Relicensure for Continued Practice

Robert C. Derbyshire, MD

In 1947 the American Academy of General Practice pioneered in passing a rule requiring its members to engage in programs of continuing education to maintain their membership. But 20 years were to pass before another medical organization established similar requirements. Indeed, many medical leaders, including educators, opposed this policy and scornfully referred to it as collecting "Brownie Points."

Meanwhile, whenever the subject of recertification or re-examination was brought up in almost any medical gathering it was greeted by an uncomfortable silence or open hostility. The prevailing uneasiness was increased by the passage of the Medicare and Medicaid Laws which, along with the Heart Disease, Cancer, and Stroke Amendments, have made medical care a human right as emphasized by Chapman.[1] It seemed inevitable that if the federal government was to use the taxpayers' money to pay the bills it would insist upon some type of quality controls.

In 1967 the President's Commission on Medical Manpower[2] made the following recommendation: "The professional societies and state governments should explore the possibility of periodic relicensing of physicians and other health professionals. Relicensure should be granted either upon acceptable performance in continuing education programs or upon the basis of challenge examinations in the practitioner's specialty." More recently the Department of Health, Education and Welfare[3] discussed relicensure in detail. The report enumerated the difficulties inherent in such a plan but it recognized the problem of lifelong licensure when it said, "The typical state requirements may provide adequate safeguards at the initial level of entry into a profession. It is a considerably less effective guarantee, however, against the growing problem of professional obsolescence." These statements were not calculated to allay the uneasiness of the medical profession. Nor was the recently passed New York State regulation which requires that a physician who is not a member of a hospital staff or board certified must prove his competence by matching the requirements of the Academy of Family Practice.

In view of these trends, the action of the Oregon Medical Association in passing a rule requiring participation in programs of continuing education came as no surprise. Only remarkable was the fact that a special committee had been able to persuade the House of Delegates to approve the program promptly and with minimum dissension. No doubt there was meticulous advance planning. Indeed this was a milestone in the history of organized medicine. Other state medical societies promptly began to study the Oregon plan and soon four followed its lead, namely Arizona, Pennsylvania, Ohio, and Massachusetts. Although the plans differ in some details, they are all based upon the acquisition of points or hours in approved programs.

Several specialty boards are considering institution of systems of recertification although none has gone so far as to require re-examination. But this may soon come.

To date the legislative approach to continuing education has been considered by only three states: Kansas, California and New Mexico.

The Kansas legislature passed a law which would have linked continuing education with relicensure. But there was a provision stating that the law would not go into effect until the Board of Medical Examiners unanimously recommended it. To date it has not chosen to do so.

New Mexico is the only state which has unequivocally established legal requirements of continuing education for continued licensure of physicians. This I shall discuss in detail later.

The main reasons for the present concern about continuing education were well summarized by Millis[4] when he said, "There has been a dramatic change in the period of time which elapses between scientific discovery and its technological application. Through the centuries this time lag has been of the order of a human generation. In this century it has decreased to a matter of months. Today's scientific discovery is tomorrow's clinical practice. This all adds up to the conclusion that knowledge and its consequent skill are subject to rapid obsolescence, that definitions of minimum competence need constant upward revision." Dr. Millis agrees with the previous assertion of Dr. Chapman that access to health care is now a right.

Today's scientific discovery is tomorrow's clinical practice. This all adds up to the conclusion that knowledge and its consequent skill are subject to rapid obsolescence, that definitions of minimum competence need constant upward revision.

The concept of relicensure has not met with universal approval by any means. In November 1971 *Medical Opinion*[5] reported that in a nationwide survey of 933 physicians, 57% termed it unnecessary, 37% favored it, and 6% had no opinions. *Medical Opinion* expressed surprise that as many as 37% deemed it necessary. As an aside of questionable relevance the survey revealed that, in general, those who supported relicensure most strongly had the lowest opinion of the American Medical Association.

Additional objections voiced by practicing physicians are their hatred of compulsion and their fear of governmental control of practice in any form, even though it might be exercised by fellow members of their profession.

Many medical educators are opposed to relicensure linked with continuing education. From several quarters I have heard the comment that no one has ever carried out any studies which prove that continuing education improves patient care. Another objection is that there is no evidence that continuing education modifies the physician's behavior or his habits of practice. This is true. Conversely, has anyone ever proven that continuing education influences medical care adversely? Can one escape the fact that a suitable continuing education course can do much to change the concepts of a physician whose treatment of coronary thrombosis is of the 1950 model or the surgeon who has no idea of the problems of post traumatic respiratory insufficiency? Of course, we must assume that the physician is ready to accept new ideas.

Another doubt was voiced by Dimond[6] who stated, "Appraisers of continuing education have attempted to measure the type of audience and results. The data published by some would lead one to feel that the total effort reaches such a small group of physicians and influences behavior so minutely that it is all one grand social farce and not in the least justifiable as true education." If this statement is true it merely means that the entire process of continuing education must be completely changed.

Mueller expressed doubts about the efficacy of continuing education in improving patient care. Chapman, on the other hand, in referring to the benefits of continuing education, seems convinced that it does improve patient care.

Mueller[7] expressed doubts about the efficacy of continuing education in improving patient care. "There seems to be plenty of evidence to suggest that medical performance is not related to the usual standard variety of continuing educational experience. Those who are good performers generally go to the sessions, as opposed to those who are bad performers who remain soloists in isolation. On the other hand, the evidence that the educational experience in itself will contribute to changing practice patterns is not at all clear cut."

Chapman[1] on the other hand, in referring to the benefits of continuing education, seems convinced that it does improve patient care. After describing the excellent program of the Massachusetts Medical Society, he states, "250 physicians returning each year for intellectual restoration for the physician's own good and, what is much more important, for the certain benefits of his patients."

And so the debate continues. I, trusting to my own personal observations and tending to ignore the lack of scientific proof, firmly believe that participation in continuing education does improve patient care and changes habit patterns of physicians. Let any doctor who trained 20 years or more ago who has conscientiously fulfilled his educational needs since graduation reflect on the improvement in his methods during this period. Moreover, he will be unable to escape the conclusion that most of the changes have been brought about by some form of continuing education, be it reading, attendance at meetings or listening to his colleagues. Little faith is required to accept such a truth. But I am aware that there are many methods of education and what is ideal for one is wrong for another.

Let any doctor who trained 20 years or more ago who has conscientiously fulfilled his educational needs since graduation reflect on the improvement in his methods during this period.

Indeed, I had to have conviction to expose myself to the slings and arrows of my aroused colleagues, the scorn of the educators, and the skepticism of some of the legislators. This brings me to a discussion of the amendment to the Medical Practice Act of New Mexico requiring participation in programs of continuing education for relicensure. Repeatedly challenged in the House of Delegates of the State Medical Society both before and after passage, the law became effective in June 1971 and the regulations were established in November of the same year.

In the spring of 1970, the president of the New Mexico Medical Society, at the direction of the House of Delegates, appointed a committee on continuing education. The House charged it with "the development, organization, coordination, delivery, and quality of education programs for the physicians of New Mexico pertinent to the needs of the practicing physician in the daily conduct of his practice." The president carried this further when he directed the committee to study the advisability of establishing continuing educational requirements for medical society membership or state licensure.

At the first meeting of the committee in September 1970 the discussion primarily involved the question as to whether continuing education should be made compulsory or continue to be voluntary as in the past. The members promptly agreed that some form of compulsion was necessary. The next question was whether or not membership in the Medical Society should be contingent upon participation in continuing education. As the discussion proceeded it became apparent that the members thought the Oregon program commendable but did not think it went far enough for New Mexico, where 20% of the doctors do not belong to the Medical Society. Furthermore, suspension from the Medical Society would not affect the right of the individual to practice medicine. The final conclusion: The only way to make any such requirement valid was to connect it with licensure through legislation. The members of the committee rejected the idea of re-examination for relicensure as they considered this drastic and impractical. Any doubts that we may have had concerning the constitutionality of the proposed law had been previously dispelled by Shindell,[8] who wrote, "it certainly is within the power of a state to require re-examination just as now it is within its power to require examination for initial licensure." With this our legal counsel agreed.

At the first meeting of the committee in September 1970 the discussion primarily involved the question as to whether continuing education should be made compulsory or continue to be voluntary as in the past.

The Committee recommended that the New Mexico Medical Society sponsor legislation which would require continuing education for reregistration of licenses. As chairman of the committee it became my duty to promote the proposal and to answer possible objections to it. As expected, the meeting of the reference committee which considered it was well attended and the opponents, though small in number, were vocal. Of course, they realized that they might be in the untenable position of opposing education. Therefore, they based their objections upon the hated word "compulsion," and then worked around to calling the plan "un-American," whatever they meant by that. Another argument was that the Board of Medical Examiners would be given too much power, ignoring the power that the board already had when it initially licensed them.

The report of the reference committee avoided the difficulty of taking a stand for or against education by resorting to the old ploy of approving the report in principle but recommending that it be referred back to the committee for further study. Obviously that would have accomplished nothing and was merely a

delaying tactic. On the floor the debate was hot but the final vote, after a series of parliamentary maneuvers, was 32 to 23 in favor of the proposal.

Having obtained the approval of the House, I was convinced that we had cleared the only major hurdle. Surely the legislature would not oppose any efforts of the medical society to improve the standards of practice. But soon I was to learn how wrong I was and how I had underestimated the persistence of the opponents who obviously did not subscribe to majority rule.

In December 1970 the Committee on Continuing Education held a joint meeting with the Board of Medical Examiners, representatives of the Legislative Committee, and legal counsel. All agreed that the bill should be as simple as possible to permit flexibility in the establishment of requirements. The first draft simply stated, "The Board shall have the power and authority to establish mandatory requirements for continuing education for physicians licensed in this state."

The bill was first referred to the Senate Judiciary Committee, composed largely of lawyers. At the hearing the members asked searching but reasonable questions of the representatives of the medical society who testified.

We all agreed that the requirements should be patterned in general after those of established programs such as the Physicians Recognition Award, the American Academy of Family Physicians, and the Oregon Medical Association. We also agreed that the board should recognize existing programs and that the Physicians Recognition Award and the certificate of the Academy of Family Physicians should be accepted as automatically fulfilling the requirements.

In January 1971, Senator John Eastham, minority leader, introduced Senate Bill 71 at the request of the New Mexico Medical Society. The Senator, a Republican in a legislature dominated by Democrats, was widely respected both as a lawmaker and as a highly competent attorney. We hoped that there would be no political implications but we reckoned without the impact of medical politics.

The bill was first referred to the Senate Judiciary Committee, composed largely of lawyers. At the hearing the members asked searching but reasonable questions of the representatives of the medical society who testified. But politics soon appeared when an ultraconservative senator told us that he intended to vote against the bill, having recently communicated with the members of the county medical society in his district who were unanimously opposed to it. But this was countered by another senator who said that he had polled the members of his county society and found that a large majority favored the bill.

In my testimony I explained that we intended to recognize existing programs such as the Physicians Recognition Award but the chairman rightly thought that this intention should be incorporated in the law and the bill was suitably amended.

The Judiciary Committee voted to recommend that the Senate pass the bill as amended. With that we felt that favorable action by the Senate was assured. But we failed to anticipate the objections of a powerful senator whose family physician opposed the plan. He proposed an amendment that would have deleted the word "mandatory," thus emasculating the whole bill. His attempt was defeated by only a single vote.

Another senator feared that the board might suspend the licenses of the few doctors practicing in small towns, thus depriving the citizens of all medical care.

Another senator feared that the board might suspend the licenses of the few doctors practicing in small towns, thus depriving the citizens of all medical care. His implication was that a poorly informed doctor was better than none and he persuaded the Senate to pass an amendment to cover this. We did not think that this was a real problem, particularly in view of the fact that the dean of the medical school and the director of the Regional Medical Program had assured us that they would make every effort to take continuing education into the outlying communities.

The final version, as passed by the Senate, read: "E. For the purposes of protecting the health and well being of the citizens of this state and maintaining informed professional knowledge and awareness, the board may establish mandatory continuing education requirements for physicians licensed in this state. In establishing such requirements the board shall recognize and give weight to existing educational

methods, procedures, devices, and programs in use among the various medical specialties and other recognized medical groups and the consensus of the members of the medical community. This subsection does not abrogate or affect the status, force or operation of the Uniform Licensing Act. The board shall not establish and enforce such requirements if they will reduce the availability of physicians in a community to an extent that adequate medical care is jeopardized."

Although the result of compromise, this is a workable bill and can accomplish the purpose for which it was devised. Furthermore, it contains desirable safeguards against arbitrary action by the Board of Medical Examiners.

Senate Bill 71, having been signed by the governor, became law on June 18, 1971. Thus New Mexico became the first state to reject the long established policy of lifelong licensure.

The bill next went to the House Public Affairs Committee whose members received it with enthusiasm. Their only objection was that it was not strong enough and they proceeded to correct this with gusto. By amendment they changed the wording from "the board may establish" to "the board shall establish" continuing education requirements. In addition, the committee set a definite time for implementation.

At this point we became concerned lest the good intentions of the House committee kill the bill entirely. Granted that their proposed amendments would have given us a stronger and better bill, we knew that if the House passed them the entire bill might die in joint committee in the waning moments of the legislative session. Fortunately, leaders of the House understood this and the bill as approved by the Senate was passed with only seven opposing votes.

Senate Bill 71, having been signed by the governor, became law on June 18, 1971. Thus New Mexico became the first state to reject the long established policy of lifelong licensure. It was only surprising that the opponents who had never openly objected to meeting minimal requirements for initial licensure raised the cries of un-Americanism and compulsion when it was suggested that they must continue to meet certain requirements to keep their licenses current.

The next step was up to the Board of Medical Examiners which had to formulate rules and regulations for implementation of the new law. Although the members all recognized that this was permissive legislation, they believed that they had received a mandate from the medical profession and there was no suggestion that implementation be delayed. After much deliberation the board formulated the necessary regulations. Continuing educational requirements are to be linked to re-registration of licenses. The board adopted a three year period of evaluation both because of the apparent reasonableness of such a time and to fit in with existing programs. The requirements, patterned after those of the Physicians Recognition Award, and those of the Academy of Family Practice, are more liberal in that they will require only 120 hours every three years instead of the 150 required by the other organizations. The hours are divided into two general categories, required and elective. Under required hours will be formally structured courses in continuing education which must in general conform to the requirements of the AMA as enumerated in the "Guide to the Essentials of Approved Continuing Education Courses." In addition, credit will be given for teaching of medical students and house officers, for full-time research, and for serving as a house officer in an approved program. A minimum of 40 every three years must be obtained under the required category.

After much deliberation the board formulated the necessary regulations. Continuing educational requirements are to be linked to re-registration of licenses.

The elective hours are divided into two categories; the first includes attendance at international, national, regional and state meetings; the second, attendance at journal clubs, scientific meetings of the hospital staff or county society and listening to tape recordings on scientific subjects. The requirements are flexible in that a physician must present at least 40 hours under the required category but he may also claim all of his hours in this. On the other hand, he cannot claim more than 40 hours under the second elective category but he may claim 80 under the first.

Meanwhile, the opposition had not been idle. At the annual meeting of the State Medical Society in May 1971 they introduced a resolution requesting the Board of Medical Examiners to postpone indefinitely implementation of the law. Again there was a lively session of the reference committee during which there was no lack of name calling. For example, the secretary of the board was accused of communistic tendencies and of attempting to build up a medical bureaucracy. The House of Delegates defeated the resolution on the recommendation of the reference committee. Undaunted, our opponents introduced a similar resolution at the interim session in November 1971. This time the reference committee approved it; however, a protestor submitted a minority report which was adopted. Thus the duly elected members of the House of Delegates of the New Mexico Medical Society have on three occasions gone on record as favoring compulsory continuing education as a legal requirement.

In accordance with law, the board held a public hearing, duly advertised 30 days in advance, to permit interested people to voice their opinions of the proposed regulations. Among other things the notice contained information as to where copies of the proposed rules could be obtained. In addition, the notice of hearing was published in the *Newsletter* of the State Medical Society. Despite all of the apparent opposition only six physicians requested copies of the regulations. A total of 12 people appeared at the hearing and only half of these spoke. A recurrent objection was that the rules gave credit only for full-time research and none for part-time. One protestor went so far as to claim that this would stifle individual efforts and that all research would be confined to the medical school. He was only partially mollified by the statement that he would be given due credit for his publication of the results of his research. Another wanted the local hospitals to set their own standards of continuing education. The board members thought that this would do nothing but create chaos. Another suggested that if all of the regulations could not be summarily scrapped that the required category should be eliminated. Still another thought that credit should be given for talks before service clubs! One particular objection, considered valid, was to the requirement that credit would be given only for papers presented to societies whose membership is solely confined to physicians. This would have ruled out medical legal organizations and even the American Association for the Advancement of Science. The regulations were duly corrected.

Now that participation in continuing education is a legal requirement for the maintenance of a license in good standing, other agencies are helping the members of the medical profession to fulfill their obligations.

Now that participation in continuing education is a legal requirement for the maintenance of a license in good standing, other agencies are helping the members of the medical profession to fulfill their obligations. From the first, all concerned agreed that this should be a joint responsibility of the medical school, the Regional Medical Program, and the New Mexico Medical Society. Dean Robert Stone has instituted innovative programs of continuing education which will permit physicians practically to move back into the hospital for varying periods of time. He is also making arrangements for a senior resident to act as a *locum tenens* for the physician in the remote community who wants to bring his skills up to date without neglecting his patients. The Regional Medical Program is raising both the number and quality of its postgraduate courses and is strengthening the circuit riding program in an effort to make education available to the physicians in their own communities. So far, I picture the State Medical Society mainly in the role of coordinator. But no doubt its functions will soon be broadened as more selected practicing physicians are asked to help with the educational programs.

Others have made suggestions as to how the skills of physicians can be kept up to date and how they may be re-evaluated. These include continuous observation by peer review boards, hospital staff committees or medical foundations.

Because of intense involvement in the passage of the law requiring continuing education and its subsequent implementation, I obviously must believe in it. But I share the dissatisfaction with the so-called "Brownie Point System." Others have made suggestions as to how the skills of physicians can be kept up to date and how they may be re-evaluated. These include continuous observation by peer review boards, hospital staff committees or medical foundations. A novel approach has been brought forth by Mueller[9] who suggests that "the goal of a productive life is not continued

education, but continued production. It is therefore the product of the trained physician that should be examined during the physician's productive years:" But to fulfill the requirements of the law I am afraid the "Brownie Point System" must prevail until a better one is found.

The concept of legal requirements to prevent medical obsolescence is based upon many ideas, only one of which is the fear of eventual government regulation.

The concept of legal requirements to prevent medical obsolescence is based upon many ideas, only one of which is the fear of eventual government regulation. I hold that, on principle, it is high time to abandon the policy of licensure in perpetuity, not because of anxiety about the possible pressure of outside agencies, but because periodic review of some type is essential to safeguard the public.

Presented during the Annual Meeting of the Federation of State Medical Boards of the United States, Chicago, February 3, 1972.

During his life Dr. Derbyshire served as Secretary-Treasurer of the New Mexico Board of Medical Examiners and practiced surgery in Santa Fe, New Mexico. A past-president of the Federation, he was active in the FLEX program as a member of the clinical sciences (Day II) committee. He represented the Federation as a member of the National Board of Medical Examiners, and served two terms as a member of the executive committee of that prestigious board.

A native of Hastings-on-Hudson, New York, Dr. Derbyshire earned his MD at Johns Hopkins school of medicine in Baltimore, Maryland. Following his internship and assistant residency in surgery at Johns Hopkins Hospital, he entered the Mayo program at Rochester as a fellow in surgery, ultimately receiving his MS in Surgery from the Mayo Foundation. A fellow of the American College of Surgeons, he was a member of a number of societies and associations in his specialty.

Dr. Derbyshire was editor of the *Federation Bulletin* for a number of years, wrote the authoritative book *Medical Licensure and Discipline in the United States,* and authored a number of articles published in medical journals and medical news periodicals.

References

1. Chapman, E. M.: Annual Discourse — The Physician in a Changing Social Structure. *New Eng.J. Med.* 284:1242 - 1247 (June 3), 1971.

2. *Report of the National Advisory Commission on Health Manpower.* Washington, DC, Government Printing Office. November 1967.

3. US Department of Health, Education and Welfare. *Report on Licensure and Related Health Personnel Credentialing.* June 1971.

4. Minis, J. S.: The Impact of Relicensure Upon Postgraduate Medical Education. *Mod. Med.* 38:86-89 (June 29), 1970.

5. Physicians' Attitude Survey. *Med. Opinion* 7:11, 52.

6. Dimond, E. G.: Changing Trends in Postgraduate Education. *Mod. Med.* 38: 83-85 (June 29), 1970.

7. Mueller, C. B.: Personal communication.

8. Shindell, S.: A Survey of the Law of Medical Practice. *JAMA* 193:601-606.

9. Mueller, C. B.: Continuing Assessment of Medical Performance. Editorial. *New. Eng. J. Med.* 284:1378-1380 (June 17), 1971.

I hold that, on principle, it is high time to abandon the policy of licensure in perpetuity …because periodic review of some type is essential to safeguard the public.