REPORT OF THE
VIRGINIA BOARD OF MEDICINE
DEPARTMENT OF HEALTH PROFESSIONS

STUDY OF THE NEED FOR MANDATORY CONTINUING MEDICAL EDUCATION

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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VIRGINIA BOARD OF MEDICINE
DEPARTMENT OF HEALTH PROFESSIONS

Study of the Need for Mandatory Continuing Medical Education

Background and Authority:

During the 1996 Session of the General Assembly, concerns were expressed about the competency of some health care providers who may not maintain current knowledge of practice modalities and ethical issues. Those concerns led to the introduction of two study resolutions - House Joint Resolution 68, patroned by Delegate Gladys Keating, and House Joint Resolution 157, patroned by Delegate Panny Rhodes. With the passage of HJR 68, the Virginia Board of Medicine has been directed to study the need for requiring continuing medical education for physicians of medicine and osteopathy with special emphasis on medical ethics. The Board must complete its work in time to submit its findings and recommendations to the Governor and the 1997 Session of the General Assembly. (A copy of HJR 68 is attached to this report.)

Study Task Force of the Virginia Board of Medicine:

The Legislative Committee of the Board of Medicine is a standing committee which has responsibility for consideration of regulatory and legislative issues and for recommendations to the full Board. For the purpose of reviewing information on continuing education, receiving public comment, and bringing recommendations to the Board, the Legislative Committee has served as the Study Task Force for HJR 68. Current members of the Committee are as follows:

Paul M. Spector, D.O., Chair
David Brown, D.C.
William W. S. Butler, III, M.D.
Theresa F. Kaseman, D.P.M.
Joseph A. Leming, M.D.
Clarke Russ, M.D.
Michael L. Stutts, Ph.D.

The Executive Director of the Board of Medicine, Warren W. Koontz, M.D., and Regulatory Analyst for the Department of Health Professions, Elaine J. Yeatts, are

providing staff and research assistance for the Committee.

Public Hearing on Continuing Medical Education:

A Public Hearing was held on June 17, 1996 at 1:00 p.m. in Conference Room 2, 5th floor, 6606 W. Broad Street in Richmond, VA. Notice of the hearing was sent to all persons on the Public Participation Mailing List of the Board of Medicine and was published in the Virginia Register. Delegate Gladys Keating, who was the patron of HJR 68, and Delegate Panny Rhodes, who introduced a similar resolution, were also notified of the hearing.

Persons with particular expertise and interest in the field of medical education and medical ethics were specifically invited to attend and present any material pertinent to the purpose and content of the study. Providing information at the hearing were medical educators from the three academic health centers in the Commonwealth, Eastern Virginia Medical School, the Medical College of Virginia, and the University of Virginia Health Sciences Center. Those representatives discussed the evolution of the curriculum in medical education with its current components of medical ethics and the Generalist Initiative.

Appearing on behalf of the Joint Commission on Accreditation of Healthcare Organizations (JACHO) was Dr. Alfred S. Buck from Illinois who presented material emphasizing the pervasiveness of ethics and education in the development and articulation of the Joint Commission's standards for accreditation. The Honorable Gladys Keating, legislative patron, voiced her concerns as expressed in the body of the resolution. Representatives of the chiropractic and physical therapy professions also appeared to support the concept of continuing competency as a prerequisite for renewal of licensure.

Study Methodology

Review of current literature and reports on measures of continuing competency

Findings on effectiveness of continuing education:

While empirical evidence for mandating any one method of assuring and assessing continuing competency is not conclusive, there have been a variety of reports and studies on the effectiveness of continuing education:

1) In an article for the Virginia Medical Quarterly published in the summer of 1994, Pamela M. Mazmanian, M.A. and Paul E. Mazmanian, Ph.D. wrote:

In the United States, those organizations accredited to sponsor continuing medical education (CME) providing Category 1 credit for a national audience are accredited by the Accreditation Council for Continuing Medical Education (ACCME). Organizations that provide CME to a local or statewide audience are accredited by their state medical society, under the auspices of the ACCME as intrastate sponsors of CME.

"Category 1 activities are seen as valuable, in part, because of their social utility...Yet there is no conclusive proof that Category 1 activities are better than others...Ironically, efforts to develop learning opportunities that directly relate to the clinical experience and educational needs of physicians appear constrained by the need to divert limited CME resources toward administration and documentation associated with Category 1 credit."

2) In order to assess the impact of continuing medical education interventions on physician performance and patient outcomes, a group of researchers searched the literature on continuing education from 1975 to 1991. (*David A. Davis, Mary Ann Thomson, Andrew D. Oxman, and R. Brian Haynes, "Evidence for the Effectiveness of CME", Journal of the American Medical Association, September 2, 1992*). As the authors noted, "...as regulatory bodies consider the nature of competence and its relationship to CME, the need accelerates for a careful, critical appraisal of the impact of this longest and arguably most important phase of medical education".

For the purpose of the study, the authors selected 50 CME articles out of 1445 in the literature database that met their criteria of randomized controlled trials of educational programs or activities with follow-up assessments of either physician performance or health care outcomes. For example, eleven studies assessed the impact of CME on the use or cost of laboratory tests; and all but one showed a difference between the experimental and control groups. Of the six studies that analyzed the effects of a various CME interventions on prescribing habits, five showed positive results. All five studies on the ability of CME

to improve primary prevention practices showed positive impact. However, of the eighteen studies that analyzed the effects of CME on **health care** or patient outcomes, ten showed negative or inconclusive results, while eight showed some positive change by a least one major measure. Impediments to positive patient outcomes would include such factors as noncompliance with medications and unhealthy patient behaviors. Improvement may also be limited when physicians and patients are "already functioning at on near their maximum capabilities".

In describing the implications of their research, the authors concluded with this observation, "...these randomized controlled trials provide new evidence supporting the effectiveness of broadly defined, complex, practice-linked CME".

3) In an article written to assess the effects of repeal of the CME requirements in Illinois, the authors observed, "Investigators are beginning to recognize that the relationships between teaching, learning, physician competence, physician performance, and health outcomes are much more complex than generally believed...Professionals in CME continue to discuss the problem of physicians attending conferences they want to attend, not those they need, and the physicians who may need CME the most, not coming at all." *(Charles E. Osborne, Ed.D. and Jerry A. Colliver, Ph.D., "Effects of Implementation and Repeal of Mandatory CME in Illinois: A Survey of Institutional Sponsors and Physicians," The Journal of Continuing Education in the Health Professions, 1988.)*

The Illinois study was designed to assess the "perception or opinion" of institutional sponsors and practicing physicians of the effects of mandatory CME in the state. Even without "hard data" to support its conclusions, the article does provide the following insights: "Opponents of mandatory CME can cite data from this study that most physicians and sponsors believed there was no effect on quality of patient care as a result of implementing mandatory CME...Supporters can concede this, but point to the data on those who believe there was an effect. Of this group, 93% believed implementation (of mandatory CME) had a beneficial effect and 80% believed repeal had a detrimental effect."

Mandatory CME was not designed for the majority of physicians who keep up on their own but to expose everyone to new ideas. Attendance at CME alone cannot guarantee learning; the ideal CME system would be to identify those who need to have areas of their practice brought up-to-date and design an individualized program of learning. Unfortunately, the complexity and cost of such a system for every physician would be prohibitive. These authors conclude "Until such a system is developed, tested and implemented, mandatory CME is an expensive mechanism of unproven value."

(In an author's note at the end of the article: "Legislation requiring mandatory CME has once again been passed in Illinois. However, the exact number of hours required is not specified. It appears to be a symbolic support for the principle without a reasonable mechanism of enforcement.")

4) In an analysis by the Illinois Council of Continuing Medical Education of the characteristics of continuing education programs which appear to produce positive change in a practitioner's knowledge or behavior, five common factors were found: a) a specified audience; b) an identified learning need; c) clear goals and objectives; d) relevant learning methods with an emphasis on participation in a clinical setting; and e) systematic evaluations.

5) In a study of effectiveness of continuing education in the health professions, Mark Raymond noted "Continuing education can have a positive effect on clinical behavior when programs are carefully developed. Performance-based continuing education and other quality assurance programs do have the potential for improving clinical behavior, and to a lesser extent, patient outcomes. Common sense and empirical findings suggest that medical continuing education, in the absence of strictly enforced guidelines on how continuing education is developed and prescribed, is an inadequate solution to the continued competence issue."

6) There is little consensus among the experts on recredentialing or retesting, a method of assuring continuing competency favored in the Pew Commission report. While most agree about its efficacy, there are widely differing views among the experts about issues such as performance-based assessments versus knowledge-based examinations and about the cost-effectiveness of various methods of assuring continuing competency.

Research on statutes or regulations on continuing medical education in other states

Findings on history and background information:

Mandatory continuing education for physicians has been debated for many years. In 1932, the Commission on Medical Education predicted that "The time may come when every physician may be required in the public interest to take continuation courses to insure that his practice will be kept abreast of current methods of diagnosis, treatment, and prevention." Fifteen years later the American Academy of General Practice became the first group to require continuing education as a condition for membership. Today, "continuing education of physicians has grown from an innovative idea to a vital and, in some instances, mandatory component of good medical practice." *(Gloria Allington, M.S.Ed. and Kamiar Kouzekanani, Ph.D., "A Needs Assessment Investigation of Continuing Medical Education in Risk Management," The Journal of Continuing Education in the Health Professions, 1990.)*

Speculation on the need for mandatory CME for relicensure began as early as 1955, with the American Medical Association accrediting sponsors by 1964. In 1970, Oregon

became the first state to mandate continuing education for relicensure of physicians, followed by New Mexico in 1971. Through the 1980's, mandatory CME spread rapidly through the states with a leveling off by 1985. In addition, by 1985, there were eight certification boards, six specialty societies, and twelve state medical societies with mandatory CME requirements. *(Charles E. Osborne, Ed.D. and Jerry A. Colliver, Ph.D., "Effects of Implementation and Repeal of Mandatory CME in Illinois: A Survey of Institutional Sponsors and Physicians," The Journal of Continuing Education in the Health Professions, 1988.)*

There are now 29 states that require some number of hours of CME for licensure renewal as a medical doctor, 31 states that require continuing education for relicensure of osteopaths, and 47 states (including the District of Columbia) that require continuing education for renewal of chiropractic licensure. Virginia is one of four states (including Connecticut, New Jersey, and New York) which do not have mandatory continuing education. Requirements for chiropractors range from 12 to 24 hours of approved courses each year with an average of 15.8 hours.

Requirements for doctors of medicine and surgery and for osteopaths vary widely from 12 hours of Category I of AMA-approved CME per year (Alabama) to 100 hours per two years with at least 40 hours of Category I, 10 hours of risk management and 2 hours on board regulations (Massachusetts). Among those states with mandatory CME are three which are near Virginia - Delaware, Maryland, Kentucky. North Carolina and the District of Columbia do not have any CME requirements in regulation. Florida has implemented content-specific CME for all physicians with hours required in risk management, HIV/AIDS and domestic violence.

(See charts below for CME requirements for doctors of medicine and osteopathy)

Continuing Medical Education (CME) Requirements for License Renewal
Doctors of Medicine

States	Number of hours and Category requirements	States	Number of hours and Category requirements
AL	12 hrs Category 1 per year	MI	150 hrs per 3 yrs
AK	17 hrs Category 1 per year	MN	75 hrs per 3 yrs (at least 45 hrs Category1, no more than 20 in any other Category)
AZ	20 hrs per yr in any Category	MO	25 hrs Category 1 per year
CA	Avg of 25 hrs of Category 1 per yr, with 100 hrs every 4 yrs	NV	40 hrs per 2 yrs Category 1
DE	40 hrs Category 1 per 2 yrs	NH	150 hrs per 3 yrs
FL	40 hrs Category 1 per 2 yrs, 5 hrs in risk management, 2 hrs AIDS education	NM	75 hrs Category 1 per 3 yrs
GA	40 hrs Category 1 per 2 yrs	OH	100 hrs per 2 yrs, 40 in Category 1
HI	50 hrs per yr, 20 hrs must be Category 1	RI	60 hrs per 3 yrs
IA	40 hrs Category 1 per 2 yrs	TX	24 hrs per year

KS	150 hrs per 3 yrs, 60 hrs in Category 1	VI	40 hrs per year
KY	60 hrs per 3 yrs, 30 hrs in Category 1	WA	150 hrs per 3 yrs
ME	100 hrs per 2 yrs, 40 in Category 1	WV	50 hrs Category 1 per 2 yrs
MD	50 hrs Category 1 per 2 yrs	WI	30 hrs Category 1 per 2 yrs
MA	100 hrs per 2 yrs, at least 40 hrs Category 1, 10 hrs risk management, 2 hrs board regulation		

Continuing Medical Education (CME) Requirements for License Renewal Doctors of Osteopathy

States	Number of hours and Category requirements	States	Number of hours and Category requirements
AL	12 hrs Category 1 per year	MO	25 hrs Category 1 or 1a per year
AK	17 hrs Category 1 per year	NV	35 hrs per year
AZ	20 hrs per yr in any Category	NH	150 hrs per 3 yrs
CA	150 hrs AOA Category 1 and 2 per 3 yrs	NM	150 hrs per 3 yrs, 40 hrs in Category
DE	40 hrs Category 1 per 2 yrs	OH	100 hrs per 2 yrs, 40 in Category 1
FL	40 hrs per 2 yrs, 20 hrs AOA approved, 5 hours risk management, 3 hrs HIV/AIDS	OK	16 hrs AOA Category !A per yr, one in prescribing of CDS
GA	40 hrs Category 1, AMA/AOA	PA	100 hrs AOA, 40 hrs Category 1
IL	Board regulated	RI	60 hrs per 3 yrs
IA	40 hrs Category 1 per 2 yrs	TN	16 hrs per yr, Category 1A or 2D
KS	150 hrs per 3 yrs, 60 hrs in Category 1	TX	24 hrs per year
KY	60 hrs per 3 yrs, 30 hrs in Category 1	VT	20 hrs per 2 yrs
ME	100 hrs per 2 yrs, 20 hrs AOA-approved Category 1	VI	40 hrs per yr
MD	50 hrs Category 1 per 2 yrs	WA	150 hrs per 3 yrs
MA	100 hrs per 2 yrs, at least 40 hrs Category 1, 10 hrs risk management, 2 hrs board regs	WV	32 hrs per 2 yrs, at least 16 hrs Category 1
MI	150 hrs per 3 yrs, 75 must be osteopathic	WI	30 hrs Category 1 per 2 yrs
MN	75 hrs per 3 yrs (at least 45 hrs Category1, no more than 20 in any other Category)		

(Information provided by the American Federation of State Boards of Medicine)

All states which have mandatory CME were asked whether there had been a study or data gathered on the outcome of CME to see if there has been a reduction in complaints filed with the board or in fewer malpractice claims. Of those that responded, none indicated that any study had been performed.

Research on requirements for continuing education by the medical societies, specialties organizations, malpractice carriers, or hospital credentialing committees

Findings on the role of continuing education in accreditation of health care organizations:

From Alfred S. Buck, M.D., Joint Commission on Accreditation of Healthcare Organizations, which manages the accreditation oversight of approximately 15,600 health care organizations:

"For education, there are two prime foci: the patient and the health care professional, especially the physician....In the case of the physician (or other health care professional), the central perspective is that ongoing education is necessary to maintain and enhance competence and effectiveness. An important point is that, while the specific content of continuing medical education is not delineated, it must be known to the privileging entity and it must be found relevant to the clinical privileges authorized by that entity.

For ethics, the goals are no less important. Here the standards stress ethical interactions among the patient, the patient's supporting community, the organization, health care providers, and the public."

Dr. Buck has stated that ethical and educational requirements are pervasive throughout Joint Commission accreditation standards and that consideration of the ***implementation of continuing education requirements in Virginia is consistent with the emphasis and goals of the Commission's accreditation standards.***

Dr Buck noted that there are some significant differences in standards among accrediting entities and expressed two concerns about the current landscape of options for ongoing education:

1) There are a **growing number of unaccredited health care organizations and settings**. "A major trend today appears to be the removal of many health care services traditionally provided by or in hospitals to settings that are less conventional and often not accredited." The ethical and educational components advocated by the Joint Commission for accreditation may not be available to practitioners and their patients; and

2) Constructive, objective assessments of doctor-patient relationships over time have been handicapped by a lack of sound process and outcome data. The goals of ethical education might be enhanced by implementation of pertinent performance measures. "The tools and techniques involved with data-based performance assessment require an ethical framework to produce sound implementation and achieve constructive impact. This

framework, in my opinion, is best presented and evolved through ongoing, participatory educational forums."

Findings on continuing medical education for membership in medical societies:

The Medical Society of Virginia (MSV) has been involved in continuing education for physicians since its founding in 1820 and has published scientific articles to foster the ongoing learning of the physician since 1853. Currently MSV is recognized by the Accreditation Council for Continuing Medical Education (ACCME) as the entity which accredits intrastate providers of CME; the MSV in turn accredits 13 entities to provide CME to physicians in Virginia.

The Medical Society, which is the largest voluntary medical association in the Commonwealth, requires its members to have 90 hours of continuing medical education over a three-year period of which 30 hours must be in Category I as designated by the American Medical Association. Approval of Category I CME is obtained through the Accreditation Council for Continuing Medical Education (ACCME) which establishes national standards for accreditation through "Essentials for Continuing Medical Education". Category I courses must be process-based not outcome-based, and criteria for approval include such factors as need, objectives, course content, faculty qualification, and assessment. A listing of courses approved nationally for Category I credit is published by the American Medical Association. Compliance by members of the Medical Society is self-reported on a renewal check-off.

The Virginia Academy of Family Physicians requires 150 hours of approved continuing medical education every three years to be eligible for re-election to membership. Continuing medical education is considered essential because of the responsibility of the family physician for the comprehensive care of patients and the accompanying need to keep abreast of new knowledge and technology.

Findings on how many physicians would be affected by any requirement, i.e., how many do not currently participate in any educational activities:

Since all participation in continuing medical education activities is currently voluntary, there is no statistical information available to determine how many physicians or other licensees of the Board of Medicine in Virginia would be affected by a CME requirement.

At the end of the first quarter of 1996, there were 15,059 persons licensed in Virginia to practice Medicine and Surgery. The Medical Society of Virginia (MSV), which requires hours of CME to remain active, reports a membership of approximately 5,435 (That number excludes members who are medical students, residents, or retirees who are no longer licensed to practice in Virginia). While it is believed that the vast majority of MSV members comply with the requirement, compliance with CME requirements for membership in MSV is self-reported; no individual documentation or records are

maintained by the Medical Society.

The Old Dominion Medical Society, which has approximate 200 members (who may also belong to the Medical Society), reports that they have no requirement for continuing medical education for membership.

Among the twenty-eight specialty societies active in Virginia, it is estimated that nine or ten have some mandatory continuing education required for membership. Of those members, it is believed that many would also be reported among the membership of the Medical Society of Virginia. Therefore, a compilation of numbers would not be particularly helpful.

Medical malpractice insurers typically do not require continuing medical education of their policy holders but do offer a small discount if certain types of courses have been taken in the past year. The Doctors Insurance Reciprocal, which represents approximately 3,000 licensed physicians in Virginia, offers a 10% discount on malpractice insurance premiums primarily for courses in risk management and office practice. For certain "high-risk" specialties, six hours is required; and for other physicians, the requirement is usually three hours. Hospitals also require certain types of continuing education for credentialing or for a physician to maintain hospital privileges.

While it is undetermined how many physicians might be affected by mandatory continuing education requirements; the estimates range from 10% to 15% of the physicians who receive no continuing education, and many more take only the minimal requirements in risk management for malpractice insurance.

Though there is no written documentation for publication, the Board of Medicine became concerned about those practitioners who were involved in disciplinary cases before an informal conference committee and the potential risk of harm to the public. To make a determination of the credentials of a physician under investigation, questions are asked about membership in professional associations, board certification and recertification, hospital privileges, and any adverse actions by any of the above. The physician is also asked about educational background and about continuing education. Responses to those questions are heard by the committee but no written transcript is recorded.

However, members of the Board have been distressed by the relatively high percentage of persons who have been seen in a disciplinary matter, especially related to standard of care issues, who have no affiliations and no continuing education. Whether there is a relationship between their lack of effort to obtain current knowledge and new technology and their questionable medical practice and resulting patient complaint is speculative. Anecdotally, Board members report that a relatively high percentage of disciplinary cases are reported for practitioners who seem to be maintaining no credentials or receiving any continuing education.

Examination of Department of Health Professions reports and regulations.

In 1992, the Board of Health Professions recognized the public policy implications of continuing competency issues and produced a report entitled, "Guidelines for the Evaluation of Continuing Competency and Continuing Education Requirements". As background to its findings and recommendations, the report noted that the twelve regulatory boards within the Department are authorized to promulgate regulations specifying "additional training or conditions for individuals seeking certification or licensure, or for the renewal of certificates or license" (§ 54.1-103 of the Code of Virginia). In its report to the Governor's Regulatory Reform Advisory Board in 1984, the Board of Health Professions observed:

Continuing competence is one of the dominant issues in professional regulation...The community of regulators acknowledges the need for prevention and agrees that some system for monitoring the continuous acquisition of knowledge, skills, and ability by health practitioners is a warranted use of state regulatory powers.

Regulatory boards within the Department have not sought legislative mandates for continuing education but four health professions, dentistry, pharmacy, optometry, and veterinary medicine have had specific requirements for renewal added to their practice acts. Guidelines or principles established in the 1992 report for consideration of existing or proposed continuing competency requirements are as follows:

1) Continuing competence requirements should be validated by reference to specific performance competencies (knowledge, skills, abilities) required for the continued safe practice of a licensed or certified health occupation or profession. For example, there should be credible documentation of harm to the public or complaints against practitioners resulting from incompetencies or behaviors and that those incompetencies or behaviors may be reasonably addressed by regulatory interventions.

2) Continuing competence mandates must be accompanied by a requirement that the practitioner present credible evidence of acquiring the requisite skill or knowledge. Evidence of continuing education should be based on established criteria not merely on participation.

3) Continuing competency requirements and the criteria upon which they are validated must be credible and relevant in their reflection of changing occupational roles, levels of specialization, the technological and therapeutic environment, standards of care, and public expectations.

4) Requirements should be based on a national level of evidence. Any system of continuing competence requirements should provide for the acceptance of evidence of competence on a nationwide basis so as not to impede professional mobility.

5) Continuing competence requirements must be administratively feasible, cost-effective, and equitably applied and enforced. Programs designed to meet these requirements must be accessible to all practitioners. Adequate procedural safeguards, including appeals procedures, must be available to individuals affected by continuing competence requirements.

6) Continuing competence requirements should represent the least restrictive provisions consistent with public protection and should be established only when the public is not effectively protected by other means.

In conducting this study, the Task Force has reviewed those guidelines, regulations on continuing education from other health regulatory boards, and information on patient complaints and ethical conflicts.

Examination of medical school curricula and questions on medical ethics.

To determine changes in curricula in recent years, potential gaps in knowledge, and the affect of the Generalist Initiative, the Committee worked with medical educators and ethicists from the three teaching institutions in Virginia.

Findings on current medical school curricula content:

From John A. Owen, Jr, M.D., Senior Associate Dean of the School of Medicine, University of Virginia:

"To address current curricular content and its changes, it is important to emphasize that a medical school curriculum is always changing and evolving...we find ourselves continually adding to the curriculum, not subtracting from it." In comparing the 1995-96 catalogue with the 1985-86 version, Dr. Owen noted the following changes representing the growth in medical education: 1) a 4-week clerkship in Neurology; 2) expansion of Anatomy into a broader discipline called Cell Biology; 3) expansion of Physiology into a broader discipline called Cell and Organ Systems Physiology; 4) expansion of the Emergency Medicine Section into a separate department; 5) expansion of courses in Human Biology Ethics and Society to include all the activities of the Center for Biomedical Ethics plus the Humanities in Medicine course multiple electives; 6) addition of three entirely new departments, Neuroscience, Radiation Therapy, and Health Evaluation Sciences. The only course **discontinued** was Comparative Medicine, which was entirely elective, and for which demand and faculty were no longer available. All changes occurred in response to the needs of students as they prepared to provide health care to the public.

From the James M. Messmer, Associate Dean for Medical Education at the Medical College of Virginia:

The most significant change in the curriculum occurred in 1995 with the introduction of a new Foundations of Clinical Medicine (FCM) course, which gives students patient exposure throughout the first two years. The key component of this course is the use of primary care physicians both from the MCV faculty and the community who work in small groups to provide students with skills in taking a patient history and in performing an examination. A major focus is on the development of communication skills, including dealing with ethical issues.

Similar accounts of revision and evolution have been experienced at Eastern Virginia School of Medicine. In the past 2 ½ years, a new generalist curriculum has been introduced, but the ethics course has been retained in the first year and ethical issues woven formally and informally into the rest of the curriculum .

Findings on how the Generalist Initiative relates to the need for continuing medical education:

In a 1995 newsletter entitled The Generalist, the Deans of Virginia's medical schools spoke of the urgency of the Generalist Initiative. Along with a current shortage of more than 500 physicians in medically underserved areas of the state, and with the demand for primary care physicians escalating, it is predicted that Virginia will lose more than 1,100 generalist physicians to retirement by the year 2001 and more in years to follow. Such a prospect is disturbing to families who already must travel more than two hours to seek medical care and to the economic well-being of many parts of the Commonwealth.

To address the critical need for generalist physicians, the Initiative has developed a plan to recruit, admit, train, and support students who are committed to serving the needs of those undeserved areas. Some successes have been achieved in an increased percentage of graduates who will begin residency programs in family practice, pediatrics and internal medicine from 29% in 1993 to 36% in 1995. The goal is to have 50% generalists graduating from our medical schools by the year 2000.

In addition to the numbers being produced, information provided for this study on the Generalist Initiative from Dr. John Owen of the University of Virginia reveals much about its "pervasive and highly beneficial" influence on medical student education. First-year students participate in a year-long course on Doctor-Patient-Illness which explores the way doctors relate to their patients, how they develop the necessary rapport for optimum practice, and what sort of ethical problems they may expect to face. An essential component of the program is the community precepting, wherein medical students work with physicians in their own practice. In his comments to the Task Force, Dr. Owen noted that "The overall impact of the Generalist Initiative is thus to introduce ethical considerations into real-life professional settings beginning in the very first year of medical school, focusing on those professionals who are being trained specifically for the gate-keeper roles in the practice of medicine, where the ethical problems are ubiquitous and most urgent."

With a concentrated exposure to outpatient settings, the current curriculum provides an emphasis on the knowledge, skills, and attitudes necessary for primary care as opposed to the classroom lecture and acute care setting of the hospital. Students now have an early exposure to outstanding physicians as mentors through an intensive community-based training experience. The Eastern Virginia Medical School has enhanced the generalist, post-graduate training with a new four-year residency program that will train physicians in internal and family medicine as well as a number of other specialties. Dr. Verdain Barnes, director of the Center for Generalist Medicine at EVMS, noted that "The goal of the program is to provide a better trained generalist, one with an ability to carry patient care further along the continuum before specialty expertise is needed."

A major aspect of the "generalist initiative" at EVMS is the early clinical experience located in community-based settings rather than in hospitals. That approach has the following benefits:

- Students see how patients' behaviors either increase or decrease their risk for certain diseases and explore ways to intervene earlier to decrease risk and improve overall health.

- Acute care experiences in the outpatient setting demonstrate the larger role that patients have in determining choice of treatment and adherence to treatment plans, and the importance of family support in successful treatment for many disease entities.

- Mental and emotional responses and disorders constitute a high percentage of problems seen in the ambulatory setting, and students learn the importance of learning skills in therapeutic listening and treating the whole patient in addition to the biomedical approach to the patient's disease.

While it is too early to assess the impact of the Generalist Initiative on the need for continuing education by the practicing physician, it may be that an emphasis on ethical issues and patient-doctor relationships and the mentoring by skilled, knowledgeable community physicians will produce an attitude of life-long learning. As the primary gate-keeper in managed care systems, generalist physicians will need continuing education. As Dr. Claudette Dalton wrote in an article on "The Generalist Initiative, What Does It Mean for Medical Education in Virginia?" for the Summer 1994 Virginia Medical Quarterly, "Furthermore, interest in and support of primary care graduates can not end in May with a diploma. The schools must stay actively involved in the recruitment, retention and support issues at the practice end of the pipeline." One aspect of that necessary retention and support for generalist physicians may be opportunities for obtaining competency in new technologies, ethical considerations, and specialty medicine backed by requirements for renewal of licensure to practice.

Findings on occurrences of ethical conflicts among doctors and their patients and

current medical school curricula related to medical ethics:

In the academic medical centers, a professor of surgery is commonly caught, not in an ethical conflict with a patient, but in the dilemma of having a responsibility to teach students how to actually perform a surgical procedure and being forced, in order to be able to submit a claim for reimbursement, to declare that he has performed the essential and critical parts of the surgery. With the advice of legal consultants and ethical experts, educators/physicians have charted a course to remain within the bounds of the law and ethics.

At the University of Virginia, a required course entitled "Introduction to Clinical Ethics" is taught in the first year; persons involved in its development would prefer that it be taught in the second year before clinical rotations. Content of the course focuses on the obligations of clinicians to patients and frequent ethical problems in caring for patients. In addition, beginning in 1997, there will be a regional extension Program of Education and Training in Clinical Ethics (PETCE) offered through the Division of Continuing Education at UVA.

Noting one intent of HJR 68 - namely to ensure that physicians are educated in issues of medical ethics, especially those arising from managed health care - Dr. John Fletcher of the Center for Biomedical Ethics at the University of Virginia told the Task Force:

"I have a three-part recommendation that focuses public policy less on individual physicians, except for education about ethics and managed care, than on strengthening the education resources at the regional, local, and medical school levels to serve the diverse needs of physicians and medical students for studies and reflection on ethics.

First, the General Assembly could require each licensed hospital and long-term care facility in Virginia to support an ethics program that, at a minimum, complies with the requirements of the Joint Commission for Accreditation of Health Care Organizations...Secondly, the Assembly could require that each licensed physician or osteopath in Virginia take a specific number of hours of continuing medical education concerning the ethical issues posed for physicians and patients in the context of managed care... Thirdly, in the context of the generalist initiative, the Assembly could require the state's medical schools to assure that adequate introductory instruction in basic medical ethics be given in the pre-clinical period of medical student education, as well as ample opportunity to continue these studies in the clinical setting during their clinical rotations and patient care."

At the Medical College of Virginia/Virginia Commonwealth University, a new faculty with training in biomedical ethics has been tasked with developing an expanded ethics curriculum which would occur throughout the first three years of medical school

beginning in the spring semester of 1997.

At Eastern Virginia Medical School (EVMS), there has been a well-established course in medical ethics for first years students for many years. The course content includes discussion of the basic principles of medical ethics and case studies designed to introduce students to the practical, clinical significance of the principles. Although the topic of "ghost surgery" is not specifically addressed, the thrust of the course would lead students to the conclusion that the practice is unethical and unprofessional. Instruction in medical ethics for students beyond the first year is less organized. Formal course work offered by faculty who have left EVMS has not been continued due to a lack of time by existing members of the faculty. Informally, the topic of medical ethics is frequently included in teaching conferences, on rounds, and in other settings.

Recommendation of the Pew Health Professions Commission report

In its introductory paragraph, the Pew Commission report for Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century (publication in November 1995) notes that "Our nation's health care delivery and financing structures are undergoing fundamental transformations. New integrated delivery networks and dramatically increasing managed care enrollments are forcing greater cost constraints and practice accountability on providers...This change has highlighted the roles that America's 10.5 million health care practitioners play in the cost, quality, and accessibility of health care. Consequently, their education, training, and distribution have received increased attention."

The Pew Commission, recognizing that health care workforce reform must include regulatory reform, looked for ways to "identify and explore how regulation protects the public's health and to propose new approaches to health care workforce regulation to better serve the public's interest." Among the ten policy options for consideration is included a recommendation that **"States should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals."**

Policy options which states may wish to consider include:

- Requirement for the regulated professionals to periodically demonstrate competence through appropriate testing mechanisms which could include random or targeted peer review or could be triggered by a variety of factors including a lack of specialty or private certification or length of time in solo practice.

- Cooperation with the relevant private organizations and with other states to develop standard continuing competency examinations to test minimum competence for continued practice.

- Support for the expanded used of modern technology to enhance traditional competencies and their assessment.

What, if any, requirements would improve the quality of medical care in Virginia? Observations from persons who commented on the study:

From Karen S. Rheuban, M.D., Associate Dean for Continuing Medical Education, University of Virginia Health Sciences Center:

> *"...we clearly recognize the need for continuing medical education so as to insure that our medical practitioners and other health professionals keep abreast of the explosion in medical information and technology. It is necessary, however, that the Board recognize that continuing medical education offerings in their current diverse formats do not necessarily insure quality medical practice; nor does continuing medical education provide the medium in which credentialling of physicians can readily occur. In addition, in order that any state mandated system of education to have any impact on physician behavior, the educational programming must a) meet the needs of the practitioners, and b) be delivered in a format conducive to learning (adult learning theory). Accordingly, should the Board choose to adopt a mandated continuing education requirement for re-registration of the medical license, I believe the educational requirements should be practice specific rather than content specific."*

From Reuben B. Young, M.D., Senior Associate Dean of the School of Medicine, Medical College of Virginia:

> *"...I am firmly convinced of the great benefits of continuing medical education for the physicians of Virginia. However, I think this CME comes in many forms, some accredited and much of it unaccredited. We need to find ways to motivate the relatively small number of physicians who don't stay abreast of what constitutes currently acceptable medical practice in their own particular area of practice. Perhaps voluntary recertification by examination would set an example which most physicians would then be motivated to emulate...For all the above reasons, I do not feel that we should be recommending mandatory CME for the re-licensure of physicians."*

From the Final Report of the legislative task force entitled the "Virginia Mental Health Insurance Parity Task Force", November 7, 1995:

> *"We recommend that the State Board of Medicine, the Old Dominion Medical Society, and the Medical Society of Virginia should encourage and/or require that primary care and family physicians document at least one hour of continuing medical education relevant to mental health and substance abuse problems annually."*

From Joe Foley, D.C., President of the Virginia Society of Chiropractic:

> *"Chiropractic and medicine are different approaches with the same goal in mind, the well being of the patient. While these differences are deeply fundamental, separation is necessary at times. We do share the need for practitioners of both fields to be fully trained and updated to current standards. Thus, we fully support that mandatory continuing education is essential for the public's best interest."*

From Louise Z. Malone, PT, Virginia Physical Therapy Association, Inc.:

> *"In response to HJR 68, the Virginia Physical Therapy Association supports the practice of continuing medical education for relicensure of health care professionals. The need for CME is evidenced by rapidly expanding medical and technical knowledge, evolving managed health care systems, and increasingly complex medical and ethical questions. Most importantly, we have a professional obligation to meet the needs, expectations, and confidence of the public."*

From Terrence J. Schulte, Executive Vice President of the Virginia Academy of Family Physicians:

> *"The Virginia Academy of Family Physicians urges the Board of Medicine to recommend that continuing education be required for relicensure. The Academy further recommends that continuing medical education hours approved by the AAFP satisfy the CME required for relicensure. Additionally, the VAFP encourages the Board to focus on clinical CME appropriate to the various medical specialties."*

From Gerald J. Bechamps, M.D., former president of the Virginia Board of Medicine and immediate past president of the Federation of State Medical Boards:

"...the Federation of State Medical Boards does support mandatory CME as a matter reserved for individual state jurisdictions...Medical boards...should be authorized, at its discretion, to require CME for licensing re-registration, and to require, if necessary documentation of that education.

Continuing medical education is only one tool used by state licensing boards to promote the continuing competence of licensees. Other tools include post-licensure assessment for physicians identified to be at risk, targeted remedial education, and licensing re-registration in which the state board is allowed to review a licensee's qualifications on a regular basis...The continued competence of licensees should be a coordinated effort of licensing boards, specialty boards, peer-review organizations, medical societies, medical staff organizations, and other health care organizations who should share this information in a cooperative effort to protect the public's health, welfare and safety.

...In my own experience on the Virginia Board of Medicine, having participated on over twelve hundred disciplinary cases, my impression was that many of the individuals the board encountered in disciplinary hearings were indeed outliers, i.e., those who did not have hospital affiliations, group practices, or subject to peer review.

In summary, the Federation of State Medical Boards supports mandatory CME as a matter reserved for individual state jurisdictions and that the medical boards should be authorized at its discretion to require CME for licensing, re-registration, and documentation of that education. Moreover, we would agree with the AMA that it should not be mandated to be content-specific, depending on current social issues."

From Paul E. Mazmanian, Ph.D., Associate Dean for Continuing Medical Education at the Medical College of Virginia/Virginia Commonwealth University:

"The purpose of the present document is to recommend one of two possible actions. The more highly recommended is that the Commonwealth of Virginia give further study to questions associated with mandatory continuing education for relicensure of physicians. Short of granting the opportunity for more study, I recommend that the Commonwealth prescribes neither instructional method nor content for its physician learners.

There are two major reasons for this recommendation:

- *The Accreditation Council for Continuing Medical Education (ACCME) is undergoing a period of change and serious introspective study. The ACCME is the national agency which accredits national providers of continuing medical education (CME) and recognizes state medical societies who, in turn, accredit intrastate providers of CME. Only accredited sponsors of CME can designate formal CME activities for Category 1 credit, the CME currency often used for medical relicensure, hospital staff privileges, or membership requirements.*

- *A thorough review of the research on participation in formal CME and learning suggests a low probability of clinical change from mandatory or episodic participation in formal educational activities, such as those designated for Category 1 credit. Rather change tends to occur with a series of exposures to a variety of information sources ordinarily utilized by most physicians desiring to maintain their clinical competence."*

From Ira D. Godwin, M.D., President of The Medical Society of Virginia:

"The Medical Society of Virginia supports basic CME requirements for physician licensure in Virginia. We further believe that the Board of Medicine is best suited for determining ongoing CME requirements for physicians in Virginia. However, we believe that the current system of requiring traditional "Category 1" credits is not necessarily the best or only way by which physician learning can be fostered and measured. We believe that new technologies and innovative physician learning methods have been developed which can become an integral part of a physician's ongoing medical education. These new methods should be considered as CME requirements for Virginia physicians are studied.

The MSV agrees that changes to the current policy of voluntary CME is warranted...The MSV proposes discussions with the Board of Medicine, Department of Health Professions and the Legislature over the next year to further explore the possibilities of developing an effective program to enhance physician learning and improve the quality of healthcare delivered in the Commonwealth of Virginia.

Conclusions of Study on Mandatory Continuing Medical Education:

That the current system of continuing medical education is not necessarily the most effective method of assuring continuing competency or of providing for ongoing physician learning.

That the current system is undergoing changes and is under review by the ACCME, the national agency which accredits national providers of CME and recognizes state medical societies who accredit intrastate providers.

That research into the effectiveness of continuing medical education is inconclusive except to indicate that its value lies primarily in courses or activities which are practice-specific or learner-centered as opposed to those defined and directed by the CME provider.

Final Recommendation on Mandatory Continuing Education for Licensees of the Virginia Board of Medicine

The Virginia Board of Medicine recommends that the specific hours, method, or content of continuing education for licensees of the Board should not be prescribed in the Code of Virginia. It is recommended that a statutory mandate be given to the Board of Medicine to consider various alternatives, including continuing education, to ensure continued practitioner competence.

APPENDIX A

HOUSE JOINT RESOLUTION NO. 68

GENERAL ASSEMBLY - 1996 SESSION

961869320

HOUSE JOINT RESOLUTION NO. 68

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Rules
on February 6, 1996)

(Patron Prior to Substitute—Delegate Keating)

Requesting the Board of Medicine to study the need for requiring physicians of medicine and osteopathy to participate in continuing medical education, with special emphasis on medical ethics.

WHEREAS, as with other technology, medicine is constantly changing, increasing, and becoming more complex; and

WHEREAS, the growth of managed care systems and other efforts to contain health care costs has resulted in increased numbers of generalist physicians and the restructuring of medical education to accommodate this increase; and

WHEREAS, the scope of medical knowledge has become so vast and complicated that it is virtually impossible for medical schools to provide all of the needed expertise to their students; and

WHEREAS, medical schools are, therefore, required to prioritize and even eliminate courses from the curriculum to accommodate those areas believed to be most necessary for future physicians; and

WHEREAS, as with every other aspect of life in the late twentieth century, complex medical and professional issues must be faced from moment to moment by medical professionals; and

WHEREAS, many professions have faced the modern knowledge explosion and its resultant tangle of ethical issues by requiring their members to participate in yearly continuing education, which, in many cases, includes mandatory continuing education in ethics; and

WHEREAS, among the ethical issues in medicine today, the issues related to the accuracy and completeness of informed consent are essential to maintaining the integrity of the physician/patient relationship, including disclosure of the dangers of and alternatives to various medical therapies, truthful, accurate, and complete disclosures between physicians and patients concerning the details of invasive procedures; and assurances that patient/physician communications are honest and designed to assist the patient in making a fully informed health care decision; and

WHEREAS, the term "ghost surgery" means that the physician with whom the patient has a physician/patient relationship fails to inform the patient that he will not be the surgeon performing the operation or fails to inform the patient that he will serve as attending physician to a team which will be performing the operation; and

WHEREAS, the public is not, in general, aware that this phenomenon, known as "ghost surgery," occurs, even though medical ethicists aver that such misunderstandings or failures to inform in an accurate and timely manner which physician will actually perform the operation should not happen; and

WHEREAS, members of the public frequently believe that regulatory boards monitor the quality of licensees' knowledge and skills and their adherence to ethical standards and practices; and

WHEREAS, state licensure requirements do not include continuing medical education for physicians of medicine and osteopathy; and

WHEREAS, many physicians are certified by national specialty boards which do require continuing medical education for recertification, for example, physicians who are members of the American Academy of Family Physicians must obtain 150 hours of approved continuing education every three years; and

WHEREAS, those physicians who have not sought national specialty board certification are not required to participate in any continuing education and may not be up-to-date in their understanding of various current techniques, protocols, and guidelines; and

WHEREAS, since the health regulatory boards are charged with protecting the health and safety of the public by overseeing the professionals providing treatment, these boards should, appropriately, make decisions concerning the criteria for renewing licenses; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Board of Medicine be requested to study the need for requiring physicians of medicine and osteopathy to participate in continuing medical education, with special emphasis on medical ethics. In its study, the Board shall examine and consider (i) current medical school curricula content; (ii) any courses which may have

been generally eliminated from the curricula in recent years and how potential gaps in knowledge from these eliminations are being filled; (iii) how the generalist initiative relates to the need for continuing medical education, particularly in terms of changes in acute care experiences; (iv) how many physicians would be affected by any requirement, i.e., how many do not currently participate in any educational activities; (v) common occurrences of ethical conflicts among doctors and their patients, such as "ghost surgery," and current medical school curricula, including any medical ethics courses or requirements or other means of instructing medical students concerning doctor-patient relationships and the many dilemmas facing physicians in this high technology age; and (vi) what, if any, requirements would improve the quality of medical care in Virginia.

In its study, the Board shall consult with medical ethicists, patients, physicians, medical school officials, and other health professionals.

The Board shall complete its work in time to submit its findings and recommendations to the Governor and the 1997 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

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Passed By The House of Delegates		**Passed By The Senate**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

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Clerk of the House of Delegates Clerk of the Senate