

Response Panel: Federal Government

Ciro V. Sumaya, M.D., M.P.H.T.M.

Administrator

Health Resources and Services Administration

U.S. Department of Health and Human Services

Presentation

I am pleased to have the opportunity to respond to the recommendations from the Federal Government strategy sessions. We live in a health care arena that is characterized by high-speed change, complexity, and conflicting priorities. The "one size fits all" model of health care has been eclipsed by the very real need to respond to the special health concerns of women that have been identified over the past 10 years and the demographic changes that will irrevocably alter the racial/ethnic makeup of our country in the 21st century. Issues related to the emphasis on primary care, managed care, proposed changes to Medicare and budget constraints must all be factored into the equation as the Federal Government looks at ways to train tomorrow's health professionals to meet the needs of our diverse population.

With regard to medical education, HRSA's mandate is to provide leadership, direction, and assistance to public and private agencies and entities to improve basic preparation and continuing public health competence of the health professions and the public health workforce. We must build that capacity now to respond to the needs of the future.

HRSA is also a leader in women's health through its Maternal and Child Health Bureau and other programs targeted specifically to women. Many of these programs with the States are now incorporating cultural competence principles into program design. These programs provide a model which combines women's health with cultural competence.

What should HRSA's leadership role be, now and in the future, to ensure that women's health and minority health are given necessary emphasis in medical education so that tomorrow's health professionals will be equipped to provide systems of care that truly meet the needs of their communities? The Federal Government has always been in the unique position of looking at the "big picture" and to influence health care delivery at the research, technical assistance, partnership building, and information exchange. We can help to identify key issues, bring decision makers together and help to replicate successful curricula models. Mechanisms have already been established within the Public Health Service that can help to meet these new demands.

HRSA's Centers of Excellence (COEs), for example, focus directly on health professions education for minority individuals. COE funding includes support for improving curricula and clinical education with respect to minority health issues. Innovative new approaches are also needed to focus resources where there is the greatest need. HRSA's Office of Minority Health and Women's Health Coordinators at the Administrator's level and in our Bureaus are in the vanguard of developing these approaches.

The White House Initiative on Educational Excellence for Hispanic Americans is an example of new programs designed specifically to bring more minorities into the health professions to provide culturally competent primary health care to the expanding minority population.

An important part of this initiative is capacity building and faculty development within institutions that serve a high concentration of Hispanics. On November 13, HRSA will bring together Presidents of health science centers and Deans of medical institutions serving health professions schools. These institutions will serve as the flagship schools for the development of successful educational pipelines for Hispanic students from grade school through high schools, college, and health professions schools. The culturally competent health professionals who graduate from this intensive program will be equipped to serve the rapidly expanding Hispanic population.

These programs are examples of ways in which the Federal Government is working at the national level to respond to the changing public health realities of our nation, now and into the 21st century. But we cannot do it alone. The partnerships and networking that are being developed here at this conference and at other meetings with academic institutions are critical to developing a comprehensive plan of action. That is the only way in which lasting change can occur.

Response Panel: State Government

David Werdegar, M.D., M.P.H.

Director, State of California

Office of Statewide Health Planning and Development

Presentation

Let me talk about some of the crosscutting issues in which state activities take place. First, however, when you've seen one state you've seen only one state. At the strategy session which I attended, it was clear that coming from different states, we have novel experiences because each state has a different structure for its health care system. But the powerful influence of managed care - ironically catalyzed by the Clinton health reform plan--has, in just the last five years, radically changed the health care landscape, especially in California. We have always had Kaiser. However, now all of our health care delivery is pretty much managed care.

Our healthcare delivery system has turned into a for-profit industry with the exception of Kaiser. There has been one significant benefit to this transition to managed care. Each time one of the not-for-profit plans, like Blue Cross, decides to become for-profit in California, it must contribute all the monies that it earns during the non-profit period to the state. Several foundations have been formed as a result. For example, when Healthnet went for-profit, the Wellness Foundation was formed. It is a one billion dollar foundation. All of its funds must be spent on health care. Its principal priority has been the support of domestic anti-violence programs. Now that Blue Cross has gone for-profit it has developed a \$3 billion foundation that will support health care programs to improve access to health care in California.

Competition in the managed care market is tough in California. The top six or seven managed care companies account for almost all of the insured enrollees. This competition is changing the landscape completely. Public health will never be quite the same. Professional schools will not be the same either. Because of these changes, we need to connect with state legislative bodies that influence health care legislation in our states.

Legislative bodies in each state have health committees with knowledgeable professional staff. There are ways of approaching policy makers through these staff members concerning our views. Physicians and health care professionals need to know more about these processes and use them to help shape the changes we would like to see occur. These lobbying efforts can be developed at both statewide and community levels. These efforts will help us to include women's health and cultural competence policies and programs in legislation developed in our states.

In California, we have sponsored nurse practitioner programs and have given priority to those who are training for service in under served areas. This has generated support for curriculum development changes at residency training levels and for nurse practitioner training that includes cultural competency so these health practitioners can serve in minority

communities. We also have a large state medical and health science school enterprise which participates in these programs. Five University of California medical schools and nursing, pharmacy and dentistry schools have done a superb job in minority recruitment. The University of California schools, all of them, have an excellent record in minority recruitment. Women have also constituted fifty percent of the entering classes for some years. We believe this recruitment constitutes one of the most important parts of the process of women's health and cultural competence. We have in our state government, an office that I direct, that is committed to the recruitment of minority students into the health professions. I have seen first hand that students who become residents can become faculty members. These faculty members can in turn help to change their institutions.

Another major transformation, at least in California, is the enormous demographic changes that are taking place in the state. This has led to the development within our Department of Health, of an Office of Multicultural Health and an Office of Women's Health. They are small, but provide a focal point for activities in these areas.

I don't think the revolution caused by managed care has been fully appreciated. While there is going to be some value and flexibility in the block grants, which are coming to the states, we are concerned about the possible loss of programs such as those in the Health Resources and Services Administration (HRSA).

We need to see if we can get the HMO's to tithe. By this I mean, that since they are under competitive pressures to serve primary care residents, they can also be pressured to provide culturally competent care for the populations they are targeting for service. I will say that people are looking to see how we can get managed care organizations to contribute to education, not simply for women's health and cultural competence, but for health science education in general.

The state is very much involved now in report cards and reviews of quality of care. The Department of Health Services will be looking at the quality of care of managed care for Medicaid clients. The Commissioner of Corporations will be monitoring the health care services provided by HMOs. While they will be looking at outcome measures, HEDIS measures and other ways of evaluating quality of care, an important measurement will be consumer satisfaction. Purchasing groups like the state, or the state's retirement system, or business groups purchasing health care, have used consumer satisfaction rates as one of the most important instruments of evaluating quality of care. Women's health care and cultural competence can also be included in consumer satisfaction reports and can be used to distinguish one HMO's service from another's. In this way, women's health and cultural competence can become factors in the managed care marketplace.

Response Panel: Medical Schools

Ana Nuñez, M.D.

**Assistant Dean of Generalism and Community
Medical College of Pennsylvania and
Hahnemann University School of Medicine**

Presentation

A war for survival is currently going on concerning the viability of many academic medical centers. This war concerns the survival of these institutions amidst the rapid changes that are now defining what will be our health care system. If you want to make an impact on these institutions in this environment, you need to know what strategic plans for survival the institution has made to enhance its ability to attract and develop additional resources.

Fundamental to this process is providing information to key people at your institution. Take the opportunity to de-brief the dean, or the associate dean. Report back to him or her as to what happened at this meeting. Make sure they understand the potential impact of cultural competence and women's health on policy and resource development. Yes, they are busy, but they will also want to know what goes on at defining meetings such as this one.

If you want to increase communication and contact with key people across your institution:

- ◆ Work with internal communication publications in your institution to let others know about current developments in women's health and cultural competence.
- ◆ Link with representatives of specialty organizations, your medical school delegates to the American Medical Association (AMA), colleagues in other disciplines throughout your university and in different departments on projects of mutual interest.
- ◆ Find out who in managed care is concerned with women's health and cultural competency and develop relationships with them.
- ◆ Speak to those in your hospital who are developing strategic and marketing plans about how they view women's health and health care for people of color. See if you can provide input in both the planning and implementation stages of your institution.
- ◆ Strengthen your community ties to make you more valuable to your institution.
- ◆ Establish a bulletin board or e-mail address, where people can ask questions about women's health or cultural competence.
- ◆ Determine which primary care programs in your institution need a women's health or cultural competency component.
- ◆ Find out who is doing curriculum revision and meet with them to share some of your ideas and concepts.

- ◆ Lobby internally, especially to research and contracts staff and others who decide how internal grants are distributed.
- ◆ Recruit students as advocates for women's health and cultural competency projects.
- ◆ Develop an elective in women's health and cultural competency as a beginning step towards a complete program.
- ◆ Our advice is lobby for your programs and views, look for opportunities and be ready when they come.

Response Panel: Residency & Fellowship Programs

Jeannette South-Paul, M.D.
Chair, Family Practice Department
Uniformed Services University of the Health Sciences
Bethesda, Maryland

Presentation

Once we recognize our challenges, we have to think about the approaches that we will take. The times are gone when we are going to get totally new programs that do not interface with others. We must collaborate. In my experience as chair of a department, I have learned that I am as territorial as all those other people I used to criticize when I was a resident and a medical student. I want things to look good when it seems to reflect my specific sphere of influence. We have to recognize that when we bring in new ideas, other folks may have a lot invested in their own ideas and practices. When there are time and resource crunches, we have got to make sure that we can bolster an investment in our new ideas so we all benefit.

We are dealing in multidisciplinary environments and those who contribute are not just those who have terminal degrees. We must all work together - allopaths, osteopaths, nurses, dentists, physician assistants, midwives, health educators, social workers, community educators, patient representatives and others. We cannot make any recommendations, or come up with ideas, without recognizing all of those who contribute to the health of our population.

Look what happened in geriatrics, an area that grew out of more than one discipline. It took geriatrics fifty years to develop fellowship programs. If you look at another fellowship model, which is the sports medicine fellowship model, what you see is that this is not one age range, but a whole spectrum of ages. Both are multidisciplinary. Neither works with only one specialty. They require collaboration and consensus.

We must recognize our challenges and approaches that work, given the environments in which we function. We must also remember history and what it took to get to the point where we are today. We have to insure that there is consistency and competency in both cultural competence with respect to under served populations, and in women's health, in all areas of practice, in all specialties and in all residency programs and fellowships. Then we have to evaluate how we are doing. We also have to try more than one model. There was a lot of conflict about how to achieve our goals should we try programs that focus on residency alone, or should there be certificates of added qualifications from more than one training program. We need to look at more than one model.

Whenever there is life and there is more than one of us, there are going to be challenges. We need to recognize that the focus for some is not the focus for others. We have to keep in mind that residency, fellowship, women's health and cultural competence are different, although

they sometimes overlap. But the degree of the overlap has yet to be clarified. We need to realize that there will not always be consensus.

Our professional literature is the way in which we bring together the minds that can create new things and generate discussion. It has been through our literature, our professional journals and letters to the editor that we communicate new ideas and information. Through our literature, we also take positions on issues that we care about passionately. Yet we must realize that every one of us has something that we are passionate about. Our passion may not extend to our colleagues. Our goals, however, need to be parallel. How to incorporate women's health into training at all levels of education. How to incorporate cultural competence for both men and women into medical education. However, we cannot forget that our ultimate goal is to provide the best, most consistent, most compassionate and cost-efficient healthcare possible, especially to vulnerable populations.

But we must remember that whenever we are looking at any new program, we cannot look at anything in a vacuum. We must assess the environment in which it will function. And that environment is one of shrinking resources and downsizing. Affirmative action is no longer as politically correct. Generalism is in vogue. We keep these trends in mind when proposing our programs.

Response Panel: Health Professional Associations and Accreditation Bodies

Harry S. Jonas, M.D.

**American Medical Association and Liaison Committee on Medical Education
Chicago, Illinois**

Presentation

We have recently developed a new standard on student body diversity that includes cultural awareness. I represent the Liaison Committee on Medical Education (LCME), the agency recognized by the U.S. Department of Education as the body responsible for the accreditation of our 125 educational programs leading to the M.D. degree in the United States. We also have responsibility for the accreditation of the 16 medical schools in Canada through a joint cooperative effort with the Canadian accrediting body.

I read in the draft document of the resource guide for faculty developed by the National Academy on Women's Health and Medical Education (NAWHME), the goals and objectives for medical education, which were developed by the Women's Health Interschool of Curriculum Committee of Canada.

Canadian medical educators have taken an important leadership role in defining the role of medical schools in fulfilling their obligations to society. This so-called social contract which includes the social context of women's health, is a phrase that is used widely in Canada and it is one of the most important responsibilities of any profession. We can learn a lot, I think, from our neighbors to the North and Canada when it comes to progressive trends in medical education. The LCME, which I represent, is now in its 53rd year of operation. The United States is one of a very few countries in the world that have any process at all to measure their educational programs in medicine against a set of established standards. And our standards frequently undergo changes in response to changing times. A few years ago, we assisted Australia in the development of an accreditation system of their medical schools fashioned similarly to that of the LCME. For over a year now, we have been involved with an active group of outstanding medical educators in Mexico who seek to upgrade their educational standards in medical school programs and to eliminate some of their substandard programs.

Our process for accreditation is an extensive one. We require schools to undergo a full survey every 7 years and institutions to perform an institutional self-study in preparation for the survey. This involves administration, faculty and students, where the institution conducts a detailed self-analysis of all components of the medical school. It provides an opportunity for a school to study and redefine their mission and evaluate how well it is carrying out that mission. Our standards are broadly drawn. We are not a proscriptive accrediting body that has numerical requirements for student faculty ratios, numbers of books and journals in the library, classroom square footage and numbers and types of patients required for education in the specific medical discipline. Rather, we broadly assess how well a school articulates its mission. This includes the clear enunciation of its educational objectives, how its objectives are carried out and evidence to show that those

objectives are achieved and their educational outcomes. We have an ongoing process to examine just how our standards are drawn. We receive suggestions from the public and the profession and from groups such as this on needed standard changes and to present to the LCME new standards and rewording of existing standards.

Here are some examples of the standard changes we have instituted in the past five or six years. Schools must collect, analyze and provide data on the educational outcomes of their students and graduates. Schools are now required to have a core curriculum in primary care. That is a must. Family practice is now included as one of the core clinical experiences. The curriculum must contain ambulatory and community experiences. Students must have evaluation of their clinical skills through direct observation by faculty members. That was stimulated in large part due to the outstanding work of Dr. Paula Stillman at the University of Massachusetts. She reported that about 70 percent of medical students received their M.D. degrees without ever personally being observed, by a faculty member, during a history and physical examination on a patient.

Comparable quality of educational experiences at geographically separate sites must be achieved. We are concerned right now about getting students out into diffuse ambulatory sites to be assured that they will have proper supervision and comparable and reasonably good educational experiences once medical education has been decentralized. We have developed new standards on policies on exposure to infectious and environmental hazards, and the provision of health and disability insurance, including coverage for immunizations for medical students.

One of our newest standards addresses curricular change. I will review for you the evolution of that standard. The G-PEP report, by the WMAC a few years ago, called for extensive curricular changes to bring about more small group teaching, more self-directed learning, more ambulatory and community experiences and greater use of computer resources and computer-assisted instruction.

There was very little movement in the beginning to adopt some of these ideas. I happened to be a medical school dean at the time and I can tell you even the deans dragged their feet considerably on accepting some of the recommendations of that report. When we, as the accrediting body, returned to medical schools where we had been seven years earlier, the curriculum was from the 1950's. When we asked the deans about this, his or her responses were something like, "Well, you must understand, that there's something known as academic freedom." And the faculty has full responsibility for curriculum design and function.

As a dean, I cannot change what the faculty decides. It is the primary reason why curricular change has been slow to occur. But our new standard clearly states that there must be integrated institutional responsibility for the design and management of a coherent and coordinated curriculum and that deans must be provided with appropriate resources to bring this about.

As a result of this standard change, we believe we have seen a pronounced movement in the direction of modernization of medical school curricula. I can tell you there are a lot of exciting innovations going on right now in our medical schools. We are still sensitive enough, however, to the concerns for the academic freedom concept to not push medical schools to adopt a standard template for curricular design that is the same for all medical schools.

We appreciate very much the diversity we have in our U.S. medical schools. We think that it is one of the major strengths of U.S. medical education. We have public schools, private schools, schools located in urban and rural locations; some are very heavily publicly funded. Some are rather poorly funded. Each has its own individual mission. It would be difficult to compare a rank at the University of South Dakota School of Medicine with Harvard Medical School, since each has its own approach to teaching appropriate for those schools' environments and their resources.

But it is extremely important for guidelines to be developed for schools to follow when they are undertaking curricular change. It is also important for such guidelines to be widely distributed to medical school curricula committees to serve as guidance for the faculty to design their individual curriculum, not a clone of someone else's.

We get a little nervous about model curricula where somebody is pushing the same model to be reduplicated in every medical school - but instead would prefer a curriculum that best fits a school's mission and resources. For example, problem-based learning is a wonderful educational concept, but it would not work if the faculty were not trained for it. The faculty may also be resistant to change, or may not have the educational background to understand it. I would challenge you by saying that on the issue of teaching cultural competence, many physician faculty members are not trained to do that. You are going to need a much wider array of faculty resources beyond the terminal M.D. degree to do that.

Gender issues in medical schools are widespread and the LCME has attempted to be sensitive and responsive to those issues. The gender representation on the LCME itself has improved somewhat from recent years when it was an all-male committee. Today, we have five women members out of 16. One of these is our public member, and this year, both of our student members are women. Our survey teams who visit medical schools always include at least one and sometimes two women members, but we need more women faculty members who are interested in the accreditation process and who would be willing to serve in such a capacity. It is a significant responsibility.

We are dealing with the issues of how to develop more faculty role models, both women and minorities, for students and for other faculty members. We certainly are making no headway in achieving gender changes in positions of top administrative responsibility. With now only two medical school deans who are women, we seem to be taking two steps forward and two steps back in this area. Student harassment, sexual abuse and harassment are just now getting attention.

We have yet to come to agreement on a new LCME standard involving diversity in the

medical school faculty, which is a much-needed standard that we are working on. We do not have specific standards regarding the teaching of women's health in the curriculum or research in women's health issues as such. We are presently working on a new standard to address the teaching of family violence. That wording was presented to the LCME at their meeting earlier this month. We would welcome any suggested wording that groups such as this or conferences such as this could produce and pass on to the LCME for their consideration.

Our data are somewhat slim on how effective the efforts are to teach women's health or cultural competencies in the medical school curricula. We do have a mechanism for collecting data on curricular content through our LCMF annual questionnaire, Part 2. One of the things that we enjoy is an image that we have some great deal of power as the accrediting body, therefore, we tend to get 100 percent response rates on our surveys. Everybody wants to return their survey and we will be having a meeting in about a month to develop our set of questions for the next LCME survey, which goes out each February. We also send out a set of questions each year that address what we call "hot topics that ought to be addressed". These hot topics could be generated from conferences like this one, or from the Office on Women's Health, or the Office of Minority Health.

Students conduct their own survey independently from the administration and dean's office in conjunction with the full survey. If done well, this student survey can be a critically important tool in the evaluation of the quality of the curricula. If we really want to understand how the curriculum is designed and how it is working, we don't ask the dean or the faculty, we ask the students. Quite often, it is the students who point out the most glaring deficiencies in the curriculum. With the gender shifts we are seeing in the medical student population, this year 41 percent of medical school enrollees are now women and the percentage of women in the entering class has reached 42.2 percent in the 1994 to 1995 academic year. You should know, however, that the percentage of women enrolled in entering medical school classes has plateaued. I am hopeful that with these gender shifts and through good student input, future student surveys will provide information to us on how effectively women's health issues and cultural differences are being addressed in the curricula.

Another trend is one to develop a more interdisciplinary approach to curricula. Early exposure to the clinical sciences attempts to make basic science more relevant to the world of medical practice. I am hopeful that this trend will continue and that we can avoid the turf battles over who has responsibility for women's health curriculum. We must realize that a proper approach to the teaching of both women's health issues and competencies in cultural understanding cannot be the prerogative of one discipline or one department.

The document balancing the scales of opportunity insuring racial and ethnic diversity in the health professions was published by the IOM last year. Educational environments in medical schools in recent years have provided medical students with excellent backgrounds in the biomedical sciences, biotechnology and many clinical skills. What has been missing, however, is an emphasis on the importance of human relationships, a better understanding

of the doctor-patient relationship and a more enlightened appreciation of the ethical and community responsibilities of physicians.

With the increasing diversity of cultural backgrounds in U.S. medical schools, we must promote programs in our medical schools that provide cross-cultural understanding among the students themselves, as well as, closely examining the physician-patient relationship so that the many barriers to good communication, either through language deficiencies or a poor understanding of cultural differences, can be eliminated.

One of my favorite quotes is a good ending for this presentation. "A community is a fragile creature. We have broken it with our emphasis on race and class, creed and gender. We have taught our children to fear those who are unlike us in the pigment of their skin or the content of their wallet. We have drawn red lines on white real estate maps to keep black neighbors from moving in. While we shivered at the awful deeds of Hitler's Germany, we have had no trouble telling jokes about men who are gay or children whose parents are. And even in our dying, we have maintained our well-defined patterns of segregation and discrimination from the social services that ease our suffering to the funeral home that retrieves the body."

Response Panel: Medical Board Exam Organizations

Gerald S. Golden, M.D.

Vice President

National Board of Medical Examiners

Philadelphia, Pennsylvania

Presentation

The National Board of Medical Examiners (NBME) plays a critical role in the creation of qualified medical practitioners, as does the National Osteopathic Board of Medical Examiners and many other specialty boards, such as the American Board of Pediatrics. There are a number of key questions concerning the NBME and its relationship to medical education.

First, what is the relationship between the Board, the faculty of medical schools and their curriculum? Does the National Board of Medical Examiners drive medical school curriculum?

The answer is no. In my childhood, the comic books often had an ad that showed a big bully kicking sand in the face of a 98-pound weakling. This 98-pound weakling eventually gets his revenge by writing off and sending some money to Charles Atlas for his system of dynamic tension. I think dynamic tension is the best way to describe the relationship between the NBME and medical schools. The faculty sets the curriculum. But the faculty is interested in outside evaluation of their school's curriculum. It gives them some validation that what they are doing is correct. At worst, it is used as a bludgeon by the dean and committees in the school to change current practices.

Where does this Board exam come from? Trolls in a basement do not write the Board examinations. Faculty members write them. The items themselves respond to a content outline for each of the step exams that are put together by committees of faculty members. The Board exams represent minimal competencies for core material that have been defined by a good sampling of U.S. and Canadian medical school faculty.

The examination should not be looked at as the only thing that brings pressure for change of medical school curriculum. We always get questions as to why we stick to multiple choice and fill-in-the-blank questions. However, the current format, tested worldwide with 36,000 students, has a reliability of ninety-seven percent. There are very few examinations with this level of reliability. Why stress high reliability? We are making high stakes pass or fail decisions. The way you get licensed is by obtaining an M.D. degree, by passing the Boards, and by being granted a license by a state licensing agency. Board exams are only a part of the process.

But how can we make a real impact? First, you have to know what is on the examination. The national board exams are no longer as secret as they once were. The drawbridge is down, the moats have been filled in, and the examinations are available for review by faculty. A duly constituted group can come into our office in Philadelphia and review the examination in depth.

You can spend as many days as you want reviewing any or all of the three steps. We only have two constraints. The first is you cannot come out with a published tally of the number of questions you find in given area or copy pages to show to your colleagues. The second is you must give a report as to what you found and the recommendations for improving the examination.

We also bring the examination to medical school campuses and allow it to be reviewed by faculty. Reviewers can include general faculty or specifically defined task force or committee members within your faculty. Third, we do pay attention to student feedback after each examination.

In terms of getting the material you want into the examination, there are two approaches. Although the Board does not define either the content specifications or write the items, we have certain ways to gently steer the process in certain directions. The first approach is the stealth approach and we are currently using that. The stealth approach includes seeding various committees with people from the world of family medicine and by seeding various committees with people from the world of preventive medicine and public health and there is no reason why we cannot seed committees with representatives of women's health and minority health. The second is the direct approach and that is: if review of the examination shows things are bad enough from your perspective, we always have the option of going outside of the usual committee structure and developing a task force to develop questions in a certain area. We have recently had task forces in nutrition, clinical genetics, basic genetics, family medicine and a number of other areas. So there are ways to evaluate the exam and to change the content. Remember this effort must go on parallel with what is going in the medical schools, because the medical school faculty who put the exam together really cannot stray too far from what is going on in these schools.

Let's take another look at the recommendations of our group. A task force from the Office of Women's Health, the Office of Minority Health and the Board should review the examination and components. Second, recruit new individuals to become members of Board committees. We accept nominations from anyone as long as they are currently medical school faculty. We take nominations from deans, faculty members and from professional and academic organizations.

The last recommendation is that all the specialty boards include in the pre-requisites skills, the areas of women's and minority health. I can comment on one area that was in the licensing board report; the building of standardized patients into the NBME examination. By the end of this century, the first phase of movement to computer-assisted testing including computerized patient management problems as part of Step 3 will be in effect. The next phase of development will have standardized patients, probably as part of Step 2, so we are moving towards various methods of performance-based assessment.

Response Panel: Licensing Boards

Susan Spaulding

Vice President

Federation of State Medical Boards of the U.S., Inc.

Eules, Texas

Presentation

The Federation of State Medical Boards (FSMB) was founded in 1912 with a membership comprised of 50 state medical boards, the District of Columbia, Puerto Rico, Guam, Virgin Islands and 13 independent state boards of osteopathic medicine. Beginning in 1968, the Federation, in cooperation with the National Board of Medical Examiners (NBME) structured and conducted the federation licensing exam, known as FLEX. The FLEX was used by all states until 1994.

In 1991, the Federation and the NBME announced the establishment of the United States Medical Licensing Exam (USMLE). The three-step USMLE was phased in from 1992 to 1994 replacing the FLEX and the certifying exam of the NBME. The Federation also operates what is known as the Board Action Data Bank which is a nationally recognized system for collecting, recording and distributing information to state medical boards, data on disciplinary action taken against licensees by boards and other governmental authorities. In 1994, there were 4,155 actions, which represented a 12 percent increase from 1993.

State medical boards develop licensing procedures and disciplinary processes, review charges of unprofessional conduct and complaints that they have received. My experience is that many complaints are due to miscommunication. Some are due to cultural differences. If you can prevent not only miscommunication, but future physicians and licensees from going through disciplinary processes by making a 30-minute presentation, I think most of the students and residents would find it well worth their while.

Licensing of physicians is done on a state-wide basis. California, which licenses over 100,000 physicians a year, is different than Vermont, where I am from, which licenses nearly 3,000 physicians a year. Each state has different requirements for licensure, but there are some similarities. Medical doctors are required to pass step 3 of the USMLE in order to be licensed, unless they come under the FLEX grandfather clause. None of the states are licensed by specialty and all of the states have in the statute that sets up their licensing boards protection of the public as their main goal.

The Federation does put out a publication called the *A Exchange*. The *A Exchange* comes in three parts and it is a grid on all of the information. The first part is what different states require for licensing medical doctors. The second section is for osteopathic physicians and the third section of this exchange is all the differences that licensing boards have for licensing and disciplining of physicians. Not all state boards require CMEs for license renewal. I support the idea that if you do require CMEs, it makes sense to have at least 10 of those hours be focused on tools for cultural competency and gender-based biology.

The standardized patient and the computer-based exam, both being developed by the National Board, are exciting tools for medical knowledge assessment. It is important that the National Board of Medical Examiners and the Federation continue to provide the best examinations possible to help insure the protection of the public and to work to improve the quality of health care.