dimensions of pain and minimize prescription drug misuse.”


Source: Minnesota Board of Medical Practice website
Ohio

Ohio’s New Opioid Prescribing Guidelines for Acute Pain Expand Fight Against Prescription Drug Abuse

As part of Ohio’s continuing effort to curb the misuse and abuse of prescription pain medications and unintentional overdoses, the Governor’s Cabinet Opiate Action Team has issued new opioid prescribing guidelines for the treatment of patients with acute pain.

The new acute guidelines expand upon Ohio’s existing prescribing guidelines for emergency departments and acute care facilities, issued in 2012, and for treatment of chronic pain lasting longer than 12 weeks, issued in 2013. The guidelines were developed by the Governor’s Cabinet Opiate Action Team in conjunction with clinical professionals associations, health care providers, state agencies and state licensing boards — including the State Medical Board of Ohio (SMBO).

In 2014, more than 262 million opioid doses were dispensed in Ohio for the management of acute pain — 35 percent of the state’s 750 million total dispensed opioid doses.

The new guidelines urge prescribers to first consider non-opioid therapies and pain medications — when appropriate — for the outpatient management of acute pain. When opioid medications are necessary to manage a patient’s acute pain, the guidelines recommend that the clinician prescribe the minimum quantity necessary without automatic refills.

The new acute pain guidelines call for prescribers to check the State Board of Pharmacy’s Ohio Automated Rx Reporting System (OARRS) before prescribing an opioid. A review of OARRS is required for most opioid and benzodiazepine prescriptions of seven days or longer.

Among other steps Ohio is taking to combat prescription drug abuse, it recently launched an effort to streamline access to OARRS by integrating OARRS directly into electronic medical records and pharmacy dispensing systems across Ohio. More than 110 hospitals, pharmacies and physician offices have requested integration, according to SMBO.

To view the new prescribing guidelines, and for more information about Ohio’s initiative to address prescription drug abuse, please visit www.opioidprescribing.ohio.gov.


Oklahoma

PA Practice Act Updated In Oklahoma

Oklahoma physicians who supervise Physician Assistants (PA) no longer are required to be on-site at least one half day per week, and supervising physicians also now have more autonomy in determining the scope of services offered by PAs in the state.

Oklahoma Senate Bill 753, signed by Governor Mary Fallon, allows supervising physicians to be available via telecommunications. The bill permits supervising physicians to establish the scope of practice and level of supervision for their PAs as long as the services are within the PA’s skill level, the supervising physician’s scope of practice and properly supervised.

The updated bill eliminates former requirements that the supervising physician be on-site at clinics at least one half day a week and removes the list of services that can be provided by PAs. The amended law also does away with the requirement that a PA must receive approval from the Oklahoma Board of Medical Licensure and Supervision and have practiced for at least one year before working in a remote health care setting.

The new measure also clarifies the situations when a PA must report within forty-eight hours a “newly diagnosed complex illness” to the supervising doctor. Oklahoma Senate Bill 753 states: “The supervising physician shall determine which conditions qualify as complex illnesses based on the clinical setting and the skill and experience of the PA.”

Source: Oklahoma Board of Medical Licensure and Supervision website
Oregon Board Adopts New Statement of Philosophy on Social Media

The Oregon Medical Board (OMB) adopted a formal position statement on the use of social media in health care recently.

Titled, “Statement of Philosophy: Social Media,” the position statement acknowledges that “online social networking has become a resource for healthcare professionals to share information and to form meaningful professional relationships” and offering guidelines to help ensure that the use of social media doesn’t interfere with the safe and ethical delivery of health care.

The Board’s position statement reminds its licensees that “healthcare professionals are bound by ethical and professional obligations that extend beyond the exam room, and social media creates new challenges.” The statement offers general parameters to help health care professionals avoid problems in three key areas: confidentiality, boundaries, and overall professionalism.

Confidentiality: The statement notes that health care professionals “have an obligation to protect patient privacy and confidentiality in all environments,” and that identifiable patient information—even seemingly minor details of a case or patient interaction—must never be posted online. Health care professionals should never discuss a patient’s medical treatment or answer a patient’s health-related question through personal social media, and take steps to ensure e-mail communications are secure.

Boundaries: The statement urges health care professionals to maintain appropriate boundaries in the physician-patient relationship at all times—including considering separating their personal and professional social media accounts and exercising caution if interacting with patients or their families online through personal social networking sites. The statement notes that “it is the professional’s responsibility to maintain appropriate boundaries, not the patient’s.”

Professionalism: Online actions and content directly reflect on professionalism, and therefore the statement advises health care professionals that they must “understand that their online activity may negatively impact their reputations and careers as well as undermine the public’s overall trust in the profession.” They should not make negative statements about other health care providers and should use caution when responding to the negative comments of others on social media. “When conflicted about posting online content, healthcare professionals should err on the side of caution and refrain,” the statement urges. Those who write online about their professional experiences must be “honest about their credentials and reveal any conflicts of interest.”

The new position statement is accessible at www.oregon.gov/omb/board/philosophy.

Source: Oregon Medical Board Report, Volume 128, No. 1

Rhode Island Releases 2015 Licensing and Disciplinary Statistics

The Rhode Island Board of Medical Licensure and Discipline licensed 4,836 allopathic and 335 osteopathic physicians in 2015, according to its 2015 Annual Report, released recently. It issued 377 new licenses during the year.

The Board received 422 complaints during the year and opened 200 for investigation. It suspended one license, and issued 20 reprimands and sanctions. No licenses were revoked in 2015.

The Board noted that as of December 31, 2015, 66 percent of all physicians in the state were registered with Rhode Island’s Prescription Drug Monitoring Program. The Board expects that all physicians will be in compliance with this statutory requirement by June 30, 2016.

Source: Rhode Island Board of Medical Licensure and Discipline 2015 Annual Report
ECFMG Notes IMG Participation Levels in 2016 Annual Resident Matching Program

The Educational Commission for Foreign Medical Graduates (ECFMG) has reported that the number of international medical graduates (IMGs) participating in the 2016 National Resident Matching Program (NRMP) increased from 2015. The annual NRMP Match is the system by which applicants are matched with available residency positions in U.S. graduate medical education (GME) programs.

Compared to 2015, the number of IMGs who participated in the Match increased by 403, and the number of IMGs who matched to first-year residency positions increased by 336.

Of the 12,790 IMGs who participated in the 2016 Match, 6,638 (51.9%) matched to residency positions. In the 2015 Match, 6,302 (50.9%) IMGs were matched to first-year residency positions.

Of the 5,323 U.S. citizen IMG participants, 2,869 (53.9%) were matched to first-year positions, an increase of 209 from last year. The number of U.S. citizen IMGs matching to first-year positions has increased in 12 of the last 13 Matches.

Participants in the NRMP submit a list of residency programs they would like to enter, in order of preference. Ranked lists of preferred residency candidates are likewise submitted by U.S. GME programs with available positions. The matching of applicants to available positions is performed by computer algorithm. The Match results announced in March of each year are for GME programs that typically begin the following July.

Source: ECFMG website

New Members Join IAMRA

The International Association of Medical Regulatory Authorities (IAMRA) recently announced the addition of several new members. They include:

- Rwanda Medical and Dental Council
- South Sudan General Medical Council
- Nursing and Midwifery Council (UK)
- National Board for Certification in Occupational Therapy (U.S.)
- Health Professions Authority Zimbabwe
- National Commission on Certification of Physician Assistants (U.S.)

IAMRA now has 95 member organizations, representing 44 countries.

Source: IAMRA website

Australia

Preparations for 12th International Conference on Medical Regulation Continue in Melbourne

The Medical Board of Australia (MBA) and the Australian Health Practitioner Regulation Agency (AHPRA) are busy preparing for the International Association of Medical Regulatory Authorities (IAMRA) 12th International Conference on Medical Regulation, to be held September 20–23, 2016, in Melbourne, Australia. The venue for the conference is the Melbourne Convention and Exhibition Centre.

The MBA and AHPRA, which are partners in regulating medical practitioners in Australia, are working with IAMRA representatives to develop programming for the conference, which continues to grow as more countries join IAMRA.

The conference attracts a diverse range of attendees with an interest in medical regulation, who share best practices and trends in countries from all over the world. Held biennially, IAMRA conferences have in recent years attracted anywhere from 250 to 350 delegates, representing diverse countries.

Substantial discounts are available to those who register early for the conference. Early bird registration deadline is June 23, 2016.

To register or learn more about the conference, please visit www.iamra2016.org.

Source: IAMRA 12th International Conference on Medical Regulation website
The content was designed to help IMGs explore specific standards for Canadian health care that may not be addressed in other types of learning and orientation — presenting useful information for IMGs that in many cases differs from physician practice in their country of origin. IMGs participating in focus groups testing the new program in the fall of 2015 reported that they had faced several cultural and communication issues since their arrival in Canada. These included not only language difficulties and cultural differences, but concepts such as autonomy, justice and patient-centered medicine. Professional issues such as collaborative teamwork among specialists and the less formal structure for physicians in Canada were also raised.

To learn more about the portal, please visit www.mcc.ca/home.

Source: Medical Council of Canada website

International Physician Assessment Coalition Meeting to Convene Just Before 2016 IAMRA Conference

The International Physician Assessment Coalition (IPAC), an international forum designed to encourage collaboration and best practice in the assessment and remediation of physicians, will host a conference September 19–20, 2016 at the Melbourne Convention and Exhibition Centre — just before the 2016 International Conference of IAMRA.

The IPAC conference is designed for individuals involved in assessing the performance of physicians, medical regulators and medical educators.

During the conference, participants will share experiences and insights about assessing the performance of physicians, risk factors for poor performance among physicians, and trends and developments in remediating poorly performing physicians.

To register or learn more about the conference, please visit www.iamra2016.org/3852-2/

Source: IAMRA 12th International Conference on Medical Regulation website

Ireland

Medical Council Reports Highest Number of Physicians Ever in Ireland

The Medical Council of Ireland recently reported that at the end of 2015 Ireland’s medical workforce stood at 20,473 physicians — the highest number ever recorded in the Council’s year-end statistics. The total represents an increase of 889 physicians from 2014.

The Council also reported a significant increase in the number of new physicians registered in Ireland. In 2015, 2,600 new physicians were registered, compared with 1,800 new registrations in 2014. The Council processed 50 percent more registration applications in 2015 than in 2014. There was also an increase in 2015 in the number of newly registered physicians who had received medical training outside of Europe.

Source: Medical Council of Ireland website

Canada

Web Portal Helps IMGs Understand Canadian Standards for Communication and Cultural Competence

A new web-based self education program for international medical graduates (IMGs) to learn about Canadian communication and cultural competence has been launched by Canada’s National Assessment Collaboration (NAC). The orientation portal is interactive, including videos, self-reflection questions, self-assessment and follow-up resources.

The portal content was drawn from an IMG communication and cultural competence website developed by assessment experts from the University of Toronto and the College of Physicians and Surgeons of Ontario.
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.
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The Interstate Medical Licensure Compact is a new licensing pathway for physicians that enables them to gain licensure in multiple states. Twelve 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.

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