

Ethics and Quality of Care

Report of the American Medical Association and the Federation of State Medical Boards

The Federation of State Medical Boards of the United States, Inc., accepted this report as policy in April 1995.

At its Interim Meeting in 1991, the American Medical Association (AMA) House of Delegates adopted Board of Trustees Report BBB: Council on Ethical and Judicial Affairs—Enforcement of the Code of Ethics. Among other things, that report called on the AMA to work with the Federation of State Medical Boards (FSMB) to (a) make a uniform part of the licensure examination knowledge by physicians of their unique ethical responsibilities, as described in the Principles of Medical Ethics and the Current Opinions of the Council, and (b) expand those medical society programs whereby, under the supervision of the state medical board and with its attendant investigating powers and civil suit immunity, medical societies examine and report to the boards with regard to quality of care complaints referred to the boards.

Beginning in early 1992, the AMA and the FSMB held a series of meetings designed to explore ways in which these goals could be accomplished. The FSMB appointed an Ad Hoc Committee for this purpose, and the AMA was represented by a member of its Board of Trustees, as well as a senior staff member. The most recent meeting of this group took place December 15, 1994. The purpose of this document is to summarize the conclusions reached in this process, and to identify prospects for continued cooperation.

Quality of Care Cases

State medical boards are charged by state law with the ultimate responsibility for assuring the quality of care provided by licensed physicians. The boards are directly accountable to the public for this activity. Most boards are made up of both physician and public members, and are served by full-time staff to investigate quality complaints. Yet the boards do not have on staff the wide variety of expertise needed to review the quality of all medical care provided by physicians today. Moreover, the boards are not in complete control of their resources. As state agencies, the boards are subject to the vagaries of the budget process. They may find themselves lacking full funding and staff complement.

As a result of these factors, the boards necessarily rely on practicing physicians both to report colleagues who are not meeting the standards of the profession, and to assist in reviewing quality of care complaints by serving as expert consultants. By participating in the process of the boards, physicians meet a fundamental obligation of members of the medical profession. One of the basic tenets of the profession is the duty of self-regulation, which is based on the unique qualifications physicians possess to evaluate the clinical performance of their colleagues, and on the enduring commitment of physicians to safeguard the welfare and trust of the public.

The medical profession has a long history of comprehensive peer review. Collegial review is part of the medical education process that begins in medical school and continues throughout every physician's career. As practitioners, physicians participate in, and are subject to, peer review as members of hospital medical staffs, medical societies, and increasingly, integrated health care delivery systems. Physicians spend countless additional hours in the development of practice parameters and related efforts to improve the quality of health care delivered today.

State medical boards may not now be a regular part of these activities. The boards should reach out to physicians who make up the profession's self-regulatory infrastructure and rely, to the extent necessary and appropriate, on these expert peer reviewers. Likewise, state medical societies should work to assure that the peer review efforts of practicing physicians are extended to the assistance of state boards. Cooperative

ventures between state boards and medical societies, such as with impaired physician programs and focused continuing medical education, may assist in this regard.

Making Appropriate Reports to the Boards

The Council on Ethical and Judicial Affairs described a key aspect of this duty in a December 1991 report: Reporting Impaired, Incompetent or Unethical Colleagues. That report, and the ensuing ethical opinion, require that physicians notify state boards of incompetence that poses an immediate threat to the health of patients, as well as behavior that is potentially injurious to patients and continues despite remedial efforts. In sum, “Physicians who receive reports of incompetence have an ethical duty to critically and objectively evaluate the reported information and to assure that identified deficiencies are either remedied or further reported to the state licensing board.”

State medical boards generally find that physician reports of incompetence by colleagues are among the most infrequent and yet the most reliable of the quality of care complaints received. It is critical that boards receive appropriate reports from physicians in a timely manner. As the 1991 CEJA report makes clear, this obligation extends beyond reporting incompetence that poses an immediate threat to the public. If other peer review actions, such as hospital medical staff remedial plans, fail to correct incompetent practice, then a report must be made to the medical board. This obligation takes on greater importance as medical practice moves increasingly outside the hospital setting, and traditional peer review opportunities become less available. State medical societies can, and should, facilitate reporting by physicians in their communities.

Participation in Quality of Care Review

The quality of the review process undertaken by state medical boards is determined in large part by the resources available to them. The most essential resource is physician review. Physicians possess the training and experience that uniquely qualifies them to review the competence of their colleagues. Without access to an adequate supply of qualified physician reviewers, the boards simply cannot do the job they are mandated by law to do.

State medical boards are a key element in the peer review system. The boards are accountable by law to identify and respond appropriately to the most serious quality of care complaints. They can do this most effectively by relying upon the unmatched competence and experience of practicing physicians. Collectively, the physician community provides an invaluable potential resource which remains underused or, in some jurisdictions, largely untapped.

The boards regularly report difficulty in securing practicing physicians to serve as peer reviewers. Whether this is due to a lack of understanding of the boards’ role, suspicion of their activities, or some other cause, it is a condition that should be corrected. The AMA and the FSMB believe that state medical societies and state boards have a duty to establish a cooperative relationship that will foster better understanding of the role of each entity and provide an environment in which practicing physicians regularly incorporate work on behalf of the boards into their other peer review activities. Specific recommendations about how this might be accomplished are set forth at the end of this report.

Ethics

It is a fundamental obligation of the medical profession that its members have knowledge and appreciation of the principles of medical ethics. Indeed, one of the basic requirements of accredited medical schools is that “[s]tudents must be encouraged to develop and employ scrupulous ethical principles in caring for patients, in relating to patients’ families, and to others involved in the care of the patients.” The medical practice act in most, if not all, states requires that physicians behave ethically in order to acquire and maintain a medical license. It is time to ensure that students have adequate knowledge of medical ethics when they sit for the examination required for licensure throughout the United States, the USMLE. The legal profession requires that all applicants for the bar pass a specific legal ethics examination, which is based on the American Bar Association’s ethical code.

An important part of the ethical fabric of the medical profession is the Code of Medical Ethics developed for over 100 years by the AMA. This code consists of the Principles of Medical Ethics, which are adopted by the AMA's House of Delegates, and the Current Opinions of the Council on Ethical and Judicial Affairs, which interpret the principles. The AMA's Code of Ethics is widely disseminated and has provided the most commonly cited standard for courts, legislatures, administrative agencies, medical boards and other peer review entities. Most medical societies, and virtually all state medical societies, accept the code as the profession's code.

To facilitate education and examination in ethics, the AMA will make its Code of Ethics available to every student entering medical school each year as well as to every student sitting for the USMLE. It can be an indispensable tool for discussing and addressing the central ethical issues faced by physicians today, and examination questions can be drawn from the code's opinions.

The FSMB recognizes the importance of medical ethics in guiding the development and practice of physicians, and the vital role that ethics can play in protecting the public interest. The FSMB endorses the proposal that an increased emphasis be placed on the examination of prospective licensees with respect to their knowledge of medical ethics.

Recommendations

The AMA and the FSMB recommend that the following specific actions be undertaken where feasible, and that state medical societies and state medical boards seek other means of improving the quality of care review of physicians as well as physician knowledge and appreciation of medical ethics in general:

1. State medical societies should disseminate widely the CEJA report "Reporting Impaired, Incompetent, or Unethical Colleagues" and should otherwise strive to make physicians aware of this obligation.
2. State medical societies should inform the boards of new ethical statements by CEJA, such as reports and opinions as they are published.
3. State medical societies and boards should facilitate reporting by physicians, for example, by assuring to the greatest extent possible the confidentiality of reports.
4. As prescribed by state law, state medical societies should forward quality of care complaint and the other alleged infractions to state boards. Complaints within the jurisdiction of the medical society should be resolved according to the AMA Guidebook for Medical Society Grievance Committees and Disciplinary Committees. Each state board and state medical society should develop a system for identifying and routing complaints to the appropriate entity.
5. State medical societies and boards should foster better communication and understanding among their members, for example, by a report from the board to the medical society's annual meeting, the joint sponsorship of continuing medical education activities, and the attendance of board meetings by medical society representatives.
6. State medical societies should assist the boards in securing physician reviewers for quality of care cases, perhaps by making the roster of its standing peer review committee available to the board, or by developing and maintaining a list of physicians able and willing to serve as reviewers when requested to do so.
7. State medical societies and boards should discuss legislative issues of common interest and reach agreement, to the extent possible, of a desirable course that will protect the public and the rights of physicians under review.
8. State medical societies should provide to the appropriate agency a list of possible state medical board members from the society who demonstrate the qualities of honesty, fairness, impartiality, integrity and dedication to the task.
9. State medical societies and boards should cooperate with respect to impaired physician programs, remedial continuing medical education and related matters.
10. State medical societies and boards should work together to address the issue of credentialing physicians who change their practice specialty after residency training is completed, or who relocate their practice from one state to another.