Editorials

Licensure versus Certification

State medical licensing boards have generally been charged with the regulation of the practice of medicine within their jurisdiction. State legislatures adopt a code usually in the form of a medical practice act and provide the state government with an agency that is charged with the responsibility to enforce that portion of the law. It seems that during the past several years, this has become an increasingly more complex task. Technologic advances, new ethical issues, and a higher demand for accountability have, along with other factors, led licensing boards to become more proactive than they have been in the past. The result has been an increased number of physicians who have had their licenses modified, restricted, suspended, or withdrawn.

In some cases, community standards for medical practice have substantially changed. One example is the requirement by some states of a minimum of continuing medical education. Another is the requirement of foreign medical graduates to complete several years of accredited graduate training prerequisite to licensure. In one state, candidates for licensure must be willing to accept Medicare assignments. Currently, this requirement is being considered by a few other states. Also under consideration by the Federation of State Licensing Boards is a proposal for a single pathway for licensure that could be adopted by all states.

In addition to changing standards for licensure, there seems to be a tendency toward increased vigor in the enforcement of the standards. There have been some improvements made in the investigative capabilities of licensing boards. There is also a proposal being considered that would establish a central depository of relevant information about the licensure status of physicians in all states. Clearly, licensing boards individually and collectively are intensifying their efforts to identify and prosecute physicians who are suspected of violating standards of medical practice in the community.

This gradual but definite change has begun to have effects other than the immediate and obvious ones. One of these effects is on some certification boards. At least 17 of the 23 certifying boards require licensure for certification. Several boards, including the American Board of Family Practice, require the maintenance of a full and unrestricted license to maintain Diplomacy. In some cases, loss of licensure in any state jurisdiction results in loss of Diplomacy until the license is restored, even if the Diplomate has a license in another jurisdiction.

While it does not seem unreasonable to rely on licensure boards to assess the general qualifications of a physician to practice, there are some inherent problems with this procedure. It might be unreasonable to withdraw Diplomate status from a physician who loses his license in a state that requires Medicare assignment when the physician is practicing in another state with a full and unrestricted license. In addition, physicians who are accused of violating a practice act in some jurisdiction may "plea bargain" for a temporary suspension or probation without being required to defend themselves against the allegations. Thus, it is never established whether they are guilty or innocent.

Consequently, the relation between licensure and certification becomes clouded. Perhaps it will become impossible to use licensure as a prerequisite to certification. The two processes were originally developed for different purposes. Licensure procedures generally have been intended to provide the public with assurances that a physician has met minimum training, performance, and character standards. A licensed physician should be expected to meet minimum community standards for safety and reliability commonly expected of a responsible professional.

Specialty certification is intended to identify those physicians who have special qualifications to practice in a certain defined area of interest in the broad field of medicine. The public should expect Diplomates to have had special training and demonstrate a significantly higher level of competence in their chosen field. It would generally seem reasonable to expect a specialist (Diplomate) to meet usual community standards as well as to possess the qualifications of a specialist.

Should physicians be designated as specialists if for any reason they do not meet licensure standards? Perhaps they could be, if the licensure standard that was violated has nothing to do with

their professional qualifications and if the public safety is not threatened.

Should licensure standards include factors that may be unrelated to professional competence, or safety? To what degree should licensure be used as a regulatory mechanism? These questions and others require careful assessment.

The interface between governmental regulation and professional self-regulation is important and sensitive. We must strive to maintain the intrinsic values of both; compromise and accommodation should not be at the expense of the general public.

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New Cover

There is an old adage, "You can't judge a book by its cover"; however, an attractive cover *does* get one's attention. All of us see many journals cross our desk, and as a reader I find that covers do indeed attract my attention. It is also acknowledged that regardless of how attractive or eye-catching a cover may be, it's the content that's important. Our goal for the *Journal of the American Board of Family Practice* (JABFP) has been and continues to be quality content, and with this issue we are introducing a new, bright, and colorful cover while at the same time maintaining quality content for family physicians.

How often have I gone to visit various programs and stressed to residents that outward appearances are important. It's the first thing the patient beholds. The appearance of being clean and neat, as well as a pleasing demeanor, produces a lasting favorable impression upon the patient. It is also true that a sloppy, unkempt physician may be very bright and caring, but to enhance the image of the specialty, we prefer bright, caring, *as well as* decently appearing physicians. So rather than adhering to the adage of not judging a book by its cover, we prefer the old Roman statement that "A good exterior is a silent recommendation."[1]

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References

1. Pubilius Syrus. Sententiae (c. 80 B.C.).

Our 20th Anniversary Year: Remembering the Willard Report

The first copy of the Willard Report[1] that came into my hands lies open on my desk. Other copies have come and gone, but this one has special meaning because it changed my life in ways I never imagined. Thumbing its pages, noticing underlined sentences, I recall the wholly unexpected feelings of illumination and conviction it produced in me in autumn 1966.

Then 38 years old, I had completed 11 years of contented general practice in Wichita, Kansas. While I prefer to remember myself as a socially concerned and politically observant physician in those days, the truth is that my focus was almost entirely local. I knew that general practice was falling on hard days; our numbers were steadily declining (although we comprised 20 percent of practicing physicians), and periodically we had a crisis meeting about hospital privileges; but none of this touched me directly.

I came upon the Willard Report as a naive reader; it was all news to me. I simply was unaware of the existence of the Ad Hoc Committee on Education for Family Practice, the Citizens' Commission on Graduate Medical Education (Millis Commission), and other national groups that were calling for changes in medical education to meet the shortage of primary, personal, and family physicians. That knowledge came after the Willard Report knocked my socks off and convinced me that I ought to become involved in educating the new breed of family physicians. What presumptuousness!

Less than a year later I had moved my practice 6 miles across town into a remodeled house and was the director of a new style family practice residency at Wesley Hospital. In spring 1968, through the benevolent sponsorship of George (Ned) Burket, I was shamelessly describing this residency before the State Officers' Convention of the American Academy of General Practice in Kansas City. I was not alone in this wild adventure; Lynn Carmichael (Miami), Eugene Farley (Rochester, N.Y.) and Roger Leinke (Oklahoma City) were doing the same things; and 11 other Willard-type residencies were developing elsewhere in the country, even at Harvard. Remembering these heady days and the ideas that used us seems appropriate in this 20th anniversary year of the American Board of Family Practice, the 20th primary specialty board, the first new one in 20 years after 1949.

The practical genius of the Willard Report was its description of the form and general content of