



# House of Delegates

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May 2, 2020

## **CHANGES TO VOTING DELEGATES**

**CHANGES TO DESIGNATED VOTING DELEGATES  
MUST BE MADE NO LATER THAN  
MIDNIGHT “CENTRAL” TIME ON APRIL 24, 2020.  
THIS WILL ALLOW TIME FOR THE NECESSARY  
TRAINING OF THE DELEGATE(S)**

**PLEASE NOTIFY IN WRITING  
HUMAYUN J. CHAUDHRY, DO, MACP,  
FSMB PRESIDENT/CEO, AT [PMCCARTY@FSMB.ORG](mailto:PMCCARTY@FSMB.ORG)  
IF A CHANGE IN THE DESIGNATION OF VOTING  
DELEGATE IS REQUIRED**

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## About the FSMB

The Federation of State Medical Boards represents the 70 state medical and osteopathic regulatory boards – commonly referred to as state medical boards – within the United States, its territories and the District of Columbia. It supports its member boards as they fulfill their mandate of protecting the public’s health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and, in most jurisdictions, other health care professionals.

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## Vision

The FSMB is an innovative leader, helping state medical boards shape the future of medical regulation by protecting the public and promoting quality health care.

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## Mission

The FSMB serves as the voice for state medical boards, supporting them through education, assessment, research and advocacy while providing services and initiatives that promote patient safety, quality health care and regulatory best practices.

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## 2015-2020 Strategic Goals



## Member State Medical and Osteopathic Boards

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Alabama Board of Medical Examiners	Nevada State Board of Osteopathic Medicine
<b>Medical Licensure Commission of Alabama**</b>	New Hampshire Board of Medicine
Alaska State Medical Board	New Jersey State Board of Medical Examiners*
Arizona Board of Osteopathic Examiners in Medicine and Surgery	New Mexico Medical Board
Arizona Medical Board	New Mexico Board of Osteopathic Medical Examiners
Arkansas State Medical Board*	New York State Board for Medicine*
Medical Board of California	New York State Office of Professional Medical Conduct
Osteopathic Medical Board of California	North Carolina Medical Board
Colorado Medical Board	North Dakota Board of Medicine
Connecticut Medical Examining Board	Commonwealth of the Northern Mariana Islands Health Care Professions Licensing Board
Delaware Board of Medical Licensure and Discipline	State Medical Board of Ohio*
District of Columbia Board of Medicine	Oklahoma Board of Medical Licensure and Supervision*
Florida Board of Medicine	Oklahoma State Board of Osteopathic Examiners
Florida Board of Osteopathic Medicine	Oregon Medical Board*
Georgia Composite Medical Board	Pennsylvania State Board of Medicine*
Guam Board of Medical Examiners	Pennsylvania State Board of Osteopathic Medicine
Hawaii Medical Board	Puerto Rico Board of Medical Licensure and Discipline
Idaho Board of Medicine	Rhode Island Board of Medical Licensure and Discipline*
Illinois Department of Financial and Professional Regulation: Division of Professional Regulation*	South Carolina Board of Medical Examiners*
Medical Licensing Board of Indiana	South Dakota Board of Medical and Osteopathic Examiners
Iowa Board of Medicine	Tennessee Board of Medical Examiners
Kansas State Board of Healing Arts	Tennessee Board of Osteopathic Examination
Kentucky Board of Medical Licensure	Texas Medical Board
Louisiana State Board of Medical Examiners*	Utah Physicians and Surgeons Licensing Board*
Maine Board of Licensure in Medicine	Utah Osteopathic Physicians and Surgeons Licensing Board
Maine Board of Osteopathic Licensure	Vermont Board of Medical Practice*
Maryland Board of Physicians*	Vermont Board of Osteopathic Physicians and Surgeons
Massachusetts Board of Registration in Medicine*	Virgin Islands Board of Medical Examiners
Michigan Board of Medicine*	Virginia Board of Medicine*
Michigan Board of Osteopathic Medicine and Surgery	Washington Medical Commission
Minnesota Board of Medical Practice*	Washington Board of Osteopathic Medicine and Surgery
Mississippi State Board of Medical Licensure	West Virginia Board of Medicine
Missouri Board of Registration for the Healing Arts	West Virginia Board of Osteopathic Medicine
Montana Board of Medical Examiners*	Wisconsin Medical Examining Board*
Nebraska Board of Medicine and Surgery	Wyoming Board of Medicine
Nevada State Board of Medical Examiners	

\*Original 1912 charter member board of the FSMB

\*\*New Member Medical Board, February 2020





## 2019-20 Board of Directors

<b>Chair</b>	<b>Scott A. Steingard, DO</b> Arizona Board of Osteopathic Examiners in Medicine and Surgery
<b>Chair-elect</b>	<b>Cheryl L. Walker-McGill, MD, MBA</b> North Carolina Medical Board
<b>Treasurer</b>	<b>Jerry G. Landau, JD</b> Arizona Board of Osteopathic Examiners in Medicine and Surgery
<b>Secretary</b>	<b>Humayun J. Chaudhry, DO, MACP</b> FSMB President and CEO
<b>Immediate Past Chair</b>	<b>Patricia A. King, MD, PhD, FAC, FACP</b> Vermont Board of Medical Practice
<b>Directors</b>	<b>Mohammed A. Arsiwala, MD</b> Michigan Board of Medicine
	<b>Jeffrey D. Carter, MD</b> Missouri Board of Registration for the Healing Arts
	<b>Jone Geimer-Flanders, DO</b> Hawaii Medical Board
	<b>Anna Z. Hayden, DO</b> Florida Board of Osteopathic Medicine
	<b>Frank B. Meyers, JD</b> District of Columbia Board of Medicine
	<b>Shawn P. Parker, JD, MPA</b> North Carolina Medical Board
	<b>Jean L. Rexford</b> Connecticut Medical Examining Board
	<b>Thomas H. Ryan, JD, MPA</b> Wisconsin Medical Examining Board
	<b>Kenneth B. Simons, MD</b> Wisconsin Medical Examining Board
	<b>Sarvam P. TerKonda, MD</b> Florida Board of Medicine
	<b>Joseph R. Willett, DO</b> Minnesota Board of Medical Practice



## Welcome New Fellows, Affiliate Member and Courtesy Members

### Fellows

#### Alabama Board of Medical Examiners

William Jay Suggs, MD  
Jane Ann Weida, MD  
Amanda Jean Williams, MD

#### Arizona Board of Osteopathic Examiners in Medicine and Surgery

Ken S. Ota, DO  
Dawn Walker, DO

#### Medical Board of California

Asif Mahmood, MD  
Eserick Watkins

#### Osteopathic Medical Board of California

Hemesh Mahesh Patel, DO

#### Colorado Medical Board

Lesley C. Brooks, MD  
Julie Ann Cortez, PA-C  
Roland Flores, Jr., MD

#### Connecticut Medical Examining Board

Shawn London, MD  
David A. Schwindt, MD

#### Delaware Board of Medical Licensure & Discipline

Ashish P. Shah, MD

#### District of Columbia Board of Medicine

Christopher Raczynski, MD  
Joelle Simpson, MD, MPH, FAAP, FACEP  
William Strudwick, MD

#### Florida Board of Medicine

Scot Ackerman, MD  
Kevin Cairns, MD  
David Diamond, MD  
Shailesh Gupta, MD  
Luz Marina Pages, MD

#### Georgia Composite Medical Board

Despina D. Dalton, MD  
Matthew W. Norman, MD

#### Guam Board of Medical Examiners

Arania Adolphson, MD  
Annie Bordallo, MD

#### Idaho Board of Medicine

Catherine Cunagin, MD  
Keith Davis, MD  
Paula Phelps, PA

#### Illinois Division of Professional Regulation - Medical Disciplinary Board

Amy J. Derick, MD  
Shami Goyal, MD  
Peter M. C. Hofmann, MD  
Umang Patel, MD  
Sreenivas Reddy, MD

#### Kansas Board of Healing Arts

Molly Black, MD  
Sherri Wattenbarger, JD

#### Kentucky Board of Medical Licensure

Mary Nan Mallory, MD  
Mark A. Schroer, MD  
Bill A. Webb, DO

#### Louisiana State Board of Medical Examiners

Patrick T. O'Neill, MD  
Leonard Weather, MD

#### Maine Board of Licensure In Medicine

Emory E. Liscord, MD

#### Maryland Board of Physicians

Scott A. Berkowitz, MD  
Victor M. Plavner, MD  
Scott R. Sauvageot  
Richard T. Scholz, MD  
Louise Phipps Senft, Esq

#### Michigan Board of Medicine

Cara Poland, MD  
Holly Gilmer, MD  
Michael Lewis, MD  
Bryan E. Little, MD  
Ali Molin, MD  
Teresa Robinson, PhD  
Angela Trepanier, MS  
Donald Tynes, MD

#### Mississippi State Board of Medical Licensure

Daniel Paul Edney, MD  
Thomas Edward Joiner, MD

#### Missouri Board of Registration For the Healing Arts

Naveed Razaque, MD  
Marc K. Taormina, MD

#### Montana Board of Medical Examiners

Molly Biehl, DO  
Ashleigh Magill, MD  
Gina Painter, DPM  
Douglas Womack, L.Ac

#### Nebraska Board of Medicine & Surgery

Brian J. Keegan, MD, FACP

#### Nevada State Board of Medical Examiners

Maggie Arias-Petrel  
Bret W. Frey, MD

#### New Hampshire Board of Medicine

Linda M. Tatarczuch, MSW

#### New Mexico Medical Board

Eric W. Anderson, MD  
Buffie Saavedra  
Mark Edward Unverzagt, MD

#### New York State Office of Professional Medical Conduct

Myra M. Nathan, PhD

#### North Carolina Medical Board

W. Howard Hall, MD  
Joshua D. Malcolm, JD  
Damian F. McHugh, MD  
Devdutta G. Sangvai, MD, MBA

#### North Dakota Board of Medicine

Lacey L. Armstrong, MD  
Darin Leetun  
Jay Metzger, PA-C  
Michael Quast, MD



**State Medical Board of Ohio**

Jonathan Fiebel, MD  
Harish Kakarala, MD

**Oklahoma Board of Medical Licensure & Supervision**

Clayton Bullard  
Jeremy Hall  
Trevor Nutt  
Don L. Wilber, MD

**Pennsylvania State Board of Medicine**

Ronald E. Domen, MD

**Pennsylvania State Board of Osteopathic Medicine**

Arlene Seid, MD

**Rhode Island Board of Medical Licensure & Discipline**

Crista Durand  
Sajeev Handa, MD  
Nancy Kirsch

**South Carolina Board of Medical Examiners**

Dion L. Franga, MD  
Theresa Mills-Floyd, MD

**South Dakota Board of Medical & Osteopathic Examiners**

Christopher T. Dietrich, MD  
Aaron B. Shives, MD  
Suzanne Veenis

**Tennessee Board of Medical Examiners**

Stephen D. Loyd, MD  
Samantha E. McLerran, MD

**Texas Medical Board**

Arun Agarwal  
Vanessa Hicks-Callaway  
Satish Nayak, MD  
Jason Tibbels, MD

**Utah Osteopathic Physicians & Surgeons Licensing Board**

Michael Derr, DO  
Tricia Ferrin, DO

**Utah Physicians & Surgeons Licensing Board**

K. Kumar Shah

**Vermont Board of Medical Practice**

Margaret Tandoh, MD

**Vermont Board of Osteopathic Physicians & Surgeons**

Jesper Brickley, DO  
Matthew Gilbert, DO

**Virgin Islands Board of Medical Examiners**

Brian C. Bacot, MD

**Virginia Board of Medicine**

Joel Silverman, MD

**Washington Medical Commission**

Diana Currie, MD  
Christine Hearst, CPMSM  
Scott Rodgers, JD  
Candace Vervair  
Richard Wohns, MD

**Washington State Board of Osteopathic Medicine & Surgery**

Trice Konschuh

**Wisconsin Medical Examining Board**

Milton Bond, Jr.  
Clarence Chou, MD  
Sumeet Goel, DO

**Staff Fellows**

**Alabama Board of Medical Examiners**

William M. Perkins

**Alaska State Medical Board**

Alysia D. Jones

**Arizona Medical Board**

Patricia E. McSorley, JD

**Arizona Board of Osteopathic Examiners in Medicine and Surgery**

Justin Bohall

**Arkansas State Medical Board**

Amy Embry

**Medical Board of California**

Christine Lally

**Osteopathic Medical Board of California**

Mark M. Ito

**Colorado Medical Board**

Paula E. Martinez, MBA

**Commonwealth of the Northern Mariana Islands Health Care Professions Licensing Board**

Esther S. Fleming

**Connecticut Medical Examining Board**

Jeffrey A. Kardys

**Delaware Board of Medical Licensure and Discipline**

Devashree M. Singh, MBA

**District of Columbia Board of Medicine**

Frank B. Meyers, JD

**Florida Board of Medicine**

Claudia Kemp, JD

**Florida Board of Osteopathic Medicine**

Kama Monroe, JD

**Georgia Composite Medical Board**

LaSharn Hughes, MBA

**Guam Board of Medical Examiners**

Zennia Cruz Pecina, MSN, RN, CCHP

**Hawaii Medical Board**

Ahlani K. Quiogue

**Idaho Board of Medicine**

Anne K. Lawler, JD, RN

**Illinois Division of Professional Regulation - Medical Disciplinary Board/ Medical Licensing Board**

Brian Zachariah, MD

**Medical Licensing Board of Indiana**

Laura Turner, JD

**Iowa Board of Medicine**

Kent M. Nebel, JD

**Kansas State Board of Healing Arts**

Tucker Poling, JD

**Kentucky Board of Medical Licensure**

Michael S. Rodman

**Louisiana State Board of Medical Examiners**

Vincent A. Culotta, Jr., MD

**Maine Board of Licensure in Medicine**

Dennis E. Smith, JD



**Maine Board of Osteopathic Licensure**

Susan E. Strout

**Maryland Board of Physicians**

Christine A. Farrelly

**Massachusetts Board of Registration in Medicine**

George Zachos, JD

**Michigan Board of Medicine**

TBD

**Michigan Board of Osteopathic Medicine and Surgery**

TBD

**Minnesota Board of Medical Practice**

Ruth M. Martinez, MA

**Mississippi State Board of Medical Licensure**

Kenneth E. Cleveland, MD

**Missouri Board of Registration for the Healing Arts**

Connie Clarkston

**Montana Board of Medical Examiners**

Samuel Hunthausen

**Nebraska Board of Medicine and Surgery**

Jesse Cushman

**Nevada State Board of Medical Examiners**

Edward O. Cousineau, JD

**Nevada State Board of Osteopathic Medicine**

Sandra L. Reed, MPA

**New Hampshire Board of Medicine**

Penny Taylor

**New Jersey State Board of Medical Examiners**

William V. Roeder, JD

**New Mexico Medical Board**

Sondra Frank, JD

**New Mexico Board of Osteopathic Medical Examiners**

Roberta Perea

**New York State Board for Medicine**

Stephen J. Boese

**New York State Office of Professional Medical Conduct**

Paula M. Breen

**North Carolina Medical Board**

R. David Henderson, JD, CMBE

**North Dakota Board of Medicine**

Bonnie Storbakken, JD

**North Dakota Board of Medicine**

Bonnie Storbakken, JD

**State Medical Board of Ohio**

Stephanie M. Loucka, JD

**Oklahoma State Medical Board of Licensure and Supervision**

Lyle R. Kelsey, MBA, CAE, CMBE

**Oklahoma State Board of Osteopathic Examiners**

TBD

**Oregon Medical Board**

Nicole A. Krishnaswami, JD

**Pennsylvania State Board of Medicine**

Suzanne M. Zerbe

**Pennsylvania State Board of Osteopathic Medicine**

Aaron Hollinger

**Puerto Rico Board of Medical Licensure and Discipline**

Norma Torres Delgado, MHSA

**Rhode Island Board of Medical Licensure and Discipline**

James V. McDonald, MD, MPH

**South Carolina Board of Medical Examiners**

Sheridon H. Spoon, Esq

**South Dakota Board of Medical and Osteopathic Examiners**

Margaret B. Hansen, PA-C, MPAS, CMBE

**Tennessee Board of Medical Examiners/Tennessee Board of Osteopathic Examination**

Angela Lawrence, MSM

**Texas Medical Board**

Stephen Brint Carlton, JD

**Utah Physicians and Surgeons Licensing Board/Utah Osteopathic Physicians and Surgeons Licensing Board**

Larry Marx

**Vermont Board of Medical Practice**

David K. Herlihy, Esq

**Vermont Board of Osteopathic Physicians and Surgeons**

Corey Young

**Virgin Islands Board of Medical Examiners**

Deborah K. Richardson-Peter, MPA

**Virginia Board of Medicine**

William L. Harp, MD

**Washington Medical Commission**

Melanie De Leon, JD, MPA

**Washington Board of Osteopathic Medicine and Surgery**

Renee Fullerton

**West Virginia Board of Medicine**

Mark A. Spangler, MA, LPC

**West Virginia Board of Osteopathic Medicine**

Jonathan T. Osborne, Esq

**Wisconsin Medical Examining Board**

Thomas H. Ryan, MPA, JD

**Wyoming Board of Medicine**

Kevin D. Bohnenblust, JD, CMBE

**Affiliate Member  
Texas Physician Assistant Board**

**Courtesy Members**

Christos Christolias, MD

Carlos Echevarria, MD

Alan Ericksen, MD

**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC.**

**HOUSE OF DELEGATES ANNUAL BUSINESS MEETING  
MAY 2, 2020**

<b>Agenda Item</b>	<b>Tab</b>
1. Call to Order, 2:00 p.m. PDT <i>Scott A. Steingard, DO, Chair</i>	
2. Roll Call of Member Boards <i>Humayun J. Chaudhry, DO, MACP, President/CEO</i>	
3. Approval of Agenda <i>Scott A. Steingard, DO, Chair</i> ▶ <b>For Action</b>	
4. Introduction of Parliamentarian and Tellers <i>Scott A. Steingard, DO, Chair</i>	
5. Welcome New Member Medical Board, Fellows, Affiliate Member and Courtesy Members <i>Humayun J. Chaudhry, DO, MACP, President/CEO</i>	
6. Report of the Rules Committee <i>Cheryl L. Walker-McGill, MD, MBA, Chair-elect</i> ▶ <b>For Action</b>	A
7. Consent Agenda <i>Scott A. Steingard, DO, Chair</i> ▶ <b>For Action</b>	B
8. Approval of Minutes of April 2019 Business Meeting <i>Scott A. Steingard, DO, Chair</i> ▶ <b>For Action</b>	C
9. Chair's Report of the Board of Directors <i>Scott A. Steingard, DO, Chair</i>	D
10. Report of the President-CEO <i>Humayun J. Chaudhry, DO, MACP, President/CEO</i>	E

11. Report on the FSMB 2015-2020 Strategic Plan F  
*Humayun J. Chaudhry, DO, MACP, President/CEO*
12. Treasurer’s Report G  
*Jerry G. Landau, JD, Treasurer*
13. Report of the Reference Committee H  
*Denise Pines, MBA*  
**► For Action**
14. Report of the Nominating Committee I  
*Patricia A. King, MD, PhD, FACP, Immediate Past Chair*
15. Elections  
*Scott A. Steingard, DO, Chair*  
**► For Action**
16. Installation of New Chair and Board Members  
*Scott A. Steingard, DO, Chair*
17. Remarks by Newly Elected Chair  
*Cheryl L. Walker-McGill, MD, MBA, FY 2021 Chair*
18. Announcement of 2021 Annual Meeting Site  
*Humayun J. Chaudhry, DO, MACP, President/CEO*
19. Adjournment, 4:30 p.m. PDT
- Appendix I – House of Delegates Meeting Guidebook J
- Appendix II – FSMB Bylaws K

**FEDERATION OF STATE MEDICAL BOARDS  
2020 ANNUAL HOUSE OF DELEGATES MEETING**

**Report of the Rules Committee**

Presented by: Cheryl Walker-McGill, M.D., MBA, Chair  
Saturday, May 2, 2020

**Attendees**

Cheryl Walker-McGill, M.D., MBA Chair  
Jimmy Adams, D.O.  
Larry Marx  
Mikal Smoker, PA-C

Linda Gage-White, M.D., Parliamentarian

Humayun J. Chaudhry, D.O., President and CEO  
Eric Fish, JD, Chief Legal Officer

Sandra McAllister, Executive Administrative Associate, recorder

Mr. Chairman, Members of the Federation of State Medical Boards:

Your Committee on Rules recommends the following:

---

1 **I. House Security:**

2  
3 Maximum security shall be maintained at all times to prevent disruptions of the Annual  
4 Business Meeting. Only those individuals with secure log-in shall be permitted to participate  
5 using an electronic platform.

6  
7 **II. Credentials:**

8  
9 Only those voting representatives registered as remote participants shall be allowed to cast  
10 votes using remote electronic means. Voting credentials cannot be transferred from the  
11 official voting delegate to another after the meeting is called to order.

12  
13 **III. Order of Business:**

14  
15 The agenda as published in the delegate's handbook shall be the official agenda for the  
16 Annual Business Meeting. This may be modified by the presiding officer or by majority vote  
17 of the House.

18  
19 **IV. Privilege of the Floor:**

20  
21 All classes of membership shall have the right of the floor at meetings of the House upon  
22 request of a delegate and approval of the presiding officer. The presiding officer shall have  
23 the discretion to structure and limit discussion, as needed for the orderly conduct of the  
24 meeting.

25

26 **V. Procedures of the Annual Business Meeting:**

27

28 The presiding officer shall appoint tellers for the purpose of assisting in the election process  
29 and certification of votes. In appointing a teller, the presiding officer may appoint any  
30 individual who can confirm accuracy of any electronic balloting as a teller. Tellers shall not  
31 be designated voting delegates at the Annual Business Meeting.

32

33 The presiding officer shall appoint a parliamentarian to advise on all procedural questions  
34 using the Federation Bylaws and *American Institute of Parliamentarians Standard Code of*  
35 *Parliamentary Procedure*, current edition. The parliamentarian may not participate in the  
36 general discussion but only advise on procedural issues when there is a dispute or question.

37

38 All issues not decided by voice vote shall be decided by electronic balloting. In the event  
39 electronic balloting is not possible because of technical or other reasons, voting  
40 representatives participating using the remote electronic platform shall communicate their  
41 vote through an electronic communication to a teller.

42

43 **VI. Nominations:**

44

45 The report of the Nominating Committee is presented as a list of candidates and does not  
46 require a second. At an appropriate time, the presiding officer shall introduce all nominations  
47 for office. Candidates for officers, directors, and the Nominating Committee must be Board  
48 Member Fellows at the time of election.

49

50 **VII. Elections:**

51

52 The elections shall be conducted in accordance with the Bylaws of the Federation. The  
53 presiding officer may call for a vote at any time during the meeting.

54

55 If there is only one candidate for office, then that individual shall be declared elected by  
56 acclamation.

57

58 Election to an officer/director slot requires a majority of the votes cast and all other elected  
59 positions shall be elected by a plurality vote. A majority is one more than one-half (1/2) of  
60 the number of delegates voting. A plurality vote is more votes than the number received by  
61 any other candidate.

62

63 In the event any slot on the Board of Directors is vacated by previous election or other reason,  
64 the full term at-large slots are to be filled first, concurrently, with the ballot including the  
65 names of all candidates running for the at-large positions. Following election of the full term  
66 at-large positions, the partial term at-large positions shall be filled individually, with the  
67 slate(s) including the remaining at-large candidates.

68

69 When it is necessary to meet the minimum Bylaws requirement for election of a non-  
70 physician director, election of a non-physician director from the field of non-physicians shall  
71 precede election of other at-large candidates to the Board of Directors. Non-physician



72 candidates not elected to the required seat shall join the slate of physician candidates for the  
73 remaining at-large positions on the Board of Directors. The same procedures shall be used for  
74 election of the Nominating Committee.

75  
76 If more than one seat on the Board of Directors is to be filled from a single list of candidates,  
77 and if one or more seats are not filled by majority vote on the first ballot, a runoff election  
78 shall be held with the ballot listing candidates equal in number to twice the number of seats  
79 remaining to be filled. These candidates shall be those remaining who received the most  
80 votes on the first ballot. The same procedures shall be used for any subsequent runoff  
81 elections.

82  
83 In the event of a deadlock, or tie for a single position, up to two additional runoff elections  
84 shall be held. Prior to each election, the presiding officer shall cast a sealed vote that shall be  
85 counted only to resolve a tie that cannot be decided by these additional runoff elections.

86  
87 The top vote getters shall be elected until all positions are filled when the position requires  
88 election by a plurality vote.

89  
90 A legal ballot shall be one that is 1) communicated electronically, 2) marked with the legible  
91 name of a qualified candidate(s) in that election, or 3) sent via text message by remote  
92 participant to a preassigned teller.

93  
94 A ballot containing votes for more than the number of positions to be filled is invalid.

95  
96 A ballot containing more than one vote for the same person is invalid.

97  
98 Proxies - In accordance with *American Institute of Parliamentarians Standard Code of*  
99 *Parliamentary Procedure*, current edition, no proxies shall be accepted in the voting process.

100  
101 The presiding officer shall announce the election results as soon as appropriate.

102  
103 I want to thank the committee participants.

104  
105

106 Respectfully submitted,

107



108 Cheryl Walker-McGill, M.D., MBA

109 Chair

110

**TAB B: Consent Agenda**

**MANAGEMENT NOTE:**

The following items are included on the Consent Agenda:

1. Report on the American Board of Medical Specialties (ABMS)
2. Report on the Accreditation Council for Continuing Medical Education (ACCME)
3. Report on the Accreditation Council for Graduate Medical Education (ACGME)
4. Report on the National Board of Medical Examiners (NBME)
5. Report on the National Commission on Certification of Physician Assistants (NCCPA)

**ITEM FOR ACTION:**

**APPROVE the Consent Agenda for the May 2, 2020 House of Delegates meeting.**

**Tab B: Report of the American Board of Medical Specialties (ABMS)**

**MANAGEMENT NOTE:**

Jeffrey D. Carter, MD is the FSMB representative to the American Board of Medical Specialties.

The following pages contain the report on the ABMS as well as an overview of the ABMS and its relationship with the FSMB.

**ITEM FOR ACTION:**

**No action required; report is for information only.**



American Board of Medical Specialties  
 353 North Clark Street, Suite 1400  
 Chicago, IL 60654  
 T: (312) 436-2600  
 F: (312) 436-2700

[www.abms.org](http://www.abms.org)

## American Board of Medical Specialties Report to the Federation of State Medical Boards April 2020

This report highlights activities of the American Board of Medical Specialties (ABMS) since its last report to the House of Delegates of the Federation of State Medical Board (FSMB) in March 2019.

### Navigating the Impact of COVID-19

On March 13, ABMS sent the following statement to designated institutional officials regarding the Coronavirus Disease 2019 (COVID-19):

ABMS and its 24 Member Boards appreciate the extraordinary efforts of our specialty medical professionals and trainees who are working tirelessly to treat and monitor those exposed to or diagnosed with COVID-19, and we recognize the associated enhanced health risks and the potential for training disruptions. As with others in our community, our primary concern is for the health and well-being of these individuals and patients and the desire to maintain a strong and effective health care workforce. In most cases, specialty boards' existing leave policies will cover training disruptions caused by quarantine, and boards are supportive of creative strategies to recognize learning opportunities that can take place during such times. In situations in which quarantine impedes completion of on-time training, boards are receptive to case-by-case discussions and do not wish to penalize trainees for situations beyond their control. We encourage those with questions to [contact their respective ABMS Member Board](#) for details and updates regarding COVID-19 related leave policies and the status of board examinations.

In a subsequent [statement](#) issued March 26, ABMS affirmed its support for physicians to focus on their patient care priorities as the demands of COVID-19 accelerate.

Member Boards have been working with their specialty societies to support learning about COVID-19 and have made appropriate adjustments to program requirements and deadlines. In addition, ABMS has been working with the Accreditation Council on Graduate Medical Education (ACGME) to minimize the disruption for incoming and graduating residents and fellows.

### Physician Board Certification on the Rise

More than 900,000 physicians in the United States are board certified—up 2.5 percent from last year—and more than half of those are from just 10 states. These are just a few insights to be found in the latest [ABMS Board Certification Report](#). The 2018-2019 ABMS Board Certification Report offers a variety of information about the 40 specialty and 87 subspecialty certification programs administered by the 24 Member Boards that comprise ABMS. This 58-page report also includes a snapshot of the active certificates held by ABMS Member Board certified physicians by state. Colorful charts and infographics break down important data, such as state-by-state listings of the number of board certified physicians in each specialty. A table illustrates approved Focused Practice Designations by Member Board. Published annually, the ABMS Board Certification Report can be downloaded for free from the [ABMS website](#). This report reflects information reported by the 24 ABMS Member Boards and data from the ABMS certification database, which contains more than one million records. The database is updated

daily with information received from Member Boards and is considered a primary source for professional certification verification.

### **ABMS, NBME Co-host Professionalism Symposium**

ABMS and the National Board of Medical Examiners (NBME) co-hosted the [Symposium on Professionalism: Advancing Assessment of Professionalism in Continuing Certification](#) on September 22, 2019 in Chicago. The Symposium, which included nationally recognized leaders in the areas of professional self-regulation, assessment, education, and remediation, including Patricia King, MD, PhD, then-Chair of FSMB, focused on assessing professionalism through continuing certification. A proceedings paper detailing the discussions and insights garnered from the Symposium will be available in 2020. In attendance at the Symposium were members of the ABMS Professionalism Task Force, which held its first in-person meeting on September 23. The Task Force is charged with developing new standards for the evaluation of “Professional Standing” – understood to refer to the affirmation of the professional integrity of physicians by authorities that regulate or assess physician competence, including state licensing boards and credentialing organizations – and professionalism – understood as a competency domain reflecting a physician’s commitment to a belief system and set of behaviors that place the patient’s welfare above his or her own self-interest. The Task Force will be reviewing and proposing revisions to current policies and recommending approaches to the formative assessment of professionalism in future programs of continuing board certification.

### **ABMS Collaborates with Associate Members to Co-sponsor 2019 IAMRA Symposium**

ABMS would like to thank FSMB for being a supporting sponsor of the 2019 International Association of Medical Regulatory Authorities’ (IAMRA) Symposium on Continued Competency, which ABMS co-hosted with ACGME, NBME, and the Educational Commission for Foreign Medical Graduates. ABMS also thanks the American Osteopathic Association for co-sponsoring the event. The theme of the invitation-only [Symposium](#) held September 9-10 in Chicago is *Continued Competency: Balancing Assurance and Improvement* and focused on balancing assurance and improvement in systems of continued competency. The Symposium brought together leading experts in medical professional regulation from around the world to discuss crucial issues facing today’s medical regulators.

### **ABMS, ACGME Host Resident/Fellow Parental, Family Leave Workshop**

ABMS and ACGME hosted a workshop on resident/fellow parental and family leave in February in Chicago. Residents and fellows, representatives of ABMS Member Boards, members of the ACGME’s Residency Review Committees, physician parents, trainees without children, and researchers in the areas of physician wellness and maternal health were among the individuals who convened to provide insights and best practices regarding parental and family leave for residents and fellows. Among the topics discussed were the current state of parental leave for residents and fellows, institutional challenges, program concerns, and the importance of creating a culture of support for parents and families. The workshop concluded with a special panel presentation of leaders from the American Board of Surgery, the American Board of Anesthesiology, and three training programs, who discussed how they overcame roadblocks to develop exemplary policies for their residents requesting leave. Workshop discussions will help inform policies on parental and family leave being developed by ABMS and ACGME task forces. Final policies are expected to be released by both organizations later this year.

### **Task Forces Continue Work Toward New Standards for Continuing Certification**

ABMS has convened five Task Forces to bring physician and public input to the implementation of recommendations made by the Continuing Board Certification: Achieving the Vision (Commission). The ABMS Member Boards are committed to developing new standards to guide their programs and have agreed to use the Commission recommendations as a guide to significantly overhaul their programs for continuing board certification. The Task Forces will address Commission recommendations relating to

remediation, advancing practice, professionalism, and data sharing. A Standards Task Force has committed to revising ABMS standards for continuing certification, which will be available for public comment later this year. [Learn who is serving on the Task Forces](#). Visit [Achieving the Vision](#) to learn the latest information and [download a PDF](#) or view the [video](#) recapping these changes.

The Professionalism Task Force has divided its work into two phases. In Phase I, the Task Force is developing recommendations for new policy to govern board changes in certification taken in response to actions taken by state medical boards (SMBs) or other authorities that signal a breach of professionalism, specifically those that reflect a risk to patients or that signify a threat to the trustworthiness of the physician. The Task Force is examining the ABMS licensure policy to clarify the core requirement and how the boards should address self-imposed practice limitations, alternative forms of licenses, and participation in therapeutic interventions through Physician Health Programs. The Task Force recommendations will be addressed in new standards for the boards. Reflecting that a successful effort will require coordination with FSMB and SMBs, Jeffrey Carter, MD, FSMB Board of Directors, has been added as a member of the Professionalism Task Force.

### **CertLink Longitudinal Assessment Programs Increase Learning and Retention**

[CertLink®](#) is a technology platform that supports online assessment programs designed to support physician professional development and learning. It is based on [longitudinal assessment](#), a method for enhancing the acquisition and retention of knowledge over time. Content for longitudinal assessment programs covers knowledge and clinical judgment in core and practice-specific areas as well as safety priorities in the discipline, emerging science, and important public health topics. The CertLink platform incorporates approaches to delivering the content that reinforce learning and retention, helping physicians to demonstrate the knowledge and clinical skills necessary to maintain board certification. The convenient, online, platform permits physicians to choose when, where, and how they are assessed.

The American Board of Physical Medicine and Rehabilitation (ABPMR) recently published [a study](#) demonstrating that physicians who participated in its longitudinal assessment, which uses the CertLink platform, performed better on its 10-year examination than non-participants. ABPMR decided to replace its 10-year exam with longitudinal assessment after [completing a one-year pilot](#) in 2019. The American Board of Medical Genetics and Genomics (ABMGG) [also will be replacing its 10-year, secure exam with CertLink](#), following a successful pilot program. In 2020, ABMGG began enrolling all board certified medical geneticists participating in its continuing certification program into CertLink. Five additional Member Boards are piloting longitudinal assessments using CertLink: American Boards of Colon and Rectal Surgery, Dermatology, Nuclear Medicine, Otolaryngology – Head and Neck Surgery, and Pathology.

To date, board certified physicians have answered more than one million questions across the seven Member Boards. Overall, participants have given CertLink a 97 percent approval rating.

### **Further Research Highlights Association of Certification with Lower Risk of Disciplinary Actions**

Board certified physicians have been shown by several studies to be at lower risk of receiving a disciplinary action (DA) from an SMB. New research confirms this finding, and four recently published studies add to the growing research specifically addressing participation in continuing certification. These studies of physicians certified in Anesthesiology, Emergency Medicine, Physical Medicine and Rehabilitation, and Surgery add to prior research showing similar results in Family Medicine, Internal Medicine, and Surgery.

A [study published](#) in *JAMA Surgery* analyzed severe DAs by licensing boards for 44,290 physicians who

attempted to become board certified from 1976 through 2017 based on certification status and examination performance. The incidence of severe license actions was significantly greater for surgeons who attempted and failed to obtain certification than surgeons who were certified. Adjusting for sex and international medical graduate status, the risk of receiving a severe license action across time was also significantly greater for surgeons who failed to obtain certification. Surgeons who progressed further in the certification exam sequence and surgeons with fewer repeated exams had a lower incidence and less risk over time of receiving severe license actions.

In a [study published](#) in *Anesthesia & Analgesia*, all anesthesiologists with time-limited certificates who were required to register for the American Board of Anesthesiology's (ABA's) web-based longitudinal assessment, known as MOCA Minute®, in 2016 were followed through Dec. 31, 2016. Of the 20,006 anesthesiologists in the study, 245 (1.2%) had a cumulative incidence of license actions. Non-registration and late registration for the MOCA Minute were associated with a higher incidence of license actions. Conversely, timely participation and meeting the performance standard for the MOCA Minute were associated with a lower likelihood of being disciplined by an SMB. The study results suggest that these attributes serve as markers for physician characteristics associated with lower risk of such actions.

A [historical cohort study](#) published in the *Journal of Emergency Medicine* compared physicians who did not have a lapse in certification by the American Board of Emergency Medicine (ABEM) with those who did to determine the risk of DA. Lapsing was determined at the expiration of the initial certificate. The study included all physicians who obtained initial ABEM certification from 1980 to 2005. Of the 23,002 physicians in the study, 3,370 (14.7%) let their certification lapse after initial certification. There were 701 (3.0%) physicians with DAs. Lapsed physicians had higher rates of DAs than physicians who did not lapse (6.4% vs. 2.5%). ABEM certified physicians who did not lapse were significantly less likely to be disciplined as physicians who let their certificate lapse.

A [retrospective cohort study](#) published in the *American Journal of Physical Medicine and Rehabilitation* analyzed ABPMR Maintenance of Certification (MOC) data from all board certified physiatrists who were enrolled in the ABPMR MOC program from 1993 to 2007. Matching examination and license data were available for 4,794 physicians, who received a total of 212 DA reports through FSMB. Physicians in PM&R who have a lapse in completing ABPMR's MOC program had a 2.5-fold higher incidence of receiving a DA and had higher severity violations than physicians whose certificate never lapsed.

These studies add to the growing literature demonstrating the association between ABMS board certification and higher quality, safer care, which support the public trust in certification by an ABMS Member Board.

### **ABMS Names Senior Vice President, Certification Standards and Programs**

ABMS has named Greg Ogrinc, MD, MS, its Senior Vice President of Certification Standards and Programs. In this role, Dr. Ogrinc will oversee all aspects of the ABMS program of certification, including initial certification and continuing certification. He will provide strategic leadership for the ongoing evolution and implementation of ABMS' board certification standards and programming. Dr. Ogrinc also will serve as the primary external medical expert regarding ABMS and its Member Boards' certification processes and policies. Dr. Ogrinc previously served as the Senior Associate Dean for Medical Education at Geisel School of Medicine at Dartmouth College and as a hospitalist at the White River Junction (WRJ) VA Medical Center in Vermont. Among his many leadership positions, he served as the Associate Chief of Staff for Education at WRJ and a Senior Scholar for its Quality Scholars program. Dr. Ogrinc is internationally known as a medical education innovator who is dedicated to improving the quality of care delivered by board certified physicians. [Read more.](#)

### **ABMS Invites Applications for 2020–2021 Visiting Scholars Program**

ABMS is accepting applications for the 2020-2021 [ABMS Visiting Scholars Program](#)<sup>™</sup>. The ABMS Visiting Scholars Program positions early-career physicians, and others with relevant advanced degrees, as future health care leaders. The program facilitates research in areas relevant to physician assessment, performance and quality improvement, continuing professional development, and initial and continuing certification. The one-year, part-time program provides the Visiting Scholars with opportunities to:

- Conduct research of value to their programs and organizations
- Develop professional relationships with ABMS and its Member Boards, and other leading professional health care organizations
- Have their work nationally recognized and disseminated

Remaining at their home institutions and organizations, the Visiting Scholars participate in program webinars and pursue their research projects in collaboration with identified mentors. They also attend two, three-day meetings with ABMS and Member Board leaders and the leadership of ABMS Associate Members, among others. Once the year is over, scholars can continue their ties with the Boards Community through an alumni network. Visiting Scholars will receive a financial award of \$12,500 to support their research and program participation. The Visiting Scholars Program is open to early-career physicians; junior faculty; fellows; residents; and individuals holding a master or doctorate degree in public health, health services research, public health policy, and administration or other related disciplines. Applications must be received by 5:00 pm (CT) on June 5, 2020. [Read more about the program and the application process.](#)

For more information on any topics outlined in this report, please contact Tom Granatir, Senior Vice President for Policy and External Relations, at (312) 436-2683 or [tgranatir@abms.org](mailto:tgranatir@abms.org).

###



**American Board of Medical Specialties (ABMS)**

(3-year term)

Jeffrey D. Carter, MD

Missouri, 1<sup>st</sup> term, Exp. 4/21

As the umbrella organization of the 24 allopathic medical specialty boards in the United States, ABMS assists its Member Boards in their efforts to develop and implement educational and professional standards for the evaluation, assessment, and certification of physician specialists. It also provides information to the public, the government, and the profession, as well as its Member Boards about issues involving specialization and certification in medicine. The mission of ABMS is to serve the public and the medical profession by improving the quality of health care through setting professional and educational standards for medical specialty practice and certification in partnership with its Member Boards.

The governing body of each Member Board comprises specialists qualified in the specialty represented by the board. They also include representatives from among the national specialty organizations in related fields. The individual Member Boards evaluate physician candidates who voluntarily seek certification by an ABMS Member Board. To accomplish this function, the Member Boards determine whether candidates have received appropriate preparation in approved residency training programs in accordance with established educational standards, evaluate candidates with comprehensive examinations, and certify those candidates who have satisfied the board requirements. Physicians who are successful in achieving Board Certification are called diplomates of their respective specialty board.

In 2000, the Member Boards agreed to evolve their recertification programs to one of continuous professional development through the ABMS Program for Maintenance of Certification (MOC). The MOC program is built upon the six competencies developed in conjunction with ACGME in the areas of practice-based learning and improvement, patient care and procedural skills, systems-based practice, medical knowledge, interpersonal and communication skills, and professionalism. All ABMS Member Boards' MOC programs measure these competencies using a variety of activities within a four-part framework that emphasizes professionalism and professional standing; lifelong learning and self-assessment; assessment of knowledge, judgment, and skills; and improvement in medical practice. In 2019, ABMS announced plans to implement recommendations from the Continuing Board Certification: Vision for the Future Commission's final report.

ABMS also maintains a website ([www.certificationmatters.org](http://www.certificationmatters.org)) for consumers to find out whether their physician is Board Certified.

FSMB and ABMS collaborated to create the Disciplinary Action Notification Service, a service by which information regarding licensing and certification is regularly shared and exchanged between the two organizations.

ABMS is located at: 353 North Clark Street, Suite 1400, Chicago, IL, 60654

Phone: (312) 436-2600

Website: [www.abms.org](http://www.abms.org)

President and CEO: Richard E. Hawkins, MD

**Tab B: Report of the Accreditation Council for Continuing Medical Education (ACCME)**

**MANAGEMENT NOTE:**

Linda Gage-White, MD, PhD, MBA and Michael D. Zanolli, MD, serve as the FSMB representatives to the Accreditation Council for Continuing Medical Education (ACCME). Dr. Gage-White is serving her final term and will reach maximum tenure in December 2020. Dr. Zanolli, who was elected Chair of the ACCME in December 2019, is serving his final term on the Board and will reach maximum tenure in December 2021.

The following pages contain the report on the ACCME as well as an overview of the ACCME and its relationship with the FSMB.

**ITEM FOR ACTION:**

**No action required; report is for information only.**

## FSMB HOUSE OF DELEGATES

### Report of the FSMB Representatives to the ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION (ACCME)

APRIL 2020

The ACCME provides voluntary accreditation to those providers of continuing medical education (CME) who wish to be recognized for meeting the ACCME's high level of quality. Recently, the ACCME adopted new vision and mission statements. ACCME's **vision** is a world where our community of educators supports clinicians in developing optimal healthcare for all. ACCME's **mission** is to assure and advance quality learning for healthcare professionals that drives improvements in patient care. The ACCME fulfills its mission through a voluntary self-regulated system for accrediting CME providers and a peer-review process responsive to changes in medical education and the health care delivery system.

There are seven (7) member organizations of the ACCME:

- American Board of Medical Specialties
- American Hospital Association
- American Medical Association
- Association for Hospital Medical Education
- Association of American Medical Colleges
- Council of Medical Specialty Societies
- Federation of State Medical Boards of the United States

The ACCME consists of representatives of these organizations, as well as a Federal Government Representative and a Public Representative. The FSMB is working to assure the pertinence of accreditation of CME as a trusted source on behalf of its member boards that require CME and utilize ACCME.

Linda Gage-White, MD, PhD, MBA, and Michael D. Zanolli, MD, serve as the FSMB representatives to the Accreditation Council for Continuing Medical Education (ACCME). Dr. Gage-White is serving her final term and will reach maximum tenure in December 2020. Dr. Zanolli, who was elected Chair of the ACCME in December 2019, is serving his final term on the Board and will reach maximum tenure in December 2021.

include the following:

- In March 2020, the ACCME created its COVID-19 Clinician Resources and COVID-19 Educator Resources webpages. These webpages include a list of accredited CME activities and additional resources designed to help CE providers and the clinician community respond to the novel coronavirus (COVID-19) public health emergency.
- ACCME continues to expand its state medical board pilot program to enable CME providers to report physician participation in accredited CME directly to the Boards via ACCME's Program and Activity Reporting System (PARS.) State medical boards currently participating in the

project include Maine Board of Licensure in Medicine, Maine Board of Osteopathic Licensure, North Carolina Medical Board and the Tennessee Board of Medical Examiners.

- ACCME made a number of enhancements to its PARS reporting system in early 2020 to allow for improved file uploading and formatting of learner data.
- In January 2020, the ACCME invited stakeholders to participate in a call for comment about the proposed revisions to the rules that protect the independence and integrity of accredited CME. FSMB provided comments in support of many of the revisions and offered feedback and suggestions for improving some of the proposed revisions. Once the ACCME Board of Directors reviews and adopts the revised standards, the ACCME will release a transition plan for the accredited continuing education community.
- In November 2019, FSMB's CME Story titled *Taking Aim at Sexual Boundary Violations in the Profession* was accepted for inclusion as a poster into ACCME's 2020 Annual Meeting.
- In October 2019, the ACCME released its *Learning Together: Engaging Patients as Partners in Accredited Continuing Medical Education – Report*. The report offers educators strategies and tips for engaging patients as partners in planning and teaching continuing medical education (CME). Through their participation, patients can increase the meaning, relevance, and effectiveness of CME and contribute to improving care for patients and communities.
- In July 2019, the ACCME published its *ACCME Data Report: Growth and Advancement in Accredited Continuing Medical Education – 2018*. This report included data from a community of 1,750 accredited organizations that offer physicians, other healthcare professionals, and healthcare teams an array of continuing education (CE) resources to promote high-quality, safe, and effective care for patients.

More information on these highlights as well as a summary of Board actions and key issues can be found by visiting <http://www.accme.org/>

It has been a distinct and ongoing privilege to be associated with this exemplary organization. Dr. Graham McMahon and his outstanding staff perform above and beyond expectations, and I am grateful to the FSMB for providing me this opportunity to serve.

Respectfully submitted,

Linda Gage-White, MD, PhD, MBA  
Michael D. Zanolli, MD

**Accreditation Council for Continuing Medical Education (ACCME)**  
(may serve two 3-year terms)

Linda Gage-White, MD, PhD, MBA  
Michael D. Zanolli, MD (ACCME Chair)

Louisiana, 2<sup>nd</sup> term, Exp. 12/20  
Tennessee-Medical, 2<sup>nd</sup> term, Exp.12/21

**ACCME Accreditation Review Committee (ARC)**

(initial term —2 years/2<sup>nd</sup> term specified by ACCME Board/no person may serve more than six years)

Bruce Brod, MD (PA State Board of Medicine)  
Crystal Gyiraszin  
Paul J. Lambiase (New York OPM)

2<sup>nd</sup> term, Exp. 12/21  
3<sup>rd</sup> term, Exp. 12/21  
3<sup>rd</sup> term, Exp. 12/20

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- Federation of State Medical Boards of the United States

The Accreditation Council consists of representatives of these organizations, as well as two Federal Government Representatives and two Public Representatives. The FSMB is working to assure the pertinence of accreditation of CME as a trusted source on behalf of its member boards that require CME and utilize ACCME.

The ARC is one of three working committees that reports to the ACCME Board of Directors and is made up of representatives of the CME community. The ARC reviews and evaluates national CME providers coming forward for accreditation and re-accreditation. The ARC also makes recommendations to the Board of Directors regarding accreditation policy development.

The ACCME is located at: 401 N. Michigan Avenue, Suite 1850, Chicago, IL, 60611  
Phone: (312) 527-9200  
Fax: (312) 410-9026  
Web site: [www.accme.org](http://www.accme.org)

Chief Executive Officer: Graham T. McMahon, MD, MMSc,

Last Updated March 30, 2020

**Tab B: Report on the Accreditation Council for Graduate Medical Education (ACGME)**

**MANAGEMENT NOTE:**

Kenneth B. Simons, MD, is the FSMB representative to the Accreditation Council for Graduate Medical Education.

The following pages contain the report on the ACGME as well as an overview of the ACGME and its relationship with the FSMB.

**ITEM FOR BOARD ACTION:**

**No action required; report is for information only.**

## **FSMB HOUSE OF DELEGATES**

### **Report of the FSMB Representatives to the ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME)**

**MAY 2020**

The ACGME Plenary meeting was held at the ACGME Headquarters in Chicago, Illinois on February 3, 2020. The meeting began with approval of the meeting minutes of the prior plenary session held on September 29, 2019. A report was received from the Veterans Health Administration (VA) representative. Dr. Bowman noted that the VA was moving to the Cerner EHR and that its increased security was impacting the ability of trainees to logon to the system. The VA is desirous of allowing trainees to practice across state lines via telehealth and is planning to dramatically expand telehealth. It was noted that 1300/1500 VACCA residency training positions had been allocated, with the remaining anticipated to be distributed over the next two years. It also was noted that this is the 75th year of VA education. An issue that was problematic for the VA is that J-1 visa holders are unable to supervise other trainees.

The Executive Committee reported that its work had been focusing on strategic planning and other generative matters as well as an appeal from Hahnemann University Hospital.

The Awards Committee brought forth recommendations for awardees that the Board approved. The Committee developed diversity and inclusion awards (two) for institutions that will be awarded at the 2021 Annual Education Conference.

The Audit Committee approved the audit plan and at its 6/20/19 meeting had a presentation on a strategic framework with recommendations made that will be vetted by management. The Committee also received the results of a gender equity pay study that revealed no issues. Finally, the Committee is reviewing enterprise risk management.

The Committee on Requirements (CoR) presented 26 focused revisions and 11 major revisions to the Board, which were approved. A subcommittee of the CoR approved standard language for program directors, associate program directors and program coordinators. In addition, the Committee noted that core faculty support must be in FTE's for consistency. The Fellow Faculty survey is going to all faculty and the Committee asked leadership to look at this. The CoR also noted that there had been a trend toward changing detailed requirements to core and as such, will be noting its concerns about this to the Monitoring Committee as detailed requirements were put in to allow for innovation.

The Education Committee noted that the upcoming Annual Education Conference (AEC) in San Diego would be having 15 sessions on well-being. The 2021 AEC is scheduled to be in Nashville, Tennessee.

The Finance Committee noted that total assets increased by 8.3% and net assets by 13.3%. Income was 0.5% favorable to budget. Net assets were \$65M as of 12/31/19. It was reported that the move to the new headquarters came in at \$8M under budget.

The Governance Committee reported that the final changes to the Bylaws resulting from the Single Accreditation System was being sent to the member organizations for approval. The Committee conducted an on-boarding of new members and, for the first time, asked them on which committees they were interested in serving. The Committee also reviewed Board member surveys and noted that the survey of the Chair was very positive.

The Journal Oversight Committee report from the Editor-in-Chief revealed that greater than 1,000 submissions had been received with a 13.5% acceptance rate. Podcasts of editorials have been launched and the journal will be having sessions at the upcoming AEC. There will be a supplement on Milestones and the Committee is discussing allowing online access to associate program directors, program coordinators, residents and fellows.

The Monitoring Committee noted that Anesthesiology Hospice and Palliative Care would be reviewed by the Internal Medicine Review Committee. Furthermore, the Committee was still having discussions with the Council of Review Committee Chairs noting that 100% of the Review Committees had adopted having Public Members, although Allergy & Immunology, Colon & Rectal Surgery and Ophthalmology still had vacancies. It was stated that the Orthopedic Review Committee and the Anesthesiology Review Committee were each granted a delegation of 10 years. A draft of the Neurology 10-year review is expected to be finalized soon and then sent to the Review Committee.

The Policy Committee noted it had a parental leave conference coming up and that they are reviewing two policies: gun violence and sexual misconduct. The Committee determined that it was not the role of the ACGME to add/set curricular requirements as this belonged in the purview of programs, the certifying board and the specialty societies. The Board adopted this recommendation. The Committee also noted that it received a request from the Society of Addiction Medicine requesting the ACGME sign on in support of a US House of Representatives bill on opioid addiction/pain management. The Committee did not endorse this request but was supportive of sending a letter to the bill sponsors regarding the elements that could be supported.

The Council of Public Members advised that they had selected a Vice Chair and that the group was looking at the ACGME strategic plan. They also noted that they were learning about milestones, well-being and the Hahnemann University Hospital situation.

The Council on Review Committee Residents revealed they were in the process of planning for Cycle 2 of the Back to Bedside initiative and that they were developing a video to bust myths on what the residents on the ACGME Review Committees do.

Closing remarks were made by the CEO and the Board Chair, which included a Board resolution honoring Ms. Paige Amidon on her retirement from the ACGME.

The meeting was the adjourned.

Respectfully submitted,

Kenneth B. Simons, MD



**Accreditation Council for Graduate Medical Education (ACGME)**  
(3-year term)

Kenneth B. Simons, MD

Wisconsin, 1<sup>st</sup> term, Exp. 4/21

The ACGME is responsible for the accreditation of postgraduate medical training (PGT) programs within the United States. Accreditation is accomplished through a peer-review process and is based upon established standards and guidelines. The mission of the ACGME is to improve the quality of health care in the U.S. by assessing and advancing the quality of resident physicians' education through accreditation. The ACGME establishes national standards for graduate medical education by which it approves and continually assesses educational programs under its aegis. It uses the most effective methods available to evaluate the quality of graduate medical education programs. It strives to improve evaluation methods and processes that are valid, fair, open and ethical.

In carrying out these activities, the ACGME is responsive to change and innovation in education and current practice, promotes the use of effective measurement tools to assess resident physician competency, and encourages educational improvement.

In 1999, the ACGME endorsed six general competencies for residents in the areas of: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Identification of general competencies was the first step in a long-term effort designed to emphasize educational outcome assessment in residency programs and in the accreditation process. The ACGME now requires residency programs to teach and assess residents on these six general competencies. These competencies have also been adopted by the American Board of Medical Specialties (ABMS) as the foundation for its Maintenance of Certification (MOC) program.

The ACGME and the graduate medical education community have made significant advances over recent years to transition to an accreditation model that encourages excellence and innovation.

- A single GME accreditation system is being implemented to allow graduates of allopathic and osteopathic medical schools to complete their residency and/or fellowship education in ACGME-accredited programs, and demonstrate achievement of common Milestones and competencies. This helps address the increasingly varied and complex medical care needed in both rural and urban American settings.
- The current model of accreditation has shifted emphasis from "time served" and compliance with minimum standards to competency-based assessment facilitated by monitoring and evaluating real-time data that tracks residents' and fellows' education and achievements.
- The ACGME Requirements have historically included standards to address physician well-being, but in recent years the organization has increased its focus on this issue, recognizing it is crucial to the ability of physicians to deliver the safest, best possible care to patients.

The FSMB has worked closely with the ACGME to expedite the verification of PGT for credentialing of physicians for licensure. FSMB has designed a web-based, secure verification process to expedite the process with input from ACGME. FSMB is also encouraging the ACGME to rapidly notify the FSMB of PGT programs that have been closed or are closing. To date, FSMB has obtained the resident records from 256 PGT programs that have closed and is the Agent of Record for those programs. FSMB encouraged ACGME to assure accreditation of combined training programs or to discontinue combining these programs. Internal Medicine/Pediatrics combined training programs are accredited by the ACGME. All other combined programs are accredited by the ACGME independently, i.e., each component program is independently accredited by the ACGME.

The ACGME is located at: 401 North Michigan Avenue, Suite 2000, Chicago, IL, 60611

Phone: (312) 755-5000

Fax: (312) 755-7498

Chief Executive Officer: Thomas J. Nasca, MD, MACP

Email: c/o Melissa Dyan Lynn (Executive Asst. to the CEO) – [mdl@acgme.org](mailto:mdl@acgme.org)

Web site: [www.acgme.org](http://www.acgme.org)

**Tab B: Report on the National Board of Medical Examiners (NBME)**

**MANAGEMENT NOTE:**

Drs. Arthur Hengerer, Patricia King, Ralph Loomis, Gregory Snyder and Cheryl Walker-McGill serve as FSMB representatives to the National Board of Medical Examiners (NBME).

The following pages contain the report on the NBME as well as an overview of the NBME and its relationship with the FSMB.

**ITEM FOR BOARD ACTION:**

**No action required; report is for information only.**

# FSMB HOUSE OF DELEGATES

## REPORT OF THE REPRESENTATIVES TO NBME

APRIL 2020



### INTRODUCTION

The Federation of State Medical Boards (FSMB) enjoys a strong, collaborative relationship with NBME. The following report summarizes the progress achieved through our engagements and assessment improvements for the United States Medical Licensing Examination® (USMLE®). These and other updates to programs, services, recognition, grants, and assessment-related research are included in the *2019 NBME Annual Report: Collaboration* found online at [NBME.org](http://NBME.org).

### REFLECTION AND VISION

**“We remain more committed than ever to innovating and improving through collaborative exchanges, contributions to enhance the science of assessment, and programs that further support the community.”**

-Peter J. Katsufarakis, MD, MBA, President and Chief Executive Officer, NBME

Medical education and patient care are rapidly changing. NBME aims to continuously evolve to meet the near-term and future needs of our customers. Progress last year included strategies to benefit our community:

- NBME embraced collaboration with many health care community members and subject-matter experts.
- NBME actively evaluated input from students, residents, educators, physicians, patient advocates, and regulators, whose insight and honesty were invaluable.
- NBME aligned its organization to drive transformative initiatives for improved assessment design, delivery, and product management.
- NBME enhanced and improved its infrastructure to make assessments easier to take and deliver, with many more enhancements in the works.

### USMLE

NBME enjoys working with the FSMB on creating the USMLE. Through our work writing, designing, and modernizing this essential assessment with upgraded technology, we’re committed to providing an optimized tool for licensure decision-making to aid in the next generation of medical professionals.

In February 2020, the USMLE program announced three future policy changes:

- Changing Step 1 score reporting from a three-digit numeric score to reporting only pass/fail
- Reducing the allowable number of exam attempts on each Step or Step Component from six to four
- Requiring all examinees to successfully pass Step 1 as a prerequisite for taking Step 2 Clinical Skills

Decisions were based on the 2019 **Invitational Conference on USMLE Scoring (InCUS)** which reviewed the USMLE program’s practice of numeric score reporting within the context of its primary use of initial medical licensure. The secondary use of scores, such as residency selection, was also discussed. The meeting was co-sponsored by the FSMB, NBME, the American Medical Association (AMA), Association of American Medical Colleges (AAMC), and the Educational Commission for Foreign Medical Graduates (ECFMG). Areas of consensus include:

- The current medical school-to-residency transition is not meeting stakeholders’ needs
- Unilateral changes to USMLE will not “fix” the entire system
- Changes—both systemic and specific to USMLE—must be explored, identified, and implemented on a reasonable time line.

[Four preliminary recommendations](#) emerged from InCUS that begin to address the complex challenges of a flawed system of residency selection. A [summary of themes](#) from public commentary that followed was published on USMLE.org in fall 2019. These documents illustrate valuable input to inform efforts of the FSMB, NBME, and other partner organizations as we continue this vital dialogue.

The **Medical Student and Resident Advisory Panel**, which includes US and international medical students and residents, met twice in 2019. Topics the panel addressed include **USMLE scoring policies; medical student stress and burnout; and Step 2 Clinical Skills (CS) examinee score report redesign.**

The **State Board Advisory Panel**, composed of staff and members from the FSMB and other important licensing authorities, met once in 2019. In 2019, this group discussed:

- USMLE policy issues
- The 2019 *Annual Report on USMLE to Medical Licensing Authorities in the US*
- The Invitational Conference on USMLE Scoring and USMLE score reporting
- Content coverage on USMLE exams

Following data review and discussion, the **USMLE Management Committee** raised the recommended **Step 3 minimum passing score from 196 to 198**. This decision took effect on January 1, 2020.

To continue improving the USMLE, NBME worked on the **redesign of score reports** again in 2019. A primary goal of the redesign is to provide as much meaningful and useful information as possible to examinees. Step 3 examinees saw the redesigned score report in 2018, and Step 1 and Step 2 Clinical Knowledge (CK) examinees began receiving new reports in early 2019. A redesigned version of the Step 2 Clinical Skills (CS) examinee score report will launch in the first half of 2020.

## POST-LICENSURE ASSESSMENT SYSTEM (PLAS)

**PLAS**, a joint venture of the FSMB and NBME, assists medical licensing authorities in assessing the competency of previously licensed physicians who have fallen out of practice for personal or disciplinary reasons. PLAS includes the **Special Purpose Examination (SPEX)**, which was administered to 96 examinees in the United States in 2019.

- In 2019, **the new SPEX examination was released**; it's shorter in length by 2 ½ hours, and the content focuses on tasks that physicians perform in practice (i.e.,

competencies for practice) and less on disease mechanisms.

- The PLAS program continues to provide **a toolbox of assessment services to third-party collaborators** at eight different locations.

## NBME 2019 ANNUAL REPORT SUMMARY:

### IMPROVING ASSESSMENT THROUGH RESEARCH & DEVELOPMENT

To keep pace with rapid changes both in medical education and the delivery of patient care, NBME innovates to create new products and enhance existing ones. In doing so, NBME better meets the needs of customers. In 2019, collaborations with University of Wolverhampton and the University of Pennsylvania allowed **NBME's Center for Advanced Assessment** to develop capabilities based on Natural Language Processing (NLP). These capabilities have led to improved assessment practices:

- **Computer-assisted scoring** of the patient note for USMLE Step 2 Clinical Skills Examination
- **Automatic generation of multiple-choice question distractors**—incorrect yet plausible alternatives to the correct answer—can facilitate the item writing process. NLP enables review of existing test content and the generating of a list of distractors.
- **Identifying items that should not be placed on the same test form** because of an overlap in content can be done using NLP-based procedures.

In 2019, **Psychometrics and Data Analysis** staff worked to enhance assessment-related products and services, inform best practices, and promote evidence-based decisions about students and health care professionals:

- NBME researchers have led, independently or together with collaborating organizations, a number of **studies around fairness and equity in assessment.**
- NBME has continued to support medical specialty boards by assessing the degree that performance on USMLE and in-training examinations **predicts success on respective board certification examinations.**

## CONTRIBUTING TO MEDICAL SCHOOLS, STUDENTS, & FACULTY

Health care educators and medical students receive support from NBME through several avenues. Two opportunities for medical educators available through the **Strategic Educator Enhancement Fund (SEEF)** are the **NBME Invitational Conference for Educators (NICE)** and the **SEEF Medical Education Research Fellowship**.

- **NICE** fosters skill development in assessment and provides a networking venue for medical school faculty. The second of these conferences was held in Indianapolis, Indiana, on May 15-16, 2019; 240 medical faculty participated.
- The **SEEF Medical Education Research Fellowship** was introduced in 2019 and is a project-based faculty development program. The fellowship provides an opportunity for medical school faculty to develop skills in medical education and assessment research for those who have committed to working with a team of interested colleagues. Eight individuals have been selected to form the inaugural cohort.

NBME facilitated approximately **30 in-person and virtual workshops** in 2019 for medical school faculty and others. The workshops helped faculty increase their knowledge, skills, and utilized tools to improve their own assessments.

**2020 marks the 25<sup>th</sup> year of the Stemmler Fund.** The fund promotes advancements in theory, knowledge, or practice of assessment along the continuum of medical education. Plans are in place to acknowledge and celebrate the contributions by grant recipients since its inception in 1995.

## SERVICES TO THE MEDICAL EDUCATION COMMUNITY

Technology is an essential component of the products and services NBME provides. In 2019, we refreshed our technological infrastructure to benefit users in multiple ways:

- NBME **replaced its assessment media player** with more modern capabilities.
- **Surpass** is an innovative and advanced **content management system** that enables subject-matter experts to securely submit their test items and associated content.

The [Customized Assessment Services \(CAS\)](#) program

allows faculty to build high-quality, standardized assessments targeted to local curricula using secure NBME test questions. NBME introduced the redesigned CAS system in July 2019 to enable medical educators to build better exams that reflect today's classroom demands and integrated curricula. Using the system, approximately 2,000 examinations were created and administered to more than 140,000 examinees in 2019. Key features include:

- **User-friendly interface** enables easy navigation of the entire exam-build
- **Keyword search function** helps users find test questions faster
- **New clinical and basic science content** allows exam building that integrates both content areas

NBME continues to improve the examinee experience for [NBME Self-Assessments](#). In 2019, NBME redesigned its score reports for the **Comprehensive Basic Science Self-Assessment (CBSSA)** and **Comprehensive Clinical Science Self-Assessment (CCSSA)** to include a more modern feel as well as more meaningful performance feedback.

[NBME Subject Exams](#) assist educators in measuring students' understanding of critical medical knowledge in foundational and clinical sciences, as well as identifying areas for improvement. Used in assessment throughout medical school curricula, subject exams saw modest growth in 2019 with the total number of exams administered domestically and internationally exceeding 277,000.

In 2019, several Comprehensive Basic Science Self-Assessment forms of the **NBME Self-Assessments** series were released to help examinees correctly identify their strengths and address more challenging areas. In 2020, students can look forward to begin seeing answer explanations on test forms.

Work continues on the inaugural **Re-examining Exams: NBME Effort on Wellness (RENEW) task force**, which is aimed to address the challenge of physician wellness and to acknowledge the stress caused by working in the health professions that begins during the educational and training processes.

Based on feedback from students and residents through focus groups and pilot trials, **MyNBME** went live in February 2019. **MyNBME** enables users to more easily register, purchase, and view assessments and improves how exam feedback is accessed.



## SERVICES TO THE HEALTH PROFESSIONS ORGANIZATIONS

[NBME works with organizations](#) that address medical issues of our time. NBME develops and administers assessments that support education, training, and credentialing that lead to competent practitioners at the forefront of important medical advances:

- NBME's work developing and administering **In-Training Examinations (ITEs)** serves medical residents, fellows, and anesthesiology assistants.
- By working with numerous credentialing boards for medical and other health professions, NBME develops, delivers, and scores over **30 certifying examinations**.
- In the beginning of 2020, NBME announced it will transition away from domestic, high-stakes, point-in-time certification exams to sharpen its focus on **current and evolving needs for in-training-focused assessments**, as well as to explore new methods of assessment for healthcare professionals.

## COLLABORATION FOR VETINARY ASSESSMENTS

The **North American Veterinary Licensing Examination® (NAVLE®)**, co-sponsored and co-owned by the International Council for Veterinary Assessment (ICVA) and NBME, is a requirement for licensure to practice veterinary medicine in all licensing jurisdictions in North America. The assessment recorded 6,173 total examinees with a pass rate of nearly 80%.

## SERVICES TO THE INTERNATIONAL COMMUNITY

The goal of **NBME's global initiatives** is to foster an international understanding of the value of high-quality assessment in evaluating educational programs and assessing knowledge, as well as to serve medical schools and other organizations in improving their healthcare assessment systems. Examples include Subject examinations, [Customized Assessment Services \(CAS\) self-assessments](#), the [International Foundations of Medicine® program \(IFOM®\)](#), and other collaborations with international organizations.

Recent work includes 31 international medical schools using IFOM and 21 using CAS in 2019. In addition, the FSMB

and NBME collaborated on an essential assessment with the [Health Professions Council of South Africa \(HPCSA\)](#) that debuted to 221 candidates in August 2019.

## CONCLUSION

NBME is looking forward to a continued thoughtful and productive partnership with the FSMB. Both organizations are excited for a 2020 marked by meaningful collaboration.

For additional information, feel free to reach out to **Barbara Del Duke**, Director of Communications, at 215-495-6743 or [BDelDuke@nbme.org](mailto:BDelDuke@nbme.org).

Respectfully submitted,

Freda Bush, MD  
Arthur S. Hengerer, MD  
Ralph Loomis, MD  
Gregory Snyder, MD  
Cheryl L. Walker-McGill, MD, MBA

### **National Board of Medical Examiners (NBME)**

Arthur S. Hengerer, MD  
 Patricia A. King, MD, PhD, FACP  
 Ralph C. Loomis, MD  
 Gregory B. Snyder, MD  
 Cheryl L. Walker-McGill, MD

New York PMC, 2<sup>nd</sup> term, Exp. 3/21  
 Vermont Medical, 1<sup>st</sup> term, Exp. 3/23  
 North Carolina, 1<sup>st</sup> term, Exp. 3/21  
 Minnesota, 1<sup>st</sup> term, Exp. 3/21  
 North Carolina, 1<sup>st</sup> term, Exp. 3/21

The NBME protects the public health through state-of-the-art assessment of health professionals. While centered on assessment of physicians, its mission encompasses the spectrum of health professionals along the continuum of education, training and practice and includes research in evaluation as well as development of assessment instruments. NBME programs and services include:

- The United States Medical Licensing Examination (USMLE), co-sponsored with FSMB.
- Testing, educational, consultative and research services to a number of medical specialty boards, societies and health sciences organizations.
- Intramural research in the fields of clinical skills assessment, advanced methods of testing, and ongoing studies of the validity and reliability of NBME examination programs.
- A medical school liaison program, which fosters communication between the NBME and medical schools, academic societies, and medical student organizations concerning preparation for the USMLE.
- The Post-Licensure Assessment System (PLAS), a joint program of NBME and FSMB to assist medical licensing authorities in assessing physicians who have already been licensed.

The approximately 80 members of the National Board constitute its governing body, composed of individuals with responsibility and expertise in the health professions, medical education and evaluation, medical practice, National Board test committee representatives, and representatives of national professional organizations and the public. The quarter of the National Board members represented by other organizations includes individuals from the US Air Force, Army, Navy, Public Health Service, Veterans Affairs, the FSMB, the Association of American Medical Colleges, the ABMS, the AMA, the Council of Medical Specialty Societies, the American Medical Student Association, the Student National Medical Association, and the AMA-Resident Physicians Section.

In 2004, the NBME, in collaboration with the FSMB and ECFMG, incorporated a clinical skills assessment into the USMLE Step 2. In 2009, the NBME created a permanent International Collaborations unit as part of international endeavors. In 2014, the FSMB and NBME revised and renewed their contract for the USMLE. In 2019, NBME acted as one of the co-sponsors of the Invitational Conference on USMLE Scoring (InCUS).

The NBME is located at: 3750 Market Street, Philadelphia, PA, 19104-3102.

Phone: (215) 590-9500

Fax: (215) 590-9755

Web site: [www.nbme.org](http://www.nbme.org)

President/CEO: Peter Katsufakis, MD

**Tab B: Report on the National Commission on Certification of Physician Assistants (NCCPA)**

**MANAGEMENT NOTE:**

Peggy Riley Robinson, MS, MHS, PA-C is the FSMB representative to the National Commission on Certification of Physician Assistants.

The following pages contain the report on the NCCPA as well as an organizational summary of the NCCPA.

**ITEM FOR BOARD ACTION:**

**No action required; report is for information only.**





**Report of FSMB Representative to the  
National Commission on Certification of Physician Assistants**  
*Submitted March 2020*

NCCPA is the national certifying body for Physician Assistants (PAs) in the United States. Every state, the District of Columbia, and the U.S. territories have chosen to rely on NCCPA as a criterion for initial licensure. Eighteen states require the PA-C credential for re-licensure as do most employers and many payers.

Since 2014, I have served as a member of the NCCPA Board of Directors in a position dedicated for a nominee of the FSMB, and I am pleased to provide this report on the decisions and activities of the last year that should be of interest to FSMB members.

**Alternative to PANRE Pilot Launch**

The alternative to PANRE pilot successfully launched in January 2019 and will be conducted over two years (2019-2020). More than half of all eligible PAs (those due to recertify in 2018 and 2019) elected to participate. Ninety-eight percent of the PAs who were eligible and participating at the start of the PANRE pilot in January 2019 remain in the pilot at the beginning of January 2020.

Participants answer twenty-five core medical knowledge test questions each quarter, receiving immediate feedback on each question and additional educational information about the topic. This strategy enables participants to continue to demonstrate current medical knowledge, utilizing any web accessible device. Participants are also asked to provide their feedback throughout the process, which will help inform the Board's consideration of PANRE, after the pilot period ends. We hope this approach proves to be a less stressful, more impactful approach to gauging maintenance of knowledge over time.

**2019 Annual Report from the NCCPA Review Committee**

Throughout 2019, 1048 cases for disciplinary action, requests for exception to policy, requests for re-establishment of eligibility for certification and complaints from Physician Assistants were reviewed by NCCPA staff. Per policy, the NCCPA Review Committee is seated annually to review cases presented on appeal by Physician Assistants, which totaled 15 in 2019. During the February board meeting the Chair of the Review Committee provided an overview of the Review and Appeals process and a comprehensive report of cases and conditions addressed by the NCCPA staff and the Review Committee.

**Other Highlights**

- NCCPA continues to **enforce its Code of Conduct** and to communicate with FSMB and with state licensing boards about disciplinary actions taken against PAs. In 2019, NCCPA revoked certification in 28 cases and issued 37 letters of censure.

- 2020 launches NCCPA's three-year global initiatives strategic plan. Its mission is to facilitate development of adaptable certification processes to enhance the provision of quality healthcare globally and continue to participate in global activities that are consistent with NCCPA's Purpose and Passion.
- The nccPA Health Foundation ([www.nccpahealthfoundation.net](http://www.nccpahealthfoundation.net)) continues to pursue its mental and oral health initiatives. The Foundation has awarded dozens of grants in 2019 which have supported PA-led efforts to promote skin cancer prevention, childhood nutrition, exercise, oral health, human trafficking awareness, and care for the rural, underserved. In 2020, the Health Foundation will increase available funding.
- NCCPA continues to house and support the PA History Society ([www.pahx.org](http://www.pahx.org)). In 2018 the PA History Society facilitated a successful inaugural 2-day *PA Historian Boot Camp*. Since then, additional 1-day and 2-day Boot Camps took place in 2019 at AAPA and PAEA conferences and at NCCPA headquarters, with additional Boot Camps being planned for 2020. The objective of the Boot Camps is to teach PAs how to save, study and share the story of their institutional history and the legacy of the PA profession, in addition to establishing a cohort of faculty to be future historians. Category 1 CME has been awarded to this initiative for a third year. In November 2019, the NCCPA Board of Directors purchased the remaining 16 available brick pavers for the PA Veterans Garden, located at the Stead Center in Durham, North Carolina.

It is an honor to serve in the FSMB seat on the NCCPA Board of Directors. Please feel free to contact me ([peggy.robinson@duke.edu](mailto:peggy.robinson@duke.edu)) or NCCPA's president and CEO, Dawn Morton-Rias, Ed.D, PA-C ([dmorton-rias@nccpa.net](mailto:dmorton-rias@nccpa.net)) with your comments or questions about anything contained in this report.

Respectfully submitted,



Peggy R. Robinson, MS, MHS, PA-C  
March 2020

**National Commission on Certification of Physician Assistants  
(4-year Term)**

Peggy Riley Robinson, MS, MHS, PA-C

North Carolina, 2nd term, Exp. 12/21

Established as a not-for-profit organization in 1975, the National Commission on Certification of Physician Assistants (NCCPA) is the only certifying organization for physician assistants (PAs) in the United States.

NCCPA's purpose is to provide certification programs that reflect standards for clinical knowledge, clinical reasoning and other medical skills and professional behaviors required upon entry into practice and throughout their careers as physician assistants. The NCCPA certification process requires formal collegiate education at an accredited PA educational program, examination (Physician Assistant National Recertification Exam--PANCE), and ongoing pursuit of continuing medical education (certification maintenance) as well as recertification by examination (Physician Assistant National Recertification Exam--PANRE). More than 131,000 PAs are certified today.

NCCPA is governed by a Board of Directors that includes PA, physician and public directors-at-large and individuals nominated from the FSMB and other national organizations including:

- American Medical Association
- American Osteopathic Association
- American Academy of Physician Assistants
- Physician Assistant Education Association

The alternative to PANRE Pilot, that will allow eligible PAs to answer core medical knowledge questions over time, from any device, successfully launched in January 2019. The PANRE Pilot will run for two years. Of the 32,045 eligible PAs, over 18,000 are enrolled in the Pilot.

In addition to conferring the Physician Assistant – Certified (PA-C) credential, NCCPA also offers Certificates of Added Qualifications (CAQ) to provide an additional, optional credential for certified PAs practicing in Cardiovascular and Thoracic Surgery, Emergency Medicine, Nephrology, Orthopaedic Surgery, Psychiatry, Pediatrics and Hospital Medicine.

NCCPA continues to enforce its Code of Conduct and to communicate with FSMB and with state licensing boards about disciplinary actions taken against PAs.

Leveraging its extensive database on certified PAs, NCCPA publishes a host of statistical reports on the profession available on NCCPA's website ([www.nccpa.net](http://www.nccpa.net)).

NCCPA is located at 12000 Findley Road, Suite 100, Johns Creek, GA, 30097-1409.  
Phone: 678-417-8100 Fax: 678-417-8135 Email: [nccpa@nccpa.net](mailto:nccpa@nccpa.net) Website: [www.nccpa.net](http://www.nccpa.net)

**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC.**

**DRAFT**

**MINUTES**

**Saturday, April 27, 2019  
Fort Worth, Texas**

Call to Order

The annual business meeting of the House of Delegates was called to order at 2:03 p.m. on Saturday, April 27, 2019, at the Omni Fort Worth Hotel by FSMB chair Patricia A. King, MD, PhD, FACP.

Roll Call

The roll was called by Humayun J. Chaudhry, DO, MS, MACP, MACOI, president and chief executive officer. Member boards represented by voting delegates were:

Alabama	Louisiana	Ohio
Alaska	Maine-Medical	Oklahoma-Medical
Arizona-Medical	Maine-Osteopathic	Oklahoma-Osteopathic
Arizona-Osteopathic	Massachusetts	Oregon
California-Medical	Michigan-Medical	Pennsylvania-Medical
California-Osteopathic	Michigan-Osteopathic	Puerto Rico
Colorado	Minnesota	Rhode Island
Connecticut	Mississippi	Tennessee-Medical
Delaware	Missouri	Tennessee-Osteopathic
District of Columbia	Montana	Texas
Florida - Medical	Nebraska	Utah-Medical
Florida-Osteopathic	Nevada-Medical	Utah-Osteopathic
Georgia	Nevada-Osteopathic	Vermont-Medical
Guam	New Hampshire	Virgin Islands
Hawaii	New Jersey	Virginia
Idaho	New Mexico-Medical	Washington-Medical
Illinois	New York Medical	Washington-Osteopathic
Indiana	New York-PMC	West Virginia-Medical
Iowa	North Carolina	West Virginia - Osteopathic
Kansas	North Dakota	Wisconsin
Kentucky	Northern Mariana Islands	Wyoming

Upon completion of the roll call, it was determined that a quorum was established.

Agenda

The agenda of the April 27, 2019 House of Delegates annual business meeting was reviewed. No corrections to the agenda were noted.

50 **ACTION: APPROVED the agenda of the April 27, 2019 House of Delegates annual**  
51 **business meeting.**

52  
53 Announcement of Parliamentarian and Tellers

54  
55 Dr. King announced Linda Gage White, MD as parliamentarian. Ester S. Fleming  
56 (Commonwealth of the Northern Mariana Islands) and Patricia E. McSorley, JD (Arizona Medical  
57 Board) were appointed as tellers.

58  
59 Welcome New Fellows, Affiliate Members and Official Observers

60  
61 Dr. Chaudhry welcomed new FSMB Fellows, Affiliate Members and Official Observers in  
62 attendance.

63  
64 Report of the Rules Committee

65  
66 The House of Delegates was presented with the report of the Rules Committee, which met on  
67 Wednesday, April 17, 2019 and was chaired by Scott A. Steingard, DO. No changes were  
68 requested and the report was approved as presented.

69  
70 **ACTION: APPROVED the report of the Rules Committee.**

71  
72 Consent Agenda

73  
74 The Consent Agenda was provided to the House of Delegates. No changes were noted and the  
75 Consent Agenda was accepted as presented.

76  
77 **ACTION: ACCEPTED the Consent Agenda.**

78  
79 Minutes

80  
81 Minutes of the April 28, 2018 House of Delegates annual business meeting were reviewed. No  
82 corrections to the minutes were noted.

83  
84 **ACTION: APPROVED the minutes of the April 28, 2018 House of Delegates annual**  
85 **business meeting.**

86  
87 Report of the FSMB Chair

88  
89 Dr. King presented the Chair's Report highlighting the FSMB initiatives and programs during her  
90 year as chair of the FSMB board of directors.

91  
92 Report of the President

93  
94 Dr. Chaudhry gave his Report of the President, which summarized the FSMB's activities during  
95 the past year in the Texas and Washington, D.C. offices. Dr. Chaudhry also introduced and thanked  
96 FSMB staff for their hard work on this year's Annual Meeting.

97  
98  
99

100 Report on the FSMB Strategic Plan

101

102 Dr. Chaudhry referred the House of Delegates to the written report on the FSMB Strategic Plan  
103 provided to them in their meeting materials.

104

105 Treasurer’s Report

106

107 Jerry G. Landau, JD, FSMB Treasurer, provided the Treasurer’s Report highlighting the activities  
108 of the Investment, Finance and Audit Committees this past year. The proposed FY 2020 budget  
109 was also discussed and presented for approval.

110

111 **ACTION: APPROVED the proposed FY 2020 FSMB budget as recommended.**

112

113 Report of the Reference Committee A

114

115 William K. Hoser, MS, PA-C, Reference Committee A committee member, presented the  
116 Committee’s report on behalf of chair, Darren R. Covington, JD. The Committee met on Friday,  
117 April 26 at 8 am in Fort Worth Ballroom 5 of the Omni Fort Worth Hotel in Fort Worth, Texas  
118 and considered three items of business brought before the House of Delegates for action.

119

120 **1. Report of the Bylaws Committee**

121

122 The Bylaws Committee, chaired by Katie L. Templeton, JD, met on November 5, 2018, to consider  
123 the current Bylaws, three proposed changes to the Bylaws, and make recommendations for any  
124 other necessary changes. In keeping with its charge, the Committee also discussed the FSMB  
125 Articles of Incorporation as they relate to the Bylaws. Members of the Committee included:  
126 Michael G. Chrissos, MD; W. Reeves Johnson, Jr., MD; Frank B. Meyers, JD; and Mark D.  
127 Olszyk, MD, MBA. Ex officio members included FSMB Chair Patricia A. King, MD, PhD, FACP;  
128 FSMB Chair-elect Scott A. Steingard, DO; and FSMB President-CEO Humayun J. Chaudhry, DO,  
129 MACP.

130

131 The House of Delegates was asked to consider two (2) amendments to the Bylaws as recommended  
132 by the Committee.

133

134 **PROPOSED BYLAWS AMENDMENT #1 is as follows:**

135

136 Amend **Article IV. Board of Directors** as follows:

137

138 Section A. Membership and Terms

139

140 1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, nine Directors-  
141 at-Large and two Staff Fellows. At least ~~two~~ **three** members of the Board, who are not  
142 Staff Fellows, shall be non-physicians, at least ~~one~~ **two** of whom shall be serv**ing on a**  
143 Member Medical Board as a public ~~consumer~~ member.

144

145 2. NOMINATION OF STAFF FELLOWS: Nominations for Staff Fellow positions shall be accepted  
146 from Member Boards, the Board of Directors and the Administrators in Medicine. Staff  
147 Fellows shall be appointed by the Board of Directors in staggered terms in accordance with  
148 policies and procedures established by the Board of Directors.

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3. TERMS: Directors-at-Large shall each serve for a term of three years and shall be eligible to be reelected to one additional term. Staff Fellows shall serve for a term of two years and shall be eligible to be reappointed to one additional term. A partial term totaling one-and-a-half years or more shall count as a full term.

A member of the 2019 Bylaws Committee presented the Bylaws Committee’s recommendations to and testified in favor of proposed Bylaws Amendment #1, summarizing the Committee’s discussion and conclusions outlined in Bylaws Proposal #1 of the Committee’s report. It was noted the Committee considered three proposals that represented three different perspectives on the same issue raised by the Tennessee Board of Medical Examiners in 2017, namely, how to increase public member participation on the FSMB Board of Directors and ensure that the voices of the various stakeholders in medical regulation, including the public/consumers, are well represented in FSMB governance. Due to the related nature of the three proposals, the Committee considered the proposals jointly, while acknowledging the merits of each, but ultimately came up with its own recommendation as presented, thus improving the ability of the FSMB Board of Directors to mirror the composition of its Member Medical Boards and ensure the organization provides greater opportunities for the public voice to be part of its governance, without explicitly defining the term “public member” in the Bylaws, which the Committee believed would be problematic.

The FSMB Board of Directors testified in support of proposed Bylaws Amendment #1; however, the Board suggested that a slight modification to the proposed amendment be made that would bring more alignment between the intent of the proposal and the current definition of Fellow in the Bylaws. The Board recommended the proposed amendment be modified to clarify that the two public member positions on the Board would not be restricted to public members who are *currently* serving on a Member Medical Board, but would be open to *all* public members who fit the definition of a Board Member Fellow as defined in the Bylaws, that is, public members who are serving on a Member Medical Board and for a period of 36 months thereafter.

The Reference Committee heard no further testimony.

Reference Committee A carefully considered the testimony it received and recommended that Amendment #1 be adopted as amended:

**Article IV. Board of Directors:**

Section A. Membership and Terms

1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, nine Directors-at-Large and two Staff Fellows. At least ~~two~~ **three** members of the Board, who are not Staff Fellows, shall be non-physicians, at least ~~one~~ **two** of whom shall be servng on a Member Medical Board as a public ~~consumer~~ member.
2. NOMINATION OF STAFF FELLOWS: Nominations for Staff Fellow positions shall be accepted from Member Boards, the Board of Directors and the Administrators in Medicine. Staff Fellows shall be appointed by the Board of Directors in staggered terms in accordance with policies and procedures established by the Board of Directors.
3. TERMS: Directors-at-Large shall each serve for a term of three years and shall be eligible to be reelected to one additional term. Staff Fellows shall serve for a term of two years and

199 shall be eligible to be reappointed to one additional term. A partial term totaling one-and-  
200 a-half years or more shall count as a full term.

201  
202 **ACTION: As recommended by the Reference Committee, Bylaws Amendment #1 as**  
203 **contained in the Report of the Bylaws Committee was ADOPTED AS AMENDED.**  
204

205 **PROPOSED BYLAWS AMENDMENT #2 is as follows:**

206  
207 Amend **Article IV. Board of Directors** as follows:

208  
209 Section C. Election of Directors-at-Large

- 210 1. At least three of the Directors-at-Large shall be elected each year at the Annual Meeting of  
211 the House of Delegates by a majority of the votes cast.
- 212  
213 2. If no candidate receives a majority of the votes on the first ballot, and one seat is to be  
214 filled, a runoff election shall be held between the two candidates who received the most  
215 votes on the first ballot.
- 216  
217 3. If more than one seat is to be filled from a single list of candidates, and if one or more seats  
218 are not filled by majority vote on the first ballot, a runoff election shall be held, with the  
219 ballot listing candidates equal in number to twice the number of seats remaining to be filled.  
220 These candidates shall be those remaining who received the most votes on the first ballot.  
221 The same procedure shall be used for any required subsequent runoff elections. In the event  
222 of a tie vote in a runoff election up to two additional runoff elections shall be held.  
223
- 224 4. Prior to the election, the presiding officer shall cast a sealed vote, ranking each candidate  
225 in a list. The presiding officer's vote is counted for the candidate in the runoff election who  
226 is highest on the list. The presiding officer's vote is counted only to resolve a tie that cannot  
227 be decided by the process set forth in this section.
- 228  
229 5. Directors shall assume office upon final adjournment of the Annual Meeting of the House  
230 of Delegates at which they were elected.
- 231  
232 6. Only an individual who is a **Board Member** Fellow at the time of the individual's election  
233 shall be eligible for election as a Director of the FSMB.
- 234

235 A member of the 2019 Bylaws Committee testified in favor of proposed Bylaws Amendment #2,  
236 summarizing the Committee's discussion and conclusion outlined in Bylaws Proposal #2 of the  
237 Committee's report and noted the amendment clarified that it is a Board Member Fellow, not Staff  
238 Fellow, who is eligible for election.

239  
240 A member of the FSMB Board of Directors testified in support of proposed Bylaws Amendment  
241 #2.

242  
243 The Reference Committee heard no further testimony.

244 Reference Committee A carefully considered the testimony it received and recommended  
245 proposed Amendment #2 to the FSMB Bylaws as contained in the Report of the Bylaws



246 Committee be adopted. The Committee further recommended the corresponding amendment to  
 247 Article VIII, Section H(2) of the FSMB Bylaws be changed for purposes of uniformity:

248

249 **ELECTION:** At least three Fellows shall be elected at each Annual Meeting of the House of  
 250 Delegates by a plurality of votes cast, each to serve for a term of two years. Only an individual  
 251 who is a **Board Member** Fellow at the time of the individual’s election shall be eligible for  
 252 election as a member of the Nominating Committee.

253 **ACTION:** As recommended by the Reference Committee, Bylaws Amendment #2 as  
 254 contained in the Report of the Bylaws Committee was **ADOPTED**.

255

256 **ACTION:** As recommended by the Reference Committee, its proposed amendment to  
 257 Bylaws Article VIII, Section H(2) was **ADOPTED**.

258

259 **2. BRD RPT 19-2: Report on Resolution 18-1: Acute Opioid Prescribing Guidelines**

260

261 In April 2018, Resolution 18-1: Acute Opioid Prescribing Workgroup and Guidelines was  
 262 submitted by the State Medical Board of Ohio and called for the creation of a workgroup and  
 263 model guidelines. In lieu of Resolution 18-1, the 2018 House of Delegates adopted the following  
 264 substitute resolution:

265

266 *Resolved, that the Federation of State Medical Boards (FSMB) perform a comprehensive*  
 267 *review of acute opioid prescribing patterns, practices, federal laws and*  
 268 *guidance (including Centers for Disease Control and Prevention guidelines),*  
 269 *state rules and laws across the United States, available data, and present a*  
 270 *report to the House of Delegates at the Annual Meeting in 2019.*

271

272 BRD RPT 19-2 was a status report on the work that had been completed and the data collected to  
 273 date to fulfill the charge of the resolution. The report concluded that the FSMB will continue to  
 274 provide resources to its Member Medical Boards on best practices and guidelines for addressing  
 275 substance use disorder and create a new platform on the FSMB’s website dedicated to opioid  
 276 prescribing (both acute and chronic). The dedicated website will consist of the findings in this  
 277 report and promote the FSMB’s *Guidelines for the Chronic Use of Opioid Analgesics*, the FSMB’s  
 278 *Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office*, and any  
 279 other model guidelines released by various agencies and organizations. Additionally, during the  
 280 FSMB’s Annual Meetings, sessions and forums will be held on the opioid crisis with presentations  
 281 by state medical boards on their response to the epidemic.

282

283 A member of the FSMB Board of Directors testified the Board approved BRD RPT 19-2 and  
 284 recommended the report be filed for information.

285

286 The Chair of the Texas Medical Board asked that the FSMB consider adding to the website  
 287 materials released by the FDA and CDC, particularly as they relate to the unintended consequences  
 288 of forced-tapering and the misinterpretation of the CDC’s guidelines. The Chair of the Texas  
 289 Medical Board also requested that the FSMB monitor legislation allowing pharmacists and others  
 290 to alter prescriptions or make changes to dosing that might allow them to engage in the practice of  
 291 medicine.

292

293 A representative of the State Medical Board of Ohio testified in support of the report.

294

295 A representative of the Washington Medical Commission asked the FSMB to include a model set  
296 of acute prescribing rules or other information to highlight the pitfalls of allowing pharmacists to  
297 partially fill prescriptions.

298

299 Reference Committee A heard no further testimony.

300

301 **ACTION: No action required; report was for Information Only**

302

303 **3. Resolution 19-1: Correlation Between Licensee USMLE or COMLEX Passage Attempt**  
304 **Rate and Reports of State Medical Board Discipline**

305

306 Resolution 19-1, offered by the Minnesota Board of Medical Practice, reads as follows:

307

308 *Resolved, that the FSMB will establish a task force to study existing licensing regulations*  
309 *on USMLE and COMLEX passage rate attempts, time duration to USMLE and*  
310 *COMLEX passage, and subsequent medical board discipline, medical*  
311 *malpractice claims, and other measures of clinical aptitude; and*

312

313 *Resolved, that the FSMB task force will evaluate whether mandatory limitations on USMLE*  
314 *and COMLEX passage attempts and/or limitations to the time duration to*  
315 *USMLE and COMLEX step passage correlate with a decrease in future medical*  
316 *board disciplinary action, medical malpractice claims, and other measures of*  
317 *clinical aptitude; and*

318

319 *Resolved, that the FSMB task force will develop recommendations regarding mandatory*  
320 *USMLE and COMLEX passage attempt and time limitations for licensure by*  
321 *medical boards in the United States and its territories.*

322

323 A Member of the Minnesota Board of Medical Practice testified in support of the resolution.

324

325 A Member of the FSMB Board of Directors testified on the Resolution and recommended the  
326 following substitute resolution be adopted in lieu of Resolution 19-1:

327

328 *Resolved, that the FSMB will delegate staff to work collaboratively with other relevant*  
329 *parties (e.g., NBME, NBOME) to complete the following:*

330

331 *(1) Identify current licensing requirements specific to USMLE and COMLEX,*  
332 *including time and/or attempt limits on these examinations;*

333

334 *(2) Identify existing, or facilitate additional, research evaluating whether time*  
335 *and/or attempt limitations on USMLE and COMLEX correlate with*  
336 *external measures such as a decrease in future medical board disciplinary*  
*action and/or medical malpractice;*

- 337                               (3) *Begin work toward a long-term goal of research exploring the correlation*  
 338                               *between performance on these licensing examinations and other measures*  
 339                               *of clinical aptitude or outcomes; and*  
 340                               (4) *Share initial findings through a written report to the FSMB House of*  
 341                               *Delegates in spring 2020 and with subsequent periodic reports as*  
 342                               *research becomes available.*

343  
 344 A Physician Member of the Minnesota Board of Medical Practice testified in support of the  
 345 substitute resolution because it was in line with the intent of the original resolution.

346  
 347 The Chair of the Texas Medical Board testified in support of the substitute resolution. The Chair  
 348 also asked that the FSMB provide information to boards on the correlation between passage  
 349 attempts and the likelihood of future discipline for the purposes of uniformity.

350  
 351 The Reference Committee heard no further testimony.

352  
 353 Reference Committee A carefully considered the testimony it received and recommended that in  
 354 lieu of Resolution 19-1, the substitute resolution be adopted.

355  
 356                               **ACTION: ADOPTED A SUBSTITUTE RESOLUTION as stated above, as**  
 357                               **recommended by the Reference Committee, in lieu of Resolution 19-1: *Correlation***  
 358                               ***Between Licensee USMLE or COMLEX Passage Attempt Rate and Reports of State***  
 359                               ***Medical Board Discipline***

360  
 361 Report of the Reference Committee B

362  
 363 Reference Committee B met on Friday, April 26, 2019, at 8:00 a.m. in Fort Worth Ballroom 6-8  
 364 at the Omni Fort Worth Hotel in Fort Worth, Texas and considered the following six (6) items:  
 365 Andrea A. Anderson, MD, chair of Reference Committee B, presented the Committee’s report.

366  
 367 **1. BRD RPT 19-1: Report of the Ethics and Professionalism Committee: Social Media and**  
 368 **Electronic Communications**

369  
 370 The Ethics and Professionalism Committee is a standing committee of the FSMB charged with  
 371 addressing ethical and professional issues pertinent to medical regulation. The 2018-2019  
 372 Committee, chaired by Cheryl Walker-McGill, MD, MBA, was tasked with reviewing and revising  
 373 the FSMB’s 2012 policy, *Model Guidelines for the Appropriate Use of Social Media and Social*  
 374 *Networking*, evaluating current and emerging social media and electronic communication  
 375 platforms, reviewing state medical board actions and concerns regarding professionalism in social  
 376 media and electronic communication, and providing updated recommendations for best practice  
 377 in the professional use of electronic and social media communication.

378  
 379 The Committee met via teleconference and in person, in addition to communicating via email,  
 380 while drafting its report. In completing its charge, the Committee retained the approach of the  
 381 FSMB’s 2012 policy which provided guidelines and recommendations to practicing physicians for  
 382 the appropriate use of social media and electronic communication. Significant changes in format  
 383 included eliminating the use of vignettes in favor of use cases for social media. These included  
 384 communication between and among practitioners; communication between practitioners and

385 patients; “Googling” or looking up patients online; communication in medical educational settings;  
 386 and use of social media as a marketing tool.

387  
 388 In addition to these use cases, the Committee included a section on state medical board operations  
 389 and communications that discussed state medical board use of social media. This section is based  
 390 primarily on survey data collected in the FSMB’s 2018 State Medical Board Survey and included  
 391 discussion of issues which state medical boards expressed concern, such as how best to  
 392 communicate with licensees and the public via social media, and whether and how to respond to  
 393 criticism of the board, its staff and members, or its decisions and processes.

394  
 395 A draft of the report was distributed to FSMB member boards and other key stakeholder  
 396 organizations in January 2019. Comments received were helpful and generally positive and the  
 397 Committee revised its report to address them, where appropriate.

398  
 399 The Reference Committee heard testimony from the FSMB Board of Directors in support of the  
 400 recommendations, particularly given the important guidance they provide for appropriate and  
 401 professional physician engagement in social media and electronic communication. It was stated  
 402 that the report provided valuable resources and timely advice for state medical boards and patients.

403  
 404 A representative from the Washington Medical Commission testified in support of BRD RPT 19-  
 405 1. While testimony was in support, concern was expressed regarding a physician’s ability to obtain  
 406 information regarding a patient online, stating that a physician should never search for a patient  
 407 online.

408  
 409 The Reference Committee considered the testimony it received and recommended the guidelines  
 410 and recommendations in the Ethics and Professionalism Committee *Report on Social Media and*  
 411 *Electronic Communication* be adopted by the House of Delegates, and the remainder of the report  
 412 be filed.

413  
 414 **ACTION: As recommended by Reference Committee B, the guidelines and**  
 415 **recommendations in Board Report 19-1: Report of the Ethics and Professionalism**  
 416 **Committee: Social Media and Electronic Communications, were ADOPTED and the**  
 417 **remainder of the report filed.**

418  
 419 **2. BRD RPT 19-3: Report on Resolution 18-3: Permitting Out-of-State Practitioners to**  
 420 **Provide Continuity of Care in Limited Situations**

421  
 422 In April 2018, the FSMB House of Delegates referred Resolution 18-3: Permitting Out-of-State  
 423 Practitioners to Provide Continuity of Care in Limited Situations to the FSMB Board of Directors  
 424 of Study. The resolution called for the FSMB to encourage state medical boards to interpret their  
 425 licensing laws, or work to change their licensing laws if necessary, to permit physicians duly  
 426 licensed in another jurisdiction to provide infrequent and episodic continuity of care through  
 427 follow-up care to established patients or a peer-to-peer consultation, without the need to obtain a  
 428 license in the state in which the patient is located at the time of the interaction. The Board of  
 429 Directors called upon the Advisory Council of Board Executives to evaluate the resolution and  
 430 make recommendations to the Board of Directors to inform a report to the House of Delegates in  
 431 April 2019.

432  
 433 The Advisory Council of Board Executives met via web conference to evaluate and determine  
 434 whether to recommend any changes to existing FSMB policy. The informational report is a result

435 of a review of state medical practice acts, which identified several approaches currently in place  
 436 by state medical boards addressing continuity of care. Although no policy changes were  
 437 recommended, the FSMB will continue to monitor, maintain, and make accessible changes in  
 438 applicable board rules and regulations.

439

440 The Reference Committee heard testimony from a representative of the FSMB Board of Directors  
 441 in support of Board Report 19-3. It was stated that this informational report described the various  
 442 approaches and licensure exemptions pertinent to continuity of care and the practice of medicine  
 443 across state lines. The Board of Directors recommended that the report be filed for information.

444

445 A representative from the Washington Medical Commission testified on BRD RPT 19-3. It was  
 446 stated that the original resolution was informed by the fact that the State of Washington borders  
 447 numerous states and another country. It was also stated that if the FSMB did not take action, there  
 448 are several groups interested in pursuing action.

449

450 The Reference Committee heard no further testimony and received BRD RPT 19-3 as written.

451

**ACTION: No action required; report was for Information Only.**

452

453

454 **3. Resolution 19-4: Emergency Licensure Following a Natural Disaster (NC)**

455

456 Resolution 19-4, offered by the North Carolina Medical Board, reads as follows:

457

458 *Resolved, that the Federation of State Medical Boards convene a workgroup to develop*  
 459 *model emergency licensure laws and rules and submit its recommendations to*  
 460 *the House of Delegates at the 2020 FSMB Annual Meeting.*

461

462 The Reference Committee heard testimony from a representative from the North Carolina Medical  
 463 Board in support of Resolution 19-4. It was stated that since Hurricane Katrina in 2005, health  
 464 systems have shifted to a proactive disaster preparedness approach. Most states do not have  
 465 established rules and statutes regarding emergency licensure. As such, state medical boards should  
 466 also adopt disaster preparedness procedures. It was also stated that while the FSMB has expressed  
 467 interest in the past to develop such guidelines, no action has occurred.

468

469 A representative of the FSMB Board of Directors testified in support of a substitute resolution. It  
 470 was stated the proposed resolution is timely and it is critical to ensure there is a clear understanding  
 471 as to how to access and coordinate existing systems. It was stated that there are existing  
 472 mechanisms, such as the Uniform Emergency Volunteer Health Practitioners Act and the  
 473 Emergency Management Assistance Compact, as well as the Emergency System for Advance  
 474 Registration of Volunteer Health Professionals. The Board of Directors recommended that existing  
 475 FSMB resources, specifically the Advisory Council of Board Executives, study the issue, identify  
 476 regulatory gaps or barriers, and potentially recommend model regulatory language. As such, the  
 477 Board of Directors recommended the House of Delegates adopt the following substitute resolution  
 478 in lieu of Resolution 19-4:

479

480 *Resolved, the FSMB will evaluate the experiences and disaster readiness of state medical*  
 481 *and osteopathic boards and develop recommendations to facilitate the*  
 482 *interstate mobility of properly licensed physicians and other health care*  
 483 *personnel in response to disasters and issue a report to the House of Delegates*  
 484 *in 2020.*

485

486 A representative from the College of Physicians and Surgeons of British Columbia provided  
 487 informational testimony on Resolution 19-4. It was stated that Canada has a well-developed  
 488 emergency licensing framework that exists among some, but not all, Canadian provinces. It was  
 489 stated that the concept of disasters goes beyond natural disasters, especially when considering mass  
 490 shootings or pandemics. It was suggested to broaden what is considered a disaster.

491

492 The Reference Committee carefully considered the testimony received and recommended that in  
 493 lieu of Resolution 19-4, a substitute resolution be adopted, as follows:

494

495 *Resolved, the FSMB will evaluate the experiences and disaster readiness of state medical*  
 496 *and osteopathic boards and develop recommendations to facilitate the*  
 497 *interstate mobility of properly licensed physicians and other health care*  
 498 *personnel in response to disasters, public health emergencies, and mass*  
 499 *casualties, and issue a report to the House of Delegates in 2020.*

500

501 **ACTION: ADOPTED the SUBSTITUTE RESOLUTION, as stated above, in lieu of**  
 502 **Resolution 19-4: Emergency Licensure Following a Natural Disaster, as recommended by**  
 503 **the Reference Committee.**

504

505 **4. Resolution 19-5: Informed Consent Policy (NC)**

506

507 Resolution 19-5, offered by the North Carolina Medical Board, reads as follows:

508

509 *Resolved, that the Federation of State Medical Boards convene a workgroup to address a*  
 510 *physician's obligation to discuss potential costs of tests or treatments as part*  
 511 *of the informed consent process and submit its recommendations to the House*  
 512 *of Delegates at the 2020 FSMB Annual Meeting.*

513

514 The Reference Committee heard testimony from a representative of the North Carolina Medical  
 515 Board in support of Resolution 19-5. It was stated the goal of establishing a workgroup was to  
 516 address a physician's obligation to include a discussion of cost of treatment as part of the informed  
 517 consent process. It was also suggested that the FSMB is better positioned than other organizations  
 518 to provide guidance on informed consent policy.

519

520 A representative of the FSMB Board of Directors testified in opposition to Resolution 19-5. While  
 521 the FSMB Board of Directors agree with the importance of transparency with respect to costs of  
 522 tests and treatments, the FSMB has defined critical elements of patient informed consent and  
 523 shared decision-making in several policy documents. It was stated that in many states and practice  
 524 contexts information about costs of test and treatments is not readily available to physicians,  
 525 especially in time-sensitive situations.

526

527 An individual from Pennsylvania testified in opposition to Resolution 19-5. It was stated that while  
 528 the intent of the resolution is appreciated, adverse effects must be carefully considered. In  
 529 Pennsylvania, as affirmed by the Supreme Court of Pennsylvania, no portion of informed consent  
 530 may be delegated to staff.

531

532 A representative from the American Medical Association testified in opposition of Resolution 19-  
 533 4. It was stated that there is a complexity of pricing transparency and prices can fluctuate greatly.  
 534 Concern was also expressed regarding possible anti-trust laws.

535

536 A representative from the State Medical Board of Ohio testified in opposition to Resolution 19-5.  
 537 It was recommended that the resolution be changed to ask that charges be disclosed, as it  
 538 impossible to know costs.

539

540 A representative from the Illinois Division of Professional Regulation testified in opposition to  
 541 Resolution 19-5. It was stated that while the intent of the resolution was worthy, the informed  
 542 consent process involves very specific considerations. It was noted that costs can change due to  
 543 multiple variables.

544

545 The Reference Committee considered the testimony it received and strongly recommended that  
 546 the House of Delegates not adopt the resolution.

547

548 **ACTION: Resolution 19-5: *Informed Consent Policy* WAS NOT ADOPTED, as**  
 549 **recommended by the Reference Committee.**

550

551 **5. Resolution 19-6: Model Policy on DATA 2000 and Treatment of Opioid Addiction in**  
 552 **the Medical Office Policy (2013) (NC)**

553

554 Resolution 19-6, offered by the North Carolina Medical Board, reads as follows:

555

556 *Resolved, that the Federation of State Medical Boards convene a workgroup to review*  
 557 *and update the Model Policy on DATA 2000 and Treatment of Opioid Addiction*  
 558 *in the Medical Office Policy (2013) and submit its recommendations to the*  
 559 *House of Delegates at the 2020 FSMB Annual Meeting.*

560

561 The Reference Committee heard testimony from a representative from the North Carolina Medical  
 562 Board in support of Resolution 19-6. It was stated that as the *Model Policy* was last updated in  
 563 2013, it is appropriate and timely to update the policy to reflect current terminology and help  
 564 destigmatize medication assisted treatment. It was also stated medical boards have a responsibility  
 565 to address barriers to care in cases of opioid use disorder.

566

567 A representative of the FSMB Board of Directors testified in support of a substitute resolution.  
 568 The FSMB Board of Directors support the intent and goal of the proposed resolution but asked the  
 569 House of Delegates to remain silent as to the mechanism by which it is accomplished. It was stated  
 570 that since the *Model Policy* was updated in 2013, the FSMB has maintained a strong relationship  
 571 with organizations interested in developing policies and resources to address treatment of opioid  
 572 use disorder, including SAMHSA, the American Society of Addiction Medicine, the AMA, and  
 573 AOA. The FSMB Board of Directors expressed confidence that representatives from these  
 574 organizations would be willing to assist the Board and staff in reviewing the current policy and  
 575 identifying areas in which to strengthen and/or expand the current policy, without the need of an  
 576 external workgroup. As such, the following substitute resolution was offered:

577

578 *Resolved, that the Federation of State Medical Boards will review and update the Model*  
 579 *Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office*  
 580 *(2013) and submit a report to the House of Delegates at the 2020 FSMB Annual*  
 581 *Meeting.*

582

583 A representative from the American Medical Association testified in support of Resolution 19-6.  
 584 It was stated that the resolution was timely, well-conceived and will support ongoing efforts related

585 to opioid use disorder. It was also stated that should a workgroup be convened, the AMA would  
586 like to participate.

587

588 An individual from Pennsylvania testified in support of Resolution 19-6. It was stated that mental  
589 health parity is extremely important and that vulnerable patients could face adverse effects related  
590 to criminal history, custody, employment.

591

592 The Reference Committee considered the testimony it received and recommended that in lieu of  
593 Resolution 19-6, a substitute resolution be adopted, as follows:

594

595 *Resolved, that the Federation of State Medical Boards review and update the Model*  
596 *Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office*  
597 *(2013) and submit a report to the House of Delegates at the 2020 FSMB Annual*  
598 *Meeting.*

599

600 **ACTION: A SUBSTITUTE RESOLUTION, as stated above, in lieu of Resolution 19-6:**  
601 ***Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office***  
602 ***Policy (2013), was ADOPTED as recommended by the Reference Committee.***

603

604 **6. Resolution 19-7: Policy on Physician Impairment (NC)**

605

606 Resolution 19-7, offered by the North Carolina Medical Board, reads as follows:

607

608 *Resolved, that the Federation of State Medical Boards convene a workgroup, to include*  
609 *the Federation of State Physician Health Programs, to review and update the*  
610 *FSMB Policy on Physician Impairment (April 2011) and submit its*  
611 *recommendations to the House of Delegates at the 2020 FSMB Annual Meeting.*

612

613 The Reference Committee heard testimony from a representative from the North Carolina Medical  
614 Board who testified in support of Resolution 19-7. It was stated that as the *Policy on Physician*  
615 *Impairment* was last updated in 2011, it is important to create a workgroup to update the policy to  
616 reflect the rapidly changing area of medical regulation. It was also noted that since the adoption of  
617 the *Policy* in 2011, Diagnostic and Statistical Manual of Mental Disorders (DSM–5) was released  
618 and was important to include that information in any update.

619

620 The Reference Committee heard testimony from a representative of the FSMB Board of Directors  
621 in support of Resolution 19-7. It was stated that FSMB Chair-Elect Scott Steingard, DO, will be  
622 appointing a workgroup to carry out the charge as stated in the resolution.

623

624 The Reference Committee considered the testimony it received and recommended that the House  
625 of Delegates adopt the resolution.

626

627

628 **ACTION: Resolution 19-7: Policy on Physician Impairment was ADOPTED as**  
629 **recommended by the Reference Committee.**

630

631 **Report of the Nominating Committee**

632

633 Gregory B. Snyder, MD, DABR, presented the report of the Nominating Committee and read the  
634 slate of candidates.



635

636 Elections

637

638 Delegates were provided instructions on the wireless balloting process and the system was tested.

639 Upon tally and verification of the votes by the tellers, the following individuals were declared to

640 be duly elected:

641

642 **Chair-elect: Cheryl Walker-McGill, MD (2019-2020)**

643 **(by acclamation)**

644

645 **Directors-at-Large: Jone Geimer-Flanders, DO (2019-2022)**

646 **Shawn P. Parker, JD, MPA (2019-2022)**

647 **Joseph R. Willett, DO (2019-2022)**

648

649 **Nominating Committee: Nathaniel B. Berg, MD, DABR (2019-2021)**

650 **(by acclamation) Maroulla S. Gleaton, MD (2019-2021)**

651 **Joy M. Neyhart, DO (2019-2021)**

652

653

654 Announcement of Future FSMB Annual Meeting Locations

655

656 Dr. King announced that the 2020 Annual Meeting will be held in San Diego, CA at the

657 Manchester Grand Hyatt hotel April 30-May 2, 2020. The 2021 FSMB Annual Meeting will take

658 place April 29-May 1, 2021 at the Hilton Minneapolis hotel in Minneapolis, MN.

659

660 Concluding Remarks

661

662 Dr. King announced board meeting details for those newly elected to the board along with details

663 on the Nominating Committee breakfast for those elected to the Nominating Committee. Dr. King

664 also thanked everyone in attendance.

665

666 Adjournment

667

668 There being no further business, the annual business meeting of the House of Delegates was

669 adjourned at 3:35 pm.

670

671 Sandy McAllister

672 Pat McCarty

673 Recorders

**CHAIR'S REPORT**  
**MAY 2, 2020**  
**HOUSE OF DELEGATES**

**COVID-19**

I have had the immense privilege of being the Chair of the Federation of State Medical Boards (FSMB) this past year. I have never been prouder of our organization than over the past two months as we worked with our Member Medical Boards, partner organizations and collaborators to do our part to assist in the COVID-19 pandemic response. This crisis has brought out the best in our organization – literally, from the top down – as everyone has pitched in and adapted to a rapidly changing environment. The events of the past two months have shown that our mission and vision are not simply words on a paper, but a daily calling. Our Annual Meeting may have been truncated, but our commitment to public protection is stronger than ever.

As the scope of the COVID-19 pandemic came into focus, FSMB President and CEO Dr. Hank Chaudhry and I were meeting in February with our cohorts from the National Council of State Boards of Nursing (NCSBN) and the National Association of Boards of Pharmacy (NABP). During that meeting, Dr Chaudhry brought up the concept of an Ad Hoc Task Force on Pandemic Preparedness, which would join forces with nursing and pharmacy, along with Member Medical Board executive directors and board members, to look at the pandemic from a licensing perspective. This Task Force began meeting in early March and moved almost immediately from “Preparedness” to “Response” as the coronavirus quickly overtook the country. These meetings, which continue to this day, allow the FSMB to share information and best practices, think outside the box and streamline processes, all the while ensuring public safety.

Over the course of the pandemic, the FSMB also has been contacted by several organizations with whom we have not had an association in the past. These new alliances have allowed the FSMB to expand our outreach and lend guidance and support to an even larger constituency. Additionally, we were able to help the White House Pandemic Response team with several thoughtful approaches to expedited licensure and brought forward our Physicians Data Center (PDC) as a vital resource for verification as our nation’s doctors mobilized to treat the patients afflicted with COVID-19.

The FSMB continues to partner with the National Board of Medical Examiners (NBME) in administering and maintaining the United States Medical Licensing Examination (USMLE). I want to thank the NBME for its ongoing support of our shared responsibilities. The pandemic, unfortunately, has forced our organizations to postpone USMLE testing for medical students and residents. We are monitoring the situation closely and will restart the examination process as soon as it is safe to do so.

**BOARD OF DIRECTORS**

While the events of the past two months have intensely shifted the focus of each of our lives, it is important that I relay to you how hard your Board of Directors has been working over the

course of the entire year. Highlights from our Board meetings are routinely sent to our Member Medical Boards, but here are a few items worth repeating:

#### *USMLE Score Reporting*

In February of this year, the Board made an historic decision to approve changing the score reporting for USMLE Step 1 from a three-digit numeric score to reporting only a pass/fail outcome while retaining a numeric score on Step 2 Clinical Knowledge (CK). This action also was taken by the National Board of Medical Examiners (NBME), the FSMB's co-sponsor of the USMLE, and follows a national dialogue in which the Board participated that took place over the past few years among multiple stakeholders on the pros and cons of the current USMLE numeric score reporting system. The new policy will take effect no earlier than January 1, 2022.

#### *Trilateral Meeting with the NBME and ECFMG/FAIMER*

The FSMB Board met with the NBME and the Educational Commission for Foreign Medical Graduates (ECFMG)/ Foundation for Advancement of International Medical Education and Research (FAIMER) in a joint session on August 18. This Trilateral meeting occurs every few years to ensure a mutual understanding of the key areas in which the organizations collaborate. This year, the groups discussed the summary report and recommendations resulting from the March 11-12, 2019 Invitational Conference on USMLE Scoring (InCUS), the findings of the FSMB's 2018 Physician Census of Actively Licensed Physicians in the United States, the 2023 ECFMG accreditation requirement regarding foreign medical schools, and the closure of Hahnemann University Hospital in Philadelphia and its effect on the international residents-in-training with J-1 visas who were employed at the hospital.

#### *Workgroup on Physician Sexual Misconduct*

The Board has overseen the work of multiple committees and workgroups that are meant to provide support to our Member Medical Boards in their work to protect the public. The Workgroup on Physician Sexual Misconduct concluded two years of intensive study and produced a report to be presented to this year's House of Delegates that addresses the breadth and scope of this troubling problem. Under the leadership of Immediate Past Chair Dr. Pat King, the recommendations in the report will help the state medical boards better understand and address these issues. I would like to thank the Workgroup for its dedication and passion to this effort. Included in the group's work, were special guests – medical students and leaders in this area – who shared their insights and expertise, along with abuse survivors who shared their experiences and allowed us a more profound understanding of the impact of sexual misconduct. I cannot thank Dr. King and FSMB Management Consultant on Regulatory Policy Mark Staz enough for their open and transparent work in preparing the report.

#### *Special Committee on Strategic Planning*

The Special Committee on Strategic Planning, led by our incoming Chair, Dr Cheryl Walker-McGill, has provided a roadmap for the FSMB that puts our mission and vision into action in the form of a newly developed Strategic Plan that will go to the House of Delegates for approval. This Committee, comprised entirely of state medical and osteopathic board members, worked diligently and collectively to move the organization forward. I would like to

enthusiastically thank and salute Dr. Walker-McGill and the entire Committee, as well as Mr. Paul Larson, our consultant who helped direct the Committee's work and assisted with the final report, for looking to the future and setting guideposts as we move toward a new era in medical regulation

### *Artificial Intelligence*

Throughout the year, the Board engaged in generative discussions on the challenges facing medical regulation as the growth of artificial intelligence (AI) permeates the healthcare industry. The Board discussed emerging modalities of patient engagement and explored the future impact that AI could have on the practice of medicine in general in the United States. The Board reviewed changing telehealth laws in the U.S. that now focus on issues relating to standard of care and public safety as a result of the advent of this type of technology. The Board also discussed the FSMB's efforts to ensure that digital technologies and best practices utilized in medical credentialing and licensing processes are 1) utilized to their fullest potential by regulators and healthcare administrators in order to reduce inefficiencies and barriers that can compromise public safety, and 2) meet the needs of the healthcare market of the future. These discussions about the connection between digital transformation and quality healthcare regulation, as well as the creation of the FSMB's Artificial Intelligence Taskforce to further explore the host of complex challenges that the integration of AI into healthcare presents, reflects the Board's commitment to regulatory excellence.

### **SPECIAL THANKS**

I would like to take this opportunity to offer my thanks to Dr. Chaudhry for his wisdom and guidance during my year as Chair. His thoughtfulness and insights have been invaluable and made my role so much easier. The quality of our organization starts at the top and, along with Dr Chaudhry, the C-Suite of the FSMB are simply the best! They bring professionalism and an unwavering dedication to public protection to work every day. I would also include the entire staff that works every day to help our state medical boards.

I want to say a special thank you to this year's Board of Directors. Your hard work and dedication on behalf of our Member Medical Boards is remarkable. Specifically, I want to recognize and thank Dr. Pat King, who is serving her last year on the Board. Not only did she chair the Workgroup on Physician Sexual Misconduct, but she also chaired the USMLE Composite Committee, and I am grateful to her for her years of service to the medical profession. I also want to say a fond farewell to Jean Rexford, one of our public members, and to Tom Ryan, one of our Staff Fellows on the Board. Jean was a driving force to ensure the public voice was always heard, and Tom always provided us with sound advice from the perspective of the state boards. We move into our next year with confidence because Dr. Walker-McGill is more than ready to assume the position of Chair. I feel fortunate to have had our officers – Drs. Walker-McGill, King and Chaudhry and Jerry Landau, our treasurer – as the leadership team this past year.

Finally, I want to extend my sincere gratitude to the House of Delegates, as you made this incredible year possible.

**REPORT OF THE PRESIDENT-CEO**  
**May 2, 2020**  
**HOUSE OF DELEGATES**

**FROM THE CEO'S DESK**

The COVID-19 Pandemic of 2019-2020

As this report is being written, on April 20, 2020, the COVID-19 pandemic has infected 759,786 individuals and claimed 40,683 lives in the United States so far, more cases and deaths than any other country in the world. More than 13,800 of these deaths have been in New York State, where more than 242,000 infections have been confirmed. Globally, COVID-19 has infected 2.4 million people in 210 countries and claimed 165,903 lives, reminding us of how quickly a tiny little particle can spread across the globe regardless of where it originates. As one astute commentator put it, a virus can now quietly and comfortably fly in business class halfway around the world in less than 24 hours.

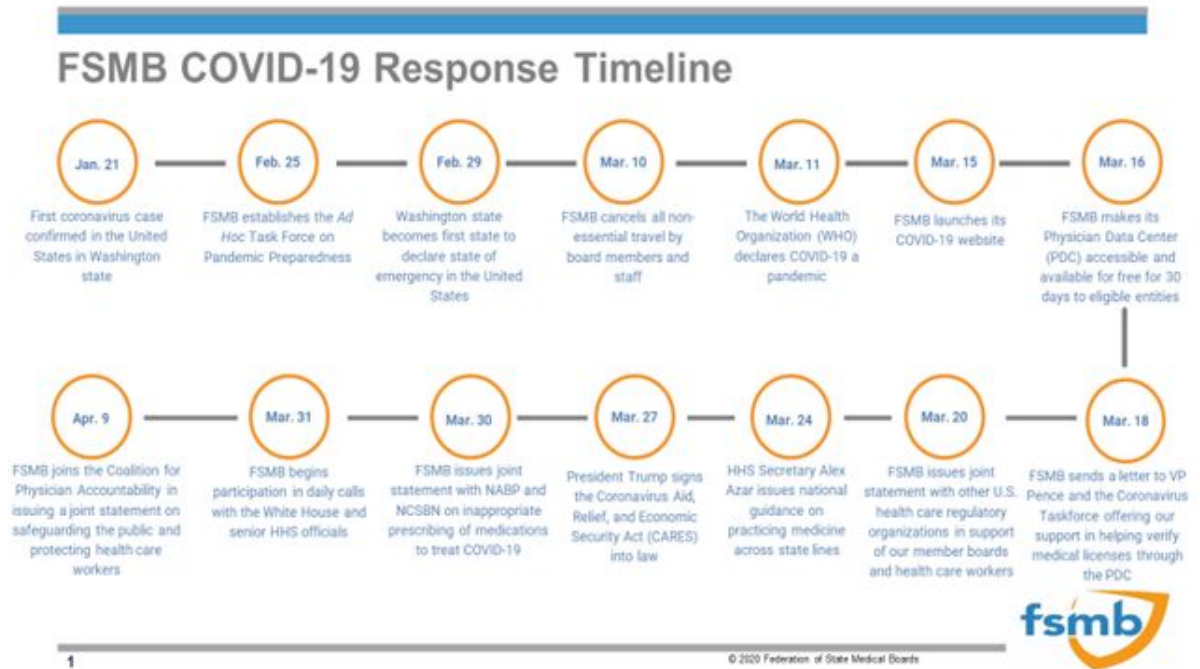
Because the role of state and territorial medical and osteopathic boards and the FSMB has been so instrumental and critical to our nation's ability to mitigate, manage and address the pandemic, it may be helpful to review some basic facts about this public health crisis.

The COVID-19 pandemic, caused by a novel coronavirus dubbed SARS-CoV-2, is easily the worst pandemic that the world has faced since the Great Pandemic of 1918, caused by an H1N1 strain of influenza virus, infected more than 500 million people and killed at least 25 million worldwide. COVID-19 has upended everyone's lives, impacting how we work, shop, and interact. Some are labeling this pandemic "the Great Pause" because it has halted most domestic and international travel and forced millions of people around the world to work from home or give up (or get laid off from) jobs where they interact with others as part of their company's business. More than four billion people – half the population of the entire earth – are said to be sheltering at home and only venturing outside as needed for essential purposes. Health care workers on the front lines in doctors' offices and clinics, emergency departments and intensive care units in hospitals here and around the world, meanwhile, are facing shortages of personal protective equipment (PPE) for themselves and ventilators for the sickest COVID-19 patients, while long hours, uncertainty and increased stress are taking an emotional toll on all of them and everyone else.

Although clinical trials of a vaccine have begun, most experts say it will be at least a year before one is developed, tested, studied, and considered carefully enough to be made available globally (and affordably) for the general population. Clinicians and researchers in the United States, Europe and around the world, meanwhile, are racing to study a large variety of chemicals, compounds, antiviral agents, antibiotics and other anti-inflammatory agents to modify disease outcomes and prevent death in those with moderate or severe signs and symptoms. More than 500,000 patients with COVID-19 worldwide have clinically recovered and are presumed to be protected from future exposure to the virus through some degree of immunity but that also needs to be studied because the virus is new and there are still many unknowns.

The virus that causes COVID-19 was first identified by Chinese clinicians and public health officials as the reason for a cluster of pneumonia cases in Wuhan, China, in December of 2019. A Canadian technology company (BlueDot) that uses artificial intelligence (natural language processing and machine learning algorithms) to monitor global health, reported on December 31 that there was a cluster of “unusual pneumonia cases” occurring in Wuhan. A week later, on January 6, the Centers for Disease Control and Prevention (CDC) reported there were pneumonia cases in Wuhan due to a presumed novel (new) respiratory virus. This was followed by a similar announcement a day later by the World Health Organization (WHO). On January 30, as cases began to appear all around the world, the WHO declared the coronavirus outbreak a “public health emergency of international concern (PHEIC).”

At the FSMB, we monitored the situation carefully throughout January and February and on February 25, during a Tri-Regulator Meeting in Washington, DC with the leaders of the National Council of State Boards of Nursing (NCSBN) and the National Association of Boards of Pharmacy (NABP), FSMB Chair Scott Steingard, DO, approved the creation of an FSMB *Ad Hoc* Task Force on Pandemic Preparedness, tentatively chaired by me, and invited the NCSBN and NABP to appoint representatives to serve on the group. The initial purpose of the task force was to monitor the public health crisis caused by COVID-19 in the United States and worldwide and to consider the possible impact on state regulatory boards for the health professions.



As the novel coronavirus spread throughout the world in February, the WHO provided more than 1.5 million tests to more than 120 countries. Diagnostic tests developed by the CDC, which is the agency’s customary approach to managing pandemic threats, were sent out in early February to state health department labs across the United States but they did not work as intended due to a contamination error that delayed wider testing until the defect could be corrected. On February 26,

a person with “no known exposure to the virus through travel or close contact with a known infected individual” was identified by the CDC in California, confirming that “community spread” of the virus was now occurring in the United States. Vice President Pence was made chair of the White House Coronavirus Task Force that same day, replacing U.S. Health and Human Services Secretary Alex Azar. By early March, the CDC’s test was repaired and the FDA allowed private companies to develop and administer their own tests as the number of cases began to rise.

As the number of COVID-19 cases continued to rise, I sent an internal communication to the FSMB’s C-Suite on March 6, to plan for an emergency conference call the following Monday to review our capabilities to support state and territorial medical and osteopathic boards should the situation worsen. On March 8, Jerome Adams, MD, MPH, the U.S. Surgeon General, and Anthony Fauci, MD, Director of the National Institute of Allergy and Infectious Diseases (NIAID), appeared separately on the Sunday morning TV talk shows to say that the federal government was moving from containment to mitigation. In public health terms, this signaled a significant shift because it meant the virus was potentially everywhere. The next day, supported by our C-Suite and approved by Dr. Steingard, we cancelled all non-essential travel for FSMB board members and staff through April 24.

On March 10, the FSMB’s *Ad Hoc* Task Force of Pandemic Preparedness met by conference call and included as members former FSMB Board Member CAPT Robin Hunter Buskey, DHSc, PA-C, Immediate Past Chair of the National Commission on Certification of Physician Assistants and Past Member of the North Carolina Medical Board; Susan Ksiazek, RPh, DPh, Past Chair of the NABP Board of Directors and a Member of the New York State Board of Pharmacy; AIM President and Idaho Medical Board Executive Director Anne Lawler, JD; L. Blanton Marchese, a public member of the Virginia Medical Board; FSMB Board Member Frank Meyers, JD, from the District of Columbia; former FSMB Board Member Jacqueline Watson, DO, MBA, Chief of Staff to the Health Commissioner of the District of Columbia; FSMB Past Chair and FSMB Foundation President Janelle Rhyne, MD, MA; Katherine Thomas, MN, RN, Past President of the NCSBN and Executive Director of the Texas Board of Nursing; FSMB Chair Scott Steingard, DO; FSMB Past Chair Pat King, MD, PhD; FSMB Chair-Elect Cheryl Walker-McGill, MD, MBA; Chief Advocacy Officer Lisa Robin, MLA; and Kandis McClure, JD, MPH, FSMB’s Director of Federal Advocacy and Policy. Ms. McClure serves as staff support for the task force. The task force discussed what was happening with COVID-19 cases across the country and, when asked for their advice about whether or not we should hold our annual meeting at the end of April, several individuals spoke forcefully against the advisability of having such a meeting, encouraging the FSMB to pursue virtual options for both the educational sessions and the House of Delegates meeting.

A day later, on March 11, the WHO officially declared the virus a “pandemic,” saying that it was present in more than 110 countries and on several continents around the world. The FSMB’s Board of Directors met by conference call that same evening to discuss the situation and agreed unanimously to cancel the annual meeting, the first time an FSMB annual meeting has not been held since the organization was founded in 1912. On March 13, the USMLE program announced that it was suspending all administrations of the Step 2 Clinical Skills examination, which remains suspended through May 31, 2020. On March 15, Joe Knickrehm, FSMB’s Director of Communications and Public Affairs, worked with FSMB’s Information Technology staff to develop a COVID-19 webpage on FSMB’s website.

On March 16, to enable physicians licensed emergently to be credentialed and deployed where they were needed most, the FSMB announced that it was going to make its PDC (Physician Data Center) database accessible and available for free for 30 days to all hospitals, health systems and similar entities. In the days that followed, FSMB staff and I reached out to the leaders of the American Hospital Association and the Greater New York Hospital Association to make them aware of PDC, information that they then posted in newsletters and other communication with their members. On March 17, the USMLE program announced that it was suspending all administrations of the Step 1, Step 2 Clinical Knowledge and Step 3 examinations in the United States and Canada, now extended through April 30.

On March 18, the same day the FSMB sent a letter to Vice President Pence to offer our support to help verify state medical licenses of physicians and physician assistants wishing to volunteer to help across state lines (and allowed to do so by states and territories that had declared public health emergencies), the Vice President announced at a news conference about COVID-19 that "... at the President's direction, HHS is issuing a regulation today that will allow all doctors and medical professionals to practice across state lines to meet the needs of hospitals that may arise in adjoining areas."

FSMB staff were unsure if this announcement by the Vice President was intended to signal an expansion of the 1135 waivers issued by the Centers for Medicare and Medicaid Services (CMS) to provide reimbursement for telemedicine when practiced by health care providers practicing across state lines or something more. We were also unsure, as were many health policy experts and attorneys we consulted, whether this was a harbinger of the President possibly overturning the 10<sup>th</sup> Amendment in the face of a national emergency to enable the practice of medicine for all physicians across state lines. Through a personal contact in Washington, DC, I was invited to participate on a conference call the next evening with senior HHS officials to discuss the efforts of state medical boards related to state medical licensure.

On the call, which was formally chaired by Laura Trueman, Director of the HHS Office of Intergovernmental and External Affairs (IEA), I discussed the FSMB's concerns about the Vice President's announcement and shared how any guidance from HHS should include safeguards that protect the public – the primary mission of state medical boards – and ensure that there is screening of health care providers who volunteer to help across state lines, whether in person or by telemedicine. I also mentioned the need for documentation in the medical record of each physician-patient encounter and the need for any guidance that is issued to only be in place for the duration of the emergency. Later that evening, the FSMB's Executive Committee met during an emergency conference call chaired by Dr. Steingard and voted unanimously on behalf of the FSMB's board of directors and the organization to stand behind our recommendations for safeguarding public protection for any guidance that may come forward.

On March 20, the FSMB, NCSBN and NABP partnered with the Association of State and Provincial Psychology Boards (ASWB), the Federation of State Boards of Physical Therapy (FSBPT), the National Board for Certification in Occupational Therapy (NBCOT), and the Association of Social Work Boards (ASWB) to issue a joint statement expressing "support for the many efforts being undertaken by our member boards and staff to enable health care providers and other professionals to deliver needed care during this COVID-19 pandemic."



To make sure the White House Coronavirus Task Force was aware of the efforts already being undertaken by the FSMB and state medical boards to facilitate expansion of access to care during the emergency, on March 21 I shared an update by e-mail with Deborah Birx, MD, one of several physician experts who serve on the task force, who replied that the information we had provided her was “very helpful” and that she was “grateful” to receive it.

On March 24, HHS Secretary Azar issued his department’s long-awaited national guidance. It was in the form of a letter to all Governors with a three-page list of recommendations that asked for (rather than mandated) greater flexibility to enable the practice of medicine and nursing across state lines by physicians, physician assistants, nurses, and nurse practitioners who are already fully licensed in at least one state or territory. It also asked for greater flexibility by states and territories to allow medical students and residents to help care for COVID-19 patients under the supervision of licensed physicians. By this point in time, all 50 states and all U.S. territories had declared a public health emergency. Our records indicate that 47 states and the District of Columbia have now modified medical licensure laws and 43 states are permitting the practice of medicine (in person or by telemedicine) across state lines. The FSMB developed helpful charts about the extraordinary efforts of state and territorial boards of medicine. These charts were updated as needed, and posted on the FSMB’s COVID-19 website and later cited or mentioned by the American Medical Association, the American Osteopathic Association, the American Hospital Association, the Council of Medical Specialty Societies, the American College of Physicians and *Politico*.

On March 26, the Management Committee of the International Association of Medical Regulatory Authorities, for which the FSMB serves as Secretariat, sent out a notice that it was cancelling the biennial international meeting of the organization that was being planned for October in Johannesburg, South Africa, which had recently declared a shelter-in-place policy to address the pandemic.

On March 30, the FSMB became aware of news reports of physicians and other prescribers beginning to hoard for themselves, their family members and friends, and office staff certain prescription medications (i.e., chloroquine, hydroxychloroquine, and azithromycin) even though none of these drugs have been approved by the Food and Drug Administration (FDA) for the prevention or treatment of COVID-19. We partnered with the NABP and NCSBN to issue a joint press release reminding physicians and other prescribers of state prescribing laws and the need to only prescribe medications for specific patients for clinically indicated situations. The FDA subsequently issued an Emergency Use Authorization (EUA) that permitted researchers and clinicians to prescribe hydroxychloroquine but only for moderately or severely ill patients who were admitted to the hospital with COVID-19, especially if the prescription was part of a clinical research trial or protocol.

Beginning March 31, I was invited by Ms. Trueman to participate on daily conference calls with the White House and senior HHS staff. The calls were chaired by Douglas Hoelscher, Deputy Assistant to the President. To support one of the goals of the working group, the FSMB provided updated information on a daily basis to this group of all the steps that the nation’s state and territorial boards of medicine were taking to modify state medical licensure regulations, to enable the practice of telemedicine and medicine across state lines, to enable the practice of medicine by retired and inactive physicians, and to enable early graduates of medical school to contribute to the health care workforce. After several conference calls, the group finalized a detailed Excel

spreadsheet that, at FSMB's suggestion, included mention of states and territories participating in the Interstate Medical Licensure Compact, before it was submitted to all Governors and to the White House Coronavirus Task Force.

On April 7, Dr. Steingard, FSMB Chair-Elect Cheryl Walker-McGill, MD, MBA, and I participated on a Zoom conference call of the Coalition for Physician Accountability. The FSMB volunteered to support several projects and workgroups that were newly created by the Coalition to enable member organizations to collectively provide guidance on such relevant matters as public safety, health care worker protection, maintaining health care quality and standards, and addressing the transition from medical school to residency during these uncertain times. Dr. Walker-McGill co-chaired a Coalition workgroup devoted to maintaining health care quality and standards. The workgroup was supported by Ms. McClure. I worked with Ms. Robin, Ms. McClure and Mr. Knickrehm to draft a consensus statement that was edited and then ultimately endorsed by 12 of the Coalition's member organizations (AACOM, AAMC, AMA, AOA, ACCME, ACGME, CMSS, ECFMG, FSMB, NBME, NBOME, LCME) on April 9. It was distributed as a press release by the FSMB on behalf of the Coalition that same day.

While there will be plenty of time in the weeks and months ahead, and especially after this pandemic is long over, to reflect upon the lessons learned and how to better prepare for the next pandemic or national emergency, at least three lessons can already be drawn from nascent observations. First, states and territories in the United States are amply capable of demonstrating extraordinary flexibility when there is a national emergency and prompt delivery of quality health care services is deemed critical. Second, state and territories care very much about safeguarding the public, their primary mission, but they also care about the health and safety of health care workers, including physicians, physician assistants, nurses, respiratory therapists, and others who are working on the front lines. And third, who we already know in medical regulation and in health care policy on a first-name basis matters because it greatly facilitates trust and collaboration in a time of uncertainty and potential chaos.

While the number of state and osteopathic board members and staff we interacted with, sometimes on a daily basis, are too numerous to mention here, I would like to take this opportunity to mention several individuals who worked very closely with FSMB staff and me to advance emergency measures in their jurisdictions while balancing patient protection with the delivery of quality health care: Frank B. Meyers, J.D., FSMB Board Member and Executive Director of the District of Columbia Department of Health; R. David Henderson, J.D., Chief Executive Officer of the North Carolina Board of Medicine; Tim Terranova, Assistant Executive Director of the Maine Board of Licensure in Medicine; Nathaniel Berg, M.D., Chair of the Guam Board of Medical Examiners; Joseph Zammuto, D.O., Chair of the Osteopathic Medical Board of California; Kenneth Cleveland, M.D., Executive Director of the Mississippi State Board of Medical Licensure; Candace Lapidus Sloane, M.D., Chair of the Massachusetts Board of Registration in Medicine; George Zachos, Executive Director of the Massachusetts Board of Registration in Medicine; Lawrence Epstein, M.D., Chair of the New York State Board of Medicine; Jerry Landau, J.D., FSMB Treasurer and Chair of the Arizona Osteopathic Board of Medicine; Denise Pines, Chair of the Medical Board of California; Jone Geimer-Flanders, D.O., Chair of the Hawaii Medical Board; Danny Takanishi, Jr., M.D., Member of the Hawaii Medical Board; Ruth Martinez, M.A., Executive Director of the Minnesota Board of Medical Practice; and Kevin Bohnenblust, J.D., Executive Director of the Wyoming Board of Medicine, which invited me to participate on an emergency conference call of their board during the pandemic.

### FSMB Activities Leading Up To The COVID-19 Pandemic

In May of 2019, the FSMB was awarded a 5-year grant of \$250,000 annually from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services, to support the Interstate Medical Licensure Compact and further enhance license portability for physician assistants.

In 2019, the FSMB's communications staff worked with our information technology staff to redesign our DocInfo.org website and include new features, such as the addition of board disciplinary orders to physician profiles and a new section that provides consumers with information about how to file a complaint with a state medical board.

For the first time in the history of the FSMB, both chambers of the U.S. Congress passed federal legislation at the end of December of 2019 that was very strongly supported by FSMB staff and board governance because it defended public protection and quality health care by requiring prompt data sharing (about adverse disciplinary actions taken against physicians and physician assistants) from the Veterans Administration (V.A.) to state medical boards and the National Practitioners Data Bank. Staff in our DC Advocacy Office worked actively to support this federal legislation over two years and were greatly supported by the FSMB's board of directors who, under the leadership of Dr. Steingard, met with 60 Members of Congress and their staff last fall to urge passage of the bills. In November 27, 2017, I testified in Congress before the House Subcommittee on Oversight and Investigations of the Committee on Veterans Affairs in a session entitled, "Examining VA's Failure to Address Provider Quality and Safety Concerns." The Improving Confidence in Veterans Care Act (H.R. 3530) sponsored by Congressman Michael Cloud (R-TX) passed with overwhelming bipartisan support (409 votes in favor and one vote opposed) in the U.S. House of Representatives on December 17, 2019, while its companion bill, the Veterans Affairs Provider Accountability Act (S. 221) sponsored by Senator Cory Gardner (R-CO) passed out of the U.S. Senate on unanimous consent on December 19, 2019 and was referred to the House Subcommittee on Health on January 14, 2020. The bills, which will require the President's signature to become law once they have been reconciled in committee, also require the V.A. to verify provider credentials and to limit settlement agreements that include terms requiring the Secretary to conceal serious medical errors or certain lapses in clinical judgment. During a speech on the House floor on December 16, 2019, Representative Mark Takano (D-CA) specifically recognized FSMB's support of the bill in advance of the House vote.

In January, the Finance and Nominating Committees met at the FSMB's Texas office. The Finance Committee, chaired by FSMB Treasurer Jerry Landau, JD, thoughtfully and diligently discussed the FY2021 budget, which was presented and approved by the FSMB's board for presentation to the House of Delegates. The FSMB's Nominating Committee, chaired by Immediate Past Chair Patricia King, MD, PhD, carefully reviewed and discussed nominees for higher office at the FSMB.

On January 1, 2020 Massachusetts became the 15<sup>th</sup> state medical board to require the Federation's Credentials Verification Service (FCVS) profile as part of their medical licensure process. The other 14 state medical boards that require FCVS are KY, LA, OH, ME, NC (for IMGs and existing FCVS users), NH, NY (for IMGs), NV Medical, NV Osteo, RI, SC, UT Medical, UT Osteo, and the U.S. Virgin Islands. The FCVS team achieved significant improvements in their processes over the last year: The overall FCVS cycle time is now just over 17 days, while the customer satisfaction

average is now 90% (September of 2019 saw a record setting 97% customer satisfaction rate.) The current FCVS cycle time performance represents a significant improvement over historic performance by as much as thirty to forty-five days and continues a favorable trend.

In early February, the USMLE program announced a series of policy changes adopted by the FSMB and NBME governing boards as well as the USMLE Composite Committee.

- Lowering the maximum number of attempts on a USMLE Step or Component from six to four (implementation no earlier than January 2021)
- Requiring a passing Step 1 score before taking Step 2 Clinical Skills (implementation no earlier than March 2021)
- Changing Step 1 score reporting from a 3-digit numeric score to solely a pass/fail outcome (implementation no earlier than 2022)

The latter policy change stemmed largely from the national dialogue that commenced with the Invitational Conference on USMLE Scoring (InCUS) held in March 2019.

While the latter policy change is likely to have little direct impact on state medical boards, it has been a topic of extensive discussion within the medical education community for some time. The decision by FSMB and NBME governance to make this change at this time has been well-received by most stakeholders within the educational community as a positive first step toward broader system-wide changes to enhance the transition from undergraduate to graduate medical education. The National Board of Osteopathic Medical Boards has announced that it, too, is evaluating its score reporting policies for its examination and said additional information will likely be forthcoming by the summer of 2020.

On February 27, I joined more than 4,000 doctors and professional staff in San Francisco at the annual meeting of the Accreditation Council for Graduate Medical Education, where I spoke on a panel discussion about the closure of Hahnemann University Hospital (Philadelphia) in 2019 and the role that FSMB played in helping preserve records of thousands of current and former physicians in training through our Closed Residency Program service. I also gave a presentation and then spoke at a town hall meeting about the decision of the USMLE program to change score reporting of Step 1 of the USMLE exam from a three-digit numerical score to pass/fail, a change that is expected to be implemented no earlier than 2022. Dr. Steingard flew that same weekend to Manalapan, Florida, to present an FSMB update at a summit meeting of the American Association of Osteopathic Examiners (AAOE).

Although the 2020 FSMB Annual Meeting is not taking place as normal this year, we will be providing educational content virtually to our member boards and staff throughout the year. I would like to take this opportunity to recognize and thank the work of the FSMB's Education Committee, chaired by Dr. Steingard. The committee, working with FSMB staff such as Ms. Robin and Kelly Alfred, Director of Education Services, and Kay Taylor, Director of Meetings and Travel, and many others, worked very hard and diligently to plan a productive annual educational meeting that would have made for an exciting and enjoyable time for all attendees. We are pleased that technology will enable us to hold a meeting of our House of Delegates, vote on resolutions and reports, and hold elections to enable a smooth transition in leadership of our board governance and our nominating committee. Several members of the FSMB staff have been working long hours

to assure that the preparations for a Zoom conference call involving our House of Delegates runs smoothly and seamlessly as if we were together in person. The educational content we were going to have at our annual meeting will now be delivered virtually over many months, beginning in May or June.

I am grateful for the outstanding staff at the FSMB who make all our efforts on behalf of state and territorial medical and osteopathic boards possible in the first place. I would particularly like to recognize our senior staff in Eules and in Washington, DC: Lisa Robin, M.A., our Chief Advocacy Officer; David Johnson, MA, our Chief Assessment Officer; Todd Philips, MBA, our Chief Financial Officer; Michael Dugan, MBA, our Chief Operating Officer; and Eric Fish, JD, our Chief Legal Officer. I am grateful to Sandy McAllister, my Executive Administrative Associate, for her diligent and consistent support behind the scenes of all my activities, domestic and international; and to Patricia McCarty, Director of Leadership Services, for her attentive and exceptional diligence on behalf of our board of directors.

We thank Dr. Steingard for a very strong leadership year in which the last three months of our fiscal year (February through April) were completely overtaken by the many events surrounding the COVID-19 pandemic. Dr. Steingard and our board of directors helped us maintain a steady hand on the wheel as we sailed several uncharted waters and worked very long hours supporting our state and territorial medical boards.

While our ship has not completely sailed into calmer waters as of yet, we look forward to the leadership of Cheryl Walker-McGill, M.D., MBA. Dr. Walker-McGill has already hit the ground running by chairing this past year's Strategic Planning Committee, whose report will be considered by the House of Delegates, and volunteering to co-chair an important working group of the Coalition for Physician Accountability focused on assuring quality and standards as physicians across the continuum of medical education step forward to volunteer their services during the pandemic.

Finally, I would like to take this opportunity to thank Patricia King, M.D., Ph.D., who completes her term of service as Immediate Past Chair of the FSMB. Dr. King will be long remembered for the energy and passion she has brought to her year of service as FSMB Chair, from 2018-2019, and for such critically important roles she played as chair of the FSMB's Board Action Content Evaluation (BACE) Task Force, chair of the FSMB's Workgroup on Education about Medical Regulation (which released four individualized online educational modules about medical regulation designed for medical students and residents but also applicable to practicing physicians), and especially as chair of the FSMB's Workgroup on Physician Sexual Misconduct, a mammoth two-year undertaking whose thoughtful report and many helpful recommendations will also be considered this year by the House of Delegates.

While we don't know what the year ahead will be like as the pandemic continues to evolve, I can assure our member boards and their staff that the FSMB is here to assist you and work with you as we continue to help you protect the public and provide the best and safest healthcare system in this great nation. We wish everyone well and hope for a safe and pleasant year ahead for everyone.

## **WASHINGTON, D.C. OFFICE**

### **ADVOCACY AND POLICY**

The FSMB's Washington, D.C. Office provides federal and state legislative services on behalf of state medical and osteopathic boards. The goal of the office is to serve as a respected resource on state medical regulatory policy for FSMB member boards, state and federal legislators, the Administration, health care organizations, and other key stakeholders.

Over the past year, the FSMB was actively engaged on Capitol Hill, educating the U.S. Congress on a variety of initiatives and policies of importance to state medical boards, including the need for the Department of Veterans Affairs to report adverse actions to state licensing boards, telemedicine, antitrust liability, the Indian Health Services, the Interstate Medical Licensure Compact and criminal background checks, and patient safety.

The FSMB works directly with member boards to achieve their individual legislative and policy priorities. FSMB state legislative and policy staff routinely respond to research inquiries and requests for support from state boards and are also called upon to provide testimony and distribute policy documents directly to legislative and policymaking bodies. The FSMB assists state boards by monitoring, tracking, and analyzing relevant legislation and regulations and maintains a robust portfolio of policy documents which are continually updated to reflect the most current regulatory and legal landscape.

*Department of Veterans Affairs Reporting to State Licensing Boards:* The FSMB has continued its support of stronger reporting requirements from VA facilities to state licensing boards through the *Department of Veterans Affairs Provider Accountability Act (S. 221)*. The FSMB is pleased that S. 221 passed out of the Senate on Unanimous Consent in December. Additionally, the U.S. House of Representatives passed with overwhelming bipartisan support *the Improving Confidence in Veterans' Care Act (H.R. 3530 - as amended)* which requires the VA to: 1) report adverse actions to state licensing boards and the National Practitioner Data Bank; 2) limit settlement agreements that include terms requiring the Secretary to conceal serious medical errors or certain lapses in clinical judgment; and, 3) to verify provider credentials. During his speech on the House floor on December 16, Rep. Takano (D-CA) specifically recognized the FSMB's support of the bill in advance of the House vote.

*Professional Licensing Coalition:* The FSMB continues its work as a founding member of the Professional Licensing Coalition (PLC), comprised of organizations representing state occupational and licensing boards and professional associations, to secure bipartisan legislation that would provide private damages relief for persons acting at the direction of state medical boards, while permitting injunctive relief. This legislation is in response to the 2015 U.S. Supreme Court decision issued in *North Carolina State Board of Dental Examiners v. Federal Trade Commission*, which has left state professional and occupational licensing boards and their staff members in a state of uncertainty and vulnerability.

*Interstate Medical Licensure Compact:* The FSMB continues to support state medical boards interested in implementing the Interstate Medical Licensure Compact (IMLC). As of March 2020, twenty-nine (29) states, one territory, and the District of Columbia have enacted the compact, while the IMLC has been introduced during the 2020 legislative session in Florida, Missouri, New

Jersey, New York, and South Carolina. FSMB staff has supported state legislative efforts by submitting written and oral testimony, assisting boards with testimony, and coordinating technical and legal assistance.

In May 2019, the FSMB was awarded a five-year grant of \$250,000 annually from the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, to support the IMLC and further enhance license portability for physicians and physician assistants (PAs). The five-year HRSA grant will be used to support license portability for PAs, enhance the IMLC technology platform to enable secure communications among IMLC member boards, and expand outreach to educate stakeholders on how to utilize the IMLC to improve access to care using telemedicine across state lines. The grant will also support new and existing IMLC member states in increasing efficiency in conducting required criminal background checks. The FSMB continues to be engaged with HRSA to provide status reports on the project.

*Congressional Activity:* In addition to legislative efforts spearheaded by the FSMB, the DC Advocacy Office has been active on other federal legislative and regulatory issues pertinent to state medical boards. The FSMB submitted comments on the *FCC's Promoting Telehealth for Low-Income Consumers Notice of Inquiry, WC Docket No. 18-213*, highlighting the FSMB's Policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine and the importance of state licensure in the use of telemedicine, and to the *Bipartisan Policy Center's Rural Health Task Force*, highlighting the importance of state licensure and the use of the IMLC to expand access to care in rural areas.

The FSMB also submitted a comment on *CMS Proposed Rule (CMS-1715-P)* that raised concerns over a proposal that would allow CMS to expand its authority to revoke or deny physicians' and other healthcare providers' Medicare billing privileges in instances where providers have been subject to prior disciplinary actions based on conduct that resulted in patient harm. The FSMB highlighted issues over the scope of the proposal and asked for clarity on any procedures that would be used in determining patient harm.

The FSMB continued its advocacy efforts for better reporting from VA facilities by providing a letter to the House Committee on Veterans Affairs for a hearing entitled "*Broken Promises: Assessing VA's Systems for Protecting Veterans from Clinical Harm.*" The letter highlighted the importance of requiring the VA to report adverse actions to state licensing boards.

In addition to endorsing the *Department of Veterans Affairs Provider Accountability Act (S. 221)* that would require the Department of Veterans Affairs to report major adverse actions to state licensing boards and to the National Practitioner Data Bank (NPDB), the FSMB has supported additional pieces of legislation in the 116<sup>th</sup> Congress. The FSMB issued a joint letter of support with the National Council of State Boards of Nursing for the *HEALTHIER Act (H.R. 2216)* that would create a grant program for states that offer flexibility in licensing for health care providers who offer services on a volunteer basis through volunteer provider laws. The FSMB also endorsed the *CONNECT for Health Act of 2019 (S. 2471, H.R. 4932)* that would extend access to telemedicine in accordance with state licensing laws. The FSMB had endorsed previous versions of these bills in the 115<sup>th</sup> Congress.

*FSMB Advocacy Alert:* This e-newsletter is distributed monthly to more than 400 recipients and provides updates on pertinent federal and state legislative and regulatory activity of interest to

member boards. The Alert also includes a “call to action,” requesting targeted advocacy efforts when necessary.

*State Legislative and Regulatory Activity:* The FSMB assists its member boards in achieving their legislative priorities. The FSMB monitors state legislative and regulatory developments occurring in each legislative cycle, in order to timely identify bills and proposed rules likely to impact the state boards. The FSMB is regularly called upon to supply policy documents, white papers, and other materials in support of, or in opposition to, pending legislation.

In 2019, the FSMB monitored more than 4,500 legislative bills, on issues such as pain management, including prescription drug monitoring programs, opioid abuse and prevention, and controlled substances; state health-professional licensing/disciplinary boards, including occupational licensure reforms, board investigations, board composition and oversight, reporting requirements, and funding; physician scope of practice; continuing medical education; and telemedicine. The FSMB submitted official letters and testimony in response to legislation in Florida, Minnesota, New Jersey, and South Carolina.

*Policy Documents and Legislative Summaries:* The FSMB develops and maintains various documents setting forth the unique jurisdictional approaches espoused by the states and state medical boards with respect to key issues of importance to the state boards. These documents are available to the public on the FSMB website and are frequently circulated upon request to a variety of stakeholders. Legislative summaries that were updated during 2019 included: Board Composition, Continuing Medical Education, Marijuana, Medical Marijuana-Continuing Medical Education, Pain Management, Prescription Drug Monitoring Programs, Standard of Proof, Physician Profiles, and Telemedicine.

*Policy Development Support:* The FSMB state legislative and policy staff monitors and evaluates state statutory and regulatory developments as well as how states approach issues of interest to state medical boards. Consequently, the FSMB state legislative and policy staff is often requested to support the development of policy through producing legislative summaries, compiling best practice document, conducting relevant research, and participating in or consulting on the generation of draft policy.

*Workgroups and Committees:* Several FSMB Workgroups and Committees developed policies and guidance documents to support state medical boards.

*Advisory Council of Board Executives:* Charged with providing guidance on the FSMB’s Board Action Content Evaluation (BACE) project and Resolution 19-4: Emergency Licensure Following a Natural Disaster, submitted by the North Carolina Medical Board and referred by the House of Delegates to the FSMB Board of Directors for study. The Advisory Council provided guidance to the Board of Directors in developing an informational report on Resolution 19-4 to the House of Delegates in April 2020.

*Workgroup on Board Education, Service and Training (BEST):* The Workgroup, chaired by Dr. Kenneth Simons, has developed multiple resources to support state medical board members in their roles and responsibilities associated with service on a state medical or osteopathic board. In December 2018, the Workgroup released its first module in a series of online educational activities titled *Understanding Medical Regulation in the United States*.



*Workgroup on Education on Medical Regulation:* Chaired by Dr. Patricia King, the Workgroup on Education on Medical Regulation has released four individual online educational modules about medical regulation designed primarily for medical students and residents but generally applicable to all practicing physicians:

- “The Role of State Medical Boards,”
- “Understanding and Navigating the Medical Licensing Process”
- “The Disciplinary Process”
- “Common Reasons Physicians Get into Trouble”

All four modules are available at <http://www.fsmb.org/education/> with a fifth module on physician health/wellness expected to be launched in 2020.

*The Ethics and Professionalism Committee:* Chaired by Kenneth Simons, MD, the Committee’s charge for 2019-20 included 1) developing a position statement on physician treatment of self and family members, 2) considering updates to the policy on Ethics and Quality of Care developed jointly with the American Medical Association, and 3) finalizing guidance to state medical boards on compounding of medications by physicians. The Committee will be consulting with state medical boards on a draft position statement on the treatment of self and family members in early-summer of 2020. FSMB staff will continue to liaise with contacts at the American Medical Association to determine whether there is mutual interest in revising the policy on Ethics and Quality of Care collaboratively. A guidance document for state medical boards addressing considerations in physician compounding and summarizing relevant federal legislation was shared with state medical boards in March of 2020.

*Workgroup on Physician Sexual Misconduct:* This Workgroup, chaired by Dr. Patricia A. King, M.D., Ph.D., has been charged with 1) collecting and reviewing available disciplinary data, including incidence and spectrum of severity of behaviors and sanctions, related to sexual misconduct; 2) identifying and evaluating barriers to reporting sexual misconduct to state medical boards, including, but not limited to, the impact of state confidentiality laws, state administrative codes and procedures, investigative procedures, and cooperation with law enforcement on the reporting and prosecution/adjudication of sexual misconduct; 3) evaluating the impact of state medical board public outreach on reporting; 4) reviewing the FSMB’s 2006 policy statement, *Addressing Sexual Boundaries: Guidelines for State Medical Boards*, and revising, amending or replacing it, as appropriate; and 5) assessing the prevalence of sexual misconduct training in undergraduate and graduate medical education and developing recommendations and/or resources to address gaps. After two years of careful study and extensive consultation with state medical boards, partner organizations, survivors of sexual assault by physicians, and members of the public, a final report with recommendations has been completed and will be considered by the FSMB House of Delegates in May 2020.

*Workgroup to Study Risk and Support Factors Affecting Physician Performance:* Chaired by Mohammed Arsiwala, MD, this Workgroup is charged with: 1) Collecting and evaluating data and research on factors affecting physician performance and ability to practice medicine safely, including but not limited to practice context (specialty, workload, solo/group, urban/rural), gender, time in practice, examination scores, and culture; 2) Convening stakeholder organizations and experts to engage in collaborative discussions about patient safety issues and ethical and professional responsibilities as they relate to physician performance, including the duty to report; 3) Identifying principles, strategies, resources and best practices for assessing and mitigating

potential impacts on physician performance; and 4) Providing information to state medical boards about the risk and support factors affecting physician performance throughout their careers, how these can impact patient care, and what key principles should be applied to consideration of fair, equitable and transparent regulatory processes. In 2020-2021, Workgroup members will prioritize the study of biopsychosocial risk factors for physicians and determining best practices in the use of regulatory data for identifying physicians at risk for poor performance and effectively targeting support to those physicians. The workgroup will use a framework for analyzing risk factors across all career stages, attempting to map existing supports onto each of these.

## COMMUNICATIONS AND PUBLIC AFFAIRS

FSMB is frequently contacted by the nation's news media to provide insight and national perspective on issues of relevance to the medical regulatory community. In the past year, FSMB has granted interviews and provided statements to numerous media outlets, including The New York Times, the Wall Street Journal, the Associated Press, NPR, CBS News, Men's Health, as well as numerous health care-related publications and regional news outlets.

In 2019, the communications team worked with FSMB's IT team to redesign and launch a new and improved DocInfo.org. The purpose of the redesign was to make it easier for consumers to seek credible, fact-based information about physicians. New features were added to the site, including a more robust search function, adding board orders to physician profiles and adding a new section that provides consumers with information about how to file a complaint with a state medical board.

A promotional campaign was launched to raise awareness by informing key news outlets, lawmakers and the public about the existence of Docinfo.org. In June 2019, members of the FSMB Board of Directors visited with more than 60 Members of Congress and their staffs about the value of DocInfo.org and the resources state medical boards provide their constituents. FSMB reached the public by utilizing social media ads (Twitter, Facebook) and an animated video to target key demographics and encourage them to visit DocInfo.org.

The promotional video was viewed more than ten thousand times and DocInfo.org traffic increased by 1.8 million pageviews in 2019. The campaign to promote DocInfo.org and raise awareness about the importance of state medical boards was recognized by "PR NEWS" as one of the top "social good" campaigns of 2019. Efforts to further promote DocInfo on social media and with national media outlets is ongoing and will continue to be a top priority for FSMB communication staff in 2020 and beyond.

Additionally, the team provided media relations assistance to medical boards for both state and national stories on a variety of issues, such as physician sexual misconduct and the opioid epidemic. The communications team continued to highlight the progress being made by state medical boards through issuing press releases on a wide variety of topics. These topics included the success of the Interstate Medical Licensure Compact, the release of FSMB's latest regulatory trends and actions report, the efforts of FSMB Workgroups to support member boards and the development of additional free education modules for medical students and residents.

## STATUS OF RESOLUTIONS TO THE HOUSE OF DELEGATES

Resolution 19-1; *Correlation Between Licensee USMLE or COMLEX Passage Attempt Rate and Reports of State Medical Board Discipline*, submitted by the Minnesota Board of Medical Practice. The 2019 FSMB House of Delegates adopted a substitute resolution proposed by the FSMB Board of Directors, which called for FSMB, in collaboration with other relevant parties, to identify current licensing requirements specific to USMLE and COMLEX-USA; to identify and facilitate research on whether time and/or attempt limitations on USMLE and COMLEX-USA correlate to external measures; to work toward a long-term goal of research exploring the correlation between performance on licensing examinations and measures of clinical aptitude or outcomes; and to share initial findings back to the 2020 FSMB House of Delegates. The Board of Directors report on Resolution 19-1 detailing the Board's initial findings in these areas was issued to the 2020 FSMB House of Delegates. Future reports will provide updates on time and attempt limits and relevant research, as available or requested.

Resolution 19-4; *Emergency Licensure Following a Natural Disaster*, submitted by the North Carolina Medical Board and referred to the FSMB Board of Directors for study. The Advisory Council provided guidance to the Board of Directors in developing an informational report on Resolution 19-4 to the House of Delegates in April 2020.

Resolution 19-6; *Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office Policy (2013)*, submitted by the North Carolina Medical Board. In 2019, FSMB staff began reviewing and identifying areas of the *Model Policy* to update, as well as reached out to relevant stakeholder organizations to gather input. As part of the review, FSMB staff identified that it was pertinent to include any newly or expected federal guidance. With the Special Registration for Telemedicine Act of 2018, which was part of the SUPPORT for Patients and Communities Act signed into law in late 2018, the Drug Enforcement Agency (DEA) had until October 24, 2019 to set the rules for providers with a special registration to prescribe controlled substances. As of March 2020, the rules have yet to be released. As a result, FSMB staff continues to review the *Model Policy*. A draft of proposed amendments should be circulated to Member Boards in the second half of 2020.

Resolution 19-7; *Policy on Physician Impairment*, submitted by the North Carolina Medical Board was referred to the Workgroup on Physician Impairment. The Workgroup was charged with reviewing the FSMB Policy on Physician Impairment (HoD 2011) in cooperation with the Federation of Physician Health Programs (FSPHP), and making recommendations to revise the policy in light of new and emerging issues, including the management of licensees receiving Medication Assisted Therapy (MAT) for Opioid Use Disorder, implementation of the DSM-V, and revisions to the FSPHP's *Physician Health Program Guidelines*. The Workgroup is in the process of completing a draft report that includes an updated definition of physician impairment and guidance on the management of physicians receiving MAT. The report also addresses the role of PHPs and state medical boards in supporting licensee wellness and combatting burnout, and updates the description of the stigma associated with physician impairment, including barriers to reporting, treatment/rehabilitation, and re-entry to practice. The revised draft report will be distributed to state medical boards for comment in the summer of 2020.

## **EULESS, TEXAS OFFICE**

What follows in the next several pages are highlights of the FSMB's many activities and services on behalf of the nation's state medical and osteopathic boards, the bulk of which are managed and supervised by the more than 160 full-time employees at our Eules, Texas office.

### **Continuing Professional Development (CPD)**

The FSMB continues to support state medical boards' efforts to evolve their Continuing Medical Education (CME) requirements for license renewal, such as by encouraging physicians to complete a portion of their CME in areas that are relevant to their practices.

The FSMB has also engaged in conversations with state medical boards and medical specialty societies about ways in which data held by specialty societies can be used to facilitate CME audits conducted by state medical boards. In some states, these conversations have led to pilot programs for reporting of CME data that have resulted in streamlined processes for state medical boards and reduced compliance efforts for licensees.

The FSMB continues to receive and support requests for information and presentations regarding the continuing professional development of physicians from external stakeholders. A significant focus of these communications has been on recognizing the existing efforts and initiatives of state medical boards as they move towards increasing the effectiveness of CME requirements for license renewal.

### **Post-Licensure Assessment System (PLAS)**

The Post-Licensure Assessment System (PLAS), a joint program of the FSMB and the National Board of Medical Examiners (NBME), provides diagnostic tools for evaluating the ongoing competence of currently or previously licensed physicians. The PLAS collaborates with assessment programs across the country to provide standardized and personalized assessments of physicians for whom there is a question regarding clinical competence. The assessment tools provided by PLAS complement the programs' other performance-based methods of assessment and assist in evaluating a physician's medical knowledge, clinical judgment and patient management skills in his or her current or intended area of practice.

FSMB also maintains a Directory of Physician Assessment and Remedial Education Programs as a courtesy resource guide for physicians and state boards.

### **Special Purpose Examination (SPEX)**

The Special Purpose Examination (SPEX), a joint program of the FSMB and the National Board of Medical Examiners (NBME), is a generalist examination for use by state medical boards in evaluating the current medical knowledge of physicians who are some years away from having passed a national medical licensing examination. An updated SPEX exam was implemented in January 2019. The new exam is 2.5 hours shorter than the previous version (from 8.5 hours to 6 hours) to better accommodate examinees' busy practice schedules. Other improvements included an update of the exam blueprint and item pool (i.e., new test forms and questions), and implementation of new item formats (e.g., drug ads and abstracts).

## United States Medical Licensing Examination (USMLE)

The USMLE continues to draw upon the expertise and insight of the medical licensing community to inform ongoing enhancements (and their implementation) to the examination. In 2018, 37 individuals from 26 boards participated in a USMLE activity in some capacity. This recent activity reflects the long-standing tradition of medical board participation in the USMLE. Since the program's inception, 255 individuals from 61 medical and osteopathic boards have participated on a USMLE committee, panel, workgroup, etc.

One mechanism for tapping into the expertise of the licensing community is a sounding board group comprised of members and staff from state medical boards. Constituted in 2011 as an ongoing mechanism to provide feedback and guidance to the program, the State Board Advisory Panel to the USMLE convened most recently in fall 2019. Representatives from the California-Medical, District of Columbia, Florida-Medical, Illinois, Maine-Medical, Missouri, Nevada-Medical, North Carolina and Wisconsin boards participated.

In 2019, 37 individuals with experience as members or staff of a medical board actively participated or served on a USMLE committee, task force, advisory or standard setting panel. These individuals came from 26 boards, including: Alabama, Alaska, Arizona-Medical, Arizona-Osteo, California-Medical, Colorado, District of Columbia, Florida-Medical, Hawaii, Idaho, Illinois, Iowa, Kansas, Maine-Medical, Minnesota, Missouri, Montana, Nevada-Medical, New Hampshire, New York-OPMC, North Carolina, Oklahoma-Medical, Vermont-Medical, Virginia, Wisconsin and Wyoming. The members and executive directors of state medical boards serving on these committees provide the USMLE program with assistance in multiple areas, including setting program policy, approving examination blueprints, establishing the fees for each Step exam, rendering final determinations relative to allegations of examinee misconduct, etc. Physician members of state medical boards are also involved in the process of test item development for the USMLE.

FSMB actively works to increase state board participation in the USMLE program and hosts an annual orientation workshop for state board members and staff. The most recent workshop took place in fall 2019. To date, 130 individuals representing 52 state medical and osteopathic boards have participated in these workshops. Approximately 44% of the individuals have subsequently served on a USMLE committee, workgroup or standard-setting panels.

In 2017, the USMLE program increased its presence on social media as a way to supplement and strengthen USMLE communication and outreach via the USMLE website. The USMLE Facebook, LinkedIn and Twitter accounts help the program reach and communicate with the 100,000+ individual examinees taking the USMLE each year, as well as medical educators at both the undergraduate and graduate levels and members of the state medical board community.

On March 11-12, 2019, the FSMB co-hosted an Invitational Conference on USMLE Scoring (InCUS) with co-sponsors NBME, ECFMG, American Medical Association and the Association of American Medical Colleges. This conference culminated in a report and recommendations on specific to USMLE and its impact on medical education and the transition into residency <https://www.usmle.org/inCus/> In February 2020, the USMLE announced three policy changes:

- Lowering the maximum number of attempts on a USMLE Step or Component from six to four (implementation no earlier than January 2021)

- Requiring a passing Step 1 score before taking Step 2 Clinical Skills (implementation no earlier than March 2021)
- Changing Step 1 score reporting from a 3-digit numeric score to solely a pass/fail outcome (implementation no earlier than 2022)

The latter policy change stemmed largely from the national dialogue commenced through InCUS.

## Education Services

2020 FSMB Annual Meeting – April 30 – May 2, 2020: Over the last year, the Education Committee has worked very hard to identify topics that are of importance to the work of the state medical board community. Using data collected from the 2019 Annual Meeting post-evaluation, the 2019-2020 Education Committee, chaired by Scott A. Steingard, DO, held its first planning meeting in Washington, DC, on July 19, 2019. Tasked with the responsibility to provide recommendations in the development of FSMB’s educational program, as well as to prioritize educational topics in accordance with FSMB’s mission, vision and goals, the committee will work to identify key performance gaps to address in 2020 as well as potential speakers. Topics for this year’s Annual Meeting were going to include new developments in international graduate medical education and accreditation, understanding the next generation of U.S. physicians, physician sexual misconduct, ensuring fairness for victims in disciplinary proceedings, credentialing and reporting within the Department of Defense, and physician wellness and burnout.

For the 2020 keynote addresses, the Education Committee had invited Cary Coglianese, JD, PhD, and John Whyte, MD, to present. Dr. Coglianese, Professor of Law and Political Science at the University of Pennsylvania Law School, was going to deliver the *Dr. Herbert Platter Lecture* on Thursday, April 30 and speak on achieving regulatory excellence in a world of advanced technologies and complex risks. Dr. Whyte, Chief Medical Officer for WebMD, was going to explore where consumer empowerment in health care might lead regulators in a digital landscape during this year’s *Dr. Bryant L. Galusha Lecture* on Saturday, May 2. We are now exploring ways to have these speakers give their presentations virtually over the course of the year.

2019 New Directors and New Executive Directors Orientations: The FSMB held its New Directors and New Executive Directors Orientation on June 23-24, 2019, in the Texas office. The purpose of the event is to provide newly employed state medical board executive directors and newly elected directors of the FSMB board an opportunity to become familiar with the organization’s structure, activities and operations, thereby enhancing their understanding of how the FSMB can fulfill the needs of its membership and how they can be effective leaders in their respective roles. Twelve (12) new Executive Directors and/or senior medical board staff attended this year’s event, along with three (3) new members of the FSMB board of directors, including Dr. Scott Steingard, FSMB Chair. Attendees were given an overview of the FSMB and its activities, the roles and responsibilities of FSMB’s board of directors’ and information on FSMB products and services. The program focused on addressing the individual needs of attendees, combining presentations and tours of FSMB headquarters with roundtable discussions.

The next New Directors and New Executive Directors Orientation is scheduled for June 28-29, 2020, at the Eules, Texas office.

2019 Tri-Regulator Symposium: On September 26-27, the FSMB, the National Council for State Boards of Nursing (NCSBN), and the National Association of Boards of Pharmacy (NABP) hosted

the fourth Tri-Regulator Symposium in Frisco, Texas. The theme of this year's Symposium was *Proactive Regulation as a Team-based Collaborative*. Throughout the two days, attendees were engaged in discussions on artificial intelligence and its impact on regulatory boards, effective acquisition and use of licensing and disciplinary data, common reasons that lead to disciplinary action, legislative priorities of the professions, and the current state of risk-based regulation in the United States. One hundred and twenty-five (125) representatives from the medical, nursing and pharmacy professions were in attendance. Additionally, on Friday, September 27, a meeting of researchers from other regulatory and licensing authorities was held. This meeting included representatives from the Association of Social Work Boards (ASWB), the Association of State and Provincial Psychology Boards (ASPPB), the Federation of State Boards of Physical Therapy (FSBPT), and the National Board for Certification in Occupational Therapy (NBCOT.)

*2019 Fall Board Attorneys Workshop:* The FSMB held its 13<sup>th</sup> annual fall Board Attorneys Workshop on November 7-8, 2019, in New Orleans, LA. The 2019 workshop hosted 72 attendees from 28 different states. Sessions offered during the workshop included the corporate practice of medicine doctrine, understanding drug tests and what they tell you, common behaviors seen in addicted professionals, what to do when your board gets sued, ethical dilemmas for board attorneys, and the standard of care for experimental modalities. Additionally, this year's program included 1.0 hour of ethics as well as the popular "State of the States" session.

The workshop was accredited by the Louisiana State Bar Association for 9.5 hours of continuing legal education (CLE) including 1.0 hour of legal ethics credit. Feedback has been extremely positive, suggesting attendees greatly benefited from the program and found the workshop quite meaningful.

*FSMB CME Program and Accreditation Services:* In 2019, the FSMB passed an important milestone! We provided continuing medical education to more than 10,000 practitioners since becoming an ACCME-accredited Continuing Medical Education provider in 2016. Since the CME program started, the FSMB has accredited a total of 59 CME activities and offered more than 212 hours of accredited CME to 10,675 physician and non-physician learners.

In 2019, CME instructional hours surged with more than 118 hours offered, and CME credit was issued to more than 5,200 health care providers.

FSMB's CME program offers its member boards free accrediting services, expertise in developing educational activities and content management and record retention.

#### *Drug Enforcement Administration (DEA) CME Collaboration*

In 2018, the FSMB partnered with the DEA to serve as the accredited CME provider for their multiple regional Practitioner Diversion Awareness Conferences (PDAC.) Designed to assist health care practitioners identify and prevent diversion activity, the conferences are open to all DEA registered practitioners and prescribers including physicians, nurses, pharmacists, dentists and veterinarians.

Since May 2018, the DEA has hosted nineteen (19) live Practitioner Diversion Awareness Conferences (PDACs) for a combined attendance of over 7,500 physician and non-physician learners. Several more conferences are scheduled to take place throughout 2020. Each live activity

has been accredited for 6.5 *AMA PRA Category 1 Credits™*. More information about the conferences is available at <https://www.deadiversion.usdoj.gov/>

#### *National Board of Medical Examiners (NBME)*

On May 15-16, 2019, the National Board of Medical Examiners (NBME) hosted a live activity titled “NBME Invitational Conference for Educators (NICE)” in Indianapolis, IN. This meeting was designed for medical educators involved in the assessment and evaluation in medical education. FSMB served as the activity’s accredited CME provider and accredited the live event for a total of 6.25 *AMA PRA Category 1 Credits™* with 152 medical educators claiming CME credit. A similar conference is being planned for May 2020.

#### *North Carolina Medical Board*

Through a joint providership agreement with the North Carolina Medical Board, the FSMB served as the accredited CME provider for a live activity hosted by the Board in conjunction with one of their Board meetings. On May 16, 2019, the FSMB accredited the live activity titled *Unconscious Bias Training*. This two-hour activity was designed to help physicians, physician assistants, nurse practitioners, and medical regulatory staff identify the different forms of bias and how those biases can negatively impact patient care or regulatory decisions.

#### *Washington Medical Commission*

On October 4-5, 2019, the FSMB accredited a live activity for the Washington Medical Commission. Titled *Health Care’s Role in Achieving Social Change*, this two-day conference was designed to help physicians, physician assistants, nurse practitioners, and other health care providers identify the many different health care disparities that exist in Washington, in the United States and throughout the world. Feedback from the 120 licensees who participated in the activity has been extremely positive.

The FSMB also accredited a live internet course for the Washington Medical Commission in March 2020. This activity focused on the recent updates to the state’s immunization requirements, rules and exceptions to the rules.

### Operational Update

During the past year, we have continued our focus on improving the services provided to our member boards and our physician user community.

On January 1, 2020 Massachusetts became the 15<sup>th</sup> SMB to require the FCVS profile as part of their licensure process. The other 14 requiring SMBs are: KY, LA, OH, ME, NC (for IMGs and existing FCVS users), NH, NY (for IMGs), NV Medical, NV Osteo, RI, SC, UT Medical, UT Osteo, and USVI.

The FCVS team achieved the following metrics since May 2019:

- Overall FCVS cycle time of just over 17 days



- FCVS customer satisfaction average of 90%; with a record setting 97% in September 2019

The current FCVS cycle time performance represents a significant improvement over historic performance by as much as thirty to forty-five days and continues a favorable trend. To address the finer points of efficiency and further establish a Continuous Process Improvement culture, a Lean Process Improvement consultant was hired in September 2019. With her help, we were able to solicit feedback directly from our team members to further eliminate non-value-added activities in our processing. The estimated annual cost savings were \$95,682.

We also determined what operational tasks are considered “rote” and do not require extensive manual review. We identified a high-volume, high-value task that could be automated with little human intervention. We also recently implemented a software automation tool that can process these transactions 24/7. We anticipate this will reduce this particular task volume significantly and will be looking for additional opportunities to implement this technology throughout our processes.

Customer satisfaction is as important as any of our metrics and the team takes great pride in the continued trend of positive results. This metric is driven in part by cycle time; however, through the Lean Management process, we have identified additional technology improvements that have been prioritized with our IT team. When implemented, these changes will improve how our team manages day to day tasks and improve physician applicant response times

Implementing inclusion of NPDB Continuous Query reports as part of the FCVS process was a significant milestone this year. Different from the previous option of an NPDB One Time Query, this report now allows the FSMB to provide participating state medical boards reports of any new NPDB actions reported about a physician that has been processed through FCVS for one year after the profile has been delivered. Adding this feature reduces process steps for member boards and for physicians. Twenty state medical boards have added this feature, either the One Time or Continuous Query as the optional service for their FCVS profiles. Feedback from these boards has been overwhelmingly positive.

These goals have been met by focusing on process improvement and digitization (digital signatures, electronic notarization, etc.) and these efforts will continue.

Uniform Application for Medical Licensure (UA): The UA has been adopted by twenty-seven (27) state medical boards. Functionality was added to allow use of the UA by Physician Assistants and has been adopted for this purpose thus far by six (6) state boards. In the past year, we implemented several enhancements to improve the applicant user experience and address individual state boards requirements that include the addition of license sub-types, pre-population of medical education, and validation of training dates as well as state-specific addenda enhancements. The technology platform used by several participating boards was also updated to current standards.

Closed Residency Programs: The FSMB’s Closed Residency Programs service provides ongoing storage of training records for physicians who attended a training program that no longer exists. This is an important service for those physicians and our member boards.

The FSMB has now also begun to digitize our Closed Programs service. In 2019, the resident training records for ProMedica Health System, Toledo Hospital, Providence Hospital, The George

Washington University, Hahnemann University Hospital, and Hahnemann University Hospital/Drexel University College of Medicine were added to the Closed Programs repository maintained by FSMB. All these programs were able to use an electronic process to deliver training records. This digital service is offered for free to closing institutions. Only resident training record information used for credentials verification of Graduate Medical Education are stored in this permanent repository. Currently, there are 300 closed residency programs stored by FSMB.

*Digital Credentials:* In January 2020, FSMB launched Digital Credentials: The Official GME Verification. This secure digital verification will be offered to physicians requesting post-graduate training (PGT) verifications from our current Closed Programs repository for a one-time fee. As part of this service, digital credentials can be sent through FCVS directly to state medical boards through their SMB portal. Physicians can also use their digital GME verification for employment or privileging.

*Physician Data Center – (PDC):* The PDC acts as a data hub and communication tool between state boards. Our dedicated data team receives licensure and discipline data from our member boards and combines this data with additional information such as specialty certification status using NCQA-certified processes and procedures. The culmination of these processes are the detailed reports and alerts available via the PDC.

Key metrics achieved during 2019 include: loading of 1,634 licensure files with/from state boards, the delivery of 117,232 detailed profile reports, and 15,714 disciplinary alerts delivered to our member boards.

*Exhibitions/Outreach:* In an effort to promote the use of FCVS, the PDC and the UA through other channels, the FSMB exhibited or presented at meetings of the following organizations during the past year:

- American Association of Colleges of Osteopathic Medicine (AACOM)
- Texas Society of Medical Staff Services
- Verity – A HealthStream Company
- National Association of Medical Staff Services (NAMSS)
- National Credentialing Forum (NCF)
- Association of American Medical Colleges (AAMC)

*Research:* In a national survey of state medical board executive directors conducted by the FSMB, boards ranked what they considered the three most important topics to the regulatory community in 2019. Opioid prescribing/addiction treatment was the most frequently cited topic, followed by physician impairment and physician wellness and burnout. The Research Department also completed its 5<sup>th</sup> biennial census of licensed physicians. This biennial project was first conducted in 2010 and offers a valuable snapshot of licensed physicians in the United States. Findings were published in the *Journal of Medical Regulation*.

To support state medical boards, the department fulfilled several requests from leadership throughout the year: leading the Board Action Content Evaluation (BACE) task force to analyze board actions and basis code data to see if redundant basis codes could be eliminated and helping pilot a second set of basis codes and definitions to help categories be more descriptive; supporting

the Accreditation Council for Continuing Medical Education's (ACCME) pilot program for participating state boards to exchange data related to CME renewal; completing a comprehensive analysis of Interstate Medical Licensure Compact (IMLC) applications and licenses issued by states as well as the average cycle time of IMLC licensing process; and conducting two online FSMB strategic planning surveys to state board executive directors, board chairs and to CEOs of partner organizations.

The department worked on publishing additional articles in peer-reviewed medical journals in 2019. In conjunction with the Medical Society of the State of New York, the FSMB published a manuscript in the *Journal of Legal Medicine* examining reporting barriers to receiving mental health care and physician burnout. Four articles were published in *Academic Medicine*: (1) a survey of public members serving on health care governing boards, completed with colleagues from the ACCME and UT-Southwestern; (2) a manuscript completed with researchers from the American Board of Family Medicine (ABFM) looking at whether ABFM-certified physicians received fewer actions from state medical boards than non-ABFM certified physicians; (3) a manuscript investigating the relationship between COMLEX-USA performance and state medical board disciplinary actions, completed with colleagues from NBOME; and (4) a manuscript with authors from Harvard University addressing professionalism lapses in medical schools as well as their relationship with problems in residency and clinical practices.

### Editorial Services

FSMB publishes several publications to help state medical boards and stakeholders stay current on emerging trends and issues in medical regulation, as well as equip them with the most current available data to enable informed decision-making by board members and policymakers.

The FSMB published its *2019 Annual Report*, which highlighted FSMB's service to its members, the public and its partner in health care. The report, which was officially released at the 2019 Annual Meeting, included updates on the FSMB's advocacy efforts in Washington, D.C.; developments in its data-gathering and data-processing capabilities; and educational initiatives.

During 2019, FSMB distributed 100 issues of the bi-weekly *FSMB eNews* e-mail bulletin to more than 5,000 individuals in the medical regulatory community, government and affiliated organizations with helpful information about FSMB events and initiatives, state medical board news and relevant health care news.

FSMB's quarterly peer-reviewed scholarly journal, the *Journal of Medical Regulation (JMR)*, continued to provide a worldwide forum of original research articles to inform and engage medical regulators on innovative strategies and solutions to improve public protection. The *JMR* launched several new initiatives in 2019 to raise the publication's visibility and improve its accessibility to both readers and researchers:

- The new "JMR Podcasts" series features interviews with authors of published JMR articles discussing what spurred their interest in the research topic and the importance of the findings for medical regulators. The debut podcasts included the lead author of the latest FSMB Census of Licensed Physicians in the United States; North Carolina Medical Board attorneys providing advice on recruiting expert witnesses in quality-of-care cases; leaders from the Educational Commission for Foreign Medical Graduates discussing ECFMG's

2023 Medical School Accreditation Requirement; and the Chief Medical Officer of the American Foundation for Suicide Prevention discussing an evidence-based approach to physician mental health.

- Several new departments to support state medical board staff and members with key resources as they carry out their work of public protection. The new sections include “Resources for Regulators,” which provides easily accessible lists of online resources specifically tailored for medical regulators; and “State Medical Board Practices,” which explores various innovative practices used by boards.

*FSMB Editorial Committee:* Under the leadership of Editor-in-Chief Heidi Koenig, MD, the Committee met in May 2019 to provide editorial guidance and article ideas to staff. Throughout the year, Committee members served on peer-review panels to evaluate each manuscript submitted to the *Journal of Medical Regulation* for potential publication. Dr. Koenig was re-elected to a second three-year term as Editor-in-Chief.

*FSMB Roundtable Webinars:* FSMB’s Editorial Services department coordinates the program of conference calls that facilitates communication among member medical boards and FSMB. These webinars provide regular opportunities for member boards to communicate with one other on current issues, public policy and legislative trends.

Topics covered during the last year included the Interstate Medical Licensure Compact; new rules from the Massachusetts board on informed consent; new rules from the Maine board on physician-patient communications; technology updates from the FSMB’s Physician Data Center and FCVS; ECFMG’s 2023 Medical School Accreditation System; the new Single GME Accreditation System; and an overview of resources available from the National Emergency Management Association for state medical boards.

## **FSMB FOUNDATION**

The Federation of State Medical Boards Research and Education Foundation (FSMB Foundation) is organized as a 501(c)(3) non-profit corporation and is recognized as a public charity by the Internal Revenue Service based on its supporting relationship to the FSMB. The mission of the FSMB Foundation is to support and promote research and education initiatives that strengthen the safety and quality of health care through effective medical regulation.

The FSMB Foundation’s Board of Directors reflects the diversity of the FSMB and its member organizations. Currently serving on FSMB Foundation’s Board of Directors are Janelle A. Rhyne, MD, MACP, of North Carolina, as President; Randal Manning, MBA, of Illinois, as Vice President; Ralph Loomis, MD, of North Carolina, as Treasurer; Humayun J. Chaudhry, DO, MACP, President and Chief Executive Officer of the FSMB, *ex officio*, as Secretary; Claudette Dalton, MD, of Virginia, as a Director; Kathleen Haley, JD, of Oregon, as a Director; Arthur Hengerer, MD, FACS, of New York, as a Director; Patricia A. King, MD, PhD, of Vermont, as a Director; Scott A. Steingard, DO, of Arizona, Chair of FSMB, *ex officio*, as a Director, and Cheryl Walker-McGill, MD, MBA, of North Carolina, Chair-elect of FSMB, as a Director.

Through generous support of the FSMB and its member boards, the FSMB Foundation has facilitated several successful and well-received initiatives and will continue to bring innovative tools and resources to state medical boards. In addition to the grants awarded to help boards in their readiness to participate and implement the Interstate Medical Licensure Compact, the FSMB Foundation widened its grantmaking in 2019, and awarded grants to state medical boards who are conducting research, creating educational materials and increasing awareness on the issues impacting medical regulation.

Additionally, during FSMB's 2019 Annual Meeting, the FSMB Foundation hosted its seventh annual luncheon on Friday, April 26, 2019. The keynote speaker for the event was Nic Sheff, author of two memoirs about his struggles with addiction and contributor to the film, *Beautiful Boy*.

## **INTERNATIONAL ORGANIZATIONS**

### **IAMRA**

IAMRA is a membership organization whose purpose is to promote effective medical regulation worldwide by supporting best practice, innovation, collaboration, and knowledge sharing in the interest of public safety and in support of the medical profession. IAMRA membership currently consists of 117 organizations from 48 countries, including the FSMB, a founding member. The FSMB continues to serve as the secretariat for IAMRA.

2019 IAMRA Symposium on Continued Competency: IAMRA held its Symposium on Continued Competency in Chicago, Illinois September 9-10, 2019. The Symposium was hosted by the American Board of Medical Specialties in co-sponsorship with the Accreditation Council for Graduate Medical Education, the Educational Commission for Foreign Medical Graduates, and the National Board of Medical Examiners. The theme of the Symposium was *Continued Competency – Balancing Assurance and Improvement*.

2020 IAMRA Conference: IAMRA was to hold its 14<sup>th</sup> International Conference on Medical Regulation in Johannesburg, South Africa September 15-18, 2020, with the Health Professions Council of South Africa hosting. Due to the COVID-19 Pandemic, it became necessary to cancel the Conference. IAMRA will explore having a conference in 2021 and holding its symposium in 2022.

IAMRA Committees and Working Groups: Dr. Humayun Chaudhry is the Secretary of IAMRA. FSMB staff participate in the Physician Information Exchange Working Group, the Research Working Group, and the IAMRA Membership and Programs Committee.

The *IAMRA Management Committee* is comprised of 3 officers and 8 Members-at-Large. The committee is comprised as follows:

*Chair:* Dr. Tebogo Kgosietsile Solomon Letlape, President, Health Professions Council of South Africa

*Chair-elect:* Dr. Heidi Oetter, Registrar, College of Physicians and Surgeons of British Columbia (Canada)

*Secretary:* Dr. Humayun Chaudhry, President and Chief Executive Officer, Federation of State Medical Boards of the United States

*Members-at-Large:*

Mr. Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency

Ms. Nicole Krishnaswami, J.D., Executive Director, Oregon Medical Board (U.S.)

Dr. Shabir Ahmed Lehri, Council Member, Pakistan Medical and Dental Council

Mr. William Prasifka, Chief Executive, Medical Council of Ireland

Mr. Paul Reynolds, Director of Strategic Communications and Engagement, General Medical Council (U.K.)

Dr. Mauro Luiz de Britto Ribeiro, President, Brazilian Federal Medical Council

Mrs. Joan Simeon, Chief Executive Officer, Medical Council of New Zealand

Mr. Daniel Yumbya, Chief Executive Officer, Kenya Medical Practitioners and Dentists Board

The Physician Information Exchange (PIE) Working Group's primary focus is to enhance patient safety and public confidence in medical regulation, and facilitate international professional mobility, through the timely exchange of relevant, accurate and reliable information on physicians between medical regulatory authorities.

The Research Working Group's primary focus is strengthening the evidence base for regulation and encouraging research and evaluation of regulatory processes.

The Membership Committee's primary focus is on membership-related objectives set by the Management Committee, including tasks related to adding value to the IAMRA membership.

### International Academy for CPD Accreditation

The International Academy for CPD Accreditation is a network of colleagues, dedicated to promoting and enhancing continuing professional development (CPD) accreditation systems throughout the world. It is also devoted to assisting and supporting the development, implementation and evolution of CPD and continuing medical education (CME) accreditation systems throughout the world.

#### Substantive Equivalency Discussions

This year, the FSMB participated in strategic sessions held in Cologne, Germany and hosted by the International Academy for CPD Accreditation on the development of standards to determine and recognize the substantive equivalency of CPD accreditation systems from different jurisdictions around the world. These standards will provide value for medical regulatory authorities and licensees by supporting the mobility of learners, allowing them to access accredited learning activities that are recognized by state medical boards and CPD accreditation systems in a manner that maximizes value of learning activities, while minimizing the burden of adhering to regulatory and accreditation requirements.

## **OTHER CONFERENCES AND MEETINGS**

A comprehensive list of the conferences/meetings attended and presentations by the FSMB's board of directors and executive management is included in **Attachment 1** (tracking of meetings attended by the FSMB board of directors began in October 2007).

**Attachment 1**

**FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF  
ACTIVITY SUMMARY  
April 28, 2019 through May 2, 2020**

<b>DATE</b>	<b>EVENT</b>	<b>BOD/EXEC</b>
April 28, 2019	Nominating Committee Kick-off Breakfast – Fort Worth, TX	<i>P. King H. Chaudhry</i>
April 28, 2019	FSMB BOD Meeting – Fort Worth, TX	<i>S. Steingard M. Arsiwala J. Carter J. Geimer-Flanders A. Hayden P. King J. Landau S. Parker J. Rexford T. Ryan K. Selzler Lippert K. Simons S. TerKonda C. Walker-McGill J. Willett H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
April 29-30, 2019	NAM Opioid Steering Committee Meeting – Washington, DC	<i>H. Chaudhry</i>
April 30, 2019	Meeting with Medical and Dental Council of Ghana – Philadelphia, PA	<i>D. Johnson</i>
May 1, 2019	Meeting with Medical and Dental Council of Ghana – Washington, DC	<i>H. Chaudhry</i>
May 2, 2019	Meeting with Gensler DC Architecture Firm and Project Manager – Washington, DC	<i>T. Phillips</i>
May 3, 2019	Massachusetts Medical Society Annual Education Meeting – Boston, MA <i>Presentation: Physician Wellness and Medical Licensing</i>	<i>H. Chaudhry</i>
May 3, 2019	NABP Annual Meeting Presentation Pre-briefing Videoconference	<i>K. Simons</i>
May 5, 2019	FSMB Chair-CEO Weekly Teleconference	<i>S. Steingard H. Chaudhry</i>
May 6, 2019	Leadership Meeting with Dr. Peter Katsufakis, NBME President – Philadelphia, PA	<i>S. Steingard</i>
May 6, 2019	Teleconference with Gensler DC Architecture Firm and Project Manager	<i>T. Phillips</i>



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**FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF  
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April 28, 2019 through May 2, 2020**

DATE	EVENT	BOD/EXEC
May 7-10, 2019	PESC Spring 2019 Data Summit/Program – Washington, DC	<i>M. Dugan</i>
May 8, 2019	World Health Organization China Roundtable – Beijing, China <i>Presentation: Medical Education, Training and Licensure in the United States</i>	<i>H. Chaudhry</i>
May 13, 2019	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish D. Johnson L. Robin</i>
May 13, 2019	Interview with “The City”	<i>H. Chaudhry</i>
May 13, 2019	June USMLE Composite Committee Planning Meeting WebEx	<i>P. King H. Chaudhry D. Johnson</i>
May 13, 2019	NABP Annual Meeting Presentation Pre-briefing Teleconference	<i>K. Simons</i>
May 13, 2019	Meeting with Gensler DC Architecture Firm and Project Manager – Washington, DC	<i>H. Chaudhry T. Phillips</i>
May 15, 2019	Michigan Board of Medicine Board Site Visit – Lansing, MI <i>Presentation: FSMB Update</i>	<i>M. Arsiwala M. Dugan</i>
May 16, 2019	Osteopathic Medical Board of California Board Site Visit – Chino, CA <i>Presentation: FSMB Update</i>	<i>J. Landau L. Robin</i>
May 17, 2019	NABP 115 <sup>th</sup> Annual Meeting – Minneapolis, MN <i>Panel Discussion Presentation: How to Make a Case in a Standards of Care World</i>	<i>K. Simons</i>
May 18, 2019	NABP Awards Presentation – Minneapolis, MN	<i>C. Walker-McGill</i>
May 20, 2019	IAMRA 2019 Symposium Panel Teleconference	<i>H. Chaudhry</i>
May 22, 2019	Monthly Teleconference with Dr. Peter Katsufakis, CEO, NBME	<i>H. Chaudhry</i>
May 23, 2019	INCUS Report Teleconference	<i>H. Chaudhry D. Johnson</i>
May 28, 2019	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish T. Phillips L. Robin</i>

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**FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF  
ACTIVITY SUMMARY  
April 28, 2019 through May 2, 2020**

<b>DATE</b>	<b>EVENT</b>	<b>BOD/EXEC</b>
May 29-31, 2019	USMLE Management Committee Meeting – Philadelphia, PA	<i>P. King D. Johnson</i>
May 31, 2019	Interview with Medpage	<i>H Chaudhry</i>
May 31, 2019	FSMB Chair-CEO Teleconference	<i>S. Steingard H. Chaudhry</i>
June 1, 2019	International Bar Association, 7th Annual World Life Sciences Conference – Philadelphia, PA <i>Panel: Artificial intelligence in the present and future of healthcare</i>	<i>E. Fish</i>
June 3, 2019	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips</i>
June 3, 2019	NAM Opioid Collaboration Steering Committee Teleconference	<i>H. Chaudhry</i>
June 3, 2019	USMLE Step 2 CS Teleconference	<i>H. Chaudhry D. Johnson</i>
June 5, 2019	FSMB Hill Visits – Washington, DC	<i>S. Steingard M. Arsiwala J. Carter J. Geimer-Flanders A. Hayden P. King J. Landau S. Parker J. Rexford K. Selzler Lippert K. Simons C. Walker-McGill J. Willett H. Chaudhry E. Fish D. Johnson</i>
June 6, 2019	Workgroup on Sexual Boundary Violations Symposium – Washington, DC	<i>S. Steingard J. Geimer-Flanders P. King J. Landau J. Rexford K. Selzler Lippert C. Walker-McGill</i>

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ACTIVITY SUMMARY  
April 28, 2019 through May 2, 2020**

DATE	EVENT	BOD/EXEC
June 7-9, 2019	AMA Council on Medical Education Stakeholders' Forum and Annual HOD Meeting – Chicago, IL	<i>C. Walker-McGill D. Johnson</i>
June 8, 2019	Special Meeting of FMRAC Board with Stakeholder Organizations – Whistler, British Columbia	<i>S. Steingard H. Chaudhry</i>
June 8-10, 2019	FMRAC Annual Meeting – Whistler, British Columbia <i>Dr. King - Keynote Speaker: Physician Sexual Boundary Violations-Effective &amp; Proactive Regulation for Public Protection</i> <i>Dr. Steingard - Panelist/Presenter: Regulatory Approaches to Handling Investigations &amp; Hearings</i>	<i>S. Steingard P. King H. Chaudhry</i>
June 9, 2019	ACGME Plenary Session – Chicago, IL	<i>K. Simons</i>
June 12-14, 2019	ONC Healthcare Directory Workshop – Washington, DC	<i>M. Dugan</i>
June 17, 2019	Teleconference with Gensler DC Architecture Firm and Project Manager	<i>H. Chaudhry T. Phillips L. Robin</i>
June 18, 2019	USMLE Composite Committee Meeting – Philadelphia, PA	<i>P. King D. Johnson</i>
June 19-20, 2019	ABMS Board of Directors Meeting – Chicago, IL	<i>J. Carter</i>
June 20, 2019	AIM-FSMB Leadership Teleconference with Diana Shepard	<i>H. Chaudhry</i>
June 20, 2019	FSMB Roundtable Webinar <u>Speakers:</u> Boyd Buser, DO, AOA Board of Trustees Executive Committee and William Mayo, DO, AOA President <u>Topic:</u> New Single GME Accreditation System	<i>H. Chaudhry</i>
June 20, 2019	Governance Committee Teleconference	<i>S. Steingard J. Carter A. Hayden S. Parker T. Ryan S. TerKonda C. Walker-McGill H. Chaudhry E. Fish L. Robin</i>
June 21, 2019	Monthly Teleconference with Dr. Peter Katsufraakis, CEO, NBME	<i>H. Chaudhry</i>
June 23, 2019	NBOME Liaison Committee Meeting – Philadelphia, PA	<i>P. King</i>
June 23-24, 2019	New Directors and New Executives Orientation – TX FSMB Office	<i>S. Steingard J. Geimer-Flanders</i>

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April 28, 2019 through May 2, 2020**

<b>DATE</b>	<b>EVENT</b>	<b>BOD/EXEC</b>
		<i>K. Selzler Lippert J. Willett H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
June 27, 2019	USMLE Staff Committee on Irregular Behavior Teleconference	<i>D. Johnson</i>
June 27, 2019	CLEAR International Congress on Professional and Occupational Regulation – Vancouver, BC <i>Presentation: Artificial Intelligence, Machine Learning, and Technology</i>	<i>E. Fish</i>
July 8, 2019	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry D. Johnson E. Fish T. Phillips L. Robin</i>
July 8, 2019	Taskforce on Artificial Intelligence Videoconference	<i>S. Steingard S. TerKonda C. Walker-McGill H. Chaudhry M. Dugan E. Fish</i>
July 9, 2019	NAM Opioid Collaboration Steering Committee Teleconference	<i>H. Chaudhry</i>
July 9, 2019	Teleconference with Vikisha Fripp, MD, Vice Chair, District of Columbia Board of Medicine	<i>C. Walker-McGill</i>
July 10-13, 2019	FSMB Compensation/Investment Committee Meetings and BOD Strategic Meeting – Kohler, WI	<i>S. Steingard M. Arsiwala J. Carter J. Geimer-Flanders A. Hayden P. King J. Landau S. Parker J. Rexford (excused) T. Ryan K. Simons S. TerKonda C. Walker-McGill J. Willett</i>

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April 28, 2019 through May 2, 2020**

<b>DATE</b>	<b>EVENT</b>	<b>BOD/EXEC</b>
		<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
July 19, 2019	Education Committee Meeting – Washington, DC	<i>S. Steingard P. King T. Ryan C. Walker-McGill H. Chaudhry L. Robin</i>
July 22, 2019	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
July 22, 2019	Monthly Teleconference with Dr. Peter Katsufraakis, CEO, NBME	<i>H. Chaudhry</i>
July 22, 2019	FSMB-DC Office Architects Teleconference	<i>H. Chaudhry</i>
July 22, 2019	NAM Opioid Webinar	<i>H. Chaudhry</i>
July 23, 2019	Congressional Briefing – Washington, DC	<i>S. Steingard H. Chaudhry L. Robin</i>
July 23, 2019	FSMB Spotlight Taping Session – Washington, DC	<i>S. Steingard H. Chaudhry</i>
July 24, 2019	Healthcare Regulatory CEO Meeting – Chicago, IL	<i>H. Chaudhry</i>
July 24, 2019	AOA Town Hall – Chicago, IL	<i>S. Steingard H. Chaudhry</i>
July 24-27, 2019	AAOE Business Meeting and AOA House of Delegates Meeting – Chicago, IL	<i>S. Steingard</i>
July 25, 2019	Council of Osteopathic Student Government Presidents Meeting – Chicago, IL	<i>H. Chaudhry</i>
July 25, 2019	FSMB Roundtable Webinar <u>Speakers:</u> William Pinsky, MD, President-CEO, ECFMG Lisa Cover, MHA, SVP for Business Development and Operations, ECFMG <u>Topic:</u> ECFMG 2023 Medical School Accreditation Requirement	<i>C. Walker-McGill D. Johnson</i>

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April 28, 2019 through May 2, 2020**

<b>DATE</b>	<b>EVENT</b>	<b>BOD/EXEC</b>
July 26, 2019	ECFMG-NBME-FSMB CEO Teleconference	<i>H. Chaudhry</i>
July 26-27, 2019	American Medical Women’s Association (AMWA): Centennial Congress of the Medical Women’s International Association (MWIA) – Brooklyn, NY	<i>P. King</i>
July 27, 2019	University of the Incarnate Word School of Osteopathic Medicine White Coat Ceremony – San Antonio, TX	<i>H. Chaudhry</i>
July 28-30, 2019	USMLE Management Committee Retreat – Cleveland, OH	<i>S. Steingard P. King H. Chaudhry D. Johnson</i>
July 29, 2019	Bilateral/Trilateral PreBriefing Teleconference	<i>F. Meyers H. Chaudhry</i>
July 29, 2019	Special Committee on Strategic Planning Pre-briefing Teleconference	<i>S. Steingard C. Walker-McGill P. King L. Robin</i>
August 2, 2019	Wyoming Board of Medicine Board Site Visit – Cheyenne, WY <i>Presentation: FSMB Update</i>	<i>S. Steingard H. Chaudhry</i>
August 2, 2019	USMLE Composite Committee Orientation WebEx	<i>C. Walker-McGill</i>
August 7, 2019	USMLE Composite Committee September Planning WebEx	<i>P. King H. Chaudhry D. Johnson</i>
August 7, 2019	Single GME Update Webinar	<i>H. Chaudhry</i>
August 9, 2019	IAMRA Executive Director Contract Teleconference	<i>H. Chaudhry</i>
August 9, 2019	FSMB-DC Office Architects Teleconference	<i>H. Chaudhry</i>
August 9, 2019	Medical Board of California Board Site Visit – San Francisco, CA <i>Presentation: FSMB Update</i>	<i>S. Steingard H. Chaudhry</i>
August 13, 2019	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
August 13, 2019	Nominating Committee Videoconference	<i>P. King H. Chaudhry</i>

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April 28, 2019 through May 2, 2020**

DATE	EVENT	BOD/EXEC
August 14, 2019	Coalition Speaker PreBriefing Teleconference with Dr. Howard Koh	<i>H. Chaudhry</i>
August 14-15, 2019	Special Committee on Strategic Planning Meeting – TX FSMB Office	<i>S. Steingard P. King F. Meyers C. Walker-McGill H. Chaudhry L. Robin</i>
August 17-18, 2019	FSMB Board of Directors, Bilateral (FSMB-NBME) and Trilateral (FSMB-ECFMG-NBME) Board Meetings – Chicago, IL	<i>S. Steingard M. Arsiwala J. Geimer-Flanders A. Hayden P. King J. Landau F. Meyers S. Parker J. Rexford T. Ryan K. Simons S. TerKonda C. Walker-McGill J. Willett H. Chaudhry E. Fish D. Johnson T. Phillips L. Robin</i>
August 19, 2019	FSMB Neighborhood Meeting – Washington, DC	<i>H. Chaudhry L. Robin</i>
August 22, 2019	New Directors Orientation – DC FSMB Office	<i>F. Meyers H. Chaudhry L. Robin</i>
August 22, 2019	Tri-Regulator Speaker PreBriefing Teleconference with Dr. Anthony Chang	<i>H. Chaudhry</i>
August 25-28, 2019	Association of Medical Educators in Europe (AMEE) Meeting – Vienna, Austria	<i>S. Steingard H. Chaudhry</i>
September 3, 2019	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>

Attachment 1

**FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF  
ACTIVITY SUMMARY  
April 28, 2019 through May 2, 2020**

DATE	EVENT	BOD/EXEC
September 4, 2019	Teleconference to Review Fail Rates on SPEX Forms	<i>H. Chaudhry</i>
September 4, 2019	Teleconference with Dr. Boyd Buser, Past President, AOA	<i>H. Chaudhry</i>
September 4, 2019	Workgroup on Physician Impairment Teleconference	<i>S. Steingard S. Parker C. Walker-McGill H. Chaudhry L. Robin</i>
September 4, 2019	Governance Committee Teleconference	<i>S. Steingard J. Carter A. Hayden S. Parker T. Ryan S. TerKonda C. Walker-McGill H. Chaudhry L. Robin</i>
September 5, 2019	Lunch Meeting with Dr. John Whyte, Chief Medical Officer, WebMD – Washington, DC	<i>H. Chaudhry</i>
September 6, 2019	Ethics & Professionalism Committee Teleconference	<i>S. Steingard K. Simons C. Walker-McGill H. Chaudhry</i>
September 6, 2019	Teleconference with Dr. Ronald Burns, President, AOA	<i>S. Steingard H. Chaudhry</i>
September 9, 2019	Breakfast Meeting with Ducksun Ahn – Chicago, IL	<i>H. Chaudhry</i>
September 9-10, 2019	IAMRA Symposium 2019– Chicago, IL	<i>S. Steingard P. King H. Chaudhry</i>
September 10, 2019	Pennsylvania State Board of Medicine Board Site Visit – Harrisburg, PA <i>Presentation: FSMB Update</i>	<i>S. TerKonda D. Johnson</i>
September 11, 2019	NBME Governance Review Task Force Teleconference	<i>P. King</i>
September 11, 2019	New York State Board for Medicine Board Site Visit PreBriefing Teleconference with Steve Boese, Executive Director and Dr. Amit Shelat, Vice Chair	<i>J. Landau H. Chaudhry</i>
September 11, 2019	Tri-Regulator Symposium Session PreBriefing Teleconference with Susan Ksiazek, RPh, DPh, Chair, NABP	<i>P. King H. Chaudhry</i>



## Attachment 1

**FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF  
ACTIVITY SUMMARY  
April 28, 2019 through May 2, 2020**

DATE	EVENT	BOD/EXEC
September 12, 2019	Teleconference with Dr. Tom Nasca, CEO, ACGME	<i>H. Chaudhry</i>
September 12, 2019	ABMS-NBME Professionalism Symposium Planning WebEx	<i>P. King</i>
September 12, 2019	Oklahoma Board of Medical Licensure & Supervision Board Site Visit – Oklahoma City, OK <i>Presentation: FSMB Update</i>	<i>M. Arsiwala L. Robin</i>
September 12, 2019	Hawaii Medical Board Board Site Visit – Honolulu, HI <i>Presentation: FSMB Update</i>	<i>K. Simons T. Phillips</i>
September 13, 2019	Teleconference with Dr. John Prescott, Chief Academic Officer, AAMC	<i>H. Chaudhry</i>
September 13, 2019	Texas Medical Association Council on Medical Education Meeting – Lost Pines, TX <i>Presentation: Trends in Medical Licensing, Assessment and Discipline</i>	<i>H. Chaudhry</i>
September 13, 2019	Tri-Regulator Symposium Session PreBriefing Teleconference	<i>S. Steingard H. Chaudhry</i>
September 16, 2019	Coalition for Physician Accountability Meeting – Chicago, IL	<i>S. Steingard P. King H. Chaudhry D. Johnson</i>
September 18, 2019	USMLE Composite Committee Meeting – Philadelphia, PA	<i>P. King C. Walker-McGill H. Chaudhry D. Johnson</i>
September 18, 2019	Introductory Teleconference with Dr. David Skorton, CEO, AAMC	<i>H. Chaudhry</i>
September 18-21, 2019	AMA's ChangeMedEd 2019 Conference – Chicago, IL	<i>P. King</i>
September 19, 2019	CSEC Steering Committee Meeting – Philadelphia, PA	<i>H. Chaudhry D. Johnson T. Phillips</i>
September 19, 2019	Meeting with Dr. Peter Katsufakis, CEO, NBME – Philadelphia, PA	<i>H. Chaudhry</i>
September 20, 2019	New York State Board for Medicine Board Site Visit – New York City, NY <i>Presentation: FSMB Update</i>	<i>J. Landau H. Chaudhry</i>
September 20, 2019	Meeting with Gensler DC Architecture Firm and Project Manager – Washington, DC	<i>T. Phillips</i>
September 22, 2019	ABMS-NBME Symposium on Professionalism – Chicago, IL	<i>J. Carter P. King</i>

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**FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF  
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April 28, 2019 through May 2, 2020**

DATE	EVENT	BOD/EXEC
	<i>Dr. King – Panelist: Ensuring Professionalism from the Perspective of the Public and Regulatory Bodies</i>	
September 22-24, 2019	Medical Council of Canada (MCC) Annual Meeting – Ottawa, Ontario, Canada	<i>S. Steingard H. Chaudhry</i>
September 23, 2019	Reception for Dr. David Skorton, CEO, AAMC – Washington, DC	<i>H. Chaudhry</i>
September 23-25, 2019	ABMS Conference – Chicago, IL	<i>J. Carter</i>
September 24, 2019	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
September 24, 2019	FSMB Roundtable Webinar <u>Speakers:</u> Dr. Ken Simons, Chair, IMLCC and Marschall Smith, Executive Director, IMLCC <u>Topic:</u> An Update on the Interstate Medical Licensure Compact	<i>K. Simons C. Walker-McGill H. Chaudhry L. Robin</i>
September 26-27, 2019	Tri-Regulator Symposium – Frisco, TX	<i>S. Steingard P. King K. Simons S. TerKonda C. Walker-McGill H. Chaudhry M. Dugan E. Fish D. Johnson L. Robin</i>
September 29, 2019	ACGME BOD Annual Meeting/Plenary Session – Chicago, IL	<i>K. Simons</i>
September 30, 2019	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
October 2, 2019	Vermont Board of Medical Practice Board Site Visit – Randolph, VT <u>Presentation:</u> FSMB Update	<i>P. King D. Johnson</i>
October 4-5, 2019	NRMP Conference – Chicago, IL	<i>D. Johnson</i>

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April 28, 2019 through May 2, 2020**

<b>DATE</b>	<b>EVENT</b>	<b>BOD/EXEC</b>
October 4-6, 2019	Osteopathic International Alliance Annual Conference – Bad Nauheim, Germany	<i>S. Steingard H. Chaudhry</i>
October 6, 2019	Alabama Board of Medical Examiners Board Site Visit – Destin, FL <i>Presentation: FSMB Update</i>	<i>J. Carter L. Robin</i>
October 8, 2019	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
October 8, 2019	NAM Opioid Collaborative Steering Committee Teleconference	<i>H. Chaudhry</i>
October 9, 2019	Business of Healthcare Podcast with Dr. Brian Miller and Dr. Micah Levine – Washington, DC	<i>H Chaudhry</i>
October 10, 2019	National Academies GME Workshop – Washington, DC	<i>H. Chaudhry</i>
October 11, 2019	New York State Office of Professional Medical Conduct Board Site Visit – Albany, NY <i>Presentation: FSMB Update</i>	<i>S. TerKonda H. Chaudhry</i>
October 11, 2019	State Board Advisory Panel to the USMLE – Philadelphia, PA	<i>D. Johnson</i>
October 14, 2019	NBME Governance Review Task Force Teleconference	<i>P. King</i>
October 14, 2019	FSMB Treasurer and Chief Financial Officer Meeting	<i>J. Landau T. Phillips</i>
October 15, 2019	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan D. Johnson T. Phillips L. Robin</i>
October 15, 2019	Audit Committee Teleconference	<i>S. Steingard M. Arsiwala A. Hayden J. Landau C. Walker-McGill J. Willett H. Chaudhry T. Phillips</i>
October 15, 2019	New DC Office Budget and Financing Teleconference	<i>S. Steingard J. Landau H. Chaudhry</i>

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ACTIVITY SUMMARY  
April 28, 2019 through May 2, 2020**

<b>DATE</b>	<b>EVENT</b>	<b>BOD/EXEC</b>
		<i>T. Phillips</i>
October 16, 2019	Monthly Teleconference with Dr. Peter Katsufarakis, CEO, NBME	<i>H. Chaudhry</i>
October 18, 2019	Pennsylvania Historical Society Annual Meeting – Indiana, PA	<i>D. Johnson</i>
October 18-20, 2019	Litchfield Meeting – Cape Elizabeth, ME	<i>H. Chaudhry</i>
October 21, 2019	NAM Annual Meeting – Washington, DC	<i>H. Chaudhry</i>
October 22, 2019	FSMB Neighborhood Meeting – Washington, DC	<i>H. Chaudhry L. Robin</i>
October 22, 2019	USMLE Orientation for State Medical Boards – Philadelphia, PA	<i>D. Johnson</i>
October 23-24, 2019	FSMB Board of Directors Meeting – Washington, DC	<i>S. Steingard M. Arsiwala J. Carter J. Geimer-Flanders A. Hayden P. King J. Landau F. Meyers S. Parker J. Rexford T. Ryan K. Simons S. TerKonda C. Walker-McGill J. Willett H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
October 25, 2019	FSMB Board of Director/Investment Committee Meetings – Washington, DC	<i>S. Steingard M. Arsiwala J. Carter J. Geimer-Flanders A. Hayden P. King J. Landau F. Meyers</i>

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**FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF  
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April 28, 2019 through May 2, 2020**

DATE	EVENT	BOD/EXEC
		<i>S. Parker J. Rexford T. Ryan K. Simons S. TerKonda C. Walker-McGill J. Willett H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
October 25, 2019	FSMB Board of Directors & FSMB Foundation Board of Directors Joint Meeting – Washington, DC	<i>S. Steingard M. Arsiwala J. Carter J. Geimer-Flanders A. Hayden P. King J. Landau F. Meyers S. Parker J. Rexford T. Ryan K. Simons S. TerKonda C. Walker-McGill J. Willett H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
October 26, 2019	Foundation Board of Directors Meeting – Washington, DC	<i>S. Steingard C. Walker-McGill H. Chaudhry L. Robin</i>
October 28, 2019	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips</i>

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DATE	EVENT	BOD/EXEC
		<i>L. Robin</i>
October 28, 2019	FCVS Advisory Council Teleconference	<i>M. Dugan</i>
October 28, 2019	Bylaws Committee Videoconference	<i>S. Steingard C. Walker-McGill H. Chaudhry E. Fish L. Robin</i>
October 31- November 2, 2019	Korean Medical Association Annual Congress – Seoul, South Korea <i>Presentation: Self Regulation in Medicine: Global Trends</i> <i>Presentation: IAMRA: Introduction and Overview</i>	<i>H. Chaudhry</i>
November 5, 2019	Teleconference with Dr. William Pinsky, CEO, ECFMG	<i>H. Chaudhry</i>
November 6, 2019	New Hampshire Board of Medicine Board Site Visit – Concord, NH <i>Presentation: FSMB Update</i>	<i>S. Parker D. Johnson</i>
November 6, 2019	CMSS Specialty Forum Panel Teleconference	<i>H. Chaudhry</i>
November 6, 2019	USMLE Composite Committee Agenda Review Teleconference	<i>P. King H. Chaudhry D. Johnson</i>
November 7-8, 2019	FSMB Board Attorneys Workshop – New Orleans, LA	<i>J. Landau F. Meyers</i>
November 8, 2019	HAVEN Mandated Reporting of Healthcare Professionals Meeting – Plantsville, CT	<i>J. Rexford</i>
November 8-12, 2019	AAMC Annual Meeting – Phoenix, AZ	<i>C. Walker-McGill D. Johnson</i>
November 9, 2019	ECFMG-FAIMER Reception and Dinner – Paradise Valley, AZ	<i>S. Steingard</i>
November 10, 2019	AAMC Annual Meeting – Phoenix, AZ (on behalf of LCME) <i>Presentation: LCME Accreditation: Where Does Process End and Outcome Begin</i>	<i>K. Simons</i>
November 11, 2019	Teleconference with Drs. Darilyn Moyer, CEO, and Davoren Chick, SVP, Medical Education, American College of Physicians	<i>H. Chaudhry</i>
November 12, 2019	Tennessee Board of Medical Examiners Board Site Visit – Nashville, TN <i>Presentation: FSMB Update</i>	<i>J. Willett L. Robin</i>
November 12, 2019	Teleconference with Dr. Ken Simons, board member	<i>H. Chaudhry</i>

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DATE	EVENT	BOD/EXEC
November 13, 2019	Puerto Rico Board of Medical Licensure & Discipline Board Site Visit – San Juan, PR <i>Presentation: FSMB Update</i>	<i>P. King L. Robin</i>
November 13, 2019	Military Reporting (Army) to State Medical Boards Teleconference	<i>H. Chaudhry L. Robin</i>
November 13, 2019	Adopting Price Controls for US Prescription Drugs: Federal Policy Outlook for 2020 Webinar	<i>H. Chaudhry</i>
November 14, 2019	IAMRA Management Committee Teleconference	<i>H. Chaudhry</i>
November 15, 2019	Washington Medical Commission Board Site Visit – Tumwater, WA <i>Presentation: FSMB Update</i>	<i>S. Steingard M. Dugan</i>
November 15, 2019	Investiture Teleconference with Paul Larson and FSMB Staff	<i>C. Walker-McGill</i>
November 17, 2019	Pre-briefing Teleconference for FSMB-NBME Subcommittee on USMLE Score Reporting Teleconference	<i>P. King K. Simons S. TerKonda C. Walker-McGill D. Johnson</i>
November 18, 2019	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
November 18, 2019	Monthly Teleconference with Dr. Peter Katsufarakis, CEO, NBME	<i>H. Chaudhry</i>
November 19, 2019	FSMB-NBME Subcommittee on USMLE Score Reporting Teleconference	<i>P. King K. Simons S. TerKonda C. Walker-McGill D. Johnson</i>
November 20, 2019	IAMRA 2022 Hosting Teleconference with Dr. Fleur-Ange Lefebvre, CEO, FMRAC and Dr. Heidi Oetter, Registrar, College of Physicians and Surgeons of British Columbia	<i>H. Chaudhry</i>
November 20, 2019	NBME Governance Review Task Force Teleconference	<i>P. King</i>
November 21, 2019	License Portability for Physician Assistants Meeting – Washington, DC	<i>S. TerKonda H. Chaudhry L. Robin</i>
November 21, 2019	Special Committee on Strategic Planning Videoconference	<i>S. Steingard P. King</i>

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April 28, 2019 through May 2, 2020**

<b>DATE</b>	<b>EVENT</b>	<b>BOD/EXEC</b>
		<i>F. Meyers C. Walker-McGill H. Chaudhry L. Robin</i>
November 22-23, 2019	CMSS Annual Meeting and Specialty Forum – Arlington, VA	<i>S. TerKonda H. Chaudhry E. Fish</i>
November 25, 2019	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish T. Phillips L. Robin</i>
November 25, 2019	Teleconference with Dr. Richard Hawkins, CEO, ABMS	<i>H. Chaudhry</i>
November 25, 2019	FSPHP-ACGME-FSMB Staff Teleconference	<i>H. Chaudhry</i>
November 25, 2019	Teleconference with Dr. Steve Shannon, former CEO, AACOM	<i>H. Chaudhry</i>
November 25, 2019	Teleconference with Dr. Holly Humphrey, CEO, Macy Foundation	<i>H. Chaudhry</i>
November 25, 2019	USMLE Communications Scenario Planning Meeting – Philadelphia, PA	<i>D. Johnson</i>
November 26, 2019	Teleconference with Stephanie Loucka, Executive Director, State Medical Board of Ohio	<i>H. Chaudhry L. Robin</i>
December 1, 2019	Pre-briefing for Board of Directors Videoconference	<i>S. Steingard P. King J. Landau C. Walker-McGill H. Chaudhry</i>
December 2, 2019	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
December 3, 2019	Board of Directors Videoconference	<i>S. Steingard M. Arsiwala J. Carter J. Geimer-Flanders A. Hayden P. King J. Landau</i>



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DATE	EVENT	BOD/EXEC
		<i>F. Meyers S. Parker J. Rexford T. Ryan K. Simons S. TerKonda C. Walker-McGill J. Willett H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
December 4-5, 2019	USMLE Management Committee Meeting – Philadelphia, PA	<i>P. King D. Johnson</i>
December 6, 2019	Nebraska Board of Medicine & Surgery Board Site Visit – Lincoln, NE <i>Presentation: FSMB Update</i>	<i>J. Carter M. Dugan</i>
December 6, 2019	ECFMG/FAIMER Stakeholders Meeting – Philadelphia, PA	<i>D. Johnson</i>
December 9, 2019	Arizona Medical Board Board Site Visit – Phoenix, AZ <i>Presentation: FSMB Update</i>	<i>S. Steingard C. Walker-McGill L. Robin</i>
December 9-10, 2019	USMLE Committee for Individualized Review (CIR) Meeting – Philadelphia, PA	<i>D. Johnson</i>
December 10-11, 2019	Global Symposium on Health Workforce Accreditation and Regulation – Istanbul, Turkey	<i>H. Chaudhry</i>
December 11-14, 2019	AIMed Summit and Chair’s Dinner – Laguna Beach, CA <i>Verbal Report: The use of artificial intelligence in multiple specialties</i>	<i>S. TerKonda E. Fish</i>
December 12, 2019	Staff Committee for the Review of Anomalous Performance (SCRAP) Videoconference	<i>D. Johnson</i>
December 13, 2019	NAM Opioid Collaborative Steering Committee De-Briefing Teleconference	<i>H. Chaudhry</i>
December 13, 2019	FSMB Holiday Party –TX FSMB Office	<i>S. Steingard</i>
December 14, 2019	NBOME Annual Board Dinner and Awards Ceremony – Santa Barbara, CA	<i>S. Steingard</i>
December 16, 2019	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan T. Phillips</i>

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<b>DATE</b>	<b>EVENT</b>	<b>BOD/EXEC</b>
		<i>L. Robin</i>
December 16, 2019	Teleconference with Linda Bresnahan, Executive Director, FSPHP	<i>H. Chaudhry</i>
December 16, 2019	Teleconference with Moe Auster, Senior Vice President, Philip Schuh, Executive Vice President and Dr. Art Fougner, President, Medical Society of the State of New York	<i>H. Chaudhry</i>
December 16, 2019	IAMRA 2022 Hosting Teleconference with Dr. Fleur-Ange Lefebvre, CEO, FMRAC and Dr. Heidi Oetter, Registrar, College of Physicians and Surgeons of British Columbia	<i>H. Chaudhry</i>
December 16, 2019	Coalition for Physician Accountability Planning Teleconference for Reviewing UME/GME Transition	<i>H. Chaudhry</i>
December 16, 2019	FSMB-NBME Subcommittee on USMLE Score Reporting Meeting – Philadelphia, PA	<i>P. King K. Simons C. Walker-McGill H. Chaudhry D. Johnson</i>
December 17, 2019	Monthly Teleconference with Dr. Peter Katsufakis, CEO, NBME	<i>H. Chaudhry</i>
December 17, 2019	Teleconference with Dr. Cheryl Walker-McGill, FSMB Chair-elect	<i>H. Chaudhry</i>
December 17, 2019	Planning Committee Meeting Pre-Briefing Teleconference	<i>C. Walker-McGill H. Chaudhry L. Robin</i>
December 18, 2019	Interview for <i>ACOInformation</i> newsletter	<i>H. Chaudhry</i>
December 18, 2019	NBME Governance Review Task Force Teleconference	<i>P. King</i>
December 18, 2019	CSEC Steering Committee Videoconference	<i>H. Chaudhry D. Johnson T. Phillips</i>
December 18, 2019	Teleconference with Tom Ryan, JD, board member	<i>H. Chaudhry</i>
December 19, 2019	Teleconference with Dr. Mohammed Arsiwala, board member	<i>H. Chaudhry</i>
December 19, 2019	FSMB-AIM Leadership Teleconference with Anne Lawler, AIM President	<i>H. Chaudhry</i>
December 19, 2019	Workgroup to Study Risk and Support Factors Affecting Physician Performance Teleconference	<i>S. Steingard M. Arsiwala C. Walker-McGill H. Chaudhry</i>

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<b>DATE</b>	<b>EVENT</b>	<b>BOD/EXEC</b>
December 20, 2019	FSMB-FDA Teleconference	<i>H. Chaudhry L. Robin</i>
December 23, 2019	Teleconference with Dr. William Pinsky, CEO, ECFMG	<i>H. Chaudhry</i>
December 23, 2019	Teleconference with Jean Rexford, board member	<i>H. Chaudhry</i>
January 6, 2020	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
January 6, 2020	Monthly Teleconference with Dr. Peter Katsuftrakis, CEO, NBME	<i>H. Chaudhry</i>
January 7, 2020	Academic Medicine Commentaries on the USMLE Teleconference	<i>S. Steingard P. King J. Landau C. Walker-McGill H. Chaudhry D. Johnson</i>
January 8, 2020	NBME Governance Review Task Force Meeting – Philadelphia, PA	<i>P. King</i>
January 8-10, 2010	Harvard Business School Executive Education Program – Boston, MA	<i>H. Chaudhry</i>
January 9, 2020	Awards Committee Videoconference	<i>S. Steingard P. King J. Landau J. Rexford T. Ryan C. Walker-McGill J. Willett H. Chaudhry L. Robin</i>
January 10, 2020	AMA State Advocacy Summit – Bonita Springs, FL <i>Panel Presentation: “A Primer on Augmented Intelligence and its Transformational Impact on Health Care”</i>	<i>S. TerKonda</i>
January 13, 2020	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>

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<b>DATE</b>	<b>EVENT</b>	<b>BOD/EXEC</b>
January 13, 2020	Meeting with Drs. Peter Katsufakis, CEO and Mike Barone, VP, Licensure Programs, NBME	<i>H. Chaudhry D. Johnson</i>
January 14, 2020	USMLE Composite Committee Meeting – TX FSMB Office	<i>P. King C. Walker-McGill H. Chaudhry D. Johnson</i>
January 16, 2020	Finance Committee Planning Proposed FY 2021 Budget Teleconference	<i>J. Landau T. Phillips</i>
January 16-17, 2020	ASAE CEO Symposium – Orlando, FL	<i>C. Walker-McGill H. Chaudhry</i>
January 17, 2020	Missouri Board of Registration for the Healing Arts Board Site Visit – Jefferson City, MO <i>Presentation: FSMB Update</i>	<i>J. Carter D. Johnson</i>
January 21, 2020	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
January 21, 2020	Monthly Teleconference with Dr. Peter Katsufakis, CEO, NBME	<i>H. Chaudhry</i>
January 21, 2020	Teleconference with Carmen Catizone, CEO, NABP and Dr. David Benton, CEO, NCSBN	<i>H. Chaudhry</i>
January 21, 2020	IAMRA 2022 Hosting Teleconference with Dr. Fleur-Ange Lefebvre, CEO, FMRAC and Dr. Heidi Oetter, Registrar, College of Physicians and Surgeons of British Columbia	<i>H. Chaudhry</i>
January 22, 2020	Finance Committee Meeting – TX FSMB Office	<i>S. Steingard J. Landau C. Walker-McGill H. Chaudhry T. Phillips</i>
January 23, 2020	Nominating Committee Meeting – TX FSMB Office	<i>P. King H. Chaudhry E. Fish</i>
January 24, 2020	Meeting with Paul Jung, HRSA – DC FSMB Office	<i>H. Chaudhry L. Robin</i>
January 27, 2020	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>

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<b>DATE</b>	<b>EVENT</b>	<b>BOD/EXEC</b>
January 27, 2020	Manatee Memorial Hospital Presentation – Bradenton, FL	<i>H. Chaudhry</i>
January 28, 2020	Meeting with Dr. Steve Kanter, CEO, Association of Academic Health Centers – DC FSMB Office	<i>H. Chaudhry</i>
January 29, 2020	Medical Educational Engagement to Support Safer Prescribing Webinar	<i>H. Chaudhry</i>
January 29, 2020	ACGME Annual Educational Conference Panel Teleconference	<i>H. Chaudhry</i>
January 29, 2020	FSMB-AIM Leadership Teleconference with Anne Lawler, AIM President	<i>H. Chaudhry</i>
January 29, 2020	Workgroup on Physician Sexual Misconduct Teleconference	<i>P. King J. Rexford C. Walker-McGill H. Chaudhry</i>
January 29, 2020	USMLE Communications Scenario Planning Meeting – Philadelphia, PA	<i>D. Johnson</i>
January 30, 2020	FSMB-AMA Quarterly Staff Teleconference	<i>H. Chaudhry L. Robin</i>
January 30, 2020	NAM Opioid Collaborative Steering Committee Teleconference	<i>H. Chaudhry</i>
January 31, 2020	FSMB-FSPHP Planning Teleconference	<i>S. Stengard</i>
February 1, 2020	Leadership Teleconference with National Medical Association Past President Dr. Cedric Bright	<i>C. Walker-McGill</i>
February 3, 2020	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry E. Fish D. Johnson T. Phillips L. Robin</i>
February 3, 2020	ACGME Plenary Session – Chicago, IL	<i>K. Simons</i>
February 5, 2020	C-Suite Retreat – Dallas, TX	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
February 5, 2020	Composite Committee Agenda Review Teleconference	<i>H. Chaudhry D. Johnson</i>
February 5, 2020	FSMB Investment Committee Meetings – Dallas, TX	<i>S. Steingard J. Carter P. King J. Landau K. Simons S. TerKonda</i>

**Attachment 1**

**FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF  
ACTIVITY SUMMARY  
April 28, 2019 through May 2, 2020**

<b>DATE</b>	<b>EVENT</b>	<b>BOD/EXEC</b>
		<i>C. Walker-McGill H. Chaudhry T. Phillips</i>
February 6-8, 2020	FSMB Board of Director Meetings – Dallas, TX	<i>S. Steingard M. Arsiwala J. Carter J. Geimer-Flanders A. Hayden P. King J. Landau F. Meyers S. Parker J. Rexford T. Ryan K. Simons S. TerKonda C. Walker-McGill J. Willett H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
February 9, 2020	Teleconference with Dr. John Gimpel, CEO, NBOME	<i>H. Chaudhry</i>
February 9, 2020	Teleconference with Dr. Robert Zena, President, American Association of Dental Boards (AADB)	<i>H. Chaudhry</i>
February 9, 2020	Teleconference with Dr. Tom Nasca, CEO, ACGME	<i>H. Chaudhry</i>
February 9, 2020	Teleconference with Dr. Darilyn Moyer, CEO, ACP	<i>H. Chaudhry</i>
February 9, 2020	Teleconference with Dr. Kevin Klauer, CEO, AOA	<i>H. Chaudhry</i>
February 11, 2020	Teleconference with Dr. Helen Burstin, CEO, CMSs	<i>H. Chaudhry</i>
February 11, 2020	Teleconference with Dr. Robert Cain, CEO, AACOM	<i>H. Chaudhry</i>
February 11, 2020	Interview for NAM Action Collaborative webpage	<i>H. Chaudhry</i>
February 11, 2020	FSMB Neighborhood Meeting – Washington, DC	<i>H. Chaudhry L. Robin</i>

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April 28, 2019 through May 2, 2020**

<b>DATE</b>	<b>EVENT</b>	<b>BOD/EXEC</b>
February 13, 2020	ECFMG-NBME-FSMB Quarterly CEO Teleconference	<i>H. Chaudhry</i>
February 13, 2020	IAMRA Management Committee Teleconference	<i>H. Chaudhry</i>
February 14, 2020	Chair-elect-CFO Teleconference	<i>C. Walker-McGill T. Phillips</i>
February 18, 2020	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish T. Phillips L. Robin</i>
February 18, 2020	FMRAC-FSMB IAMRA 2022 Teleconference	<i>H. Chaudhry T. Phillips</i>
February 19, 2020	Planning Committee Videoconference	<i>S. Steingard M. Arsiwala J. Geimer-Flanders F. Meyers K. Simons C. Walker-McGill H. Chaudhry L. Robin</i>
February 20, 2020	Teleconference with Niva Lubin-Johnson, MD, President, National Medical Association (NMA)	<i>C. Walker-McGill</i>
February 21, 2020	USMLE Medical Student and Resident Advisory Panel Meeting	<i>H. Chaudhry D. Johnson</i>
February 21, 2020	A.T. Still University School of Osteopathic Medicine Presentation – Mesa, AZ <i>Presentation: Introduction to Aerospace Medicine Presentation: Trends in Medical Licensure and Professionalism”</i>	<i>S. Steingard H. Chaudhry</i>
February 24, 2020	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan D. Johnson T. Phillips L. Robin</i>
February 24, 2020	Lunch Meeting with Dr. Jacqueline Watson, Chief of Staff, DC Department of Health	<i>H. Chaudhry</i>
February 24, 2020	Teleconference with Dr. Peter Katsufakis, CEO, NBME	<i>H. Chaudhry</i>
February 25, 2020	Tri-Regulator Leadership Collaborative Meeting – Washington, DC	<i>S. Steingard H. Chaudhry</i>
February 25, 2020	NBME Governance Review Task Force Teleconference	<i>P. King</i>

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February 25, 2020	USMLE CSEC Steering Committee Meeting – Philadelphia, PA	<i>D. Johnson T. Phillips</i>
February 26, 2020	FSMB-AIM Leadership Teleconference with Anne Lawler, President	<i>H. Chaudhry</i>
February 26, 2020	Teleconference with Danielle Mitchell, AIA, McKinley Advisors Sr. Project Associate, McKinley Advisors	<i>C. Walker-McGill</i>
February 27-29, 2020	ACGME Annual Educational Conference – San Diego, CA <i>Presentation (Simons): How DIOs Address International Experiences for Residents, and Other Issues</i> <i>Panelist (Chaudhry): Looking Back at the Closure of Hahnemann University Hospital</i> <i>Speaker (Chaudhry): The USMLE Score Reporting Decision</i>	<i>K. Simons H. Chaudhry</i>
February 28, 2020	Teleconference with Leon McDougle, MD, MPH, President-elect, National Medical Association (NMA)	<i>C. Walker-McGill</i>
February 29, 2020	AAOE Summit Meeting – Manalapan, FL <i>Presentation: FSMB Update</i>	<i>S. Steingard</i>
March 2, 2020	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
March 2, 2020	Planning Committee Videoconference	<i>S. Steingard M. Arsiwala J. Geimer-Flanders F. Meyers K. Simons C. Walker-McGill H. Chaudhry L. Robin</i>
March 2, 2020	FSMB Board of Directors Videoconference	<i>S. Steingard M. Arsiwala J. Carter J. Geimer-Flanders A. Hayden P. King J. Landau F. Meyers S. Parker J. Rexford T. Ryan</i>



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DATE	EVENT	BOD/EXEC
		<i>K. Simons S. TerKonda C. Walker-McGill J. Willett H. Chaudhry</i>
March 3, 2020	Teleconference with Dr. Shantanu Agrawal, CEO and Ayesha D'Avena, Vice President, Strategic Planning, National Quality Forum (NQF)	<i>H. Chaudhry</i>
March 4, 2020	Teleconference with Dr. Kgosì Letlape, Chair, IAMRA	<i>H. Chaudhry</i>
March 4, 2020	Radiology Technology Innovations: AI and Beyond Webinar	<i>H. Chaudhry</i>
March 4, 2020	USMLE Committee for Individualized Review Meeting – Philadelphia, PA	<i>D. Johnson</i>
March 6, 2020	Committee Appointments Review – DC FSMB Office	<i>C. Walker-McGill H. Chaudhry L. Robin</i>
March 6, 2020	USMLE Step 2 CS Redesign Teleconference	<i>H. Chaudhry D. Johnson</i>
March 9, 2020	C-Suite Meeting – DC and TX FSMB Offices	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
March 10, 2020	NAM Webinar: Caring for Patients with Chronic Pain	<i>H. Chaudhry</i>
March 10, 2020	Ad Hoc Task Force on Pandemic Preparedness Teleconference	<i>H. Chaudhry</i>
March 10, 2020	Maine Board of Licensure in Medicine Board Site Visit – Augusta, ME <i>Presentation: FSMB Update</i>	<i>P. King D. Johnson</i>
March 11, 2020	USMLE Program COVID-19 Crisis Response Teleconference	<i>H. Chaudhry D. Johnson</i>
March 11, 2020	Board of Directors Videoconference	<i>H. Chaudhry T. Phillips</i>
March 13, 2020	FSMB Roundtable Webinar <u>Speaker:</u> Anne Lawler, JD, RN, AIM President and Executive Director, Idaho State Board of Medicine <u>Topic:</u> State Medical Board Response to COVID-19	<i>P. King C. Walker-McGill</i>
March 16, 2020	C-Suite Meeting	<i>H. Chaudhry M. Dugan</i>

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		<i>E. Fish D. Johnson T. Phillips L. Robin</i>
March 23, 2020	Teleconference with Dr. Janis Orlowski, Chief Health Care Officer, AAMC	<i>H. Chaudhry</i>
March 23, 2020	IAMRA Management Committee Teleconference	<i>H. Chaudhry</i>
March 23, 2020	C-Suite Meeting	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
March 23, 2020	Healthcare Workforce Needs During COVID-19 Teleconference	<i>H. Chaudhry D. Johnson</i>
March 24, 2020	C-Suite Meeting	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
March 24, 2020	Education Committee Teleconference	<i>S. Steingard P. King T. Ryan C. Walker-McGill H. Chaudhry L. Robin</i>
March 24, 2020	House of Delegates Script Pre-briefing Teleconference	<i>S. Steingard H. Chaudhry</i>
March 25, 2020	NAM Opioid Collaborative State Licensing Board Symposium Planning Teleconference	<i>H. Chaudhry</i>
March 25, 2020	Chair-elect and CEO Teleconference	<i>C. Walker-McGill H. Chaudhry</i>
March 25, 2020	NAM/APHA Webinar on Social Distancing	<i>H. Chaudhry</i>
March 25, 2020	Ad Hoc Task Force on Pandemic Response Teleconference	<i>S. Steingard P. King F. Meyers C. Walker-McGill H. Chaudhry L. Robin</i>

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<b>DATE</b>	<b>EVENT</b>	<b>BOD/EXEC</b>
March 26, 2020	New York Times Interview	<i>H. Chaudhry</i>
March 26, 2020	ABC News Interview	<i>H. Chaudhry</i>
March 26, 2020	AACOM Board of Deans Meeting Pre-Briefing Teleconference with Dr. Peter Katsufakis, CEO, NBME and Dr. Michael Barone, VP, Licensure Programs	<i>H. Chaudhry D. Johnson</i>
March 27, 2020	Teleconference with Dr. William Pinsky, CEO, ECFMG	<i>H. Chaudhry</i>
March 27, 2020	Institute for Healthcare Improvement Webinar on Mobilizing to Reduce COVID-19	<i>H. Chaudhry</i>
March 28, 2020	Teleconference with Dr. Tom Nasca, CEO, ACGME	<i>H. Chaudhry</i>
March 28, 2020	AACOM Board of Deans COVID-19 Discussion	<i>H. Chaudhry</i>
March 28, 2020	Teleconference with Dr. Joseph Zammuto, Chair, Osteopathic Medical Board of California	<i>H. Chaudhry</i>
March 29, 2020	Teleconference with Dr. Lawrence Epstein, Chair, New York State Board for Medicine	<i>H. Chaudhry</i>
March 29, 2020	Chair-CEO Teleconference	<i>S. Steingard H. Chaudhry</i>
March 30, 2020	NAM Opioid Collaborative Steering Committee Teleconference	<i>H. Chaudhry</i>
March 30, 2020	USMLE Composite Committee WebEx	<i>P. King C. Walker-McGill H. Chaudhry D. Johnson</i>
March 30, 2020	NYIT COM Advisory Board Videoconference	<i>H. Chaudhry</i>
March 31, 2020	C-Suite Videoconference	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
March 31, 2020	Rules Committee Teleconference	<i>C. Walker-McGill H. Chaudhry</i>
April 1, 2020	Litchfield CEO COVID-19 Teleconference	<i>H. Chaudhry</i>
April 3, 2020	Harvard HPM Executive Council Videoconference	<i>H. Chaudhry</i>
April 7, 2020	Coalition for Physician Accountability Teleconference	<i>S. Steingard C. Walker-McGill</i>

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		<i>H. Chaudhry</i>
April 7, 2020	C-Suite Videoconference	<i>H. Chaudhry E. Fish D. Johnson T. Phillips L. Robin</i>
April 8, 2020	Nominating Committee Annual Meeting Pre-briefing Videoconference	<i>P. King H. Chaudhry</i>
April 9, 2020	Ad Hoc Task Force on Pandemic Response Teleconference	<i>S. Steingard P. King F. Meyers C. Walker-McGill H. Chaudhry L. Robin</i>
April 15, 2020	Monthly Teleconference with Dr. Peter Katsufakis, CEO, NBME	<i>H. Chaudhry</i>
April 15, 2020	IAMRA Management Committee Teleconference	<i>H. Chaudhry</i>
April 17, 2020	Healthcare Regulatory CEO Virtual Meeting	<i>H. Chaudhry</i>
April 21, 2020	C-Suite Meeting	<i>H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
April 29, 2020	FSMB Compensation Committee Teleconference	<i>S. Steingard J. Carter P. King J. Landau K. Simons S. TerKonda C. Walker-McGill H. Chaudhry T. Phillips</i>
April 29, 2020	FSMB Board of Directors Videoconference	<i>S. Steingard M. Arsiwala J. Carter J. Geimer-Flanders A. Hayden P. King J. Landau</i>

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DATE	EVENT	BOD/EXEC
		<i>F. Meyers S. Parker J. Rexford T. Ryan K. Simons S. TerKonda C. Walker-McGill J. Willett H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>
April 29, 2020	FSMB Executive Session Videoconference	<i>S. Steingard M. Arsiwala J. Carter J. Geimer-Flanders A. Hayden P. King J. Landau F. Meyers S. Parker J. Rexford T. Ryan K. Simons S. TerKonda C. Walker-McGill J. Willett H. Chaudhry E. Fish</i>
May 2, 2020	FSMB House of Delegates Virtual Meeting	<i>S. Steingard M. Arsiwala J. Carter J. Geimer-Flanders A. Hayden P. King J. Landau F. Meyers S. Parker J. Rexford T. Ryan K. Simons</i>

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DATE	EVENT	BOD/EXEC
		<i>S. TerKonda C. Walker-McGill J. Willett H. Chaudhry M. Dugan E. Fish D. Johnson T. Phillips L. Robin</i>

## Report to the House of Delegates on the FSMB 2015-2020 Strategic Plan

*The following is a status report on progress toward achievement of the Strategic Goals as adopted by the House of Delegates in April 2015.*

### Goal I: State Medical Board Support

#### **Serve state medical boards by promoting best practices and providing policies, advocacy, and other resources that add to their effectiveness.**

The FSMB continues to advocate for bipartisan federal legislation that would limit antitrust liability for state licensing boards, with the *Occupational Licensing Board Antitrust Damages Relief and Reform Act of 2018* (H.R. 6515) being introduced in the House of Representatives in July, and a companion bill (S. 3598) introduced in the Senate in October. This effort is in response to the 2015 U.S. Supreme Court decision issued in *North Carolina State Board of Dental Examiners v. Federal Trade Commission*, which has left state professional and occupational licensing boards, their appointed members and their staff members in a state of uncertainty and vulnerability.

- As a founding member of the Professional Licensing Coalition (PLC), which is comprised of organizations representing state occupational and licensing boards, the FSMB communicates regularly with communications with coalition members and with Congressional staff.

The FSMB continues to support state medical boards interested in implementing the Interstate Medical Licensure Compact (IMLC), which creates a new, voluntary pathway to expedite the licensing of interested and eligible physicians seeking to practice medicine in multiple states.

- As of March 2020, 29 states, the District of Columbia, and Guam have enacted the Compact and six additional states have introduced the legislation.
- The FSMB submitted written testimony and letters of support for the IMLC in Florida, New Jersey, and South Carolina.
- In May 2019, the FSMB was awarded a five-year grant of \$250,000 annually from the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, to support the IMLC and further enhance license portability for physicians and physician assistants (PAs). The five-year HRSA grant will be used to support license portability for PAs, enhance the IMLC technology platform to enable secure communications among IMLC member boards, and expand outreach to educate stakeholders on how to utilize the IMLC to improve access to care using telemedicine across state lines. The grant will also support new and existing IMLC member states in increasing efficiency in conducting required criminal background checks.
- In November 2019, the FSMB held a meeting in Washington, D.C., to explore license portability options for the nation's physician assistants.
- Working with the IMLCC, the FSMB fielded an online survey to states that have implemented the IMLC to learn more about their experiences, positive outcomes and challenges. Additionally, FSMB conducted research that 1) provided findings of licenses issued by Compact states and the distribution of specialties by state for a HRSA grant application; 2) updated statistics of physician eligibility for licensure through the IMLC from Compact states; and 3) provided a data analysis of IMLC applications and licenses issued by states and the average cycle time of the IMLC licensing process.

Several FSMB Committees and Workgroups met this year to develop policies and guidance documents to support state medical boards.

- *FSMB Editorial Committee*: The Committee met in May 2019 to provide guidance and article ideas to staff facilitating development of editorial content for the *Journal of Medical Regulation*

(*JMR*). Throughout the year, Committee members served on peer-review panels to evaluate each manuscript submitted to *JMR* for potential publication. Heidi Koenig, MD, was re-elected to a second three-year term as Editor-in-Chief.

- *Ethics and Professionalism Committee*: The Committee's charge for 2019-20 included 1) developing a position statement on physician treatment of self and family members; 2) considering updates to the policy on Ethics and Quality of Care developed jointly with the American Medical Association; and 3) finalizing guidance to state medical boards on compounding of medications by physicians. The Committee will be consulting with state medical boards on a position statement on the treatment of self and family members in the summer of 2020. FSMB will continue to work with the American Medical Association to determine whether there is mutual interest in revising the policy on Ethics and Quality of Care collaboratively. A guidance document for state medical boards addressing considerations in physician compounding and summarizing relevant federal legislation was shared with state medical boards in March 2020.
- *Special Committee on Strategic Planning*: The Committee was charged with evaluating the continued relevance of the FSMB's 2015-2020 Strategic Plan, which includes the organization's Vision, Mission Statement and Strategic Goals that guide the FSMB's work in supporting its member boards as they protect the public's health, safety and welfare through the proper licensing, disciplining and regulation of physicians and other health care professionals. The Committee will present a new and enhanced Strategic Plan to the 2020 House of Delegates for approval.
- *Advisory Council of Board Executives*: Charged with providing guidance on Resolution 19-4: Emergency Licensure Following a Natural Disaster, submitted by the North Carolina Medical Board and referred by the House of Delegates to the FSMB Board of Directors for study. The Advisory Council provided guidance to the Board of Directors in developing an informational report on Resolution 19-4 to the House of Delegates in April 2020.
- *Workgroup on Board Education, Service and Training (BEST)*: The Workgroup is developing multiple resources to support state medical board members in their roles and responsibilities associated with service on a state medical or osteopathic board. The Workgroup launched its first online resource, "Understanding Medical Regulation in the United States," this year.
- *Workgroup on Physician Sexual Misconduct*: This Workgroup has been charged with 1) collecting and reviewing available disciplinary data, including incidence and spectrum of severity of behaviors and sanctions, related to sexual misconduct; 2) identifying and evaluating barriers to reporting sexual misconduct to state medical boards, including, but not limited to, the impact of state confidentiality laws, state administrative codes and procedures, investigative procedures, and cooperation with law enforcement on the reporting and prosecution/adjudication of sexual misconduct; 3) evaluating the impact of state medical board public outreach on reporting; 4) reviewing the FSMB's 2006 policy statement, *Addressing Sexual Boundaries: Guidelines for State Medical Boards*, and revising, amending or replacing it, as appropriate; and 5) assessing the prevalence of sexual misconduct training in undergraduate and graduate medical education and developing recommendations and/or resources to address gaps. After two years of careful study and extensive consultation with state medical boards, partner organizations, survivors of sexual assault by physicians, and members of the public, a final report with recommendations has been completed and will be considered by the FSMB House of Delegates in May 2020.
- *Workgroup to Study Risk and Support Factors Affecting Physician Performance*: This Workgroup is charged with 1) collecting and evaluating data and research on factors affecting physician performance and ability to practice medicine safely, including but not limited to practice context (specialty, workload, solo/group, urban/rural), gender, time in practice, examination scores, and culture; 2) convening stakeholder organizations and experts to engage in collaborative discussions about patient safety issues and ethical and professional responsibilities as they relate to physician performance, including the duty to report; 3) identifying principles, strategies,



resources and best practices for assessing and mitigating potential impacts on physician performance; and 4) providing information to state medical boards about the risk and support factors affecting physician performance throughout their careers, how these can impact patient care, and what key principles should be applied to consideration of fair, equitable and transparent regulatory processes. In 2020-2021, workgroup members will prioritize the study of biopsychosocial risk factors for physicians and determining best practices in the use of regulatory data for identifying physicians at risk for poor performance and effectively targeting support to those physicians. The workgroup will use a framework for analyzing risk factors across all career stages, attempting to map existing supports onto each of these.

The FSMB works directly with state medical boards to achieve their individual legislative and policy priorities. In 2019, FSMB State Legislative and Policy staff:

- Routinely responded to numerous research inquiries and requests for support from state boards.
- Attended state legislative hearings to testify and distribute policy documents directly to legislative and policymaking bodies. Legislative bills that the FSMB provided letters of support for included the Interstate Medical Licensure Compact (Florida, New Jersey, and South Carolina), as well as Minnesota HF 637 and SF 583, which provided Minnesota the statutory authority to conduct criminal background checks as part of the IMLC process.
- Assisted state boards by monitoring, tracking, and analyzing relevant legislation and regulations.
- Maintained a robust portfolio of policy documents, which are continually updated to reflect the most current regulatory and legal landscape. Legislative tracking documents that were updated during 2019 included: Board Composition, Continuing Medical Education, Marijuana, Medical Marijuana, Continuing Medical Education, Pain Management, Prescription Drug Monitoring Programs, Standard of Proof, Physician Profiles, and Telemedicine.

The FSMB works directly with state medical boards to review their operational practices, procedures and policies and provide recommendations that encourage established best practices.

- As part of completing the charge of Resolution 18-1: Acute Opioid Prescribing Guidelines, the FSMB created an “Opioids and Pain Management” resource site at [fsmb.org/opioids](http://fsmb.org/opioids) to provide medical boards and other interested parties a repository of FSMB policies, federal resources, state-by-state overviews of key issues, and highlighted state initiatives that may assist states in tackling the opioid epidemic.

The FSMB continues to provide data services that support state medical boards in their mission of protecting the public.

- The FSMB Physician Data Center (PDC) is a central repository for actions taken against physicians and physician assistants by state licensing and disciplinary boards and other national and international regulatory bodies. The PDC notifies querying organizations and state medical boards if the physician of interest has been disciplined, as well as other states in which the physician is licensed. State medical boards queried the PDC 117,232 times in 2019. State boards also continue to successfully collaborate in using the FSMB’s Disciplinary Alert Service (DAS) to prevent disciplined physicians with multiple licenses from resuming practice undetected in new locations. In 2019, state boards received 15,714 alerts from the FSMB’s DAS.

The USMLE is a premier tool for medical boards seeking to accurately evaluate physicians applying for initial licensure. The FSMB continues to explore mechanisms by which it may bolster state board participation in the USMLE program and identify and implement further program improvements.

- The FSMB and NBME co-hosted the 13th annual USMLE orientation for current and former members of state medical boards to identify individuals interested in participating with the USMLE. To date, 130 individuals representing 52 state medical and osteopathic boards have

participated in these workshops. Approximately 44% of the individuals have gone on to serve subsequently on a USMLE committee, workgroup or standard-setting panels.

- The State Board Advisory Panel to USMLE, which consists of representatives from 10 state boards, provided guidance to FSMB and NBME staff on issues impacting the program.
- Thirty-seven representatives from 26 state medical boards participated in the USMLE program in 2019, including service on item-writing committees, advisory or standard-setting panels, governance committees, and task forces.
- The USMLE program has continued to increase its use of social media to supplement and strengthen communication and outreach via the USMLE website. The USMLE Facebook, Twitter and LinkedIn accounts help the program reach and communicate with the more than 100,000 individual examinees taking the USMLE each year, as well as medical educators at both the undergraduate and graduate levels and members of the state medical board community.
- FSMB partnered with the NBME to better understand the impact of the USMLE on physician wellness, by piloting two online surveys of individuals who recently took Step 1.
- Communications staff from the FSMB and the NBME held multiple calls and meetings to develop a communications plan to address impact of any potential changes to USMLE scoring.
- A joint FSMB-NBME subcommittee was established to make final recommendation on USMLE scoring. FSMB members included Drs. Patricia King, Kenneth Simons, Sarvam TerKonda and Cheryl Walker-McGill. The subcommittee met in November and December 2019, and a final report was produced in January 2020 for review by FSMB and NBME governance.
- FSMB's Board of Directors approved the FSMB-NBME subcommittee's recommendation to adopt Pass/Fail score reporting for USMLE Step 1 while retaining a numeric score on Step 2 CK, and steps were taken in collaboration with the NBME to begin implementation.
- In February 2020, the FSMB and NBME announced three upcoming changes to the USMLE program: 1) changing Step 1 score reporting from a three-digit numeric score to reporting only pass/fail (implementation no earlier than 2022); 2) reducing the allowable number of exam attempts on each Step or Step Component from six to four (implementation no earlier than January 2021); and 3) requiring all examinees to successfully pass Step 1 as a prerequisite for taking Step 2 Clinical Skills (implementation no earlier than March 2021).

The Special Purpose Examination (SPEX), a joint program of the FSMB and the National Board of Medical Examiners, is a generalist examination for use by state medical boards in evaluating the current medical knowledge of physicians who are some years away from having passed a national medical licensing examination.

- An updated SPEX exam was implemented in January 2019. The changes made to SPEX help ensure that the exam continues to be relevant to current standards of practice. Specific improvements included an update of the exam blueprint, an update of the item pool (i.e., new test forms and questions), and implementation of new item formats (e.g., drug ads and abstracts). The exam was also shortened by 2.5 hours (from 8.5 hours to 6 hours) to better accommodate physicians' busy schedules.
- Representatives from the Iowa and Hawaii boards served on the SPEX Oversight Committee in 2019.

The FSMB distributes electronic and print communications to inform state medical boards of trends in medical regulation and facilitate intra-board communications.

- *FSMB eNews* is distributed twice weekly to more than 5,000 individuals in the medical regulatory community and individuals interested in medical regulation, with updates on FSMB, state medical board activities, and breaking health care news.
- The *Journal of Medical Regulation (JMR)*, the FSMB's peer-viewed, quarterly journal, published articles during 2019 that illuminated various issues of interest to medical boards. *JMR* launched several new initiatives to raise the publication's visibility and improve its accessibility to both

readers and researchers, including 1) the new JMR Podcasts series, which features interviews with authors of select published JMR articles discussing what spurred their interest in the research topic and the importance of the findings for medical regulators; and 2) a “Resources for Regulators” department that provides easily accessible lists of online resources specifically tailored for medical regulators.

- The FSMB educates the public and policymakers on the work of FSMB and state medical boards by distributing press releases announcing policy updates, new FSMB publications and special reports, and hosting educational events such as the Annual Meeting.

## Goal II: Advocacy and Policy Leadership

### **Strengthen the viability of state-based medical regulation in a changing, globally connected health care environment.**

The FSMB educates policymakers, leaders and legislators on the role of state boards at the state and federal level.

- The FSMB submitted a comment on *FCC’s Promoting Telehealth for Low-Income Consumers Notice of Inquiry, WC Docket No. 18-213*, highlighting the FSMB’s Policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine and the importance of state licensure in the use of telemedicine.
- The FSMB submitted a comment to the *Bipartisan Policy Center’s Rural Health Task Force*, highlighting the importance of state licensure and the use of the IMLC to expand access to care in rural areas.
- The FSMB submitted a comment on *CMS Proposed Rule (CMS-1715-P)* that raised concerns over a proposal that would allow CMS to expand its authority to revoke or deny physicians’ and other healthcare providers’ Medicare billing privileges in instances where providers have been subject to prior disciplinary actions based on conduct that resulted in patient harm. The FSMB highlighted issues over the scope of the proposal and asked for clarity on any procedures that would be used in determining patient harm.
- The FSMB responded to a letter from the Department of Veterans Affairs asking for comments on a proposal to expand VA telehealth rules to trainees. The FSMB highlighted the importance of only allowing licensed practitioners to practice telemedicine in any setting.
- The FSMB provided a letter to the House Committee on Veterans’ Affairs for a hearing entitled “*Broken Promises: Assessing VA’s Systems for Protecting Veterans from Clinical Harm.*” The letter highlighted the importance of requiring the VA to report adverse actions to state licensing boards.
- The FSMB continued outreach to the Administration, including the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC), Office of the National Coordinator for Health Information Technology (ONC), Food and Drug Administration (FDA), Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Defense (DOD), and the Drug Enforcement Administration (DEA).
- FSMB’s *Advocacy Alert* E-Newsletter provides regular updates on federal and state legislative and regulatory activity and includes occasional “calls to action” in support/opposition to legislation.
- FSMB provided legislative and research assistance to many member boards and organizations on various issues, including camp doctor licensure, occupational licensure reform, prescription drug monitoring programs, the Interstate Medical Licensure Compact, telemedicine, state death certificate programs, medical malpractice and licensure, opioid prescribing for chronic pain, residency training licenses, public information and data sharing, criminal background checks, medication-assisted treatment, and locum tenens license applications.

- The FSMB responded to information requests from the State Medical Board of Ohio, the Louisiana State Board of Medical Examiners, the New Mexico Medical Board, the New Hampshire Board of Medicine, the District of Columbia Board of Medicine, the Wisconsin Medical Examining Board, the Georgia Composite Medical Board, the Idaho Board of Medicine, the Maryland Board of Physicians, the Massachusetts Board of Registration in Medicine, the American Osteopathic Association, ECFMG, and the Florida Office of Program Policy and Accountability.

The FSMB endorses legislation that is consistent with FSMB’s mission and its policies and that supports the mission of state medical boards. Recent federal legislation endorsed by FSMB included:

- The *Department of Veterans Affairs Provider Accountability Act (S. 221)* that would require the Department of Veterans Affairs to report major adverse actions to the National Practitioner Data Bank (NPDB) and state licensing boards and limit settlement agreements. It passed out of the Senate as amended with Unanimous Consent on December 23, 2019. Additionally, the House amended and passed the *Improving Confidence in Veterans’ Care Act (H.R. 3530)*, which would also require reporting to state licensing boards and the NPDB.
- The *HEALTHIER Act (H.R. 2216)* that would create a grant program for states that offer flexibility in licensing for health care providers who offer services on a volunteer basis through volunteer provider laws. The FSMB issued a joint letter of support with the National Council of State Boards of Nursing. FSMB had previously supported this legislation in the 115th Congress.
- The *CONNECT for Health Act of 2019 (S. 2471, H.R. 4932)* that would extend access to telemedicine in accordance with state licensing laws.

The FSMB establishes workgroups and taskforces to respond to and address evolving and changing areas of medical regulation.

- The FSMB created the Artificial Intelligence Taskforce after recognizing the need to study the regulatory structures necessary for the use of AI in a clinical setting without sacrificing patient safety. The Taskforce provides educational resources to state boards and the public that focus on emerging technologies that may impact the practice of medicine and safe delivery of care, including a dedicated resource website at [fsmb.org/ai](http://fsmb.org/ai).
- In response to the COVID-19 pandemic, the FSMB mobilized its data and advocacy resources to assist state medical boards and the public with staying informed on emergency regulatory changes and efforts to address workforce needs. The FSMB engaged with federal and state authorities, individual state medical boards, and representatives of the medical regulatory community to ensure information regarding state medical licensure is timely and accurate. The FSMB formed an Ad Hoc Task Force on Pandemic Response, at the direction of FSMB BOD Chair Dr. Scott Steingard, creating a forum for members to discuss preparedness and response efforts on a regular basis. Important information and resources, including a chart of state-by-state emergency declarations and licensing waivers, is updated daily on the FSMB’s COVID-19 website created for use by individual state medical boards and the public.

### Goal III: Collaboration

#### **Strengthen participation and engagement among state medical boards and expand collaborative relationships with national and international organizations.**

FSMB maintains valuable and constructive relationships with its Member Medical Boards in the United States, the District of Columbia and the U.S. territories. In addition, the FSMB maintains valuable relationships with a variety of regulatory, professional and certifying organizations in both the U.S. and international health care communities.

- The FSMB Member Medical Board application of the Medical Licensure Commission of Alabama was approved by the FSMB Board of Directors in February 2020, which raises the FSMB's total membership from 70 state medical and osteopathic boards to 71.
- The FSMB Affiliate Member application of the Texas Physician Assistant (PA) Board was approved by the FSMB Board of Directors in February 2020. The Texas PA Board joins the PA boards from Tennessee and Arizona, as well as the Federation of Medical Regulatory Authorities of Canada (FMRAC), as an Affiliate Member of the organization.
- To enhance communications between FSMB and its member boards, the Board of Directors, as part of its State Medical Boards Liaison Program, will have visited 19 state medical and osteopathic boards between May 1, 2019, and April 30, 2020.
- Through the Tri-Regulator Collaborative, the FSMB works closely with the National Council of State Boards of Nursing (NCSBN) and the National Association of Boards of Pharmacy (NABP) to address issues of mutual concern for the nation's state boards of medicine, nursing and pharmacy. The Collaborative held its 4<sup>th</sup> Tri-Regulator Symposium in September 2019 in Frisco, Texas. The two days of lectures and discussion brought together more than 120 members and staff of state medical, nursing and pharmacy boards.
- FSMB periodically participates in trilateral meetings with the National Board of Medical Examiners (NBME) Executive Board and the Educational Commission for Foreign Medical Graduates (ECFMG)/Foundation for Advancement of International Medical Education and Research (FAIMER) Board of Trustees to discuss issues pertinent to each organization. The Trilateral meeting of the ECFMG/FAIMER, FSMB and NBME was held in August 2019 in Chicago, Illinois. A bilateral meeting of the FSMB and NBME also was held.
- FSMB continues its long-time collaborative efforts with the National Board of Medical Examiners (NBME) through ongoing programs supporting state medical board needs, such as the United States Medical Licensing Examination (USMLE), the Special Purpose Examination (SPEX) for physicians who are already licensed, and the Post-Licensure Assessment System (PLAS), which provides diagnostic tools for evaluating the ongoing competence of currently or previously licensed physicians.
- The FSMB served as the accredited CME provider for NBME's Invitational Conference for Educators (NICE) in May 2019.
- FSMB partnered with the NBME to better understand the impact of the USMLE on physician wellness by piloting two online surveys of individuals who recently took Step 1. Preliminary results are planned to be shared at AAMC's regional educational affairs meetings.
- The FSMB maintains communications with health policy representatives from the American Medical Association (AMA), the American Osteopathic Association (AOA), and the American Academy of Physician Assistants, as well as representatives of state governments, including the Council of State Governments (CSG), the National Conference of State Legislatures (NCSL), and associations of professional licensing boards.
- The FSMB continues to work closely with the Federation of State Physician Health Programs through regular communications, as well as a joint research project aimed at examining referral data from state physician health programs and comparing these across states based on licensing processes.
- The FSMB continues to work with the National Academy of Medicine (NAM) to support two action collaboratives (one on clinician wellness, and the other on the opioid epidemic).
- The FSMB participates in several distinguished health care organizations and coalitions, including the Coalition for Physician Accountability, the Conjoint Committee on Continuing Medical Education (CCCME), and the Professional Licensing Coalition.
- The FSMB provides support to the ABMS as it continues to implement the recommendations of its Vision Commission to evolve the framework for specialty certification in the U.S. Members of the FSMB Board of Directors have presented and participated in discussions about the importance of medical professionalism, patient safety and continued competence.

The FSMB continues to support organizations and activities that encourage information exchange and collaborative relationships in the international medical regulatory community.

- The FSMB is a founding member of the International Association of Medical Regulatory Authorities (IAMRA) and continues to serve as the organization’s Secretariat. As of March 2020, IAMRA has 117 members from 48 countries.
- FSMB President and CEO Dr. Humayun Chaudhry serves as Secretary of IAMRA.
- Representatives of the FSMB serve on various IAMRA committees, including the IAMRA Membership and Programs Committee, the Physician Information Exchange Working Group, and the Research Working Group.
- Representatives of the FSMB attended and presented at IAMRA’s International Symposium in Chicago in September 2019. The theme of the symposium was *Continued Competency: Balancing Assurance and Improvement*.
- The FSMB continued to engage in collaborative activities with international medical regulatory authorities and education accreditation organizations and consortia, including the International Academy for CPD Accreditation and International Society for Quality in Health Care.
- The *Journal of Medical Regulation* continues to solicit submissions from authors addressing international regulatory concerns.

The FSMB is engaged in various collaborative activities supporting Continuing Professional Development (CPD) programs that align with the mission of state medical boards. The FSMB has continued to engage with several international medical regulatory authorities regarding the issue of continued competence of licensed physicians.

- The FSMB continues to work closely with its partners from the CME community in the U.S., including the organizations that are responsible for accreditation of CME providers, as well as accreditation and certification of CME activities.
- The FSMB provided in-kind support to the Coalition for Physician Enhancement (CPE). CPE is an organization representing programs and individuals responsible for the assessment and remediation of physicians in both the U.S. and Canada. The services of many of CPE’s organizational members are often used by state medical boards to support decisions about re-entry to practice and remedial practice pathways for licensees.

**Goal IV: Education**

**Provide educational tools and resources that enhance the quality of medical regulation and raise public awareness of the vital role of state medical boards.**

The FSMB conducts a variety of educational opportunities designed to equip the medical regulatory community with the information, skills and best practices vital to effective regulation.

- The FSMB planned to hold its 107th Annual Meeting in San Diego, California, in April 2020. The Annual Meeting is designed specifically for physicians and public representatives of state medical boards and members of their staff, influential federal and state government representatives, and leaders of national medical organizations.
- The annual Board Attorneys Workshop for attorneys and legal staff of state medical and osteopathic boards provided participants with the opportunity to share and exchange valuable information on case experiences, best practices and current issues pertinent to board attorneys. Sessions offered during the November 2019 workshop included the corporate practice of medicine doctrine, understanding drug tests and what they tell you, common behaviors seen in addicted professionals, what to do when your board gets sued, ethical dilemmas for board attorneys, and the standard of care for experimental modalities.

The FSMB, an accredited CME provider through the ACCME, is available to assist state medical boards with accredited educational program development and management. FSMB's recent CME activities include:

- Since becoming an accredited CME provider through the ACCME in 2016, the FSMB has educated more than 10,000 physician and non-physician learners.
- FSMB has accredited a total of 59 CME activities totaling 212 hours of instruction since 2016.
- Since May 2018, the DEA has hosted 19 live Practitioner Diversion Awareness Conferences (PDACs) for a combined attendance of more than 7,500 physician and non-physician learners. Several more conferences are scheduled to take place throughout 2020. Each live activity has been accredited for 6.5 *AMA PRA Category 1 Credits™*.
- In May 2019, the FSMB accredited a live activity for the North Carolina Medical Board. Titled *Unconscious Bias Training*, this two-hour activity was designed to help physicians, physician assistants, nurse practitioners, and medical regulatory staff identify the different forms of bias and how those biases can negatively impact patient care or regulatory decisions.
- In October 2019, the FSMB accredited a live activity for the Washington Medical Commission. Titled *Health Care's Role in Achieving Social Change*, this two-day conference was designed to help physicians, physician assistants, nurse practitioners, and other health care providers identify the many different health care disparities that exist in Washington, in the United States and throughout the world.
- In March 2020, the FSMB accredited a live internet course for the Washington Medical Commission. This activity focused on the recent updates to the state's immunization requirements, rules and exceptions to the rules.

The FSMB facilitates regular forums that facilitate intra-board information sharing, as well as foster strong collaborative relationships between FSMB and state medical boards.

- The New Directors and New Executive Directors Orientation provide new medical board executives and FSMB board members with an overview of FSMB's services and mission to foster future partnership and collaborative opportunities.
- FSMB's monthly Roundtable Webinars during 2019 addressed issues of interest to the medical board community, including the Interstate Medical Licensure Compact; new rules from the Massachusetts board on informed consent; new rules from the Maine board on physician-patient communications; technology updates from the FSMB's Physician Data Center and FCVS; ECFMG's 2023 Medical School Accreditation System; the new Single GME Accreditation System; and an overview of National Emergency Management Association resources for state medical boards.

#### Goal V: Data and Research Services

**Expand the FSMB's data-sharing and research capabilities while providing valuable information to state medical boards, the public and other stakeholders.**

In recognition of its role as an information organization, the FSMB has dramatically changed its technology organization in recent years to provide world-class technology solutions to its constituents. This effort has changed the way FSMB works internally in many ways, adding to its effectiveness.

- FSMB continues to improve efficiencies and customer satisfaction by implementing a series of system enhancements throughout its technical infrastructure.
- FSMB continues to make major investments in technology and a system-wide integration of its previously diverse data systems into a single, integrated enterprise.

The FSMB collaborated with other organizations to explore opportunities to generate research, including for publication, to better inform state medical boards and the public about FSMB policy development and the information needs of physicians and physician assistants across the continuum of medical education.

- In a national survey of state medical board executive directors conducted by the FSMB, boards ranked what they considered the three most important topics to the regulatory community in 2019. Opioid prescribing/addiction treatment was the most frequently cited topic, followed by physician impairment and physician wellness and burnout.
- The FSMB published its 5th Census of Licensed Physicians in the United States in the *Journal of Medical Regulation*. This bi-annual project was first conducted in 2010 and offers a valuable snapshot of licensed physicians in the United States.
- In conjunction with the Medical Society of the State of New York, the FSMB published a manuscript in the *Journal of Legal Medicine* examining reporting barriers to receiving mental health care and physician burnout.
- The FSMB participated in four articles published in *Academic Medicine*: (1) a perspective on public members serving on health care governing boards with colleagues from the Accreditation Council for Continuing Medical Education and UT-Southwestern; (2) a study with researchers from the American Board of Family Medicine (ABFM) examining whether ABFM-certified physicians received fewer actions from boards than non-ABFM certified physicians; (3) a study investigating the relationship between COMLEX-USA performance and disciplinary actions with colleagues from NBOME; and (4) a study with FSMB authors addressing professionalism lapses in medical school and problems in residency and clinical practice.
- During the 2019 Tri-Regulator Symposium, a special meeting of organizational researchers was also held. This included researchers representing state boards of physical therapy, occupational therapy, psychology and social work. During this meeting, researchers shared current research projects being conducted within their organizations and sought opportunities for future research collaborations among the professions.

The FSMB reviewed board actions received from state medical boards and board action and basis codes to determine how actions are coded and the underlying reason for those actions to better understand physician discipline, increase transparency and enhance research opportunities in the area of physician discipline.

- The Board Action Content Evaluation (BACE) Task Force reviewed several thousand board orders to determine if additional information on why a physician was disciplined could be gathered. Project goals also included to explore whether redundant basis codes could be eliminated and piloting a second set of basis codes and definitions to help categories be more descriptive.

The FCVS provides a centralized, uniform process for state medical boards to obtain a verified, primary-source record of a physician and physician assistant's core medical credentials.

- Due to technology and process improvements, cycle times continued to trend downward in 2019.
- Customer Satisfaction scores continued to consistently reach 90% or higher in 2019.
- Twenty state medical boards now participate in the optional service to systematically add an NPDB report to the FCVS profile. This feature reduces steps in the licensure process for both member boards and physicians.
- In January 2020, the Massachusetts Board of Registration in Medicine became the 15<sup>th</sup> medical board to require FCVS for the purposes of licensure.

The Uniform Application for Medical Licensure (UA) is designed to enhance license portability by allowing medical boards to use common application elements while capturing unique state requirements in an addendum.



- The UA has been adopted by 27 state boards. The functionality has also been adopted by six state boards for Physician Assistants. In the past year additional technology enhancements were implemented to improve the applicant user experience and further address individual state board requirements.

FSMB's Closed Residency Programs service provides ongoing storage of training records for physicians who attended a training program that no longer exists. This is an important service for those physicians and state medical boards. This service has transitioned to a digital collection format, away from the historic use of paper and completion of unique verification requests.

- With the closure of Hahnemann University Hospital in September 2019, FSMB became the central repository and primary source for all graduate medical records of residents and fellows who completed training at the hospital after 1990.
- In January 2020, FSMB launched its first Digital Credentials: The Official GME Verification. This secure digital verification is offered to physicians requesting training verifications from our current Closed Program repository, for a one-time fee. As part of this service these digital credentials can be sent through FCVS directly to state medical boards through their SMB portal. Physicians can also use their digital GME verifications for employment or privileging.

#### Goal VI: Organizational Strength and Excellence

**Enhance the FSMB's organizational vitality and adaptability in an environment of change and strengthen its financial resources in support of its mission.**

The FSMB's continues to work at many organizational levels to become more efficient, build stronger teams, be fiscally strong and create a technology infrastructure that is adaptable and expandable. These steps will ensure that the FSMB can deliver outstanding service to its stakeholders while being able to adapt as the health care and regulatory landscapes continue to shift and change.

- The Finance and Accounting staff have worked with each department within the organization to identify value and eliminate waste. These staff efforts, in concert with those of the Board of Directors and Finance, Audit, and Investment Committees, have led the organization to improve its reserves, which in turn, will provide for the organization's future as it works to meet the needs of the state medical boards.
- Understanding that workspace plays a vital role in the productivity and work lives of staff, FSMB continued its multi-year project to update its facilities and redesign workflows to promote accuracy, efficiency and innovation. A side benefit of these efforts has led to greater ability to attract and retain talent.

FSMB leadership has reviewed and worked on updating the FSMB's Strategic Plan (includes Vision, Mission and Goals) to reflect the changing regulatory and health care environment to ensure the ongoing importance and relevance of the FSMB and state medical boards.

- To make informed updates, FSMB collected strategic planning information using three separate surveys: a sample of attendees at FSMB's Annual Meeting in 2019; online surveys to state board executive directors and board chairs; and to CEOs of partner organizations. Results were shared with the Special Committee on Strategic Planning.

## **TAB G: Treasurer's Report**

Through ten months of FSMB's Fiscal Year 2020, which extended from May 1, 2019 to March 1, 2020, FSMB's financial performance could be characterized just as it had been for the past several years: consistent and strong with manageable and healthy growth.

Evidence of the organization's healthy performance over the past two years was noted in the Auditor's "Report and Financial Statements for Fiscal Years ended April 30, 2019 and 2018", which is provided under **Attachment 1**. In this report, accounting firm Clifton+LarsonAllen issued an opinion that the consolidated financial statements presented fairly the financial position of FSMB in all material respects. This report was reviewed and approved by the Audit Committee in October 2019, then was accepted by the FSMB Board of Directors later that month.

'Business as usual' continued through the third quarter. From a financial standpoint, FSMB was well on its way to a healthy bottom line that was exceeding Budget, once again. FY2020 'Actual' performance compared to 'Budget' through three quarters (May 1, 2019–January 31, 2020) is included under **Attachment 2**.

The Investment Committee, working and meeting regularly with the Investment Advisor, developed and deployed an investment policy that is conservative and defensive in nature, and consistent with organization's long-term strategic plan. This approach has served the organization well in the past, and through the third quarter invested reserves were performing at a very high level again (also noted in **Attachment 2**).

COVID-19 began to impact every facet of life around the globe, including the FSMB and its member boards and constituents in the last quarter of the Fiscal Year. Operationally, FSMB responded appropriately and quickly and was able to convert office-based routines to secure, home-based operations. As a result, critical functions performed for State Medical Boards have remained largely intact with minimal interruptions or modifications.

All but the last 45-60 days of the fiscal year were 'normal'. Since March 15, however, regular revenue streams in some departments have been interrupted and reserves have lost significant ground. It is still very possible that the organization will meet its operational budget for the year, though investment performance will not. We should caution, the final impact on the FY2020 bottom line will not be known until the books are closed and the Financial Statements are audited in June/July of this year.

Looking forward, COVID-19, social distancing, shelter-in-place, and the interruption of many aspects of life will have an impact on revenue in FY2021 which begins May 1, 2020. It remains unknown at this time whether the impact will be a simple matter of timing within the year, or if lower revenue will be realized due to interruption of normal medical education, examination, and state licensing routines.

The Budget for FY2021 was developed over several months, beginning with work by Staff last October, and continuing into January 2020, when the Finance Committee reviewed and

recommended the proposed FY2021 Budget (**Attachment 3**) to the Board of Directors. The Board considered and approved this budget on February 6, 2020.

Staff, led by the CFO, and the Treasurer debated whether adjustments should be made quickly to the FY2021 Budget. But given (1) the length of time it takes to develop a meaningful budget, (2) challenges with reconvening the Finance Committee and the BOD during the days leading up to the House of Delegates meeting, and (3) the future uncertainties caused by the current environment, it was decided that the FY2021 Budget should be provided to the HOD as previously reviewed and approved.

It should be noted that the Bylaws of the organization do not require approval of the Budget by the House of Delegates. Staff and the Board of Directors will continue to monitor the situation carefully and will adjust fiscal decisions, as necessary, to ensure FSMB's ability to continue providing critical services to State Medical Boards, the medical community, and the public.

I would like to thank each member of the Finance, Investment, and Audit Committees, FSMB management, the Board of Directors, and the House of Delegates for allowing us to serve you.

Respectfully submitted,

Jerry G. Landau, JD  
FSMB Treasurer

**ITEM FOR ACTION:**

**No Action Required**

## **Attachment 1**

**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY**

**CONSOLIDATED FINANCIAL STATEMENTS AND  
SUPPLEMENTARY INFORMATION**

**YEARS ENDED APRIL 30, 2019 AND 2018**

**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
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## INDEPENDENT AUDITORS' REPORT

Board of Directors  
Federation of State Medical Boards  
of the United States, Inc. and Subsidiary  
Euless, Texas

### **Report on the Financial Statements**

We have audited the accompanying consolidated financial statements of Federation of State Medical Boards of the United States, Inc. and Subsidiary (Federation of State Medical Boards Research and Education Foundation), which comprise the consolidated statements of financial position as of April 30, 2019 and 2018, and the related consolidated statements of activities, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

### ***Management's Responsibility for the Financial Statements***

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

### ***Auditors' Responsibility***

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.



Board of Directors  
Federation of State Medical Boards  
of the United States, Inc. and Subsidiary

**Opinion**

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Federation of State Medical Boards of the United States, Inc. and Subsidiary (Federation of State Medical Boards Research and Education Foundation) as of April 30, 2019 and 2018, and the changes in their net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

**Report on Supplementary Information**

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplemental budget information presented in the consolidated statements of activities is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information has not been subjected to the auditing procedures applied in the audits of the consolidated financial statements and, accordingly, we express no opinion on it. The consolidating statement of financial position and consolidating statement of activities are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

*CliftonLarsonAllen LLP*

**CliftonLarsonAllen LLP**

Minneapolis, Minnesota  
October 15, 2019



**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
CONSOLIDATED STATEMENTS OF FINANCIAL POSITION  
APRIL 30, 2019 AND 2018**

<b>ASSETS</b>	2019	2018
<b>CURRENT ASSETS</b>		
Cash and Cash Equivalents	\$ 11,894,389	\$ 7,396,117
Accounts Receivable:		
Disciplinary Searches	361,567	205,081
Other	164,499	106,791
Prepaid Expenses	895,115	691,341
Other Assets	25,779	72,550
Total Current Assets	13,341,349	8,471,880
<b>NONCURRENT ASSETS</b>		
Investments	39,080,588	37,211,357
Prepaid Expenses	27,868	65,743
Property and Equipment, Net	8,770,956	9,004,312
Total Noncurrent Assets	47,879,412	46,281,412
 Total Assets	 \$ 61,220,761	 \$ 54,753,292
<b>LIABILITIES AND NET ASSETS</b>		
<b>CURRENT LIABILITIES</b>		
Accounts Payable	\$ 3,900,286	\$ 4,239,975
Unearned Revenue - USMLE and SPEX	12,376,923	11,476,162
Deferred Compensation	1,621,854	1,432,009
Capital Lease Payable	13,289	18,522
Total Current Liabilities	17,912,352	17,166,668
<b>NONCURRENT LIABILITIES</b>		
Capital Lease Payable	-	13,298
Total Noncurrent Liabilities	-	13,298
<b>NET ASSETS</b>		
Without Donor Restrictions:		
Board-Designated Endowment	2,561,788	2,467,504
Undesignated	40,746,621	35,105,822
Total Net Assets	43,308,409	37,573,326
 Total Liabilities and Net Assets	 \$ 61,220,761	 \$ 54,753,292

See accompanying Notes to Consolidated Financial Statements.

(3)

**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
CONSOLIDATED STATEMENTS OF ACTIVITIES  
YEARS ENDED APRIL 30, 2019 AND 2018**

	April 30, 2019			April 30, 2018		
	Without Donor Restrictions	Unaudited		Without Donor Restrictions	Unaudited	
		Budget	Variance Favorable (Unfavorable)		Budget	Variance Favorable (Unfavorable)
<b>REVENUES AND GAINS</b>						
Examination Revenue - USMLE	\$ 27,769,615	\$ 26,436,800	\$ 1,332,815	\$ 25,756,220	\$ 25,879,250	\$ (123,030)
Examination Revenue - PLAS	149,500	234,000	(84,500)	185,900	240,500	(54,600)
Transfer Fees - USMLE	(20,219,655)	(19,298,864)	(920,791)	(17,525,421)	(19,150,645)	1,625,224
Transfer Fees - PLAS	(118,000)	(225,000)	107,000	(129,600)	(225,000)	95,400
Subtotal	7,581,460	7,146,936	434,524	8,287,099	6,744,105	1,542,994
Examination History Reports	6,687,642	6,334,000	353,642	6,541,022	6,142,700	398,322
Other Exam Revenue	985,415	851,627	133,788	950,065	870,020	80,045
Physician Data Center	1,789,713	1,635,945	153,768	1,747,755	1,516,000	231,755
Registration Fees	131,215	134,300	(3,085)	138,485	147,000	(8,515)
FCVS Revenue	9,907,611	9,029,496	878,115	9,442,198	8,970,797	471,401
Member Dues	173,675	174,775	(1,100)	174,000	174,775	(775)
Shipping and Handling Fees	73,075	82,500	(9,425)	77,245	82,500	(5,255)
Grants and Contributions	300,306	-	300,306	277,480	-	277,480
Interest and Dividends	1,024,426	500,000	524,426	689,081	250,000	439,081
Net Investment Gain	1,011,325	(144,000)	1,155,325	1,819,988	-	1,819,988
Loss on Sale of Fixed Assets	(25,496)	-	(25,496)	(74,043)	-	(74,043)
Other Revenue	537,793	312,500	225,293	373,134	256,500	116,634
Total Revenues and Gains	30,178,160	26,058,079	4,120,081	30,443,509	25,154,397	5,289,112
<b>EXPENSES</b>						
Salary and Benefits	15,586,109	16,193,452	607,343	15,168,492	15,022,681	(145,811)
Data Processing	958,624	909,148	(49,476)	857,452	927,244	69,792
General Office	3,204,897	3,268,717	63,820	3,308,581	2,991,806	(316,775)
Travel and Program	1,844,230	2,066,436	222,206	1,752,561	2,082,405	329,844
Occupancy	724,871	885,088	160,217	743,108	627,645	(115,463)
Professional Services and Dues	725,533	794,909	69,376	799,525	563,670	(235,855)
Legislative and Legal	375,510	270,000	(105,510)	178,139	315,000	136,861
Contributions	35,000	-	-	-	-	-
Total Expenses	23,454,774	24,387,750	967,976	22,807,858	22,530,451	(277,407)
<b>CHANGES IN NET ASSETS BEFORE DEPRECIATION</b>	6,723,386	<u>\$ 1,670,329</u>	<u>\$ 5,088,057</u>	7,635,651	<u>\$ 2,623,946</u>	<u>\$ 5,011,705</u>
Depreciation	988,303			1,131,798		
<b>CHANGE IN NET ASSETS</b>	5,735,083			6,503,853		
Net Assets - Beginning of Year	37,573,326			31,069,473		
<b>NET ASSETS - END OF YEAR</b>	<u>\$ 43,308,409</u>			<u>\$ 37,573,326</u>		

See accompanying Notes to Consolidated Financial Statements.

**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
CONSOLIDATED STATEMENTS OF CASH FLOWS  
YEARS ENDED APRIL 30, 2019 AND 2018**

	<u>2019</u>	<u>2018</u>
<b>CASH FLOWS FROM OPERATING ACTIVITIES</b>		
Change in Net Assets	\$ 5,735,083	\$ 6,503,853
Adjustments to Reconcile Change in Net Assets to Net Cash Provided by Operating Activities:		
Depreciation	988,303	1,131,798
Net Investment Gain	(1,011,325)	(1,819,988)
Loss on Sale of Fixed Assets	25,496	74,043
Change in:		
Accounts Receivable	(214,194)	298,289
Prepaid Expenses	(165,899)	(226,591)
Other Assets	46,771	(22,241)
Accounts Payable	(339,689)	(3,716,993)
Unearned Revenue - USMLE and SPEX	900,761	2,047,888
Deferred Compensation	189,845	189,430
Net Cash Provided by Operating Activities	<u>6,155,152</u>	<u>4,459,488</u>
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>		
Proceeds from Sales and Maturities of Marketable Securities	18,534,620	7,675,643
Purchase of Marketable Securities	(19,392,526)	(14,068,909)
Purchases of Property and Equipment	(780,443)	(4,958,391)
Net Cash Used by Investing Activities	<u>(1,638,349)</u>	<u>(11,351,657)</u>
<b>CASH FLOWS FROM FINANCING ACTIVITIES</b>		
Payments on Capital Lease Obligation	<u>(18,531)</u>	<u>(16,975)</u>
<b>NET CHANGES IN CASH AND CASH EQUIVALENTS</b>	4,498,272	(6,909,144)
Cash and Cash Equivalents - Beginning of Year	<u>7,396,117</u>	<u>14,305,261</u>
<b>CASH AND CASH EQUIVALENTS - END OF YEAR</b>	<u>\$ 11,894,389</u>	<u>\$ 7,396,117</u>

See accompanying Notes to Consolidated Financial Statements.

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**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS  
APRIL 30, 2019 AND 2018**

**NOTE 1 NATURE OF ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

**Organization and History**

The Federation of State Medical Boards of the United States, Inc. (FSMB) is a nonprofit corporation involved with the promotion and support of medical licensure and discipline in the United States. The Federation established the Federation of State Medical Boards Research and Education Foundation, doing business as FSMB Foundation (the Foundation) for the purpose of providing research and education regarding medical licensure and discipline and shares some of the same officers and board members.

The Federation's primary source of revenue is through the administration of the United States Medical Licensing Examination (USMLE). Under the joint agreement with the National Board of Medical Examiners, the Federation shares the net revenues from the joint administration of the USMLE.

The Federation derives a significant portion of its revenue from two additional sources: the Federation Credentials Verification Service (FCVS) and the Physician Data Center (PDC). The FCVS provides primary source verification of a physician's or physician assistant's core credentials, primarily for licensure purposes. The PDC performs database searches for interested parties.

**Principles of Consolidation**

The consolidated financial statements include the accounts of the Federation and the Foundation, collectively referred to herein as the Federation. All significant intracompany transactions and accounts have been eliminated upon consolidation.

**Use of Estimates**

The preparation of these consolidated financial statements, in conformity with accounting principles generally accepted in the United States of America, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and reported revenues and expenses during the reported period. Actual results could differ from those estimates.

**Cash and Cash Equivalents**

For the purpose of presentation in the consolidated statements of cash flows, the Federation considers cash on deposit and highly liquid money market funds with original maturities of less than three months as cash and cash equivalents.

**Accounts Receivable**

The Federation records accounts receivable as services are rendered. An allowance is established for an estimate of any uncollectible accounts. If a receivable is deemed to be uncollectible in full, the entire amount is charged off at that time. No allowance was deemed necessary at April 30, 2019 and 2018.

**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS  
APRIL 30, 2019 AND 2018**

**NOTE 1 NATURE OF ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)**

**Investments**

The Federation carries investments in marketable securities with readily determinable fair values and all investments in debt securities at their fair values in the consolidated statements of financial position. Accordingly, unrealized gains and losses are included in the Change in Net Assets in the accompanying consolidated statements of activities.

As of the year ended April 30, 2019, the Federation carries its interests in two investment partnerships at fair value due to the insignificant ownership percentage in each partnership. The underlying investments of these partnerships are comprised primarily of marketable securities and private equity interests for which there is no actively traded market. The estimated fair value of these limited partnership investments is based on valuations provided by the external investment managers. The Federation reviews the estimated values and agrees with the methods and assumptions used in determining the fair value of these alternative investments. Because these alternative investments are not readily marketable and redemption of some amounts is restricted until future years, their estimated value may differ materially from the value that would have been used had a ready market for such investments existed. Unrealized gains or losses on these investments are recorded in the consolidated statements of activities in the year that fluctuations in fair value occur.

**Property and Equipment**

Property and equipment are stated at cost. Expenditures for property and equipment (and donated property at fair market value) in excess of \$10,000 are capitalized. Maintenance, repairs, and minor renewals are expensed as incurred. When assets are retired or otherwise disposed of, their costs and related accumulated depreciation are removed from the accounts, and the resulting gains or losses are included in income. Computer software costs, which are developmental, or which extend the life of existing software, are capitalized. Software costs, which are for maintenance or repairs, are expensed.

Depreciation is provided, using the straight-line method, over the following estimated useful lives:

Buildings	39 Years
Furniture and Fixtures	10 Years
Equipment	5 Years
Computer Systems	3 to 5 Years

**Deferred Compensation**

Deferred compensation consists of an accrued liability for employees' rights to receive compensation for future absences in the year in which such right vests to the employee, and amounts due to key employees under the Federation's nonqualified deferred compensation plans.



**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS  
APRIL 30, 2019 AND 2018**

**NOTE 1 NATURE OF ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING  
POLICIES (CONTINUED)**

**Net Assets**

The Federation and the Foundation net assets, revenues, gains, and losses are classified based on the existence or absence of donor or grantor imposed restrictions. Accordingly, net assets and changes therein are classified and reported as follows:

*Net Assets Without Donor Restrictions* – Net assets available for use in general operations and not subject to donor (or certain grantor) restrictions for both organizations. The Foundation governing board has designated, from net assets without donor restrictions, net assets for a board-designated endowment.

*Net Assets With Donor Restrictions* – Net assets subject to donor- (or certain grantor-) imposed restrictions. Some donor-imposed restrictions are temporary in nature, such as those that will be met by the passage of time or other events specified by the donor. Other donor-imposed restrictions are perpetual in nature, where the donor stipulates that resources be maintained in perpetuity. The Federation and the Foundation did not have any net assets with donor restrictions or related activity for the years ended April 30, 2019 and 2018.

**Revenue Recognition**

The Federation recognizes examination revenue when the test scores are released. Unearned revenues are reflected on the consolidated statements of financial position as deferred revenue. Other program revenues are recognized when the event occurs or services are provided, or when the Federation is entitled to the fee.

Contributions restricted by donors are reported as increases in net assets without donor restrictions if the restrictions expire (that is, when a stipulated time restriction ends or purpose restriction is accomplished) in the reporting period in which the revenue is recognized. All other donor-restricted contributions are reported as increases in net assets with donor restrictions, depending on the nature of the restrictions. When a restriction expires, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported in the consolidated statements of activities as Net Assets Released from Restrictions. Contributions are recognized when cash, securities or other assets, an unconditional promise to give, or notification of a beneficial interest is received. Conditional promises to give are not recognized until the conditions on which they depend have been substantially met.

**Transfer Fees**

As defined in the joint agreement with the National Board of Medical Examiners, a portion of the examination fees received is transferred to the NBME upon release of test scores. The per capita fee that is transferred to the NBME is based on the revenue and expenses associated with the USMLE.

**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS  
APRIL 30, 2019 AND 2018**

**NOTE 1 NATURE OF ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)**

**Functional Expenses**

The Federation charges identifiable expenses directly to the appropriate program service. Expenses of a general nature are allocated to program service based on a pro-rated percentage of usage and on management's estimate.

**Contingencies**

The amounts (assets, liabilities, net assets, revenues and expenses) presented in the accompanying consolidated financial statements relating to government awards are subject to review and audit by the grantor. Such audits could result in claims against the Federation for disallowed costs or noncompliance with grantor restrictions. No provision has been made for any liabilities that may arise from such audits, because the amounts, if any, cannot be determined at this date. The Federation does not anticipate any significant changes from a potential audit.

**Income Taxes**

FSMB is organized as a nonprofit corporation under Section 501(c)(6) of the Internal Revenue Code (IRC). This section exempts the Federation from taxes on income, with the exception of income from an unrelated business activity.

The Foundation is exempt from the payment of income taxes on their exempt activities under Section 501(c)(3) of the IRC, and are classified as organizations that are not a private foundation under Section 509(a)(3) of the Code.

The Federation follows the guidance in the income tax standard regarding the recognition and measurement of uncertain tax positions. The application of this standard had no impact on the Federation's consolidated financial statements. FSMB and the Foundation file as tax-exempt organizations.

**Change in Accounting Principle**

On August 18, 2016, FASB issued Accounting Standards Update (ASU) 2016-14, *Not-for-Profit Entities (Topic 958) – Presentation of Financial Statements of Not-for-Profit Entities*. The update addresses the complexity and understandability of net asset classification, deficiencies in information about liquidity and availability of resources, and the lack of consistency in the type of information provided about expenses and investment return. We have implemented ASU 2016-14 and have adjusted the presentation in these consolidated financial statements accordingly. The ASU has been applied retrospectively to all periods presented, with the exception of the liquidity disclosure in Note 13.

**Subsequent Events**

In preparing these consolidated financial statements, the Federation has evaluated events and transactions for potential recognition or disclosure through October 15, 2019, the date the consolidated financial statements were available to be issued. There were no events or transactions subsequent to year-end requiring recognition or disclosure.



**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS  
APRIL 30, 2019 AND 2018**

**NOTE 2 INVESTMENTS**

Investments are comprised of the following at April 30:

	2019	2018
Mutual Funds - Fixed Income	\$ 11,759,701	\$ 8,438,580
Mutual Funds - Equity	17,179,201	15,095,355
Stocks	8,228,814	5,740,044
Absolute Return Investments	59,376	57,998
Private Equity	1,853,496	1,879,380
Investment Cash	-	6,000,000
Total	<u>\$ 39,080,588</u>	<u>\$ 37,211,357</u>

**NOTE 3 FAIR VALUE MEASUREMENTS**

The Federation categorizes its financial instruments, based on the priority of the inputs to the valuation technique, into a three-level fair value hierarchy. The fair value hierarchy gives the highest priority to quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). If the inputs used to measure the financial instruments fall within different levels of the hierarchy, the categorization is based on the lowest level input that is significant to the fair value measurement of the instrument.

Financial assets and liabilities recorded on the consolidated statements of financial position are categorized based on the inputs to the valuation techniques as follows:

*Level 1* – Financial assets and liabilities, whose values are based on unadjusted quoted prices for identical assets or liabilities in an active market that the Federation has the ability to access.

*Level 2* – Financial assets and liabilities whose values are based on quoted prices in markets that are not active or model inputs that are observable either directly or indirectly for substantially the full term of the asset or liability. Level 2 inputs include the following:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in nonactive markets;
- Pricing models whose inputs are observable for substantially the full term of the asset or liability; and
- Pricing models whose inputs are derived principally from or corroborated by observable market data through correlation or other means for substantially the full term of the asset or liability.

*Level 3* – Financial assets and liabilities, whose values are based on prices or valuation techniques that require inputs that are both unobservable and significant to the overall fair value measurement. These inputs reflect management's own assumptions about the assumptions a market participant would use in pricing the asset or liability.



**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS  
APRIL 30, 2019 AND 2018**

**NOTE 3 FAIR VALUE MEASUREMENTS (CONTINUED)**

Equity securities and mutual funds listed on a national market or exchange are valued at the last sales price. Such investments are included in Level 1. The Federation elected the fair value option for certain other investments under ASC 825. The Foundation also early adopted the standard on disclosures for investments in certain entities that calculate net asset value (NAV) per share or its equivalent, which removes those investments that calculated NAV per share from the fair value disclosure.

The following tables present the Federation's fair value for those assets measured at fair value on a recurring basis as of April 30:

	2019			
	Level 1	Level 2	Level 3	Total
Mutual Funds - Fixed Income	\$ 11,759,701	\$ -	\$ -	\$ 11,759,701
Mutual Funds - Equity	17,179,201	-	-	17,179,201
Stocks	8,228,814	-	-	8,228,814
Total	37,167,716	-	-	37,167,716
NAV Funds	-	-	-	1,912,872
Total Investments	<u>\$ 37,167,716</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 39,080,588</u>

	2018			
	Level 1	Level 2	Level 3	Total
Mutual Funds - Fixed Income	\$ 8,438,580	\$ -	\$ -	\$ 8,438,580
Mutual Funds - Equity	15,095,355	-	-	15,095,355
Stocks	5,740,044	-	-	5,740,044
Total	29,273,979	-	-	29,273,979
NAV Funds	-	-	-	1,937,378
Investment Cash	-	-	-	6,000,000
Total Investments	<u>\$ 29,273,979</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 37,211,357</u>

Fair value measurements of investments in certain funds that calculate net asset value per share (or its equivalent) as of April 30 is as follows:

	2019		
	Net Asset Value	Unfunded Commitments	Redemption Frequency
Absolute Return Investments	\$ 59,376	\$ -	Quarterly
Private Equity Funds	1,853,496	-	Quarterly
Total	<u>\$ 1,912,872</u>	<u>\$ -</u>	

	2018		
	Net Asset Value	Unfunded Commitments	Redemption Frequency
Absolute Return Investments	\$ 57,998	\$ -	Quarterly
Private Equity Funds	1,879,380	-	Quarterly
Total	<u>\$ 1,937,378</u>	<u>\$ -</u>	

**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS  
APRIL 30, 2019 AND 2018**

**NOTE 3 FAIR VALUE MEASUREMENTS (CONTINUED)**

Absolute Return Funds invests using two primary styles (Event-Driven and Relative Value). Event-Driven strategies typically will include investment in common and preferred equities and various types of debt. Relative Value strategies may include long and short positions in common and preferred equity, convertible securities, and various forms of senior and junior debt. Investment under this style may also include index options, options on futures contracts, and other derivatives.

Private Equity Fund of Funds includes private equity funds that invest primarily in nonpublicly traded companies in need of capital. These funds may vary widely as to sector, size, stage, duration, and liquidity. Certain of these funds may also focus on the secondary market, buying interest in existing private equity funds, often at a discount.

**NOTE 4 PROPERTY AND EQUIPMENT**

Property and equipment consists of the following at April 30:

	2019	2018
Land	\$ 1,540,151	\$ 1,540,151
Buildings	8,440,582	8,294,606
Furniture, Fixtures, and Equipment	642,923	882,205
Computer Systems	16,368,622	21,969,230
Total	<u>26,992,278</u>	<u>32,686,192</u>
Less: Accumulated Depreciation and Amortization	<u>(18,221,322)</u>	<u>(23,681,880)</u>
Total Property and Equipment	<u>\$ 8,770,956</u>	<u>\$ 9,004,312</u>

**NOTE 5 BOARD-DESIGNATED ENDOWMENT**

In 2009, the Federation contributed \$1,000,000 to establish a board-designated endowment. In 2010 the Federation contributed an additional \$1,000,000 towards the board-designated endowment. In 2017, the Foundation moved an additional \$221,000 to the board-designated endowment. Earnings from the board-designated endowment are to be used as deemed necessary in support of the Foundation's mission to undertake educational and scientific research projects designed to expand public and medical professional awareness and knowledge of challenges impacting health care and health care regulation in order to create stronger and more effective medical licensure and regulation.

The Foundation is subject to the enacted version of the Uniform Prudent Management of Institutional Funds Act of 2006 (UPMIFA) and is required to make disclosures about endowment funds, both donor-restricted endowment funds and board-designated endowment funds.

**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS  
APRIL 30, 2019 AND 2018**

**NOTE 5 BOARD-DESIGNATED ENDOWMENT (CONTINUED)**

**Endowment Investment and Spending Policies**

The Federation has adopted investment and spending policies for endowment assets that seek to provide a predictable stream of funding to programs supported by its endowment while maintaining the purchasing power of the endowment assets. The Federation's spending and investment policies work together to achieve this objective. Actual returns in any given year may vary from this amount.

To achieve its investment objectives over long periods of time, the Federation has adopted an investment strategy that invests in fixed income securities, equity securities, mutual funds, and alternative investments. The primary performance objective is to achieve an annualized total rate of return, net of investment fees, that is equal to or greater than 6.5% over long periods of time.

The Federation's policy for the use of endowment funding is a spending formula based on an amount approved for appropriation each year by the board of directors. In establishing this policy, the Federation considered the long-term expected return on its endowment. At no time will the distributions reduce the value of the endowment below the endowment contributions.

Endowment net asset composition by type of fund as of April 30, 2019 and 2018 is as follows:

	Without Donor Restrictions
Endowment Fund Balance, April 30, 2018	\$ 2,467,504
Additions	-
Earnings and Expenses:	
Investment Income	19,933
Investment Expenses	(7,927)
Unrealized and Realized Gains	236,778
Total Earnings and Expenses	248,784
Appropriations	(154,500)
Endowment Fund Balance, April 30, 2019	<u>\$ 2,561,788</u>
	Without Donor Restrictions
Endowment Fund Balance, April 30, 2017	\$ 2,251,295
Additions	-
Earnings and Expenses:	
Investment Income	34,314
Investment Expenses	(13,025)
Unrealized and Realized Gains	280,743
Total Earnings and Expenses	302,032
Appropriations	(85,823)
Endowment Fund Balance, April 30, 2018	<u>\$ 2,467,504</u>



**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS  
APRIL 30, 2019 AND 2018**

**NOTE 6 CAPITAL LEASE**

In January 2015, the Federation began leasing phone equipment under a capital lease obligation which expires in 2019. Assets leased under such capital lease obligations and included in property and equipment are as follows at April 30:

	2019	2018
Equipment	\$ 83,063	\$ 83,063
Less: Accumulated Depreciation	(71,912)	(55,299)
Assets Under Capital Lease, Net	\$ 11,151	\$ 27,764

Included in depreciation expense for the years ended April 30, 2019 and 2018 was \$16,613 of amortization expense for assets under capital lease.

Future annual minimum payments under capital lease obligations through the term of the lease agreement consisted of the following at April 30, 2019:

Year Ending April 30,	Amount
2020	\$ 13,732
Total Future Minimum Lease Payments	13,732
Less: Amounts Representing Interest	(443)
Capital Lease Obligations, Net	\$ 13,289

**NOTE 7 OPERATING LEASE**

The Federation leases space in Washington, D.C., for lobbying and administrative purposes under the terms of an 80-month noncancelable operating lease beginning on May 1, 2013. The Federation also leases equipment under a noncancelable operating lease ending in September 2024. Future minimum rental payments due under the leases are as follows:

Year Ending April 30,	Amount
2020	\$ 91,333
2021	2,136
2022	2,130
2023	2,130
2024	888
Total	\$ 98,617

Rental expense totaled \$146,461 for the year ended April 30, 2019.

**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS  
APRIL 30, 2019 AND 2018**

**NOTE 8 FINANCIAL INSTRUMENTS AND CONCENTRATION OF CREDIT RISK**

Financial instruments, which potentially subject the Federation to concentrations of credit risk, are cash and cash equivalents and investments. The Federation places its cash with high-credit quality financial institutions and periodically maintains deposits in amounts which exceed FDIC insurance coverage. Management does not believe the Federation is exposed to any significant credit risk on cash and cash equivalents.

The Federation's marketable securities primarily consist of investments in mutual funds, equity collective funds, stocks, absolute return investment, among others. Management believes diversity within the portfolio avoids significant concentration of credit risk with respect to these investments.

The Federation currently has investments in two limited partnerships, which are not considered material to these consolidated financial statements as of April 30, 2019. These investments are carried at fair value, and in total amount to less than 5% of total assets.

**NOTE 9 RETIREMENT AND DEFERRED COMPENSATION PLANS**

The Federation has a defined contribution plan, which covers substantially all of its employees. The plan allows for employee contributions and discretionary matching contributions by the Federation, as well as discretionary profit sharing contributions. Contributions by the Federation to this qualified, defined contribution plan were \$1,462,797 during 2019 and \$1,454,750 during 2018, and are included in Salary and Benefits expense in the consolidated statements of activities.

The Federation sponsors nonqualified deferred compensation plans for certain key executives. The plans provide for payment upon retirement, death, or disability based on the amounts contributed to the plans adjusted by investment gains or losses. Benefits vest over a five-year period or upon termination without cause. Compensation expense related to these plans amounted to \$66,814 and \$71,781 during 2019 and 2018, respectively, and is included in Salary and Benefits expense in the consolidated statements of activities.

**NOTE 10 COMMITMENTS**

**Hotel Commitments**

The Federation has entered into hotel agreements to provide for room accommodations for its future meetings. These agreements contain clauses that provide for the loss of revenue to the hotel in the event of cancellation or nonperformance by the Federation. At April 30, 2019, the potential liability to the Federation is approximately \$800,724 for meetings contracted through fiscal year 2020. Based on prior performance, management believes the likelihood of cancellations to be remote.

**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS  
APRIL 30, 2019 AND 2018**

**NOTE 11 FUNCTIONAL EXPENSES**

Expenses were incurred for the following functional areas of the Federation for the years ended April 30:

	2019											2018												
	Total Expenses	Administration	Member Services	Governance	Other Initiatives	Examination Services	Uniform Application	FCVS	Physician Data Center	Information Services	FSMB Foundation	Total Program	Total Expenses	Administration	Member Services	Governance	Other Initiatives	Examination Services	Uniform Application	FCVS	Physician Data Center	Information Services	FSMB Foundation	Total Program
Salary and Benefits	\$ 15,586,109	\$ 5,341,277	\$ 432,941	\$ -	\$ -	\$ 1,177,600	\$ 85,906	\$ 4,588,054	\$ 1,113,035	\$ 2,847,296	\$ -	\$ 10,244,832	\$ 15,168,492	\$ 5,322,879	\$ 316,800	\$ -	\$ -	\$ 1,076,519	\$ 120,261	\$ 4,574,140	\$ 1,098,290	\$ 2,659,603	\$ -	\$ 9,845,613
Data Processing	958,624	65,773	63,898	540	-	11,123	-	72,327	13,319	731,644	-	882,851	857,452	97,174	54,621	432	-	16,757	-	31,690	1,688	655,090	-	760,278
General Office	3,204,897	617,843	71,579	254,119	286	871,023	13,343	1,128,914	107,202	132,478	8,110	2,597,054	3,308,581	822,161	75,783	258,304	21	868,898	14,022	1,052,807	119,284	83,387	13,914	2,486,420
Travel and Program	1,844,230	201,884	848,312	457,595	131,110	106,898	-	30,125	6,272	21,185	40,849	1,642,346	1,752,561	191,627	772,963	544,301	30,841	140,094	-	18,101	6,883	17,557	30,194	1,560,934
Occupancy	724,871	430,653	7,169	-	-	16,365	-	162,778	31,280	76,626	-	294,218	743,108	460,013	5,576	-	-	16,487	4,038	159,286	30,604	67,104	-	283,095
Professional Services																								
and Dues	725,533	289,045	289,429	28,080	-	355	-	54,241	250	46,229	17,904	436,488	799,525	305,115	305,730	78,810	-	75	15,000	68,950	8,434	13,375	4,036	494,410
Legislative and Legal	375,510	348,922	26,588	-	-	-	-	-	-	-	-	26,588	178,139	76,021	41,338	-	-	-	-	-	-	788	59,992	102,118
Contribution	35,000	-	-	-	-	-	-	-	-	-	35,000	35,000	1,131,798	373,493	79,226	-	-	113,180	11,318	305,585	67,908	181,088	-	758,305
Depreciation	988,303	325,775	75,909	-	-	95,256	4,330	263,359	55,467	168,207	-	662,528	1,131,798	460,013	5,576	-	-	16,487	4,038	159,286	30,604	67,104	-	283,095
Total	\$ 24,443,077	\$ 7,621,172	\$ 1,815,825	\$ 740,334	\$ 131,396	\$ 2,278,620	\$ 103,579	\$ 6,299,798	\$ 1,326,825	\$ 4,023,665	\$ 101,863	\$ 16,821,905	\$ 23,939,656	\$ 7,648,483	\$ 1,652,037	\$ 881,847	\$ 30,862	\$ 2,232,010	\$ 164,639	\$ 6,210,559	\$ 1,333,091	\$ 3,677,992	\$ 108,136	\$ 16,291,173



**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS  
APRIL 30, 2019 AND 2018**

**NOTE 11 FUNCTIONAL EXPENSES (CONTINUED)**

As reported above, certain categories of expenses are attributed to more than one program or supporting function. Therefore, expenses require allocation on a reasonable basis that is consistently applied. The expenses that are allocated include salary and benefits, which are allocated based on the number of full-time equivalents in each cost center, and occupancy, which is allocated based on square footage.

**NOTE 12 MARGIN LOAN**

The Organization has an available margin borrowing agreement with its investment broker that functions as a line of credit. The amount available to withdraw fluctuates based on the amount of qualifying securities held in the related brokerage account. The interest rate on the margin loan also varies based on the amount borrowed, at a base rate subject to change at the broker's discretion plus an additional percentage. At April 30, 2019 and 2018, the interest rate ranges were 6.00% to 9.82% and 6.00% to 9.07%, respectively. As of April 30, 2019 and 2018, the funds available to withdraw totaled \$6,362,570 and \$5,199,371, respectively, and there was no amounts outstanding.

**NOTE 13 LIQUIDITY AND AVILABILITY**

Financial assets available for general expenditure, that is, without donor or other restrictions limiting their use, within one year of the statement of financial position date, comprise the following:

	Amount
Cash and Cash Equivalents	\$ 11,894,389
Accounts Receivable:	
Disciplinary Searches	361,567
Other	164,499
Operating Investments	37,167,716
Less: Board-Designated Endowment	<u>(2,561,788)</u>
Total financial assets available for general expenditures in the next 12 months	<u>\$ 47,026,383</u>

The Organization's board-designated endowment is subject to a spending formula based on an amount approved for appropriation each year by the board of directors. Although the Organization does not intend to spend from this board-designated endowment (other than amounts appropriated for general expenditure as part of the Board's annual budget approval and appropriation), these amounts could be made available if necessary.

The Organization regularly monitors the liquidity required to meet its operating needs and other contractual commitments, while also striving to maximize the investment of its available funds. The Organization has various sources of liquidity at its disposal, including cash and cash equivalents, marketable debt and equity securities, and lines of credit.

**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS  
APRIL 30, 2019 AND 2018**

**NOTE 13 LIQUIDITY AND AVAILABILITY (CONTINUED)**

For purposes of analyzing resources available to meet general expenditures over a 12-month period, the Organization considers all expenditures related to its ongoing activities, as well as the conduct of services undertaken to support those activities to be general expenditures.

In addition to financial assets available to meet general expenditures over the next 12 months, the Organization operates with a balanced budget and anticipates collecting sufficient revenue to cover general expenditures.



**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
CONSOLIDATING STATEMENT OF FINANCIAL POSITION  
APRIL 30, 2019  
(SEE INDEPENDENT AUDITORS' REPORT)**

<b>ASSETS</b>	<u>FSMB</u>	<u>Foundation</u>	<u>Eliminations</u>	<u>Consolidated</u>
<b>CURRENT ASSETS</b>				
Cash and Cash Equivalents	\$ 11,659,360	\$ 235,029	\$ -	\$ 11,894,389
Accounts Receivable:				
Disciplinary Searches	361,567	-	-	361,567
Other	173,345	36,878	(45,724)	164,499
Prepaid Expenses	895,115	-	-	895,115
Other Assets	25,279	500	-	25,779
Total Current Assets	<u>13,114,666</u>	<u>272,407</u>	<u>(45,724)</u>	<u>13,341,349</u>
<b>NONCURRENT ASSETS</b>				
Investments	35,928,015	3,152,573	-	39,080,588
Prepaid Expenses	27,868	-	-	27,868
Property and Equipment, Net	8,770,956	-	-	8,770,956
Total Noncurrent Assets	<u>44,726,839</u>	<u>3,152,573</u>	<u>-</u>	<u>47,879,412</u>
<b>Total Assets</b>	<u>\$ 57,841,505</u>	<u>\$ 3,424,980</u>	<u>\$ (45,724)</u>	<u>\$ 61,220,761</u>
<b>LIABILITIES AND NET ASSETS</b>				
<b>CURRENT LIABILITIES</b>				
Accounts Payable	\$ 3,930,388	\$ 15,622	\$ (45,724)	\$ 3,900,286
Unearned Revenue - USMLE and SPEX	12,376,923	-	-	12,376,923
Deferred Compensation	1,621,854	-	-	1,621,854
Capital Lease Payable	13,289	-	-	13,289
Total Current Liabilities	<u>17,942,454</u>	<u>15,622</u>	<u>(45,724)</u>	<u>17,912,352</u>
<b>NET ASSETS</b>				
Without Donor Restrictions:				
Board-Designated Endowment	-	2,561,788	-	2,561,788
Undesignated	39,899,051	847,570	-	40,746,621
Total Net Assets	<u>39,899,051</u>	<u>3,409,358</u>	<u>-</u>	<u>43,308,409</u>
<b>Total Liabilities and Net Assets</b>	<u>\$ 57,841,505</u>	<u>\$ 3,424,980</u>	<u>\$ (45,724)</u>	<u>\$ 61,220,761</u>

**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC. AND SUBSIDIARY  
CONSOLIDATING STATEMENT OF ACTIVITIES  
YEAR ENDED APRIL 30, 2019  
(SEE INDEPENDENT AUDITORS' REPORT)**

	FSMB		Foundation		Consolidating Eliminations	Consolidated	
	Without Donor Restrictions	With Donor Restrictions	Without Donor Restrictions	With Donor Restrictions		Without Donor Restrictions	With Donor Restrictions
<b>REVENUES AND GAINS</b>							
Examination Revenue - USMLE	\$ 27,769,615	\$ -	\$ -	\$ -	\$ -	\$ 27,769,615	\$ 27,769,615
Examination Revenue - PLAS	149,500	-	-	-	-	149,500	149,500
Transfer Fees - USMLE	(20,219,655)	-	-	-	-	(20,219,655)	(20,219,655)
Transfer Fees - PLAS	(118,000)	-	-	-	-	(118,000)	(118,000)
Subtotal	7,581,460	-	-	-	-	7,581,460	7,581,460
Examination History Reports	6,687,642	-	-	-	-	6,687,642	6,687,642
Other Exam Revenue	985,415	-	-	-	-	985,415	985,415
Physician Data Center	1,789,713	-	-	-	-	1,789,713	1,789,713
Registration Fees	131,215	-	-	-	-	131,215	131,215
FCVS Revenue	9,907,611	-	-	-	-	9,907,611	9,907,611
Member Dues	173,675	-	-	-	-	173,675	173,675
Shipping and Handling Fees	73,075	-	-	-	-	73,075	73,075
Grants and Contributions	249,045	51,261	-	-	-	300,306	300,306
Interest and Dividends	994,593	29,833	-	-	-	1,024,426	1,024,426
Net Investment Gain	728,839	282,486	-	-	-	1,011,325	1,011,325
Loss on Sale of Fixed Assets	(25,496)	-	-	-	-	(25,496)	(25,496)
Other Revenue	537,791	2	-	-	2	537,793	537,793
Total Revenues and Gains	29,814,578	363,582	-	-	363,582	30,178,160	30,178,160
<b>EXPENSES</b>							
Salary and Benefits	15,586,109	-	-	-	-	15,586,109	15,586,109
Data Processing	958,624	-	-	-	-	958,624	958,624
General Office	3,204,749	148	-	-	148	3,204,897	3,204,897
Travel and Program	1,803,381	40,849	-	-	40,849	1,844,230	1,844,230
Occupancy	724,871	-	-	-	-	724,871	724,871
Professional Services and Dues	707,629	17,904	-	-	17,904	725,533	725,533
Legislative and Legal	375,510	-	-	-	-	375,510	375,510
Contributions	-	35,000	-	-	35,000	35,000	35,000
Total Expenses	23,360,873	93,901	-	-	93,901	23,454,774	23,454,774
<b>CHANGES IN NET ASSETS - BEFORE DEPRECIATION</b>							
Depreciation	6,453,705	269,681	-	-	269,681	6,723,386	6,723,386
Depreciation	988,303	-	-	-	-	988,303	988,303
<b>CHANGE IN NET ASSETS</b>							
Net Assets - Beginning of Year	5,465,402	269,681	-	-	269,681	5,735,083	5,735,083
Net Assets - End of Year	34,433,649	3,139,677	-	-	3,139,677	37,573,326	37,573,326
<b>NET ASSETS - END OF YEAR</b>	\$ 39,899,051	\$ 3,409,358	\$ -	\$ -	\$ 3,409,358	\$ 43,308,409	\$ 43,308,409



## **Attachment 2**

**FEDERATION OF STATE MEDICAL BOARDS  
Variance Report  
Through 3rd Quarter Ended January 31, 2020**

	Actuals	YTD	Budget	Variance \$ Favorable (Unfavorable)	Variance % Favorable (Unfavorable)	
<b>Unrestricted Revenues and Gains from Operations</b>						<b>Comments</b>
USMLE						
Examination Revenue	\$ 5,237,326		\$ 5,928,110	(690,784)	(12%)	16% below 2019, 2.5% below 2018 actuals
Examination History Reports	4,562,445		4,377,099	185,346	4%	
Eligibility Extension Fees	280,540		262,841	17,699	7%	
Other Exam Revenue-Rescoring & Admin, S&H	101,920		93,937	7,983	8%	
Physician Data Center:						
PDC Profile (formerly "disciplinary searches")	814,565		849,000	(34,435)	(4%)	
Disciplinary Alert, PDC Monitoring & ABMS services	475,183		427,050	48,133	11%	
Data Licensing Revenue	578,809		375,000	203,809	54%	
FCVS Revenue	7,107,031		5,845,910	1,261,121	22%	10% above 2019 actuals
Uniform Application Fee	374,760		330,120	44,640	14%	
Other Revenue						
Publication Revenue	3,500		2,438	1,063	44%	
Annual Meeting Fees/CME fees	4,480		450	4,030	100%	
Member Dues	174,475		175,275	(800)		
Grant Revenue-Federal	115,234			115,234	100%	Pass-through to Licensure Compact
Other Revenue	878			878	100%	
<b>Total Unrestricted Revenues and Gains from Operations</b>	<b>\$ 19,831,146</b>		<b>\$ 18,667,230</b>	<b>\$ 1,163,915</b>		6% FCVS growth continues; makes up for decreased Exam Revenue

**FEDERATION OF STATE MEDICAL BOARDS  
Variance Report  
Through 3rd Quarter Ended January 31, 2020**

Expense	YTD		Variance \$ Favorable (Unfavorable)	Variance % Favorable (Unfavorable)	Comments
	Actuals	Budget			
Salary Expense:					
Exempt	\$ 5,517,724	\$ 5,628,116	110,392	2%	
Non-Exempt	2,621,194	2,823,621	202,427	7%	Fewer employees than budgeted (see Temps, below).
Temporary	394,954	227,250	(167,704)	(74%)	Greater use of "Temps" than budgeted
Benefits Expense	2,534,258	2,886,340	352,082	12%	Lower benefits cost due to turnover and Temps
HR & Employee Relation ( Other Employee Exp.)	97,152	127,882	30,730	24%	
	<u>11,165,282</u>	<u>11,693,209</u>			
Travel and Program Expense					
Annual Meeting	10,135	10,750	615	6%	
Board Meetings	293,819	237,626	(56,192)	(24%)	
Board Site Visits	53,228	44,940	(8,288)	(18%)	
Other Meetings	596,326	789,723	193,396	25%	
	<u>953,508</u>	<u>1,083,039</u>			
Credit Card Processing	815,199	778,096	(37,103)	(5%)	Higher sales volume directly correlates to higher CC expense
Direct Cost of Sales	532,698	476,955	(55,743)	(12%)	FCVS direct cost correlates to incr volume
General Office Expense	817,620	933,611	115,991	12%	Timing.
Occupancy Expense	517,012	535,536	18,524	3%	
Data Processing Expense	856,053	927,789	71,736	8%	
Chair / Chair Elect / Past Chair Stipend	161,250	165,000	3,750	2%	Chair-Dr. King donated \$1,250.00 to Foundation each Qtr.
Licensure Compact (not reimbursed by grant)	4,566		(4,566)	(100%)	
Compact Grant (reimbursed by grant)	115,234		(115,234)	(100%)	Tied to Grant Revenue (see previous page)
Legal Expense (External)	104,096	120,000	15,904	13%	
Government Relations	70,000	90,000	20,000.00		
Professional Services	399,536	410,239	10,702	3%	Timing
<b>Total Expense</b>	<b>\$ 16,512,054</b>	<b>\$ 17,213,473</b>	<b>\$ 701,419</b>	<b>4%</b>	<b>Most of the lower expenses relate to lower Salary/Benefit expense, other portion spread across multiple categories-- many of which are tied to timing.</b>

**FEDERATION OF STATE MEDICAL BOARDS  
Variance Report  
Through 3rd Quarter Ended January 31, 2020**

	Actuals	YTD Budget	Variance \$ Favorable (Unfavorable)	Variance % Favorable (Unfavorable)	Comments
Total Unrestricted Revenues and Gains from Operations	\$ 19,831,146	\$ 18,667,230	\$ 1,163,915	6%	FCVS growth continues, offsets lower Exam revenue YTD
Total Expense	16,512,054	17,213,473	701,419	4%	Most of the lower expenses relate to lower Salary/Benefit expense, other portion spread across multiple categories-- many of which are tied to timing.
<b>Change in Net Assets before depreciation and investment gains</b>	3,319,092	1,453,757	1,865,335	128%	
Depreciation Expense	(669,158)	(900,000)	230,842	26%	
Investment Gain	2,159,665	420,000			<i>All investment gains that existed at the end of Q3 have been wiped out by the COVID-19 market decline. A significant decline will likely be recorded at the end of the Fiscal Year (4/30/20)</i>
Investment Management Fee/Interest exp.	(149,672) 2,009,994	(120,150) 299,850	1,710,144		
<b>Change in Net Assets</b>	<b>\$ 4,659,928</b>	<b>\$ 853,607</b>	<b>3,806,321</b>		<i>Change in Net Assets at Fiscal Year End will be impacted by the COVID-19 market and interruption of normal routines.</i>

## **Attachment 3**



**FEDERATION OF STATE MEDICAL BOARDS  
FY 2021 PROPOSED BUDGET  
VS FY 2020 ADOPTED BUDGET AND FY2019 ACTUAL RESULTS**

<b>Unrestricted Revenues and Gains from Operations</b>	2019	2020	2021	Variance		<b>Comments</b>
	Actual Results	Adopted Budget	Proposed Budget	\$ Favorable (Unfavorable)	Variance %	
<b>USMLE</b>						
Examination	7,581,460	7,729,332	8,251,025	521,693	6.75%	Increased Exam Fee and higher volume budgeted
Examination History Reports	6,687,642	6,500,000	6,500,000	0	0.00%	
Exam Eligibility Extension Fee	385,640	350,455	350,455	(0)	0.00%	
Other Exam Revenue	138,670	125,750	123,750	(2,000)	-1.59%	
<b>Physician Data Center</b>						
PDC Profile (formerly "disciplinary searches")	1,135,676	1,132,000	1,140,000	8,000	0.71%	
Disciplinary Alert, PDC Monitoring, & ABMS services	654,037	569,400	609,402	40,002	7.03%	
Data Licensing Revenue	494,958	500,000	999,996	499,996	100.00%	New customers budgeted in FY21
<b>FCVS</b>						
	9,912,661	8,861,916	11,115,961	2,254,045	25.44%	Analytics used to budget increased revenue
<b>Uniform Application</b>						
	534,180	503,880	525,000	21,120	4.19%	
<b>Other Revenue</b>						
Publication Revenue	4,029	3,250	3,000	(250)	-7.69%	
Registration Fees/Exhibitor Fees	162,715	146,450	148,500	2,050	1.40%	
Member Dues	168,000	168,000	168,000	0	0.00%	
Grant Revenue-Federal	249,045	0	0	0	0.00%	Compact Grant
Grant Revenue-Other	0	0	0	0	0.00%	
Other Revenue	7,931	7,275	7,275	0	0.00%	
<b>Total Unrestricted Revenues and Gains from Operations</b>						
	28,116,644	26,597,708	29,942,364	3,344,655	12.57%	

FEDERATION OF STATE MEDICAL BOARDS  
 FY 2021 PROPOSED BUDGET  
 VS FY 2020 ADOPTED BUDGET AND FY2019 ACTUAL RESULTS

Unrestricted Expenses	2019	2020	2021	Variance	Variance	Comments
	Actual Results	Adopted Budget	Proposed Budget	\$ Reduced Increased		
Salary Expense						
Salaries-Exempt	7,581,373	8,196,780	8,771,240	574,461	7.01%	5 New Positions budgeted
Salaries-Non-exempt	3,734,290	3,987,331	3,865,860	(121,471)	-3.05%	Adjustments made to reflect higher use of temps
Temporary Help	652,851	303,000	415,371	112,371	37.09%	Adjustments made to reflect higher use of temps
Benefits Expense	3,613,097	4,141,920	4,122,808	(19,112)	-0.46%	Impr. deductible for EE's; EE Dependent Ins Subsidy; Reduced Retirement Projections for FCVS
HR & Employee Relations	137,207	164,726	169,600	4,874	2.96%	
<b>Total</b>	<b>15,718,818</b>	<b>16,793,757</b>	<b>17,344,880</b>	<b>551,123</b>	<b>3.28%</b>	
Travel and Program Expense						
Annual Meeting	607,467	651,150	645,750	(5,400)	-0.83%	
Board Meetings	340,871	410,225	432,590	22,365	5.45%	
Board Visits	37,579	59,100	95,120	36,020	60.95%	
Other Meetings	789,214	973,270	1,005,593	32,323	3.32%	
	1,775,131	2,093,745	2,179,053	85,308	4.07%	
Credit Card Processing	1,095,463	1,075,094	1,193,256	118,161	10.99%	Increased revenue leads to increased cc charges
Direct Cost of Sales	748,690	635,940	879,338	243,398	38.27%	ECFMG 'Previously Verified' cost increase Jan. '20
General Office	920,828	1,152,267	1,220,937	68,671	5.96%	
Texas Occupancy	665,301	606,047	622,074	16,028	2.64%	
DC Rent	146,461	134,370	120,750	(13,620)	-10.14%	New DC Building expected to open Dec 2020
DC Building	60,725	120,000	123,000	3,000	2.50%	
Data Processing	958,622	1,107,547	1,090,640	(16,907)	-1.53%	
Chair/Chair Elect / Past Chair Stipend	199,250	220,000	220,000	0	0.00%	
Licensure Compact - Grant	249,045	0	0	0	0.00%	Tied to Grant Revenue
Licensure Compact - (not reimb by grant)	4,332	0	0	-	0.00%	
Legal (External)	228,922	160,000	210,000	50,000	31.25%	Elevated legal costs anticipated
Government Relations	120,000	120,000	120,000	0	0.00%	
Professional Services/Consulting	494,783	640,893	702,993	62,100	9.69%	
<b>Total Unrestricted Expenses</b>	<b>23,386,371</b>	<b>24,859,659</b>	<b>26,026,921</b>	<b>1,167,263</b>	<b>4.70%</b>	

**FEDERATION OF STATE MEDICAL BOARDS  
 FY 2021 PROPOSED BUDGET  
 VS FY 2020 ADOPTED BUDGET AND FY2019 ACTUAL RESULTS**

	2019 Actual Results	2020 Adopted Budget	2021 Proposed Budget	Variance \$ Favorable (Unfavorable)	Variance %
Total Unrestricted Revenues and Gains from Operations	28,116,644	26,597,708	29,942,364	3,344,655	12.57%
Total Unrestricted Expenses	(23,386,371)	(24,859,659)	(26,026,921)	(1,167,263)	-4.70%
<b>Change in Net Assets-Unrestricted before depreciation and investment gains</b>	<b>4,730,273</b>	<b>1,738,049</b>	<b>3,915,442</b>	<b>2,177,393</b>	<b>125.28%</b>
Depreciation Expenses	(988,303)	(1,200,000)	(1,200,000)	0	0.00%
Investment Gains/(Losses)	1,891,634	560,000	560,000	0	0.00%
Investment Management Fees	(168,203)	(160,200)	(208,000)	(47,800)	-29.84%
	1,723,431	399,800	352,000	(47,800)	-11.96%
<b>Change in Net Assets-Unrestricted</b>	<b>5,465,402</b>	<b>937,849</b>	<b>3,067,442</b>	<b>2,129,593</b>	<b>227.07%</b>



**Request for Capital  
FY2021**

<b>Project Name</b>	IT Initiatives
<b>Description</b>	<p>IT projects for FY2021 have been planned in support of the following goals:</p> <ol style="list-style-type: none"> <li>1) Improved customer experience</li> <li>2) Enhanced performance for improved staff efficiency</li> <li>3) Support of State Medical Board needs</li> <li>4) Greater research capabilities</li> <li>5) Security</li> </ol> <p>The work to be funded by the requested budget will support enhancements that will benefit our physician and state medical board users.</p>
<b>Project Management</b>	<p>This project will be completed with a combination of internal and external resources; however, we have worked to minimize the need for external staff. Management and staff from the appropriate operating teams will be involved, as will IT staff. Internal staff will be augmented with external consultants to provide application coding or other expertise where needed.</p>
<b>Business Unit(s)</b>	<p>Assessment Services                  Physician Data Center                  FCVS                  Uniform Application                  Accounting and Finance                  Information Technology</p>
<b>Capital Costs</b>	<p>\$ 287,100 - External Resources                  \$       0 - Hardware                  \$       0 - Software  <u>          </u>                  \$ 287,100 - Total</p>

**TAB H: Report of the Reference Committee**

**MANAGEMENT NOTE:**

The following reports have been submitted to the Reference Committee for consideration:

1. Report of the Bylaws Committee  
*(For Action)*
2. BRD RPT 20-1: Report of the Special Committee on Strategic Planning  
*(For Action)*
3. BRD RPT 20-2: Report of the Workgroup on Physician Sexual Misconduct  
*(For Action)*
4. BRD RPT 20-3: Report on Resolution 19-1: Licensing Exam Research  
*(For Information)*
5. BRD RPT 20-4: Report on Resolution 19-4: Emergency Licensure Following a Natural Disaster  
*(For Information)*

During the Reference Committee's deliberations on April 30<sup>th</sup>, it will consider any written testimony submitted by Member Medical Boards. The deadline for submitting testimony is **April 23**. The testimony should be in the form of a letter addressed to:

Denise Pines, MBA  
Reference Committee Chair  
Send to: [pmccarty@fsmb.org](mailto:pmccarty@fsmb.org)

Following the deliberations of the Reference Committee, a report containing the Reference Committee's recommendations will be posted on the Members Portal on **May 1** and presented to the House of Delegates on **May 2**.

**REPORT OF THE BYLAWS COMMITTEE**

**SUBJECT:                    PROPOSED AMENDMENTS TO THE BYLAWS OF THE FEDERATION OF STATE MEDICAL BOARDS**

**REFERRED TO:            REFERENCE COMMITTEE**

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The Bylaws Committee, chaired by W. Reeves Johnson, Jr. MD, met on October 28, 2019 to consider the current Bylaws, review two proposed amendments and additional commentary submitted for consideration, and make recommendations for any necessary changes. In keeping with its charge, the Committee also discussed the FSMB Articles of Incorporation as they relate to the Bylaws. Members of the Committee include: Lawrence J. Epstein, MD; Genevieve M. Goven; MD, Sandra Schwemmer; DO, Timothy E. Terranova; and Stuart T. Williams, JD. Ex officio members include FSMB Chair Scott A. Steingard, DO, FSMB Chair-Elect Cheryl L. Walker-McGill, MD, MBA and FSMB President-CEO Humayun J. Chaudhry, DO.

In accordance with Article XIV, Section A of the FSMB Bylaws, notice of the meeting of the Bylaws Committee was provided on August 26, 2019.

The Bylaws Committee received two formal proposals for amendments and two other submissions of comments that did not communicate specific amendments but raised organizational issues worthy of general review and discussion. These issues included a review of the state of incorporation, modification of the existing Candidates Forum, nomination process for staff fellows, and roles of chair-elect and past chair, as well as the interdependence of the Bylaws allowing for the role of FSMB President and his or her appointment as the corporate secretary. The Bylaws Committee noted its appreciation of such questions, but ultimately decided that addressing these issues would not be proper through Bylaws amendments and shared the ideas with FSMB staff for future consideration.

After thorough review of the Bylaws and consideration of all questions, comments and proposed amendments, the Bylaws Committee presents the following two proposed amendments for consideration. The Bylaws may be amended at any annual meeting of the House of Delegates by *two-thirds* of those present and voting.

**PROPOSED AMENDMENT #1**

The North Carolina Medical Board urged the Bylaws Committee to review the composition of the Ethics and Professionalism Committee and consider whether allowing for additional members would increase opportunities for Fellows to serve on this increasingly important committee.

The Committee engaged in a discussion of the current process and methodology of committee appointments. Membership in standing committees, including Ethics and Professionalism, is determined by the Chair, with the approval of the Board of Directors (Bylaws, Article VIII, Section A). Each year, the FSMB surveys current Fellows for interest in serving on committees and consults with executive staff. Each Chair selects individuals for committee assignments in accordance with the

45 FSMB Bylaws and the FSMB Board of Directors Policy Compendium. In general, the Policy  
46 Compendium urges that the number of individuals appointed to committees and/or external  
47 organizations be maximized in order to expand participation. The Policy Compendium includes  
48 appointment guidelines that stress the experience and qualifications of individuals recommended for  
49 appointments should reflect the duties and responsibilities commensurate with the appointments. The  
50 Policy Compendium also stresses the importance of diversity of membership and directs the Chair to  
51 make decisions that ensure a broad representation of the Federation's membership.

52

53 The committee recognized that interest in serving on committees continues to grow. For example,  
54 over 20 individuals indicated interest in serving on the Ethics and Professionalism Committee for  
55 Fiscal Year 2019-2020. Recognizing the importance and scope of the areas studied by the Ethics and  
56 Professionalism Committee, it was discussed how the current membership structure could make  
57 appointment decisions difficult for the Chair and limit the ability for qualified Fellows to contribute.

58

59 The Bylaws Committee aligned behind the rationale of the proposal and agreed that increasing  
60 Committee membership provides additional perspectives on challenging topics and allows the  
61 Committee's membership greater ability to collaborate with the FSMB's other generative committees,  
62 such as the Education and Editorial Committees. The Bylaws Committee entertained discussion  
63 regarding the impact an increase in the size of the Ethics and Professionalism Committee would have  
64 on its scope and nature. The Committee also discussed other methods of increasing participation on  
65 committees. Committee members shared practices from other organizations, including the use of  
66 adjunct members to committees. These members would participate in the study and discussion of  
67 issues but would not have a vote on matters before the committee. According to Committee members,  
68 several other healthcare organizations have used this model to greatly benefit the diversity of opinions  
69 as well as foster future leadership.

70

71 The Bylaws Committee questioned the budgetary impact of additional members. Because most  
72 committees, including the Ethics and Professionalism Committee, meet through teleconference or  
73 other electronic platforms, the Committee determined any cost to be de minimis.

74

75 *Proposed Amendment #1*

76

77 ARTICLE VIII

78 SECTION F. ETHICS AND PROFESSIONALISM COMMITTEE

79 The Ethics and Professionalism Committee shall be composed of up to ~~five~~ eight Fellows and up to  
80 two subject matter experts. The Ethics and Professionalism Committee shall address ethical and  
81 professional issues pertinent to medical regulation.

82

83 **PROPOSED AMENDMENT #2**

84

85 Both the FSMB Board of Directors and the North Carolina Medical Board asked the Bylaws  
86 Committee to review the effective date of Bylaws approved by the FSMB House of Delegates and  
87 assess whether amendment would be proper. The North Carolina Medical Board suggested the

88 adoption of language so that amendments become effective “. . . upon adjournment of the Annual  
89 Meeting of the House of Delegates at which they were adopted . . .”, citing that such a change would  
90 prevent Bylaws amendments from unduly impacting subsequent matters coming before the House of  
91 Delegates during that meeting. The FSMB Board of Directors’ Governance Committee met in  
92 Summer 2019 and expressed similar concerns about the immediate applicability of approved changes,  
93 but determined that the Bylaws review process, rather than modification to governance policies, would  
94 provide a more proper forum for discussion. In July 2019, the Board of Directors approved a motion  
95 referring to the Bylaws Committee the issue of the House of Delegates election balloting and a possible  
96 change to the effective date of approved Bylaws amendments.

97

98 The Bylaws Committee understood that as Article XIV, Section B, is currently written and interpreted,  
99 any changes to the Bylaws go into effect immediately after passage by the House of Delegates. Over  
100 the past 6 years, several Bylaws changes impacted the process of voting at the House of Delegates and  
101 the structure of the Board of Directors, requiring immediate actions to ensure legal compliance with  
102 the Bylaws. The Bylaws Committee recognized that the shared intent of the recommendations of both  
103 the North Carolina Medical Board and the FSMB Board of Directors would provide clarity of  
104 interpretation and allow for issues that impact organizational structure or process, such as additional  
105 Board of Directors membership or changes to the voting procedures at the House of Delegates, to be  
106 implemented with heightened fairness and proper notice.

107

108 However, the Bylaws Committee debated the proper manner in which to apply the intent of both of  
109 these proposals. The Bylaws Committee discussed whether it may be necessary for some amendments  
110 to go into immediate effect and the possible need to preserve immediacy in the Bylaws. Members of  
111 the Bylaws Committee also shared experiences and scenarios gleaned from experience with medical  
112 boards, legislation and other organizations that assisted in identification of best practices. Specifically,  
113 it was noted that when proposed to reference committees as well as the House of Delegates,  
114 resolutions before the FSMB House of Delegates do not contain an effective date. Inclusion of an  
115 effective date was identified as a more proper vehicle to address concerns about immediate applicability  
116 of amendments that would impact organizational structure or election process. A Bylaws change that  
117 alludes to the inclusion of an effective date on future amendments to the Bylaws would also allow  
118 reference committees to review the impact of the amendment and delay implementation of a desired  
119 change, if deemed necessary to maintain integrity of process.

120

121 *Proposed Amendment #2*

122

123 ARTICLE XIV

124 SECTION B. EFFECTIVE DATE

125 These Bylaws and any other subsequent amendments thereto, shall become effective upon their  
126 adoption, except as otherwise provided ~~herein~~ in the amendment.



## REPORT OF THE BOARD OF DIRECTORS

**Subject: Report of the Special Committee on Strategic Planning: *FSMB Strategic Plan***

**Referred to: Reference Committee**

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The Special Committee on Strategic Planning was convened in August and November 2019 by FSMB Chair-elect/Committee Chair Cheryl Walker-McGill, MD, MBA to evaluate the continued relevance of the FSMB's 2015-2020 Strategic Plan, which includes the organization's Vision, Mission Statement and Strategic Goals. The Committee was asked to develop recommendations for enhancing or changing the current Strategic Plan and presenting its recommendations to the House of Delegates in 2020 for approval.

Members of the Committee include George Abraham, MD (MA); Ronald Domen, MD (PA-M), FSMB Past Chair Daniel Gifford, MD (AL); William Hoser, MS, PA-C (VT-M); Lyle Kelsey, MBA (OK-M); FSMB Immediate Past Chair Patricia King, MD, PhD (VT-M); Frank Meyers, JD (DC); Kevin O'Connor, MD (VA); FSMB Past Chair Janelle Rhyne, MD (NC); Katie Templeton, JD (OK-O); Christy Valentine, MD (LA) and Sherif Zaafran, MD (TX). FSMB Chair Scott Steingard, DO participated as ex officio. Facilitating the Committee's work was FSMB consultant Paul Larson, MS of Paul Larson Communications.

In completing its charge, the Special Committee met in person on August 14-15 and by videoconference on November 22, 2019. During its deliberations, the Committee considered key facts about the FSMB and its Member Medical Boards including their structure and function; environmental factors impacting medical regulation; challenges and opportunities affecting key stakeholders; and information on the changing national healthcare policy landscape.

The result of the Special Committee's work are recommendations for a revised Strategic Plan that are intended to respond to:

- The need for the FSMB to provide strong **leadership in an era of accelerating change** in the health care sector, and the importance of adaptability and the ability to manage change in this new era.
- The continuing rise of **data-use and technology** – including telemedicine and artificial intelligence – as significant factors in health care.
- The particular need to maintain vigilance, safety and oversight in the midst of **new team-based care models and a blurring scope-of-practice environment**.
- The continuing need for **service and support from the FSMB for its member boards** – which will rely increasingly on the FSMB to serve as a hub and facilitator

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at a time when the sharing of data, resources and best practices requires a strongly interconnected medical regulatory community.

- **Increasing public empowerment** – bringing with it the need for state medical boards to be responsive to the clear preferences of consumers/patients, who put a priority on efficiency, speed and transparency when dealing with institutions.
- Trends toward **corporatization, commoditization and consolidation** in health care, which may have potentially profound impacts on medical regulation.
- The rise of **legislative/political incursions into medicine and de-regulatory forces** in the United States, including developments since the Supreme Court’s *North Carolina Board of Dental Examiners v. Federal Trade Commission* decision.
- Changing trends in the nation’s **workforce of physicians, physician assistants and other health care professionals**, and in the ways **medical education** is delivered.

The draft report of the Special Committee on Strategic Planning (**Attachment 1**) was distributed to FSMB member boards in December 2019 and January 2020 for comment. All comments received were in support of the new Strategic Plan. Accordingly, the Board of Directors approved the Special Committee’s report but removed the original timeframe of the new Strategic Plan (2020-2025) since this is a living document and will be adjusted as needed. The new Strategic Plan also has been updated to reflect the addition of a new Member Medical Board – the Medical Licensure Commission of Alabama – increasing the total number of Member Medical Boards from 70 to 71. The Board of Directors recommends that the proposed *FSMB Strategic Plan* contained in the report be adopted by the House of Delegates and the remainder of the report be filed.

**ITEM FOR ACTION:**

**The Board of Directors recommends that,**

**the House of Delegates ADOPT the *FSMB Strategic Plan* contained in the Report of the Special Committee on Strategic Planning and the remainder of the report be filed.**

1                                   **FEDERATION OF STATE MEDICAL BOARDS**  
2                                   **SPECIAL COMMITTEE ON STRATEGIC PLANNING**

3  
4                                   **Report on FSMB Strategic Plan Recommendations**

5  
6                                   **FSMB Strategic Planning Committee Summary and Proposed Plan**

7  
8                                   The FSMB Special Committee on Strategic Planning met August 14-15, 2019 in Euless, Texas,  
9                                   and again by videoconference on November 22, to review the FSMB's current strategic plan and  
10                                   make recommendations for a new plan, to be implemented in May 2020.

11  
12                                   In preparation for its discussions, the Committee reviewed a variety of documents and information  
13                                   resources, including the:

- 14                                   • 2015 FSMB Board Report on Strategic Planning  
15                                   • 2019 FSMB Strategic Planning Surveys, gauging opinions of state medical boards leaders  
16                                   and other stakeholders  
17                                   • Summaries of strategic-visioning exercises conducted by the FSMB Board of Directors  
18                                   and FSMB staff in 2018 and 2019  
19                                   • 2019 Report of the FSMB House of Delegates on the FSMB 2015-2020 Strategic Plan  
20

21                                   At its August meeting, the Committee engaged in large-group and small-group discussions,  
22                                   identifying environmental factors, challenges and opportunities in health care and medical  
23                                   regulation that could impact the next Strategic Plan.

24  
25                                   After a comprehensive review of the current Strategic Plan, the Committee concluded that the plan  
26                                   remains fundamentally sound in that it continues to focus on core values and relevant strategic  
27                                   imperatives. The Committee recommended slight adjustments, however, to align elements of the  
28                                   plan more closely with emerging trends and new issues of importance to state medical boards.  
29

30                                   The recommended changes are intended to respond to:

- 31                                   • The need for the FSMB to provide strong **leadership in an era of accelerating change** in  
32                                   the health care sector, and the importance of adaptability and the ability to manage change  
33                                   in this new era.  
34                                   • The continuing rise of **data-use and technology** – including telemedicine and artificial  
35                                   intelligence – as significant factors in health care.  
36                                   • The particular need to maintain vigilance, safety and oversight in the midst of **new team-**  
37                                   **based care models** and a **blurring scope-of-practice environment**.  
38                                   • The continuing need for **service and support from the FSMB for its member boards** –  
39                                   which will rely increasingly on the FSMB to serve as a hub and facilitator at a time when  
40                                   the sharing of data, resources and best practices requires a strongly interconnected medical  
41                                   regulatory community.  
42                                   • **Increasing public empowerment** – bringing with it the need for state medical boards to  
43                                   be responsive to the clear preferences of consumers/patients, who put a priority on  
44                                   efficiency, speed and transparency when dealing with institutions.

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- 45 • Trends toward **corporatization, commoditization and consolidation** in health care,  
46 which may have potentially profound impacts on medical regulation.
- 47 • The rise of **legislative/political incursions into medicine** and **de-regulatory forces** in the  
48 United States, including developments since the Supreme Court's *North Carolina Board*  
49 *of Dental Examiners v. Federal Trade Commission* decision.
- 50 • Changing trends in the nation's **workforce of physicians, physician assistants and other**  
51 **health care professionals**, and in the ways **medical education** is delivered.

52

53 The Committee's discussions and conclusions underscore the need for strong leadership and wise  
54 policies from the medical regulatory community to help guide the next generation of medicine in  
55 the United States through a period of historic change.

56

**SUMMARY OF DISCUSSIONS**

57

**Environmental Factors**

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The Committee discussed a variety of environmental factors impacting medical regulation that  
62 should be taken into account in developing a new strategic plan. These included:

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**The rapid advance of technology in health care.** Technological innovations – particularly the  
65 use of telemedicine and the growth of artificial intelligence – are changing the way health care is  
66 delivered. While technology is clearly impacting medicine, it is also impacting the process of  
67 medical regulation: As an example, the digitization of records and use of block-chain technology  
68 will impact standard oversight processes, such as credentialing and credentials verification.

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**The role and importance of data.** "Big Data" is a powerful factor across all sectors, as technology  
71 improves our ability to gather, analyze and share large amounts of information. The volume of  
72 health-care-related data – and new technology platforms that widen its potential use – continue to  
73 expand. This ability brings both opportunities and challenges, as issues of privacy, data ownership  
74 and systems-compatibility must be managed in a complex, dynamic environment.

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**Consolidation and corporatization in health care delivery.** The rate of merger among hospitals  
77 and physician group-practices continues to increase, with a variety of impacts. More and more  
78 physicians are now working as employees of large health systems – which maintain their own  
79 internal physician oversight processes and practice standards, independent of the regulatory  
80 system. Additionally, large retailers – such as CVS and Walmart – are increasing their reach into  
81 the health care sector, with expanded health care delivery services offered through retail clinics.  
82 Google, Apple and other huge technology-based corporations are also expanding their role in  
83 health care – and changing consumer behavior and expectations in the process. The influence of  
84 these large corporate entities on the health system overall will continue to rise.

85

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**"Commoditization" in medical practice.** The confluence of technological innovation and  
87 corporate growth and influence has led to an environment in which health care outcomes, quality,  
88 price and access are increasingly driven by the competitive marketplace. As a result, medicine  
89 becomes more vulnerable to de-professionalization, and the patient-physician relationship

**BRD RPT 20-1 Attachment 1**

90 becomes more vulnerable to de-personalization. As concerns about the impacts of  
91 commoditization grow, there is a perception that the overall influence of the medical community  
92 – an important bulwark for patient safety and quality in health care – is being undercut as a result  
93 of these trends.

94

95 **The continued rise of consumer empowerment.** Thanks largely to the growth of the Internet  
96 over several decades, consumers continue to wield greater influence in health care – ranging from  
97 increased awareness of medical options to self-diagnosis and heightened expectations for  
98 outcomes, cost and care delivery. The development of household and wearable medical devices  
99 and greater access to data have led patients to be given a larger role as partners in the health care  
100 team. Telemedicine, the growth of retail clinics and other fast, relatively inexpensive models of  
101 health care delivery are increasing the expectations of consumers – who don't want impediments  
102 and are less concerned about traditional titles, roles and scope of practice of those who provide  
103 their care.

104

105 **Blurring of lines and traditional roles in health care.** In the new team-based health care delivery  
106 environment, traditional scope-of-practice boundaries are beginning to shift – particularly in terms  
107 of the role of mid-level providers. Physician assistants and other health professionals continue to  
108 play a more prominent role in this environment, and the use of artificial intelligence and other  
109 technologies is accelerating new scope-of-practice trends.

110

111 **Physician workforce changes.** Demographic shifts indicate that physician shortages in key  
112 medical specialties – including primary care – will grow, creating access-to-care issues,  
113 particularly in rural areas of the United States. Additionally, the physician workforce is aging and  
114 some physicians are working at older ages than previous generations.

115

116 **Issues in medical education.** As technology continues to reshape medical practice, there is a  
117 growing need to re-think longstanding approaches in medical education. At the same time, the  
118 enormous cost of medical education – including debt-burdens of medical students – is raising  
119 concerns and impacting the distribution of new physicians across medical specialties, further  
120 contributing to workforce and access-to-care issues.

121

122 **Physician wellbeing.** Concerns about stress-related health issues in the medical workforce have  
123 risen in recent years. There is growing evidence that the wellbeing of physicians has significant  
124 impact on the quality of health care delivery and issues in medical regulation.

125

**Challenges**

126

127  
128 **Anti-occupational-licensing efforts and a culture of deregulation.** In the wake of the Supreme  
129 Court's *North Carolina State Board of Dental Examiners v. Federal Trade Commission* decision,  
130 organized efforts are increasing nationally to scale back on occupational-licensing requirements.  
131 In addition, a culture of deregulation at both state and federal levels has noticeably grown in recent  
132 years – with what some perceive as legislative incursions or overreach into the practice of  
133 medicine. These trends put new pressures on boards' ability to conduct regulatory oversight.

134

**BRD RPT 20-1 Attachment 1**

135 **Inefficiency of systems in a team-based, consumer-driven health care environment.** With  
136 blurring lines in the scope of medical practice, professional regulators must be well-coordinated  
137 across sectors – but the current lack of systems integration and aligned policies make that a  
138 challenge. The issue is exacerbated by the demands of increasingly empowered consumers – and  
139 health care professionals – who have little tolerance for inefficiencies in systems. Of particular  
140 concern to boards is how to transition from legacy systems in an environment that requires  
141 nimbleness and speed.

142

143 **Questions of accountability and responsibility in regulation.** Rapid changes in health care  
144 delivery – including the rise of telemedicine, the use of artificial intelligence and an increase in  
145 team-based care models – have created new “grey areas” and challenges in determining  
146 accountability and responsibility in medical decision-making and care outcomes.

147

148 **Quality control and maintenance of privacy in a data-rich environment.** The ubiquity of data,  
149 the proliferation of entry-points for its collection, and the ease with which it can be shared raise  
150 new questions for boards regarding its management – including security, privacy and quality.

151

**Opportunities**

152

153

154 **Leadership.** In an era of great change and a high level of uncertainty about the future, the FSMB  
155 has an opportunity to play a strong leadership role. The health care system is experiencing  
156 “pendulum swings” – and institutions can earn support and trust in this environment by helping to  
157 provide stability to their stakeholders. By helping state boards navigate change – and helping build  
158 the public’s trust in boards at the same time – the FSMB can establish its value.

159

160 **Technology and data.** The growing availability and importance of technology and data provides  
161 a unique opportunity for the FSMB, which in recent years has expanded its data capabilities –  
162 including infrastructure investments and a transition to digital platforms. The FSMB is positioned  
163 to serve as an information-hub, convener and facilitator as the regulatory community enters a new  
164 era of technology and data processing. The growing reality within medicine is that telemedicine,  
165 artificial intelligence and other modalities are here and have enormous potential but must be shaped  
166 by wise policy.

167

168 **Education for boards and licensees.** In the current health care environment, there is a strong need  
169 for ongoing educational opportunities for state medical boards – as well as their licensees. This is  
170 particularly important, given the relatively high turnover-rate in the state medical board  
171 community: Surveys show that 40% of stakeholders within the Federation have worked in medical  
172 regulation for less than five years. By focusing on educating its member boards about emerging  
173 trends and best practices and helping them provide targeted continuing professional education for  
174 their licensees, the FSMB can help ensure stability amid change.

175

176 **Communications and advocacy.** With the pace of change faced by the health care community,  
177 the need for close communication between institutions and their stakeholder audiences – and  
178 strong advocacy on key issues – has never been greater. In this environment, the FSMB has the  
179 opportunity to deliver value by keeping boards informed, helping raise public awareness of the

**BRD RPT 20-1 Attachment 1**

180 work they do, and coordinating advocacy on their behalf. This is particularly important in an era  
181 when many boards face tight budgets and lean staffing.  
182

DRAFT

183 **CURRENT FSMB STRATEGIC PLAN, 2015-2020**

184

185 **About the FSMB**

186

187 The Federation of State Medical Boards represents the 70 state-medical and osteopathic regulatory  
188 boards – commonly referred to as state medical boards – within the United States, its territories  
189 and the District of Columbia. It supports its member boards as they fulfill their mandate of  
190 protecting the public’s health, safety and welfare through the proper licensing, disciplining, and  
191 regulation of physicians and, in most jurisdictions, other health care professionals.

192

193 **Vision**

194

195 The FSMB is an innovative leader, helping state medical boards shape the future of medical  
196 regulation by protecting the public and promoting quality health care.

197

198 **Mission**

199

200 The FSMB serves as the voice for state medical boards, supporting them through education,  
201 assessment, research and advocacy while providing services and initiatives that promote patient  
202 safety, quality health care and regulatory best practices.

203

204 **Strategic Goals**

205

206 • **State Medical Board Support:** Serve state medical boards by promoting best practices and  
207 providing policies, advocacy, and other resources that add to their effectiveness.

208

209 • **Advocacy and Policy Leadership:** Strengthen the viability of state-based medical  
210 regulation in a changing, globally-connected health care environment.

211

212 • **Collaboration:** Strengthen participation and engagement among state medical boards and  
213 expand collaborative relationships with national and international organizations.

214

215 • **Education:** Provide educational tools and resources that enhance the quality of medical  
216 regulation and raise public awareness of the vital role of state medical boards.

217

218 • **Data and Research Services:** Expand the FSMB's data-sharing and research capabilities  
219 while providing valuable information to state medical boards, the public and other  
220 stakeholders.

221

222 • **Organizational Strength and Excellence:** Enhance the FSMB’s organizational vitality and  
223 adaptability in an environment of change and strengthen its financial resources in support  
224 of its mission.

225

226

227

228



## BRD RPT 20-1 Attachment 1

229 **PROPOSED FSMB STRATEGIC PLAN (RECOMMENDATIONS)**

230

231 Changes to each of the sections of the current Strategic Plan that have been suggested are noted  
232 below.

233

234 **1. “ABOUT THE FSMB” Statement**

235

236 ***Current Statement***

237

238 The Federation of State Medical Boards represents the 70 state medical and osteopathic regulatory  
239 boards – commonly referred to as state medical boards – within the United States, its territories  
240 and the District of Columbia. It supports its member boards as they fulfill their mandate of  
241 protecting the public’s health, safety and welfare through the proper licensing, disciplining, and  
242 regulation of physicians and, in most jurisdictions, other health care professionals.

243

244 Recommendation for change:

- 245 • Update “70 state medical and osteopathic regulatory boards” to “71 state medical and  
246 osteopathic regulatory boards”

247

248 ***Proposed Revised Statement***

249

250 The Federation of State Medical Boards represents the 71 state medical and osteopathic  
251 regulatory boards – commonly referred to as state medical boards – within the United States,  
252 its territories and the District of Columbia. It supports its member boards as they fulfill their  
253 mandate of protecting the public’s health, safety and welfare through the proper licensing,  
254 disciplining, and regulation of physicians and, in most jurisdictions, other health care  
255 professionals.

256

257 **2. VISION**

258

259 ***Current Vision***

260

261 The FSMB is an innovative leader, helping state medical boards shape the future of medical  
262 regulation by protecting the public and promoting quality health care.

263

264 Recommendations for change:

- 265 • Replace “helping state medical boards” with “supports state medical boards”
- 266 • Update the language slightly to better articulate the FSMB’s role of working as an  
267 innovative partner as it meets the needs of state medical boards

268

269 ***Proposed Revised Vision***

270

271 The FSMB supports state medical boards as they protect the public and promote quality health  
272 care, partnering and innovating with them to shape the future of medical regulation.

273

## BRD RPT 20-1 Attachment 1

## 274 3. MISSION

275

276 *Current Mission*

277

278 The FSMB serves as the voice for state medical boards, supporting them through education,  
 279 assessment, research and advocacy while providing services and initiatives that promote patient  
 280 safety, quality health care and regulatory best practices.

281

282 Recommendations for change:

283

- Delete “the voice” and replace with “a national voice”
- Add “data”

284

285

286 *Proposed Revised Mission*

287

288 The FSMB serves as a national voice for state medical boards, supporting them through  
 289 education, assessment, data, research and advocacy while providing services and initiatives  
 290 that promote patient safety, quality health care and regulatory best practices.

291

## 292 4. STRATEGIC GOALS

293

294 *Current Goal 1 – no recommended changes*

295

296 *State Medical Board Support:* Serve state medical boards by promoting best practices and  
 297 providing policies, advocacy, and other resources that add to their effectiveness.

298

299 *Current Goal 2*

300

301 *Advocacy and Policy Leadership:* Strengthen the viability of state-based medical regulation  
 302 in a changing, globally-connected health care environment.

303

304 Recommendations for change:

305

- Replace “viability” with “impact”
- Change “state-based medical regulation” to “state medical regulation”
- Delete “globally” and replace “changing” with “dynamic, interconnected”

306

307

308

309 *Proposed Revised Goal 2*

310

311 *Advocacy and Policy Leadership:* Strengthen the impact of state medical regulation in a  
 312 dynamic, interconnected health care environment.

313

314 *Current Goal 3*

315

- *Collaboration:* Strengthen participation and engagement among state medical boards and  
 317 expand collaborative relationships with national and international organizations.

318

319 Recommendations for change:

**BRD RPT 20-1 Attachment 1**

- 320 • Add “government entities” to help clarify that collaboration is sought with both private-
- 321 sector and public-sector partners
- 322 • Include “state” in addition to “national” and “international”
- 323 • Replace “strengthen” with “build” to reduce the repetition of the word “strengthen” in the
- 324 strategic plan goals

**Proposed Revised Goal 3**

**Collaboration:** Build participation and engagement among state medical boards and expand collaborative relationships with state, national and international organizations and government entities.

**Current Goal 4**

**Education:** Provide educational tools and resources that enhance the quality of medical regulation and raise public awareness of the vital role of state medical boards.

Recommendations for change:

- 338 • Add “Communications” to the goal’s title
- 339 • Move the phrase “Raise public awareness” to the beginning of the goal’s description
- 340 • Add the word “effectiveness”

**Proposed Revised Goal 4**

**Communications and Education:** Raise public awareness of the vital role of state medical boards while providing educational tools and resources that enhance the quality and effectiveness of medical regulation.

**Current Goal 5**

**Data and Research Services:** Expand the FSMB's data-sharing and research capabilities while providing valuable information to state medical boards, the public and other stakeholders.

Recommendations for change:

- 354 • Add “Technology” to the goal’s title; collapse “Research Services” under the heading
- 355 “Data”
- 356 • Begin the stated goal as follows: “Provide leadership in the use of emerging health care
- 357 technology that impacts medical regulation, and...”
- 358 • Change “data-sharing and research capabilities” to “data integration and research
- 359 capabilities”
- 360 • Change “while providing” to “to share”
- 361 • Streamline verbiage to keep goal consistent in length with the other goals by changing “to
- 362 state medical boards, the public and other stakeholders” to “with stakeholders”

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**Proposed Revised Goal 5**

**Technology and Data:** Provide leadership in the use of emerging health care technology that impacts medical regulation, and expand the FSMB’s data integration and research capabilities to share valuable information with stakeholders.

**Current Goal 6**

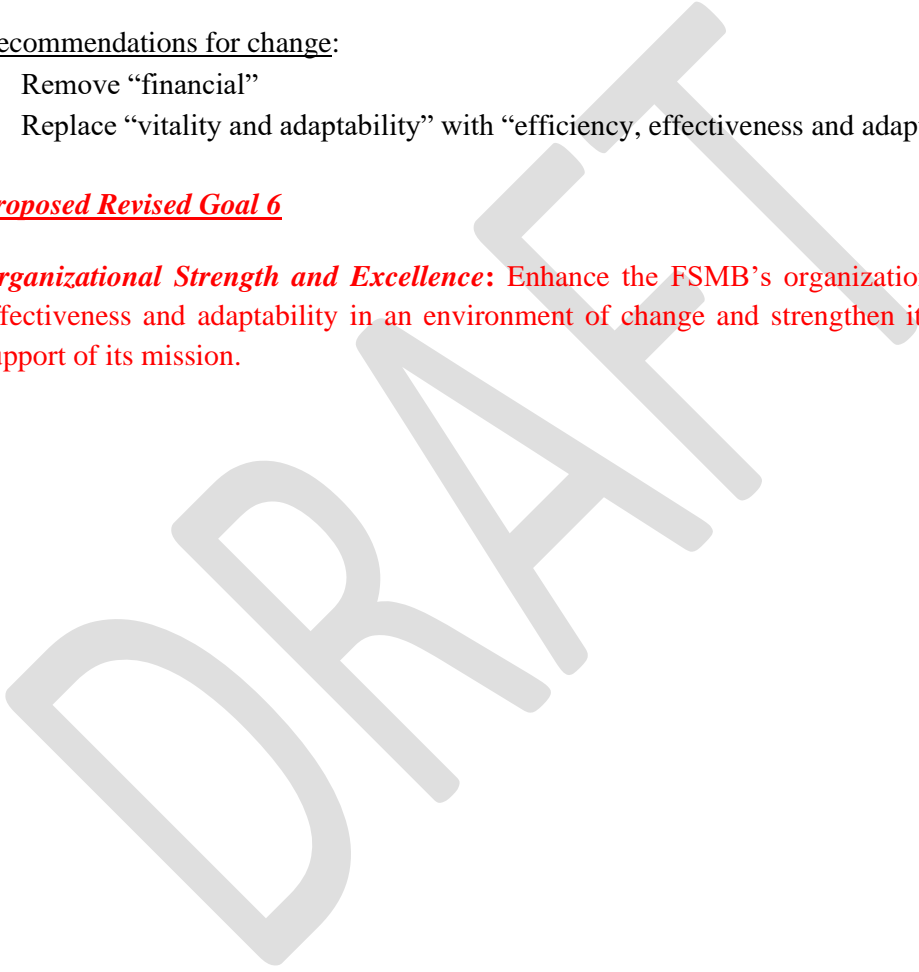
**Strength and Excellence:** Enhance the FSMB’s organizational vitality and adaptability in an environment of change and strengthen its financial resources in support of its mission.

Recommendations for change:

- Remove “financial”
- Replace “vitality and adaptability” with “efficiency, effectiveness and adaptability”

**Proposed Revised Goal 6**

**Organizational Strength and Excellence:** Enhance the FSMB’s organizational efficiency, effectiveness and adaptability in an environment of change and strengthen its resources in support of its mission.



## BRD RPT 20-1 Attachment 1

385 **FSMB STRATEGIC PLAN (FOR APPROVAL)**

386

387 **About the FSMB**

388

389 The Federation of State Medical Boards represents the 71 state medical and osteopathic regulatory  
390 boards – commonly referred to as state medical boards – within the United States, its territories  
391 and the District of Columbia. It supports its member boards as they fulfill their mandate of  
392 protecting the public’s health, safety and welfare through the proper licensing, disciplining, and  
393 regulation of physicians and, in most jurisdictions, other health care professionals.

394

395 **Vision**

396

397 The FSMB supports state medical boards as they protect the public and promote quality health  
398 care, partnering and innovating with them to shape the future of medical regulation.

399

400 **Mission Statement**

401

402 The FSMB serves as a national voice for state medical boards, supporting them through education,  
403 assessment, data, research and advocacy while providing services and initiatives that promote  
404 patient safety, quality health care and regulatory best practices.

405

406 **Strategic Goals**

407

408 • **State Medical Board Support:** Serve state medical boards by promoting best practices and  
409 providing policies, advocacy, and other resources that add to their effectiveness.

410

411 • **Advocacy and Policy Leadership:** Strengthen the impact of state medical regulation in a  
412 dynamic, interconnected health care environment.

413

414 • **Collaboration:** Build participation and engagement among state medical boards and  
415 expand collaborative relationships with state, national and international organizations and  
416 government entities.

417

418 • **Communications and Education:** Raise public awareness of the vital role of state medical  
419 boards while providing educational tools and resources that enhance the quality and  
420 effectiveness of medical regulation.

421

422 • **Technology and Data:** Provide leadership in the use of emerging health care technology  
423 that impacts medical regulation, and expand the FSMB’s data integration and research  
424 capabilities to share valuable information with stakeholders.

425

426 • **Organizational Strength and Excellence:** Enhance the FSMB’s organizational efficiency,  
427 effectiveness and adaptability in an environment of change and strengthen its resources in  
428 support of its mission.

## REPORT OF THE BOARD OF DIRECTORS

**Subject: Report of the FSMB Workgroup on Physician Sexual Misconduct**

**Referred to: Reference Committee**

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The Federation of State Medical Boards (FSMB) Workgroup on Physician Sexual Misconduct, chaired by Dr. Patricia A. King, M.D., Ph.D., has been charged with 1) collecting and reviewing available disciplinary data, including incidence and spectrum of severity of behaviors and sanctions, related to sexual misconduct; 2) identifying and evaluating barriers to reporting sexual misconduct to state medical boards, including, but not limited to, the impact of state confidentiality laws, state administrative codes and procedures, investigative procedures, and cooperation with law enforcement on the reporting and prosecution/adjudication of sexual misconduct; 3) evaluating the impact of state medical board public outreach on reporting; 4) reviewing the FSMB's 2006 policy statement, *Addressing Sexual Boundaries: Guidelines for State Medical Boards*, and revising, amending or replacing it, as appropriate; and 5) assessing the prevalence of sexual misconduct training in undergraduate and graduate medical education and developing recommendations and/or resources to address gaps.

Over the course of two years, the workgroup carried out its charge by reviewing existing research, policy, resources, and strategies for addressing physician sexual misconduct. The workgroup also held two in-person meetings in 2018, received additional information during the FSMB's 2019 Annual Meeting through a Plenary Panel Discussion that included several viewpoints, as well as a Board Forum that hosted more than 200 attendees for an in-depth discussion of key issues, and held a Symposium on Sexual Boundary Violations in Washington, D.C. on June 6, 2019, that also included participants from several state medical boards not represented on the workgroup. A teleconference was held on October 16, 2019 to discuss an initial draft Report with feedback and proposed changes conveyed to the FSMB Board of Directors during an oral report at its October 2019 meeting, followed by a discussion of the board.

A revised draft incorporating feedback received from the Board of Directors was distributed to state medical boards during a comment period held from November 26, 2019 to January 10, 2020. Comments were received from several organizations and members of the public, as well as seven state medical boards. Feedback received was categorized according to the following themes:

- Requirements for notification to law enforcement
- Feasibility of and best practices for remediation
- The duty to report, including peer and institutional reporting, as well as whistleblower protection
- Transparency of data, regulatory processes, complaints, and bases for discipline
- Notification to existing patients of stipulation and to new patients of previous disciplinary action
- Education of clinicians, state medical boards and the public
- Chaperones and practice monitors
- Additional requests of the FSMB:

- Model legislation (e.g., Duty to Report)
- Collection of background data on state laws, made publicly available
- Education across the continuum for appropriate treatment of patients (in collaboration with partners, e.g., AACOM, AAMC, ACGME, AOA)
- Facilitation of development and exchange of best practices among boards
- Facilitation and provision of training on implicit bias and trauma-informed investigations
- Funding for data development, coding, and analysis pilots by boards and others

The workgroup met again via teleconference on January 29, 2020 to discuss feedback received and provide input for its incorporation into a new draft. This revised draft was distributed to the Board of Directors electronically and discussed during a videoconference held on March 2, 2020. During this videoconference, the Board voted to approve the Report (**Attachment 1**) and recommended its adoption by the House of Delegates.

**ITEM FOR ACTION:**

**The Board of Directors recommends that:**

**The House of Delegates ADOPT the recommendations contained in the *Report of the FSMB Workgroup on Physician Sexual Misconduct* and the remainder of the Report be filed.**

## BRD RPT 20-2 Attachment 1

1 **Report of the FSMB Workgroup on Physician Sexual Misconduct**2  
3 **DRAFT**4  
5 **Section 1: Introduction and Workgroup Charge**6  
7 The relationship between a physician and patient is inherently imbalanced. The knowledge, skills  
8 and training statutorily required of all physicians puts them in a position of power in relation to  
9 the patient. The patient, in turn, often enters the therapeutic relationship from a position of  
10 vulnerability due to illness, suffering, and a need to divulge deeply personal information and  
11 subject themselves to intimate physical examination. This vulnerability is further heightened in  
12 light of the patient's trust in their physician, who has been granted the power to deliver care,  
13 prescribe needed treatment and refer for appropriate specialty consultation.  
1415 It is critical that physicians act in a manner that promotes mutual trust with patients to enable the  
16 delivery of quality health care. When there is a violation of that relationship through sexual  
17 misconduct, such behavior and actions can have a profound, enduring and traumatic impact on  
18 the individual being exploited, their family, the public at large, and the medical profession as a  
19 whole. Properly and effectively addressing sexual misconduct by physicians through sensible  
20 standards and expectations of professionalism, including preventive education, as well as  
21 through meaningful disciplinary action and law enforcement when required, is therefore a  
22 paradigmatic expression of self-regulation and its more modern iteration, shared regulation.  
2324 In May of 2017, Patricia King, M.D., PhD., Chair at the time of the Federation of State Medical  
25 Boards (FSMB), created and led a Workgroup on Physician Sexual Misconduct (hereafter  
26 referred to as "the Workgroup"), and charged its members with 1) collecting and reviewing  
27 available disciplinary data, including incidence and spectrum of severity of behaviors and  
28 sanctions, related to sexual misconduct; 2) identifying and evaluating barriers to reporting sexual  
29 misconduct to state medical boards, including, but not limited to, the impact of state  
30 confidentiality laws, state administrative codes and procedures, investigative procedures, and  
31 cooperation with law enforcement on the reporting and prosecution/adjudication of sexual  
32 misconduct; 3) evaluating the impact of state medical board public outreach on reporting; 4)  
33 reviewing the FSMB's 2006 policy statement, *Addressing Sexual Boundaries: Guidelines for*  
34 *State Medical Boards*, and revising, amending or replacing it, as appropriate; and 5) assessing  
35 the prevalence of sexual boundary/harassment training in undergraduate and graduate medical  
36 education and developing recommendations and/or resources to address gaps.  
3738 In carrying out its charge, the Workgroup adopted a broad lens with which to scrutinize not only  
39 the current practices of state medical boards and other professional regulatory authorities in the  
40 United States and abroad, but also elements of professional culture within American medicine,  
41 including notions of professionalism, expectations related to reporting instances of misconduct or  
42 impropriety, evolving public expectations of the medical profession, and the impact of trauma on  
43 survivors of sexual misconduct. In analyzing these issues, the Workgroup benefited  
44 tremendously from discussions with several of the FSMB's partner organizations and  
45 stakeholders that also have a role in addressing the issue of physician sexual misconduct. The  
46 Workgroup extends its thanks, in particular, to the American Association of Colleges of



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47 Osteopathic Medicine (AACOM), Association of American Medical Colleges (AAMC), Student  
48 Osteopathic Medical Association (SOMA), Australian Health Practitioner Regulation Agency  
49 (AHPRA), American Medical Association (AMA), American Medical Women’s Association  
50 (AMWA), American Osteopathic Association (AOA), Council of Medical Specialty Societies  
51 (CMSS), Federation of Medical Regulatory Authorities of Canada (FMRAC), Federation of  
52 State Physician Health Programs (FSPHP), several provincial medical regulatory colleges from  
53 Canada, subject matter experts from Justice3D, PBI Education, and additional physician experts,  
54 and especially the victim and survivor advocates who bravely shared their experiences with  
55 Workgroup members. This report has been enriched by these partners’ valuable contributions.  
56

57 *A call for cultural change*  
58

59 The Workgroup acknowledged the importance of the environment and culture, from medical  
60 school to practice, for the development of and commitment to positive professional values and  
61 behaviors in medicine. In this regard, the Workgroup also acknowledged the existence of several  
62 highly problematic aspects of sexual misconduct in medical education and practice, many of  
63 which permeate the prevailing culture of medicine and self-regulation. The National Academies  
64 of Sciences report that organizational culture plays a primary role in enabling harassment and  
65 that sexually harassing behaviors are not typically isolated incidents.<sup>1</sup> Medical students and  
66 trainees who are subjected to environments in which harassment is accepted suffer not only as  
67 victims, but may also be undermined in their educational and professional attainment, resulting  
68 in loss of talent for the profession. To the extent that a culture that is permissive of sexual  
69 harassment results in perceived license to engage in such conduct oneself, patients are ultimately  
70 put at risk of dire consequences. Permissive environments could also reduce the likelihood that  
71 bystanders will feel responsibility to report misconduct.  
72

73 Beyond the many instances, both reported and unreported, of sexual assault and boundary  
74 violations, concerns about sexual misconduct in medicine include various aspects of the  
75 investigative and adjudicatory processes designed to address them; the professional  
76 responsibility of health care practitioners to report suspected instances of sexual misconduct and  
77 patient harm; variation in state medical board policies and processes, as well as in state laws;  
78 transparency of state medical board processes and actions; a widespread need for education and  
79 training among medical regulators, board investigators, attorneys, and law enforcement  
80 personnel about trauma and how it might impact complainant accounts and the investigative  
81 process; and challenges posed for decisions about re-entry to practice and remediation.  
82

83 This report summarizes these problematic elements so that they may be more widely appreciated,  
84 while offering potential solutions and strategies for state medical boards to consider for their  
85 jurisdictions. It aspires to provide best practice recommendations and highlight existing  
86 strategies and available tools to allow boards, including board members, executive directors,  
87 staff, and attorneys, to best protect the public while working within their established frameworks  
88 and resources. The report also advocates for an educational focus to change and improve

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<sup>1</sup> National Academies of Sciences, Engineering, and Medicine. 2018. *Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine*. Washington, DC: The National Academies Press. doi: <https://doi.org/10.17226/24994>.

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89 culture, awareness, and behaviors across the continuum of medical education and practice, so as  
90 to improve care for and protection of patients.

91

92

### 93 **Section 2: Principles**

94

95 The analysis in this report is informed by the following principles:

- 96 • **Trust**: The physician-patient relationship is built upon trust, understood as a confident  
97 belief on the part of the patient in the moral character and competence of their physician.<sup>2</sup>  
98 In order to safeguard this trust, the physician must act and make treatment decisions that  
99 are in the best interests of the patient at all times.
- 100 • **Professionalism**: The avoidance of sexual relationships with patients has been a principle  
101 of professionalism since at least the time of Hippocrates. Professional expectations still  
102 dictate today that sexual contact or harassment of any sort between a physician and  
103 patient is unacceptable.
- 104 • **Fairness**: The principle of fairness applies to victims (also sometimes described as  
105 survivors) of sexual misconduct, who must be granted fair treatment throughout the  
106 regulatory process and be afforded opportunities to seek justice for wrongful conduct  
107 committed against them. Fairness also applies to physicians who are subjects of  
108 complaints in that they must be granted due process in investigative and adjudicatory  
109 processes; proportionality should be considered in disciplinary actions.
- 110 • **Transparency**: The actions and processes of state medical boards are designed in the  
111 public interest to regulate the medical profession and protect patients from harm. As  
112 such, the public has a right to information about these processes and the bases of  
113 regulatory decisions.

114

115

### 116 **Section 3: Terminology:**

117

#### 118 *Sexual Misconduct:*

119

120 For the purposes of this report, physician sexual misconduct is understood as behavior that  
121 exploits the physician-patient relationship in a sexual way. Sexual behavior between a physician  
122 and a patient is never diagnostic or therapeutic. This behavior may be verbal or physical, can  
123 occur in person or virtually,<sup>3</sup> and may include expressions of thoughts and feelings or gestures  
124 that are of a sexual nature or that a patient or surrogate<sup>4</sup> may reasonably construe as sexual.  
125 Hereinafter, the term “patient” includes the patient and/or patient surrogate.

126

127 Physician sexual misconduct often takes place along a continuum of escalating severity. This  
128 continuum comprises a variety of behaviors, sometimes beginning with “grooming” behaviors  
129 which may not necessarily constitute misconduct on their own, but are precursors to other, more

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<sup>2</sup> Beauchamp T and Childress J., (2001) *Principles of Biomedical Ethics*, 5<sup>th</sup> ed., 34.

<sup>3</sup> Federation of State Medical Boards, *Social Media and Electronic Communication*, 2019.

<sup>4</sup> Surrogates are those individuals closely involved in patients’ medical decision-making and care and include spouses or partners, parents, guardians, and/or other individuals involved in the care of and/or decision-making for the patient.

**BRD RPT 20-2 Attachment 1**

130 severe violations. Grooming behaviors may include gift-giving, special treatment, sharing of  
131 personal information or other acts or expressions that are meant to gain a patient's trust and  
132 acquiescence to subsequent abuse.<sup>5</sup> When the patient is a child, adolescent or teenager, the  
133 patient's parents may also be groomed to gauge whether an opportunity for sexual abuse exists.  
134

135 More severe forms of misconduct include sexually inappropriate or improper gestures or  
136 language that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually  
137 demeaning to a patient. These may not necessarily involve physical contact, but can have the  
138 effect of embarrassing, shaming, humiliating or demeaning the patient. Instances of such sexual  
139 impropriety can take place in person, online, by mail, by phone, and through texting.  
140

141 Additional examples of sexual misconduct involve physical contact, such as performing an  
142 intimate examination on a patient with or without gloves and without clinical justification or  
143 explanation of its necessity, and without obtaining informed consent.  
144

145 The severity of sexual misconduct increases when physical contact takes place between a  
146 physician and patient and is explicitly sexual or may be reasonably interpreted as sexual, even if  
147 initiated by the patient. So-called "romantic" behavior between a physician and a patient is never  
148 appropriate, regardless of the appearance of consent on the part of the patient. Such behavior  
149 would at least constitute grooming, depending on the nature of the behavior, if not actual sexual  
150 misconduct, and should be labeled as such.  
151

152 The term "sexual assault" refers to any type of sexual activity or contact without consent (such as  
153 through physical force, threats of force, coercion, manipulation, imposition of power, etc., or  
154 circumstances where a person lacks the capacity to provide consent due to age or other  
155 circumstances) and may be used in investigations where there is a need to emphasize the severity  
156 of the misconduct and related trauma. Sexual assault is a criminal or civil violation and should  
157 typically be handled in concert with law enforcement. Sexual assault should be reported to law  
158 enforcement immediately, except in cases where reporting would contravene the wishes of an  
159 adult complainant and non-reporting in such an instance is permitted by applicable state law.  
160

161 While the legal term "sexual boundary violation" is a way of denoting the breach of an  
162 imaginary line that exists between the doctor and patient or surrogate, and is commonly used in  
163 medical regulatory discussions, the members of the Workgroup felt that it was an overly broad  
164 term that may encompass everything from isolated instances of inappropriate communication to  
165 sexual misconduct and outright sexual assault. Thus, this report avoids the term in favor of more  
166 specific terms.  
167

168 *Trauma:*  
169

170 For the purposes of this report, the definition of trauma provided by the Substance Abuse and  
171 Mental Health Services Administration (SAMHSA) is used:  
172

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<sup>5</sup> American Academy of Pediatrics "Protecting Children from Sexual Abuse by Health Care Providers," Committee on Child Abuse and Neglect, 2010-2011, Published in *Pediatrics*, August 2011, Vol. 128, Issue 2.

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173 “Individual trauma results from an event, series of events, or set of circumstances that is  
174 experienced by an individual as physically or emotionally harmful or life threatening and that has  
175 lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or  
176 spiritual well-being.”<sup>6</sup>

177

178 According to SAMHSA, “a program, organization, or system that is *trauma-informed* realizes  
179 the widespread impact of trauma and understands potential paths for recovery; recognizes the  
180 signs and symptoms of trauma in clients, families, staff, and others involved with the system; and  
181 responds by fully integrating knowledge about trauma into policies, procedures, and practices,  
182 and seeks to actively resist re-traumatization.”<sup>7</sup>

183

184 *Patient:*

185

186 A patient is understood as an individual with whom a physician is involved in a care and  
187 treatment capacity within a legally defined and professional physician-patient relationship.

188

189 *Physician:*

190

191 While this report primarily addresses physician licensees, the content and recommendations  
192 should be viewed as applying to all health professionals licensed by member boards of the  
193 FSMB, as well as other members of the health care team, including medical students.

194

195

196 **Section 4: Patient Rights and Expectations for Professional Conduct in the Physician-**  
197 **Patient Encounter**

198

199 *Communication and Patient Education*

200

201 Communication between a physician and patient should occur throughout any examination or  
202 procedure (provided the patient is not under general anesthetic during the procedure), including  
203 conveying the medical necessity, what the examination or procedure will involve, any discomfort  
204 the patient might experience, the benefits and risks, and any findings. This is especially  
205 important during the performance of an intimate examination. This not only lays out the  
206 parameters of the interaction for both parties; it may also help minimize the possibility that the  
207 patient will misinterpret the physician’s actions.

208

209 The use of educational resources to educate patients about what is normal and expected during  
210 medical examinations and procedures is encouraged and should be provided by both physicians  
211 and state medical boards.

212

213

214

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<sup>6</sup> Substance Abuse and Mental Health Services Administration. *SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

<sup>7</sup> *Id.* Emphasis added.

**BRD RPT 20-2 Attachment 1**215 *Informed Consent and Shared Decision-Making*

216

217 The informed consent process can be a useful way of helping a patient understand the intimate  
218 nature of a proposed examination, as well as its medical necessity. The informed consent process  
219 should include, at a minimum, an explanation, discussion, and comparison of treatment options  
220 with the patient, including a discussion of any risks involved with proposed procedures; an  
221 assessment of the patient's values and preferences; arrival at a decision in partnership with the  
222 patient; and an evaluation of the patient's decision in partnership with the patient. This process  
223 must be documented in the patient's medical record.

224

225 Where possible, the consent process should take place well in advance of any procedure so that  
226 the patient has an opportunity to consider the proposed procedure in the absence of competing  
227 considerations about cancellation or rescheduling. Requiring decisions at the point of care puts  
228 patients at a disadvantage because they may not have time to consider what is being proposed  
229 and what it means for themselves and their values. However, it is recognized that obtaining  
230 consent well in advance is not always possible for urgent, emergency, or same-day procedures.  
231 The consent process should also include information about the effects of anaesthesia, including  
232 the possibility of amnesia, because these can be particularly problematic with respect to sexual  
233 misconduct. Use of understandable (lay, or common) language during the consent process is  
234 essential.

235

236 In instances where a patient is unable to provide consent to a pelvic or otherwise intimate  
237 examination due to the presence of anesthesia or for any other reason, an intimate examination  
238 should only be performed when it is medically necessary. Intimate examinations must never be  
239 performed for purely educational purposes when consent cannot be obtained.

240

241

242 **Section 5: Complaints and the Duty to Report**

243

244 In order for state medical boards to effectively address instances of sexual misconduct, they must  
245 have access to relevant information about licensees that have harmed or pose a significant risk of  
246 harming patients. The complaints process and physicians' professional duty to report instances of  
247 sexual misconduct are therefore central to a regulatory board's ability to protect patients.<sup>8</sup>

248

249 *Complaints and Barriers to Complaints*

250

251 It is essential for patients or their surrogates to be able to file complaints about their physicians to  
252 state medical boards in order that licensees who pose a threat to patients may be investigated and  
253 appropriate action taken. However, studies have estimated that sexual misconduct by physicians  
254 is significantly under reported, and several challenges which may dissuade patients from filing  
255 complaints must be overcome.<sup>9</sup> These include distrust in the ability or willingness of institutions

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<sup>8</sup> Additional reporting to entities other than state medical boards may also be warranted for purposes of patient protection, including law enforcement, hospital or medical staff administration, and medical school or residency program directors and supervisors.

<sup>9</sup> Dubois J, et al. Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases. *Sexual Abuse* 2019, Vol. 31(5) 503–523

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256 such as state medical boards, hospitals and other health care organizations to take action in  
257 instances of sexual misconduct; fear of abandonment or retaliation by the physician; societal or  
258 personal factors related to stigma, shame, embarrassment and not wanting to relive a traumatic  
259 event; a lack of awareness about the role of state medical boards and how to file complaints; or  
260 uncertainty that what has transpired is, indeed, unprofessional and unethical.

261

262 State medical boards can play an important role in providing clarity about the complaints process  
263 by providing information to the public about the process itself and how, why, and when to file a  
264 complaint. Recommended methods for optimizing the complaints process include:

265

- 266 • Providing the option to file complaints via multiple channels, including in writing, by  
267 telephone, email, or through online forms
- 268 • Making the process accessible to patients with information about filing complaints that is  
269 clearly posted on state medical board websites
- 270 • Ensuring that information about the complaints process is made available via translation  
271 for complainants who do not speak English

272

273 State medical boards, the FSMB and its partner organizations representing medical specialties  
274 whose members perform intimate examinations and procedures may also wish to provide  
275 education for patients on topics such as:

276

- 277 • The types of behavior that should be expected of physicians
- 278 • Types of behavior that might warrant a complaint
- 279 • What to do in the event that a physician's actions make a patient uncomfortable
- 280 • Circumstances that would warrant a report directly to law enforcement

281

282 State medical boards can also restore public trust and confidence in the complaints process by  
283 demonstrating swift and appropriate action on verified complaints.

284

285 The ability to file a complaint anonymously may be especially important in instances of sexual  
286 misconduct. The trauma and fear associated with sexual misconduct can pose barriers to  
287 legitimate complaints, especially when anonymity is not granted. While the ability of  
288 complainants to remain anonymous to the general public is recommended, complainant  
289 anonymity to the state medical board may not be possible.

290

291 State medical boards should address complaints related to sexual misconduct as quickly as  
292 possible for the benefit and protection of the complainant and other patients. Initial stages of  
293 investigations should be expedited to determine whether there is a high likelihood of imminent  
294 risk to the public, meriting steps to modify or cease practice while the investigation is completed.

295

296 State medical board staff and board investigators of administrative complaints are encouraged to  
297 communicate frequently with complainants throughout the complaint and investigative processes  
298 and to ask complainants about their preferred mode and frequency of communication, as well as  
299 their expectations from the process. Where possible, boards should consider having a patient  
300 liaison or navigator on staff who would be specially trained to provide one-on-one support to  
301 complainants and their families.

**BRD RPT 20-2 Attachment 1**

302

303 *Duty to Report*

304

305 In a complaint-based medical regulatory system, it is imperative that state medical boards have  
306 access to the information they require to effectively protect patients.<sup>10</sup> In addition to a robust  
307 complaints process, it is therefore essential that patients, physicians and everyone involved in  
308 healthcare speak up whenever something unusual, unsafe or inappropriate occurs. All members  
309 of the healthcare team, as well as institutions, including state medical boards, hospitals and  
310 private medical clinics also have a legal as well as an ethical duty to report instances of sexual  
311 misconduct and other serious patient safety issues and events. This duty extends beyond  
312 physician-patient encounters to reporting inappropriate behavior in interactions with other  
313 members of the healthcare team, and in the learning environment.

314

315 Early reporting of sexual misconduct is critical. This includes reporting of those forms of  
316 misconduct at the less egregious end of the spectrum that fall under potential grooming  
317 behaviors. Evidence indicates that less egregious violations that go unreported frequently lead to  
318 more egregious ones. Less egregious acts and grooming behaviors are almost always committed  
319 in private or after hours where they cannot be witnessed by parties external to the physician-  
320 patient encounter and therefore go unreported. Early reporting is therefore one of the only ways  
321 in which sexual misconduct with patients can be prevented from impacting more patients.

322

323 The ethical duty to report has proven insufficient in recent years, however, to provide the  
324 information state medical boards must have to stop or prevent licensees from engaging in sexual  
325 misconduct. There are likely several factors that inhibit reporting, including the corporatization  
326 of medical practice, which has led many institutions to deal with instances of misconduct  
327 internally. While corporatization increases accountability for many physicians and internal  
328 processes may be effective in addressing some types of sexual misconduct, it can also cause  
329 some institutions to neglect required reporting and the need for transparency. Physicians may  
330 also avoid reporting because of the moral distress and discomfort some physicians feel when  
331 asked to report their colleagues, and the impracticality of reporting where power dynamics exist  
332 and where stakes are high for reporters.

333

334 Thus, rather than relying on professional or ethical duties alone, alternative strategies and  
335 approaches should be considered. State medical boards should have the ability to levy fines  
336 against institutions for failing to report instances of egregious conduct. While many boards  
337 already have statutory ability to do so, they are reluctant to engage in legal proceedings with  
338 hospitals or other institutions with far greater resources at their disposal. An ability to publicize  
339 reasons for levying fines may also be helpful as the reputational risk to an institution could  
340 provide added incentives to report.

341

342 Results of hospital and health system peer review processes should also be shared with state  
343 medical boards when sexual misconduct is involved. This type of conduct is fundamentally  
344 different from other types of peer review data related to performance and aimed at quality  
345 improvement and, while still relevant to medical practice, should be subject to different rules  
346 regarding reporting. Hospitals should also be required to report to state medical boards instances

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<sup>10</sup> Federation of State Medical Boards, *Position Statement on Duty to Report*, 2016.

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347 where employed physicians have been dismissed or are forced to resign due to concerns related  
348 to sexual misconduct.

349

350 Boards should have the authority to impose disciplinary action on licensees for failure to report.  
351 Where such authority does not currently exist, legislative change may be sought.<sup>11</sup> Language  
352 used in state laws describing when reporting is mandatory varies and can include “actual  
353 knowledge” of an event, “reasonable cause” to believe that an event occurred, “reasonable  
354 belief,” “first-hand knowledge,” and “reasonable probability” (as distinguished from “mere  
355 probability”).<sup>12</sup> Despite the variance in language, the theme of reasonability runs throughout. If it  
356 is reasonable to believe that misconduct occurred, this should be reported to the state medical  
357 board and, in most instances, to law enforcement.

358

359 *Reporting to Law Enforcement*

360

361 There is variability in state laws that address when state medical boards are required to report  
362 instances of sexual misconduct to law enforcement. Despite this variability, best practices dictate  
363 that boards have a duty to report to law enforcement anytime they become aware of sexual  
364 misconduct or instances of criminal behavior. When reporting requirements are unclear,  
365 consultation with a board attorney is recommended, but boards are encouraged to err on the side  
366 of reporting. Protocols and consensus can also be established in collaboration with law  
367 enforcement to help clarify reporting requirements. This can also help to clarify circumstances  
368 where law enforcement should report instances of physician sexual misconduct to state medical  
369 boards.

370

371 In limited circumstances, boards may choose not to report to law enforcement. These may  
372 involve less egregious forms of sexual misconduct such as inappropriate speech or include  
373 circumstances where a complainant requests that law enforcement not be notified, as long as  
374 there is no law establishing a mandatory reporting requirement. Wishes of complainants should  
375 be respected in such circumstances, as victims may be at different stages of coming to terms with  
376 the trauma they’ve experienced. However, reporting to law enforcement must occur for any  
377 instance of child abuse, abuse of a minor, and abuse of a dependent adult, regardless of whether  
378 the complainant wants reporting to occur. In any instance where reporting sexual misconduct to  
379 law enforcement is considered, especially in instances where a decision is made *not* to report, a  
380 clear rationale for the board’s decision should be documented. Boards can also facilitate the  
381 reporting process for patients by offering assistance or educational resources about the reporting  
382 process and relevant contact information.

383

384 *Cultivating Professionalism*

385

386 Empowering physicians and physicians in training to report violations of professional standards  
387 is essential given the barriers posed by the hierarchical structure of most health care institutions.  
388 Those in a position to observe and report sexual misconduct should be protected from retaliation  
389 and adverse consequences for medical school matriculation, training positions, careers or

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<sup>11</sup> See, e.g., N.C. Gen. Stat. § 90-5.4

<sup>12</sup> Starr, Kristopher T Reporting a Physician Colleague for Unsafe Practice: What’s the Law?  
*Nursing2019*: [February 2016 - Volume 46 - Issue 2 - p 14](#)



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390 promotions. Cultivating positive behavior through role modelling and establishing clear guidance  
391 based on the values of the profession is the responsibility of multiple parties, not the state  
392 medical board alone. A broader notion of professionalism should be adopted that goes beyond  
393 expectations for acceptable conduct to include a duty to identify instances of risk or harm to  
394 patients, thereby making non-reporting professionally unacceptable. Physicians who fail to report  
395 known instances of sexual misconduct should be liable for sanction by their state medical board  
396 for the breach of their professional duty to report.

397  
398 Unscrupulous, frivolous or vexatious reporting motivated by competition or personal animus is  
399 counterproductive to fulfilling this notion of professionalism and protecting the public, so should  
400 be met with disciplinary action. Processes for reporting and complaints should be normalized by  
401 making them a core component of medical professionalism, rather than a burdensome  
402 responsibility that befalls particular unfortunate individuals. This may help physicians feel less  
403 like investigators and more like responsible stewards of professional values. Those physicians  
404 and other individuals who do report in good faith should be protected from retaliation through  
405 whistleblower legislation and given the option to remain anonymous.

406  
407

**Section 6: Investigations**

409

*State Medical Board Authority*

411

412 It is imperative that state medical boards have sufficient statutory authority to investigate  
413 complaints and any reported allegations of sexual misconduct. State medical boards should place  
414 a high priority on the investigation of complaints of sexual misconduct due to patient  
415 vulnerability unique to such cases. The purpose of the investigation is to determine whether the  
416 report can be substantiated in order to collect sufficient facts and information for the board to  
417 make an informed decision as to how to proceed. If the state medical board's investigation  
418 indicates a reasonable probability that the physician has engaged in sexual misconduct, the state  
419 medical board should exercise its authority to intervene and take appropriate action to ensure the  
420 protection of the patient and the public at large.

421

422 Each complaint should be investigated and judged on its own merits. Where permitted by state  
423 law, the investigation should include a review of previous complaints to identify any such  
424 patterns of behavior, including malpractice claims and settlements. In the event that such patterns  
425 are identified early in the investigation, or the physician has been the subject of sufficient  
426 previous complaints to suggest a high likelihood that the physician presents a risk to future  
427 patients, or in the event of evidence supporting a single egregious misconduct event, the state  
428 medical board should have the authority to impose terms or limitations, including suspension, on  
429 the physician's license prior to the completion of the investigation.

430

431 The investigation of all complaints involving sexual misconduct should include interviews with  
432 the physician, complainant(s) and/or patient and/or patient surrogate. The investigation may  
433 include an interview with a current or subsequent treating practitioner of the patient and/or  
434 patient surrogate; colleagues, staff and other persons at the physician's office or worksite; and

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435 persons that the patient may have told of the misconduct. Physical evidence and police reports  
436 can also be valuable in providing a more complete understanding of events.

437

438 In many states, a complaint may not be filed against a physician for an activity that occurred  
439 beyond a certain time threshold in the past. There is a growing trend among state legislatures in  
440 recent years to extend or remove the statute of limitations in cases of rape, sexual assault and  
441 other forms of sexual misconduct. Given the impact that trauma can have on a victim of sexual  
442 misconduct, the length of time that it may take to understand that a violation has occurred, to  
443 come to terms with it, or be willing to relive the circumstances as part of the complaints process,  
444 the members of the Workgroup feel that no limit should be placed on the amount of time that can  
445 elapse between when an act of misconduct occurred and when a complaint can be filed.

446

447 *Trauma-Informed Investigations*

448

449 Because of the delicate nature of complaints of sexual misconduct and the potential trauma  
450 associated with it, state medical boards should have special procedures in place for interviewing  
451 and interacting with such complainants and adjudicating their cases. In cases involving trauma,  
452 emotions may not appear to match the circumstances of the complaint, seemingly salient details  
453 may be unreported or unknown to the complainant, and the description of events may not be  
454 recounted in linear fashion. Symptoms of trauma may therefore be falsely interpreted as signs of  
455 deception by board investigators or those adjudicating cases.

456

457 Professionals who are appropriately trained and certified in the area of sexual misconduct and  
458 victim trauma should conduct the state medical board's investigation and subsequent  
459 intervention whenever possible. Best practices in this area suggest that board members and staff  
460 should undergo specialized training in victim trauma. It is further recommended that all board  
461 staff who work with complainants in cases involving sexual misconduct undergo this training to  
462 develop an understanding of how complainants' accounts in cases involving trauma can differ  
463 from other types of cases. This can inform reasonable expectations on behalf of those  
464 investigating and adjudicating these cases and help eliminate biases. The FSMB and state  
465 medical boards should work to identify and ensure the availability of high-quality training in  
466 trauma and a trauma-informed approach to investigations. While a greater understanding of  
467 victim trauma is a priority, additional training in implicit bias related to gender, gender identity,  
468 race, and ethnicity would also help ensure fair and comfortable processes for victims.

469

470 Where state medical boards have access to investigators of different genders, boards should seek  
471 the complainant's preference regarding the gender of investigators and assign them accordingly.  
472 State medical boards should also allow inclusion of patient advocates in the interview process  
473 and treat potential victims (survivors) with empathy, humanity, and in a manner that encourages  
474 healing. Questioning of both complainants and physicians should take the form of an  
475 information-gathering activity, not an aggressive cross-examination.

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**BRD RPT 20-2 Attachment 1****Section 7: Comprehensive Evaluation**

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State medical boards regularly use diagnostic evaluations for health professionals who may have a physical or mental impairment. Similarly, the use of diagnostic evaluations when handling a complaint regarding sexual misconduct provides significant information that may not otherwise be revealed during the initial phase of the investigation. A comprehensive evaluation may be valuable to the board's ability to assess future risk to patient safety.

489

A comprehensive evaluation is not meant to determine findings of fact. Rather, its purpose is to:

490

- assess and define the nature and scope of the physician's behavior,
- identify any contributing illness, impairment, or underlying conditions that may have predisposed the physician to engage in sexual misconduct or that might put future patients at risk,
- assist in determining whether a longstanding maladaptive pattern of inappropriate behavior exists, and
- make treatment recommendations if rehabilitative potential is established.

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If its investigation reveals a high probability that sexual misconduct has occurred, the state medical board should have the authority to order an evaluation of the physician and the physician must be required to consent to the release to the board all information gathered as a result of the evaluation. The evaluation of the physician follows the investigation/intervention process but precedes a formal hearing.

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**Section 8: Hearings**

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Following investigation and evaluation (if appropriate), the state medical board should determine whether sufficient evidence exists to proceed with formal charges against the physician. In most jurisdictions, initiation of formal charges is public and will result in an administrative hearing unless the matter is settled.

***Initiation of Charges***

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In assessing whether sufficient evidence exists to support a finding that sexual misconduct has occurred, corroboration of a patient's testimony should not be required. Although establishing a pattern of sexual misconduct may be significant, a single case is sufficient to proceed with a formal hearing. State medical boards should have the authority to amend formal charges to include additional complainants identified prior to the conclusion of the hearing process.

**BRD RPT 20-2 Attachment 1**527 *Open vs Closed Hearings*

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529 If state medical boards are required, by statute, to conduct all hearings in public, including cases  
530 of sexual misconduct, many patients may be hesitant to come forward in a public forum and  
531 relate the factual details of what occurred. State medical boards should have the statutory  
532 authority to close the hearing during testimony which may reveal the identity of the patient.  
533 Where closing a hearing is not possible, great care should be taken to deidentify any personally  
534 identifying or sensitive information in transcripts and medical records. The decision to close the  
535 hearing, in part or in full, should be at the discretion of the board. Neither the physician nor the  
536 witness should control this decision. Boards should allow the patient the option of having  
537 support persons available during both open and closed hearings.

538

539 *Patient Confidentiality*

540

541 Complaints regarding sexual misconduct are highly sensitive. Therefore, enhanced attention  
542 must be given to protecting a patient's identity, including during board discussion, so that  
543 patients are not discouraged from coming forward with legitimate complaints against physicians.  
544 State medical boards should have statutory authority to ensure nondisclosure of the patient's  
545 identity to the public. This authority should include the ability to delete from final public orders  
546 any patient identifiable information.

547

548 *Testimony*

549

550 Sexual misconduct cases involve complex issues; therefore, state medical boards may consider  
551 the use of one or more expert witnesses to fully develop the issues in question and to define  
552 professional standards of care for the record. Additionally, the evaluating/treating physician or  
553 mental health care practitioners providing assessment and/or treatment to the respondent  
554 physician may be called as witnesses. The evaluating clinician may provide details of treatment,  
555 diagnosis and prognosis, especially the level of insight and change by the practitioner. Also, a  
556 current or subsequent treating practitioner of the patient, especially a mental health provider,  
557 may be called as a witness. All these witnesses may provide insight into factors that led to the  
558 alleged sexual misconduct, an opinion regarding the level of harm incurred by the patient, and  
559 describe the physician's rehabilitative potential and risk for recidivism.

560

561 *Implicit Bias*

562

563 In any case that comes before a state medical board, it is important for those responsible for  
564 adjudicating the case to be mindful of any personal bias that may impact their review and  
565 adjudication. Bias can be particularly strong where board members themselves have been victims  
566 of sexual assault or have been subject to previous accusations regarding sexual misconduct. Bias  
567 may even influence the decisions of state medical board members by virtue of their being  
568 physicians themselves. Training about implicit bias is recommended for board members and staff  
569 in order to help identify implicit bias and mitigate the impact it may have on their work.<sup>13</sup>

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<sup>13</sup> Project Implicit, accessed November 13, 2019 at <https://implicit.harvard.edu/implicit/>

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571 Diverse representation on state medical boards in terms of gender, age, and ethnicity is important  
572 for ensuring balanced discussion and decisions. The inclusion of public members on state  
573 medical boards can also contribute to the reduction of bias in adjudication, while also amplifying  
574 the patient perspective through commitment to the priorities and interests of the public.<sup>14</sup> In order  
575 to ensure effective and meaningful participation from public members, appropriate orientation  
576 and education about their role should occur.

577

578

**Section 9: Discipline**

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580

581 State medical boards have a broad range of disciplinary responses available to them that are  
582 designed to protect the public. Upon a finding of sexual misconduct, the board should take  
583 appropriate action and impose one or more sanctions reflecting the severity of the conduct and  
584 potential risk to patients. Essential elements of any board action include a list of mitigating and  
585 aggravating factors, an explanation of the violation in plain language, clear and understandable  
586 terms of the sanction, and an explanation of the consequences associated with non-compliance.

587

588 Findings of even a single case of sexual misconduct are often sufficiently egregious as to warrant  
589 revocation of a physician's medical license. Certain serious forms of unprofessional conduct  
590 should presumptively provide the basis for revocation of a license in order to protect the public.  
591 Misconduct in this class would include sexual assault, conduct amounting to crimes related to  
592 sex, regardless of whether charged or convicted, or egregious acts of a sexual nature. State  
593 medical boards should also consider revocation in instances where a physician has repeatedly  
594 committed lesser acts, especially following remedial efforts.

595

596 In a limited set of instances, state medical boards may find that mitigating circumstances do exist  
597 and, therefore, stay the revocation and institute terms and conditions of probation or other  
598 practice limitations. If a physician is permitted to remain in practice and gender- or age-based  
599 restrictions are used by state medical boards, consideration may also be given to coupling these  
600 restrictions with additional regulatory interventions such as education, monitoring or other forms  
601 of probation.

602

603 In determining an appropriate disciplinary response, the board should consider the factors listed  
604 in **Table 1**.

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<sup>14</sup> Johnson DA, Arnhart KL, Chaudhry HJ, Johnson DH, McMahon GT, The Role and Value of Public Members in Health Care Regulatory Governance *Acad Med*, Vol. 94, No. 2 / February 2019

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<b>Table 1: Considerations in determining appropriate disciplinary response</b>	
<ul style="list-style-type: none"> <li>• Patient Harm<sup>15</sup></li> <li>• Severity of impropriety or inappropriate behavior</li> <li>• Context within which impropriety occurred</li> <li>• Culpability of licensee</li> <li>• Psychotherapeutic relationship</li> <li>• Existence of a physician-patient relationship</li> <li>• Scope and depth of the physician-patient relationship</li> <li>• Inappropriate termination of physician-patient relationship</li> </ul>	<ul style="list-style-type: none"> <li>• Age and competence of patient</li> <li>• Vulnerability of patient</li> <li>• Number of times behavior occurred</li> <li>• Number of patients involved</li> <li>• Period of time relationship existed</li> <li>• Evaluation/assessment results</li> <li>• Prior professional misconduct/disciplinary history/malpractice</li> <li>• Recommendations of assessing/treating professional(s) and/or state physician health program</li> <li>• Risk of reoffending</li> </ul>

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Boards should not routinely consider romantic involvement, patient initiation or patient consent to be a legal defense. Sexual misconduct may still occur following the termination of a physician-patient relationship, especially in long-standing relationships or ones that involve a high degree of emotional dependence. Time elapsed between termination of the relationship is insufficient in many contexts to determine that sexual contact is permissible. Other factors that should be considered in assessing the permissibility of consensual sexual contact between consenting adults following the termination of a physician-patient relationship can include documentation of formal termination; transfer of the patient's care to another health care provider; the length of time of the professional relationship; the extent to which the patient has confided personal or private information to the physician; the nature of the patient's health problem; and the degree of emotional dependence and vulnerability.<sup>16</sup> Termination of a physician-patient relationship for the purposes of allowing sexual contact to occur is unacceptable and would still constitute sexual misconduct because of the trust, inherent power imbalance between a physician and patient, and patient vulnerability that exist leading up to, during and following the decision to terminate the relationship. Any consent to sexual or

<sup>15</sup> Broadly understood as inclusive of physical and emotional harm, resulting distrust in the medical system and avoidance of future medical treatment, and other related effects of trauma.

<sup>16</sup> Washington Medical Commission, *Guideline on Sexual Misconduct and Abuse*, 2017.

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632 romantic activity provided by a patient within the context of a physician-patient relationship or  
633 immediately after its termination should be considered invalid.

634

635 Society's values and beliefs evolve, and some individuals may be slower to abandon long-held  
636 beliefs, even where these may be sexist or prejudiced in other ways. However, adherence to an  
637 outdated set of generational values that has since been found to be unacceptable is not a reason to  
638 overlook or excuse sexual misconduct.

639

640 The potential existence of a physician workforce shortage or maldistribution, or arguments  
641 related to particular restrictions being tantamount to taking a physician "out of work" should also  
642 not be used as reasons for leniency or for allowing patients to remain in harm's way. In cases  
643 involving sexual misconduct, it is simply not true that unsafe or high-risk care is better than no  
644 care at all. A single instance, let alone many instances, can cause an extremely high degree of  
645 damage to individuals and the communities in which they reside. However, staying true to the  
646 principle of proportionality also means considering the fact that some forms of discipline,  
647 including public notifications, generate significant shame upon the disciplined physician. This  
648 can compound the degree of severity of a disciplinary action and may be taken into consideration  
649 by state medical boards where less egregious forms of sexual impropriety are involved.

650

651 *Temporary or Interim Measures:*

652

653 In the event that a state medical board decides to remove a licensee from practice or limit the  
654 practice of a licensee as a temporary measure in order to reduce the risk of patient harm while an  
655 investigation takes place, there are several different interim measures that can be used. Common  
656 measures include an interim or summary suspension/cessation of practice, restrictions from  
657 seeing patients of a certain age or gender, restrictions from seeing patients altogether, or the  
658 mandatory use of a practice monitor (to be understood as distinct from a chaperone, as explained  
659 below) for all patient encounters.

660

661 The appropriateness of age and gender-based interim restrictions should be considered carefully  
662 before being imposed by state medical boards. Sexual misconduct often occurs for reasons  
663 related to power, rather than because of a sexual attraction to a particular gender or age group,  
664 thereby making these restrictions ineffective to protect patients in many cases.

665

666 *Remediation*

667

668 As discussed above, many forms of sexual misconduct and harmful actions that run against the  
669 core values of medicine should appropriately result in revocation of licensure. However, there  
670 may be some less egregious forms of sexual impropriety with mitigating circumstances for  
671 which a physician may be provided the option of participating in a program of remediation to be  
672 able to re-enter practice or have license limitations lifted following a review and elapse of an  
673 appropriate period of time.

674

675 The decision to allow a physician who has committed an act of sexual misconduct the  
676 opportunity to undergo a program of remediation with an end goal of potential license  
677 reinstatement is difficult for boards to make. Boards are therefore encouraged to draw from the

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678 professional resources that already exist in making determinations about remediation potential  
679 and license reinstatement.

680

681 State medical boards should be mindful that not all physicians who have committed sexual  
682 misconduct are capable of remediation. Reinstatement and monitoring in such a context would  
683 therefore be inappropriate. For those who are considered for remediation, if at any point it  
684 becomes clear that the physician presents a risk of reoffending or otherwise harming patients, the  
685 remediation process should be abandoned, and reinstatement should not occur.

686

687 In determining whether remediation is feasible for a particular physician, state medical boards  
688 may wish to make use of a risk stratification methodology that considers the severity of actions  
689 committed, the mitigating and aggravating factors listed in section 9 above (Discipline), the  
690 character of the physician, including insight and remorse demonstrated, as well as an  
691 understanding of how their actions violated standards of professional ethics and state medical  
692 practice acts, and the perceived likelihood that they may reoffend. The consequences to patients  
693 and the general public of allowing a physician to engage in remediation and re-enter practice  
694 after a finding of sexual misconduct should be considered, including any erosion of the public  
695 trust in the medical profession and the role of state medical boards.

696

697 The goals of the remediation process should be clearly outlined, including expectations for  
698 acceptable performance on the part of the physician. The process of remediation should take  
699 place in-person (online or other forms of distance learning would not be sufficient), require full  
700 disclosure of and relate to the physician's offense(s) and be targeted to identified gaps in  
701 understanding of their particular vulnerabilities and other risks for committing sexual  
702 misconduct. As a condition of successful completion of a program of remediation, participants  
703 should be required to articulate not only *why* their actions were wrong, but also *how* they arrived  
704 at the point at which they were willing to commit them, and *how* they will guard against arriving  
705 at such a point again. For this to occur, assessment and remediation partners must be provided  
706 access to investigative information in order to properly tailor remedial education to the particular  
707 context in which the misconduct occurred. Finally, state medical boards should be mindful that  
708 remediation cannot typically be said to have "occurred" following successful completion of an  
709 educational course. Rather, a longitudinal mechanism must be established for maintaining the  
710 physician's engagement in a process of coming to terms with their misconduct and avoiding the  
711 circumstances that led to it. The longitudinal mechanism both demonstrates the physician's  
712 commitment to accountability and the effectiveness of a board's monitoring reach.

713

714 The members of the Workgroup acknowledge that shortcomings exist in the current evidence  
715 base regarding the effectiveness of remediation in instances of sexual misconduct. As noted  
716 elsewhere in this report, recidivism is exceedingly difficult to study well. Recommendations  
717 about the use of consistent terminology and improving the tracking of disciplined physicians will  
718 contribute to understanding what kinds of remedial interventions are most appropriate and  
719 effective in the context of sexual misconduct. Moreover, the Workgroup feels that further  
720 research is needed in several other areas, such as group learning experiences, instruction in  
721 victim empathy, remedial instruction with or without additional interventions, and identification  
722 of subgroups of offenders who may be at higher risk of reoffending.

723



**BRD RPT 20-2 Attachment 1**724 *License Reinstatement/Removal of License Restriction(s)*

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726 In the event of license revocation, suspension, or license restriction, any petition for  
727 reinstatement or removal of restriction should include the stipulation that a current assessment,  
728 and if recommended, successful completion of treatment, be required prior to the medical  
729 board's consideration to assure the physician is competent to practice safely. Such assessment  
730 may be obtained from the physician's treating professionals, state physician health program  
731 (PHP),<sup>17</sup> or from an approved evaluation team as necessary to provide the board with adequate  
732 information upon which to make a sound decision.

733

734 *Transparency of board actions:*

735

736 As state medical boards regulate the profession in the interest of the public, it is essential that  
737 evolving public values and needs are factored into decisions about what information is made  
738 publicly available. It has been made clear in academic publications and popular media, as well as  
739 through the #MeToo and TimesUp movements that the public increasingly values transparency  
740 regarding disciplinary actions imposed on physicians. It is likely that any action short of a  
741 complete revocation of licensure will draw scrutiny from the public and popular media. Such  
742 scrutiny can also be expected regarding decisions to reinstate a license or remove restrictions.  
743 The public availability of sufficient facts to justify a regulatory decision and link it to a licensee's  
744 behavior and the context in which it occurred can help state medical boards to explain and justify  
745 their decision.

746

747 The ability to disclose particular details of investigative findings and disciplinary actions is  
748 limited by state statute in many jurisdictions. State medical boards are encouraged to convey this  
749 fact to the public in order to protect the trust that patients have in boards, but also make efforts to  
750 achieve legislative change, allowing them to publicize information that is in the public interest.  
751 Where disclosure is possible, boards should select means for conveying information that will  
752 optimally reach patients. This should include making information available on state medical  
753 board websites and reporting to the FSMB Physician Data Center, thereby allowing for  
754 disciplinary alerts to be sent to other jurisdictions in which the physician holds a license and  
755 making information about disciplinary actions publicly available through FSMB's docinfo.org  
756 website, and the National Practitioner Data Bank. The use of private agreements or letters of  
757 warning in cases involving sexual misconduct is inappropriate because of the importance of  
758 disclosure for public protection and data sharing with other state medical boards or medical  
759 regulatory authorities from other jurisdictions.

760

761 Boards should also consider additional means of communicating, such as through mobile phone  
762 applications,<sup>18</sup> notices in newspapers and other publications. California<sup>19</sup> and Washington<sup>20</sup> both

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<sup>17</sup> "A Physician Health Program (PHP) is a confidential resource for physicians, other licensed healthcare professionals, or those in training suffering from addictive, psychiatric, medical, behavioral or other potentially impairing conditions. PHPs coordinate effective detection, evaluation, treatment, and continuing care monitoring of physicians with these conditions." Source: Federation of State Physician Health Programs.

<sup>18</sup> The Medical Board of California has launched a new mobile application allowing patients to receive updates about their physician, including licensure status and practice location.

<sup>19</sup> CA Bus and Prof Code §1007 (2018)

<sup>20</sup> RCW 18.130.063

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763 require that patients be notified of sexual misconduct license stipulations/restrictions at the time  
764 of making an appointment and that the patient verify this notification. Other boards have  
765 required licensees to obtain signatures from all patients in their care acknowledging their  
766 awareness of an adjudication for professional sexual misconduct. Boards may wish to consider  
767 whether these could be viable options in their states.  
768

769 State medical boards are also encouraged to implement clear coding processes for board actions  
770 that provide accurate descriptions of cases, and clearly link licensee behaviors to disciplinary  
771 actions. Where sexual misconduct has occurred, the case should be labeled as such. A label of  
772 “disruptive physician behavior” or even “boundary violation” is less helpful than the more  
773 specific label of “sexual misconduct.” State medical boards and the FSMB should work together  
774 to develop consistent terminology that allows a violation and the underlying causes of discipline  
775 to be stated explicitly, thereby promoting greater understanding for the public and the state  
776 medical boards, while also enabling the tracking of trends, frequencies, recidivism and the  
777 impact of remedial measures.  
778

779 Where particular actions on the part of the physician may not meet a threshold for disciplinary  
780 action, but might nonetheless constitute grooming or other concerning behaviors, state medical  
781 boards should consider ways in which to allow previously dismissed cases to be revisited during  
782 subsequent cases, such as through non-disciplinary letters of education or concern which remain  
783 on a licensee’s record. The ability to revisit previous cases involving seemingly minor events can  
784 help identify patterns of behavior in a licensee and provide additional insight into whether a  
785 licensee poses a risk to future patients.  
786

### 787 **Section 10: Monitoring**

789 Following a finding of sexual misconduct, if a license is not revoked or suspended, it is essential  
790 that a state medical board establish appropriate monitoring of the physician and their continued  
791 practice. Monitoring in the context of sexual misconduct occurs differently from monitoring  
792 substance use disorders and the resources available to boards differ from state to state. Many  
793 PHPs do not offer monitoring services for physicians who have faced disciplinary action because  
794 of sexual misconduct and even where such monitoring by a PHP is possible, it is typically only  
795 part of a way forward, rather than a solution on its own.<sup>21</sup>  
796  
797

798 For the purposes of this report, the members of the Workgroup understand the use of a  
799 *chaperone* as an informal arrangement of impartial observation, typically initiated by physicians  
800 themselves. A chaperone in this context is meant to protect the doctor in the event of a  
801 complaint, although their presence may also offer comfort to the patient.<sup>22</sup> The patient may  
802 request that the chaperone not be present for any portion of the clinical encounter. The American  
803 College of Obstetricians and Gynecologists (ACOG) has recently recommended that a chaperone  
804 be present for all breast, genital, and rectal examinations because of the profoundly negative

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<sup>21</sup> Federation of State Physician Health Program Statement on Sexual Misconduct in the Medical Profession, May 2019.

<sup>22</sup> Paterson, R. Independent review of the use of chaperones to protect patients in Australia, Commissioned by the Medical Board of Australia and the Australian Health Practitioner Regulation Agency, February 2017.

**BRD RPT 20-2 Attachment 1**

805 effect of sexual misconduct on patients and the medical profession and the association between  
806 misconduct and the absence of a chaperone.<sup>23</sup>

807

808 The Workgroup supports ACOG's recommendation because of the potential added layer of  
809 protection that an impartial third party brings, while acknowledging that the use of board-  
810 mandated chaperones has been discontinued in some international jurisdictions and by particular  
811 state medical boards, because of a belief that they merely provide the illusion of safety and may  
812 therefore allow harmful behaviors to go unnoticed. There is risk of this occurring in instances  
813 where a chaperone is untrained or uninformed about their role, is an employee or colleague of  
814 the physician being monitored or does not adequately attend to their responsibilities. In order to  
815 distinguish a chaperone in a less formal arrangement with a physician from one mandated by a  
816 state medical board with established reporting requirements and formal training, the Workgroup  
817 recommends referring to the latter individual as a "practice monitor."

818

819 A *practice monitor* differs from a chaperone. We define a practice monitor as part of a formal  
820 monitoring arrangement mandated by a state medical board, required at all patient encounters, or  
821 all encounters with patients of a particular gender or age. The practice monitor's primary  
822 responsibility is to the state medical board and their presence in the clinical encounter is meant to  
823 provide protection to the patient through observation and reporting. Costs associated with  
824 employing a practice monitor are typically borne by the monitored physician, but practices may  
825 vary across states. The patient must be informed that the practice monitor's presence is required  
826 as part of a practice restriction. As the practice monitor is mandated for all clinical encounters,  
827 the patient may not request that the practice monitor not be present for any portion of the  
828 encounter. If a patient is uncomfortable with the presence of a practice monitor, they will need to  
829 seek care from a different physician. Patient supports (parents, family members, friends) may be  
830 present during examinations but do not replace, nor can they be used in lieu of a board mandated  
831 practice monitor.

832

833 While even this formal arrangement with a clearly defined role, training and direct reporting may  
834 have limitations, the practice monitor may be a useful option for boards in certain specific  
835 circumstances. In particular, in instances where there is insufficient evidence to remove a  
836 physician from practice altogether, but significant risk is believed to be present, the opportunity  
837 to mandate practice monitoring provides boards with an additional option, short of allowing a  
838 potentially risky physician to return to independent practice. As such, when practice monitors are  
839 implemented judiciously, the Workgroup believes that their use can enhance patient safety and  
840 should therefore be considered by state medical boards.

841

842 Practice monitors should only be used if the following conditions have been met:

843

- 844 • The practice monitor has undergone formal training about their role, including their  
845 primary responsibility and direct reporting relationship to the state medical board (as  
846 opposed to the physician being monitored).

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<sup>23</sup> Sexual misconduct. ACOG Committee Opinion No. 796. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2020;135:e43-50.

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- 847 • It is highly recommended that all practice monitors have clinical backgrounds. If they do  
848 not, their training must include sufficient content about clinical encounters so they can be  
849 knowledgeable about what is and is not appropriate as part of the monitored physician's  
850 clinical encounters with patients.
- 851 • The practice monitor should be approved by the state medical board and cannot be an  
852 employee or colleague of the monitored physician that may introduce bias or otherwise  
853 influence their abilities to serve as a practice monitor and report to the board or intervene  
854 when necessary. Pre-existing contacts of any sort are discouraged, but where a previously  
855 unknown contact is not available, the existing relationship should be disclosed. In some  
856 states, practice monitors are required to be active licensees of another health profession as  
857 it is felt that this reinforces their professional duty to report. When health professionals  
858 serve as practice monitors, they should not have any past disciplinary history.
- 859 • The practice monitor has been trained in safe and appropriate ways of intervening during  
860 a clinical encounter at any point where there is confidence of inappropriate behavior on  
861 the part of the physician, the terms of the monitoring agreement are not being followed,  
862 or a patient has been put at risk of harm.
- 863 • The practice monitor submits regular reports to the state medical board regarding the  
864 monitored physician's compliance with monitoring requirements and any additional  
865 stipulations made in a board order.
- 866 • Where possible, state medical boards should consider establishing a panel of different  
867 practice monitors that will rotate periodically among monitored physicians to ensure  
868 monitor availability and that a collegial relationship does not develop between a practice  
869 monitor and a monitored physician, unduly influencing the nature of the monitoring  
870 relationship.

871

872 Monitoring should be individualized and based on the findings of the multidisciplinary  
873 evaluation, and, as appropriate, subsequent treatment recommendations. If a diagnosis of  
874 contributory mental/emotional illness, addiction, or sexual disorder has been established, the  
875 monitoring of that physician should be the same as for any other mental impairment and state  
876 medical boards are encouraged to work closely with their state physician health program as a  
877 resource and support in monitoring. Conditions, which may also be used for other violations of  
878 the medical practice act, may be imposed upon the physician. Examples are listed in **Table 2**.

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**Table 2: Possible Conditions of Practice Following a Finding of Sexual Misconduct**

- Supervision of the physician in the workplace by a supervisory physician
- Requirement that practice monitors are always in attendance and sign the medical record attesting to their attendance during examination or other patient interactions as appropriate.<sup>24</sup>
- Periodic on-site review by board investigator or physician health program staff if indicated.
- Practice limitations as may be recommended by evaluator(s) and/or the state physicians health program.
- Regular interviews with the board and/or state physician health program as required to assess status of probation.
- Regular reports from a qualified and approved licensed practitioner, approved in advance by the board, conducting any recommended counseling or treatment.
- Completion of a program in maintaining appropriate professional boundaries, which shall be approved in advance of registration by the board.

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**Section 11: Education**

Education and training about professional boundaries in general and physician sexual misconduct in particular should be provided during medical school and residency, as well as throughout practice as part of a physician’s efforts to remain current in their knowledge of professional expectations. This should include education about the prevalence of victimization and abuse in the general population and the fact that more than half of patients who are exploited sexually by physicians have been exploited before.

*State Medical Board Members and Staff*

State medical boards and the FSMB should take a proactive stance to educate physicians, board members and board staff about sexual misconduct and the effects of trauma. Members of state medical boards and those responsible for adjudicating cases involving sexual misconduct can also experience trauma. Education for dealing appropriately with traumatic elements of cases and finding appropriate help and resources would also be valuable for board members.

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<sup>24</sup> Where a practice monitor does not have authority to make entries in a medical record, alternatives such as handwriting and scanning the attestation should be considered.

**BRD RPT 20-2 Attachment 1**912 *Medical Education and Training*

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914 Education and training should include information about professionalism and the core values of  
915 medicine; the nature of the physician-patient relationship, including the inherent power  
916 imbalance and the foundational role of trust; acceptable behavior in clinical encounters; and  
917 methods of reporting instances of sexual misconduct. For both medical schools and residency  
918 programs, this education and training should also include tracking assessment across the  
919 curriculum, identification of deficiencies in groups and individuals, remediation, and  
920 reassessment for correction, appropriate self-care, and the potential for developing psychiatric  
921 illness or addictive behaviors. Early identification of risk for sexual misconduct and  
922 unprofessionalism is central to public protection and maintaining public trust.

923

924 *Physicians*

925

926 For practicing physicians, because of lack of education or awareness, physicians may encounter  
927 situations in which they have unknowingly violated the medical practice act through boundary  
928 transgressions and violations. A reduction in the frequency of physician sexual misconduct may  
929 be achieved through education of physicians and the health care team. Engagement in accredited  
930 continuing medical education that addresses professionalism, appropriate and acceptable  
931 behavior, and methods for reporting sexual misconduct should be encouraged among physician  
932 licensees and other members of the healthcare team.

933

934 Resources should also be made available to physicians to help them develop better insight into  
935 their own behavior and its impact on others. These could include multi-source feedback and 360-  
936 degree assessments, and self-inventories with follow-up education based on the results. As with  
937 apology legislation, the use of these resources and the results from self-assessment or other  
938 forms of assistance should not be used against physicians. Such resources would likely be used  
939 more broadly if they came from specialty and professional societies, rather than from state  
940 medical boards alone.

941

942 *Cooperation and Collaboration*

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944 State medical boards should develop cooperative relationships with state physician health  
945 programs, state medical associations, hospital medical staffs, other organized physician groups,  
946 and medical schools and training programs to provide physicians and medical students with  
947 educational information that promotes awareness of physician sexual misconduct. This  
948 information should include a definition of physician sexual misconduct, what constitutes  
949 appropriate physician-patient boundaries, how to identify and avoid common “grooming”  
950 behaviors such as adjusting appointment timing to facilitate time alone with a particular patient,  
951 contacting patients outside of clinical hours, or divulging personal information to a patient, and  
952 the potential consequences to both the patient and the physician when professional boundaries  
953 are not maintained. Physicians should be educated regarding the degree of harm patients  
954 experience as a result of sexual misconduct.

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**BRD RPT 20-2 Attachment 1**

958 *Patients*

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960 Education for patients is also essential so that they may be better informed about what to expect  
961 during a clinical encounter, what would constitute inappropriate behavior, and how to file a  
962 complaint with their state medical board. Information about boundary issues, including physician  
963 sexual misconduct, should be published in medical board newsletters and pamphlets. Media  
964 contacts should be developed to provide information to the public. Efforts should also be made  
965 by state medical boards and the FSMB to better educate the public about the existence and role  
966 of state medical boards.

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969 **Section 12: Summary of Recommendations**

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971 The goal of this report is to provide state medical boards with best practice recommendations for  
972 effectively addressing and preventing sexual misconduct with patients, surrogates and others by  
973 physicians, while highlighting key issues and existing approaches.

974

975 The recommendations in this section include specific requests of individual entities, as well as  
976 general ones that apply to multiple parties, including state medical boards, the FSMB and other  
977 relevant stakeholders. The Workgroup felt strongly that effectively addressing physician sexual  
978 misconduct requires widespread cultural and systemic changes that can only be accomplished  
979 through shared efforts across the medical education and practice continuum.

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981

982 **Culture:**

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984 1. Across the continuum from medical education to practice, continue to eliminate  
985 harassment and build culture that is supportive of professional behavior and does not  
986 tolerate harassment of any type.

987

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989 **Transparency:**

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991 2. State medical boards should ensure that sufficient information is publicly available  
992 (without breaching the privacy of complaints) to justify regulatory decisions and provide  
993 sufficient rationale to support them.

994

995 3. State medical boards should implement clear coding processes for board actions that  
996 provide accurate descriptions of behaviors underlying board disciplinary actions and  
997 clearly link licensee behaviors to disciplinary actions.

998

999 4. State medical boards and the FSMB should work together to develop consistent  
1000 terminology for use in board actions that allows greater understanding for the public and  
1001 the state medical boards, while also enabling the tracking of trends, frequencies,  
1002 recidivism and the impact of remedial measures. These should support research and the  
1003 early identification of risk to patients.

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5. The means of conveying information to the public about medical regulatory processes, including professional expectations, reporting and complaints processes, and available resources should be carefully examined to ensure maximal reach and impact. Multiple communication modalities should be considered.

**Complaints:**

6. State medical boards are encouraged to provide easily accessible information, education and clear guidance about how to file a complaint to the state medical board, and why complaints are necessary for supporting effective regulation and safe patient care. The FSMB and its partner organizations representing medical specialties whose members perform intimate examinations and procedures should provide education to patients about the types of behavior that can be expected of physicians, what types of behavior might warrant a complaint, what to do in the event that actions on the part of a physician make a patient uncomfortable, and circumstances that would warrant a report to law enforcement.
7. State medical boards and board investigators of administrative complaints are encouraged to communicate frequently with complainants throughout the complaint and investigative process, according to the preferred mode and frequency of communication of the complainant.
8. Complaints related to sexual misconduct should be addressed as quickly as possible given their traumatic nature and to protect potential future victims.
9. State medical boards should have a specially trained patient liaison or navigator on staff who is capable of providing one-on-one support to complainants and their families.

**Reporting:**

10. State medical boards should have the ability to levy fines against institutions for failing to report instances of egregious conduct.
11. Results of hospital and health system peer review processes should be shared with state medical boards when sexual misconduct is involved.
12. Hospitals should be required to report to state medical boards instances where employed physicians have been dismissed or are forced to resign due to concerns related to sexual misconduct.
13. Physicians who fail to report known instances of sexual misconduct should be liable for sanction by their state medical board for the breach of their professional duty to report.



**BRD RPT 20-2 Attachment 1**

- 1050 14. Unscrupulous, frivolous or vexatious reporting motivated by competition should be met  
 1051 with disciplinary action.  
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 1053 15. Physicians and other individuals who report in good faith should be protected from  
 1054 retaliation and given the option to remain anonymous.  
 1055

1056 **Investigations:**

- 1057  
 1058 16. If the state medical board’s investigation indicates a reasonable probability that the  
 1059 physician has engaged in sexual misconduct, the state medical board should exercise its  
 1060 authority to intervene and take appropriate action to ensure the protection of the patient  
 1061 and the public at large.  
 1062  
 1063 17. Where permitted by state law, investigations should include a review of previous  
 1064 complaints to identify any patterns of behavior, including malpractice claims and  
 1065 settlements.  
 1066  
 1067 18. State medical boards should have the authority to impose interim terms or limitations,  
 1068 including suspension, on a physician’s license prior to the completion of an investigation.  
 1069  
 1070 19. Limits should not be placed on the length of time that can elapse between when an act of  
 1071 alleged physician sexual misconduct occurred and when a complaint can be filed.  
 1072  
 1073 20. Investigators should use trauma-informed procedures when interviewing and interacting  
 1074 with complainants alleging instances of sexual misconduct and adjudicating these cases.  
 1075  
 1076 21. State medical board members involved in sexual misconduct cases (either in investigation  
 1077 or adjudication) and all board staff who work with complainants in cases involving  
 1078 sexual misconduct should undergo training in the area of sexual misconduct, victim  
 1079 trauma, and implicit bias.  
 1080  
 1081 22. Where possible, boards should seek the complainant’s preference regarding the gender of  
 1082 investigators and assign them accordingly.  
 1083  
 1084 23. State medical boards should also allow inclusion of patient advocates in the interview  
 1085 process.  
 1086  
 1087 24. The FSMB and state medical boards should work to identify and ensure the availability  
 1088 of high-quality training in sexual trauma and a trauma-informed approach to  
 1089 investigations.  
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**BRD RPT 20-2 Attachment 1**

1096 **Comprehensive Evaluation:**

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1098 25. State medical boards should have the authority to order a comprehensive evaluation of  
1099 physicians where investigation reveals a high probability that sexual misconduct has  
1100 occurred.

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1103 **Hearings:**

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1105 26. State medical boards should have statutory authority to ensure nondisclosure of the  
1106 patient's identity to the public, including by closing hearings in part or in full, and  
1107 deleting any identifiable patient information from final public orders. Patient identity  
1108 must also be protected during board discussion.

1109

1110

1111 **Discipline:**

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1113 27. Certain serious forms of unprofessional conduct should presumptively provide the basis  
1114 for revocation of a license in order to protect the public. Misconduct in this class would  
1115 include sexual assault, conduct amounting to crimes related to sex, regardless of whether  
1116 charged or convicted, or egregious acts of a sexual nature. State medical boards should  
1117 also consider revocation in instances where a physician has repeatedly committed lesser  
1118 acts, especially following remedial efforts.

1119

1120 28. Gender and age-based restrictions should only be used by boards where there is a high  
1121 degree of confidence that the physician is not at risk of reoffending.

1122

1123 29. Practice monitors should only be used as a means of protecting patients if the conditions  
1124 outlined in this report have been met, including appropriate training, reporting  
1125 relationship to the state medical board and lack of pre-existing relationship with the  
1126 monitored physician.

1127

1128 30. When considering remedial action after sexual misconduct, state medical boards should  
1129 employ a risk stratification model that also factors in risk of erosion of public trust in the  
1130 medical profession and medical regulation.

1131

1132 31. As part of remedial efforts, any partners in the assessment and remediation of physicians  
1133 should be provided access to investigative information in order to properly tailor remedial  
1134 education to the context in which the sexual misconduct occurred.

1135

1136 32. Following remedial activities, state medical boards should monitor physicians to ensure  
1137 that they avoid being in circumstances similar to those in which they engaged in sexual  
1138 misconduct.

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**BRD RPT 20-2 Attachment 1**

1140 33. State medical boards should consider ways in which to allow pertinent information from  
1141 previously dismissed cases to be revisited during subsequent cases, such as through non-  
1142 disciplinary letters of concern or education which remain on a licensee's record.  
1143

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**Education:**

1146

1147 34. Education and training about professional boundaries and physician sexual misconduct  
1148 should be provided during medical school and residency, as well as throughout practice  
1149 as part of a physician's efforts to remain current in their knowledge of professional  
1150 expectations. This should include education about how to proceed with basic as well as  
1151 sensitive/intimate exams and the communication with the patients that is required as a  
1152 component of these exams. This education should be informed by members of the public,  
1153 as best possible.  
1154

1155

1156 35. State medical boards and the FSMB should provide education to physicians, board  
1157 members and board staff about sexual misconduct and the effects of trauma. This should  
1158 include resources to help physicians develop better insight into their own behavior and its  
1159 impacts on others. Resources and materials should be developed in collaboration with  
1160 state physician health programs, state medical associations, hospital medical staffs, other  
1161 organized physician groups, and medical schools and training programs.

1162

1163 36. As stated in Recommendation #6 regarding complaints, state medical boards are  
1164 encouraged to provide easily accessible information, education and clear guidance about  
1165 how to file a complaint to the state medical board, and why complaints are necessary for  
1166 supporting effective regulation and safe patient care. The FSMB and its partner  
1167 organizations representing medical specialties whose members perform intimate  
1168 examinations and procedures should provide education to patients about the types of  
1169 behavior that can be expected of physicians, what types of behavior might warrant a  
1170 complaint, what to do in the event that actions on the part of a physician make a patient  
1171 uncomfortable, and circumstances that would warrant a report to law enforcement.

1172

1173 37. The FSMB, state medical boards, medical schools, residency programs, and medical  
1174 specialty and professional societies should provide renewed education on professionalism  
1175 and the promotion of professional culture. A coordinated approach facilitated by ongoing  
1176 communication is recommended to ensure consistency of educational messaging and  
1177 content.

1178

1179 38. The FSMB should facilitate the adoption and operationalization of the recommendations  
1180 in this report by providing state medical boards with an abridged version of the report  
1181 which highlights key points and associates them with resources, model legislation, and  
1182 educational offerings.

## BRD RPT 20-2 Attachment 1

1183 **Appendix A: Sample Resources**

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1185 The following is a sample list of resources available to support greater understanding of  
 1186 sexual misconduct, sexual boundaries, the impacts of trauma, and implicit bias. The FSMB  
 1187 has not conducted an in-depth evaluation of individual resources, and inclusion herein does  
 1188 not indicate, nor is it to be interpreted as, an endorsement or guarantee of quality. Further,  
 1189 while some resources listed below are available free of charge, others are only accessible  
 1190 through purchase.

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1192 1. Sexual misconduct, sexual/personal/professional boundaries:

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- AMA: Code of Medical Ethics: Sexual Boundaries
    - [Romantic or Sexual Relationships with Patients](#)
    - [Romantic or Sexual Relationships with Key Third Parties](#)
    - [Sexual Harassment in the Practice of Medicine](#)
  - AMA: [CME course: Boundaries for physicians](#)
  - AAOS: [Sexual Misconduct in the Physician-Patient Relationship](#)
  - [FSMB Directory of Physician Assessment and Remedial Education Programs](#)
  - North Carolina Medical Board: [Guidelines for Avoiding Misunderstandings During Patient Encounters and Physical Examinations](#)
  - Vanderbilt University Medical Center: [Online CME Course: Hazardous Affairs – Maintaining Professional Boundaries](#)
  - Vanderbilt University Medical Center: [Boundary Violations Index](#)
2. Trauma-related resources:
- SAMHSA: [Concept of Trauma and Guidance for a Trauma-Informed Approach](#)
  - National Institute for the Clinical Application of Behavioral Medicine: [How Trauma Impacts Four Different Types of Memory](#)
  - Frontiers in Psychiatry: [Memory distortion for traumatic events: the role of mental imagery](#)
  - Canadian Department of Justice: [The Impact of Trauma on Adult Sexual Assault Victims](#)
  - NIH: [Trauma-Informed Medical Care: A CME Communication Training for Primary Care Providers](#)
  - Western Massachusetts Training Consortium: [Trauma Survivors in Medical and Dental Settings](#)
  - American Academy of Pediatrics: [Adverse Childhood Experiences and the Lifelong Consequences of Trauma](#)
  - American Academy of Pediatrics: [Protecting Physician Wellness: Working With Children Affected by Traumatic Events](#)
  - Public Health Agency of Canada: [Handbook on Sensitive Practice for Health Care Practitioners](#)
  - Psychiatric Times: [CME: Treating Complex Trauma Survivors](#)
  - NHS Lanarkshire (Scotland): [Trauma and the Brain \(Video\)](#)
  - London Trauma Specialists: [Brain Model of PTSD - Psychoeducation Video](#)

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3. Implicit bias:

- AAMC: [Online Seminar: The Science of Unconscious Bias and What To Do About it in the Search and Recruitment Process](#)
- AAMC: [Proceedings of the Diversity and Inclusion Innovation Forum: Unconscious Bias in Academic Medicine](#)
- AAMC: [Exploring Unconscious Bias in Academic Medicine \(Video\)](#)
- ASME Medical Education: [Non-conscious bias in medical decision making: what can be done to reduce it?](#)
- APHA: [Patient Race/Ethnicity and Quality of Patient–Physician Communication During Medical Visits](#)
- Institute for Healthcare Improvement: [Achieving Health Equity: A Guide for Health Care Organizations](#)
- BMC Medical Education: [Training to reduce LGBTQ-related bias among medical, nursing, and dental students and providers: a systematic review](#)
- American Psychological Association: [CE - How does implicit bias by physicians affect patients' health care?](#)
- Joint Commission: [Implicit bias in health care](#)
- Oregon Medical Board: [Cultural Competency – A Practical Guide for Medical Professionals](#)
- StratisHealth: [Implicit Bias in Health Care \(Quiz\)](#)

DRAFT

## REPORT OF THE BOARD OF DIRECTORS

**Subject:**                    **Report on Resolution 19-1: Licensing Exam Research (Minnesota Board of Medical Practice)**

**Referred to:**            **Reference Committee**

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At the April 2019 Federation of State Medical Boards (FSMB) House of Delegates (HOD) meeting, the Minnesota Board of Medical Practice submitted Resolution 19-1: Correlation between licensee USMLE or COMLEX passage attempt rate and reports of state medical board discipline:

***Resolved,*** *the FSMB will establish a task force to study existing licensing regulations on USMLE and COMLEX passage rate attempts, time duration to USMLE and COMLEX passage, and subsequent medical board discipline, medical malpractice claims, and other measures of clinical aptitude; and*

***Resolved,*** *that the FSMB task force will evaluate whether mandatory limitations on USMLE and COMLEX passage attempts and/or limitations to the time duration to USMLE and COMLEX step passage correlate with a decrease in future medical board disciplinary action, medical malpractice claims, and other measures of clinical aptitude; and*

***Resolved,*** *that the FSMB task force will develop recommendations regarding mandatory USMLE and COMLEX passage attempt and time limitations for licensure by medical boards in the United States and its territories.*

At the Reference Committee meeting, the FSMB Board of Directors testified that research already exists to address some of the issues in the resolution, and that several streams of work were already underway to further address these issues. The Board of Directors further testified that is therefore unnecessary to constitute a formal task force or workgroup and proposed the following substitute resolution, which was subsequently adopted by the FSMB HOD:

*Resolved: "That the FSMB will delegate staff to work collaboratively with other relevant parties (e.g., NBME, NBOME) to complete the following:*

- (1) Identify current licensing requirements specific to USMLE and COMLEX, including time and/or attempt limits on these examinations;*
- (2) Identify existing, or facilitate additional, research evaluating whether time and/or attempt limitations on USMLE and COMLEX correlate with external measures such as a decrease in future medical board disciplinary action and/or medical malpractice;*
- (3) Begin work toward a long-term goal of research exploring the correlation between performance on these licensing examinations and other measures of clinical aptitude or outcomes; and*

*(4) Share initial findings back to the FSMB House of Delegates in 2020 and with subsequent periodic reports as research becomes available.*

This report is divided into two sections: Section 1 dealing with licensing requirements specific to USMLE and COMLEX-USA and Section 2 addressing relevant research supportive of state medical boards' decisions to utilize attempt limits on their licensing examination. Future reports will provide updates on time and attempt limits and relevant research, as available or requested.

## **SECTION 1:**

### **Licensing Requirements Specific to the United States Medical Licensing Examination (USMLE) and the Comprehensive Osteopathic Licensing Examination of the United States (COMLEX-USA)**

#### *Requirements and Recommendations from the USMLE and COMLEX-USA Programs*

Both the USMLE and the COMLEX-USA programs limit candidates for each examination in each Step or Level, respectively. Specifically, candidates for the USMLE are limited to 4 attempts per exam per Step, while COMLEX-USA candidates are currently limited to 6 attempts per exam per Level (with plans to reduce to 4 attempts per exam per Level effective July 2022). The COMLEX-USA program allows a single exception (i.e., one additional attempt) per examinee per Level or Level component to the attempt limit policy upon sponsorship by a medical licensing authority. The USMLE exception policy, which allows for unlimited exceptions per examinee per Step or Step component upon sponsorship by a medical licensing authority, is currently under review.

Although neither the USMLE program nor the COMLEX-USA program imposes a time limit for completing their exam sequence, both make a recommendation to medical licensing authorities that the complete examination sequences be passed within a seven-year time period that begins when the examinee passes his/her first Step/Level.

The USMLE program also recommends to licensing jurisdictions that they consider allowing exceptions to the seven-year limit for MD/PhD candidates who meet the following requirements:

1. The candidate has obtained both degrees from an institution or program accredited by the LCME and a regional university accrediting body.
2. The PhD should reflect an area of study which ensures the candidate a continuous involvement with medicine and/or issues related, or applicable to, medicine.
3. A candidate seeking an exception to the seven-year rule should be required to present a verifiable and rational explanation for the fact that he or she was unable to meet the seven-year limit. These explanations will vary and each licensing jurisdiction will need to decide on its own which explanation justifies an exception. Students who pursue both degrees should understand that while many states' regulations provide specific exceptions to the seven-year rule for dual-degree candidates, others do not. Students pursuing a dual degree are advised to check the state-specific requirements for licensure listed by the FSMB.

These programmatic policies are consistent with FSMB policy in the *Guidelines for the Structure and Function of a State Medical and Osteopathic Board*, which states that a medical or osteopathic board should “be authorized to limit the number of times an examination may be taken, to require

applicants to pass all examinations within a specified period, and to specify further medical education required for applicants unable to do so.”

*Review of State Board Time and Attempt Limits for USMLE and COMLEX-USA*

Staff reviewed all state medical and osteopathic boards’ websites, statutes, and rules and regulations to identify time and attempt limits for USMLE and COMLEX-USA for initial licensure purposes. A detailed overview and explanation of the results of that review is provided below. A quick summary of the results is provided as **Attachment 1**.

*Time Limits*

Of the 69<sup>1</sup> state licensing authorities, 46 have a time limit for completion of the USMLE and/or COMLEX-USA sequence, specifically:

- 5-year limit: 1 board
- 7-year limit: 31 boards
- 10-year limit: 14 boards

For 19 of these boards, the statutes and/or rules and regulations state that time limit starts from the date of whichever Step or Level of the examination was successfully completed/passed first.

Almost half (20) of these boards allow additional time for dual degree candidates (MD/PhD, DO/PhD, MD/MPH, etc.), with the time limit ranging from 8 -15 years:

- 8-year time limit: 1 board
- 9-year time limit: 1 board
- 10-year time limit: 13 boards
  - One of these boards has a 7-year limit that can be extended to 10 years, so it was included in the 10-year count
- 12-year time limit: 1 board
- 15-year time limit: 1 board
  - This board has a 10-year limit that can be extended to 15 years, so the limit was counted as 15

Almost all of the boards allow some exception or wavier of the time limit. A listing of the exceptions and waivers identified is provided in **Attachment 2**.

Other requirements of note are:

- One composite board that licenses both allopathic and osteopathic physicians has a different time limit for USMLE and COMLEX-USA, specifically 10 years for USMLE and 7 years for COMLEX-USA.
- One board requires candidates to repeat the entire USMLE sequence if the entire examination is not passed within the stipulated time limit.

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<sup>1</sup> For purposes of this report, the New York State Office of Professional Medical Conduct was not included, since it oversees discipline only. Licensure of physicians in New York is handled by the New York State Board for Medicine.



- One board does not accept scores from a re-examination of a previously passed Step. (The USMLE and COMLEX-USA programs allow examinees to retake a previously passed Step in order to comply with the time limit imposed by a medical licensing authority for the completion of all Steps.)

### *Attempt Limits*

Forty-seven of the 69 boards have an attempt limit on one or more Steps of the USMLE and/or Levels of the COMLEX-USA. The remaining 22 boards do not have any attempt limits for the USMLE and/or COMLEX-USA; this encompasses 9 composite boards, 1 medical board and 12 osteopathic boards. One osteopathic board that accepts USMLE for purposes of licensing osteopathic physicians has attempt limits for USMLE and COMLEX-USA; therefore, this board was included in the attempt limit counts for both examinations.

Of the 47 boards that have attempt limits, 31 have limits for all Steps and/or Levels. Although one board has a different attempt limit for COMLEX-USA Levels 1, 2-CE and 2-PE than it does for Level 3, for the remaining boards the attempt limits are the same across Steps/Levels (e.g., two attempts on Step/Level 1, two attempts on Step/Level 2, and two attempts on Step/Level 3). The attempt limits range from 2 to 6, as follows:

Attempt limits on all USMLE Steps (30 boards<sup>2</sup>) –

- 2 attempts: 2 boards
- 3 attempts: 19 boards
- 4 attempts: 3 boards
- 5 attempts: 2 boards
- 6 attempts: 4 boards

Attempt limits on all COMLEX-USA Levels (23 boards<sup>3,4</sup>) –

- 2 attempts: 1 board
- 3 attempts: 14 boards
- 4 attempts: 3 boards
- 5 attempts: 3 boards
- 6 attempts: 2 boards

An additional 15 boards have an attempt limit on only one Step and/or Level. Almost all of these 15 boards (14 out of 15) have an attempt limit only on Step/Level 3, which is the final examination in the USMLE/COMLEX-USA sequence. The other board has a 4-attempt limit on Step/Level 2 or 3. The required attempt limits for Step/Level 3 range from 3 to 6 attempts, as follows:

<sup>2</sup> The USMLE count does not equal 31 is because one of the boards is an osteopathic board that does not accept USMLE for licensure.

<sup>3</sup> One board allows 6 attempts for COMLEX-USA Level 1 and 6 attempts combined for Level 2-CE and Level 2 PE combined, but only 3 attempts for Level 3; this board is included in the count for both 3 attempts and 6 attempts.

<sup>4</sup> The reason the total for COMLEX-USA does not equal 31 is because (1) three of the boards are composite boards that have an attempt limit for USMLE but not for COMLEX-USA; (2) six of the boards only license allopathic physicians and, thus, do not accept COMLEX-USA for licensure; and (3) as noted in Footnote 3, one osteopathic board is counted twice.

Attempt limits on USMLE Step 3 only (15 boards) –

- 3 attempts: 9 boards
  - One of these boards also has an added stipulation of no more than a combined total of 10 attempts for all Steps
- 4 attempts: 3 boards
- 5 attempts: 2 boards
- 6 attempts: 1 board

Attempt limits on COMLEX-USA Level 3 only (4 boards<sup>5</sup>) –

- 3 attempts: 2 boards
- 4 attempts: 1 board
- 5 attempts: 1 board

Finally, one board requires no more than 7 attempts at all Steps/Levels combined. This board stipulates that persons who have taken the three parts of the examination more than a total of seven times shall not be eligible for licensure unless or until they successfully complete either one-year post-graduate training in addition to that already required for licensure, or one or more other comprehensive and suitably-rigorous assessment, training, and evaluation programs after passage of all parts of the examination.

As with the time limits discussed above, most of the boards have stipulations around the attempt limits and/or allow for exceptions or waivers to the attempt limit under a variety of circumstances. Only 10 boards do not allow for any exceptions to their attempt limit. Examples of the stipulations on and/or exceptions to the attempt limit policies are provided as **Attachment 3**.

In reviewing these exceptions and stipulations, it is possible that some are remnants from when Step 3 had to be taken under the sponsorship and eligibility requirements of a state medical or osteopathic board. Beginning November 2014, Step 3 applicants are no longer required to apply for Step 3 under the sponsorship of a board; the only requirements that must be met to apply for and take Step 3 are those set by the USMLE program:

- Pass USMLE Step 1, Step 2 CK and Step 2 CS; and
- Possess an MD, DO or equivalent degree; and
- If a graduate of a medical school outside of the US or Canada, obtain ECFMG certification; and
- All examinees are limited to 4 attempts, with one additional attempt at the request of a medical licensing authority; and
- All examinees are limited to three attempts within a 12-month period; and

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<sup>5</sup> The reason the total for COMLEX-USA does not equal 15 is because seven of the fifteen boards only license allopathic physicians and, thus, do not accept COMLEX-USA for licensure. The remaining four boards have different attempt limits for USMLE and COMLEX-USA:

- 3 boards have a 3-attempt limit on USMLE Step 3 but no attempt limits on COMLEX-USA
- 1 board has a 6-attempt limit on USMLE Step 3 but no attempt limits on COMLEX-USA

- 4th and subsequent attempts must be at least 12 months after the first attempt and at least six months after the most recent attempt.

In other words, boards are no longer able to impose additional requirements such as additional education or training for eligibility for Step 3, unless done as part of the process to sponsor an applicant for an additional attempt beyond the 4 attempts allowed by the USMLE program. However, these requirements could still be used to qualify applicants for licensure.

The FSMB maintains a by-state summary of these and other state specific requirements for initial medical licensure on the FSMB website (<https://www.fsmb.org/step-3/state-licensure/>) as a guide for examinees and initial licensure applicants. A link to the boards' website addresses and contact information is also provided.

## Section 2:

### **Research relevant to state medical boards' attempt limit policies**

The following summarizes research into whether time and/or attempt limitations on USMLE and COMLEX-USA correlate with external measures such as a decrease in future medical board disciplinary action and/or medical malpractice claims, and other measures of clinical aptitude.

#### *Published research*

In 2017, *Academic Medicine* published a study by FSMB and National Board of Medical Examiners (NBME) staff showing a correlation with higher scores on USMLE Step 2 Clinical Knowledge (Step 2 CK) and a subsequent decrease in the likelihood of a disciplinary action. Physicians with higher Step 2 CK scores had lower odds of receiving an action. A 1-SD increase in Step 2 CK scores corresponded to a decrease in the chance of disciplinary action by roughly 25%. After accounting for Step 2 CK scores, Step 1 scores were unrelated to the odds of receiving an action<sup>6</sup>. The article is available on the *Academic Medicine* website at [https://journals.lww.com/academicmedicine/Fulltext/2017/12000/Exploring\\_the\\_Relationships\\_Between\\_USMLE.41.aspx](https://journals.lww.com/academicmedicine/Fulltext/2017/12000/Exploring_the_Relationships_Between_USMLE.41.aspx).

The National Board of Osteopathic Medical Examiners (NBOME) recently completed similar research with the assistance of FSMB staff. That study found that higher COMLEX-USA Level 3 scores were associated with significant decreased odds for all action categories: revoked license, imposed limitations to practice, and other action imposed, relative to not receiving an action. Higher COMLEX-USA Level 2 Performance Evaluation Biomedical/Biomechanical Domain scores decreased the odds for an action that revoked a license and imposed limitations to practice<sup>7</sup>.

<sup>6</sup> Monica M. Cuddy, MA, Aaron Young, PhD, Andrew Gelman, PhD, David B. Swanson, PhD, David A. Johnson, MA, Gerard F. Dillon, PhD, and Brian E. Clauser, EdD. Exploring the Relationships Between USMLE Performance and Disciplinary Action in Practice: A Validity Study of Score Inferences from a Licensure Examination. *Academic Medicine*, Vol. 92, No. 12 / December 2017; 1780-1785.

<sup>7</sup> William L. Roberts EdD; Gretta A. Gross DO, MEd; John R. Gimpel DO, MEd; Larissa L. Smith PhD; Katie Arnhart PhD; Xiaomei Pei PhD; Aaron Young PhD. An Investigation of the Relationship Between COMLEX-USA Licensure Examination Performance and State Licensing Board Disciplinary Actions. *Academic Medicine*, 2019 Oct 15. [Epub ahead of print] doi: 10.1097/ACM.0000000000003046

The article is available on the *Academic Medicine* website at [https://journals.lww.com/academicmedicine/Abstract/publishahead/An\\_Investigation\\_of\\_the\\_Relationship\\_Between.97413.aspx](https://journals.lww.com/academicmedicine/Abstract/publishahead/An_Investigation_of_the_Relationship_Between.97413.aspx)

State boards may also find the 2001 article by Clauser and Nungester regarding classification accuracy for tests that allow retakes of interest<sup>8</sup>. FSMB previously distributed this article to all state boards in 1999, when the USMLE program first issued recommendations to state boards regarding the potential impact of the USMLE program's seven-year time limit recommendation on medical students and graduates in dual degree programs and specifically recommended that boards consider exceptions to the seven-year time limit for dual degree candidates, and again in 2002 as a reference tool to medical boards when discussing or formulating policy recommendations regarding USMLE time limits for medical licensure. The article is available on the *Academic Medicine* website at [https://journals.lww.com/academicmedicine/Fulltext/2001/10001/Classification\\_Accuracy\\_for\\_Tests\\_That\\_Allow.36.aspx](https://journals.lww.com/academicmedicine/Fulltext/2001/10001/Classification_Accuracy_for_Tests_That_Allow.36.aspx)

A listing of USMLE research is available on the USMLE website at <https://www.usmle.org/data-research/>.

Similarly, a listing of COMLEX-USA research is available on the NBOME website at <https://www.nbome.org/publications/published-research/>

#### *Ongoing and future research*

A study exploring the relationship between USMLE attempt limits and disciplinary action by state medical boards is in written draft form at this time and will be submitted for publication. USMLE staff are also in the early stages of studying the correlation between USMLE performance and residents' progress in meeting Accreditation Council for Graduate Medical Education (ACGME) Milestones.

Potential for research correlating USMLE performance with medical malpractice is currently being explored with staff at the National Practitioner Data Bank (NPDB). Similarly, FSMB staff are pursuing clinical outcomes data with the University of Texas-Southwestern that may supplement limited research in this area, i.e., a 2014 study by Norcini, et al., examining the relationship between performance on USMLE Step 2 CK and outcomes of care by international medical graduates. That study found that performance on Step 2 CK had a statistically significant inverse relationship with mortality; each additional point on the examination was associated with a 0.2% decrease in mortality<sup>9</sup>. The article is available on the *Academic Medicine* website at [https://journals.lww.com/academicmedicine/Fulltext/2014/08000/The\\_Relationship\\_Between\\_Licensing\\_Examination.26.aspx](https://journals.lww.com/academicmedicine/Fulltext/2014/08000/The_Relationship_Between_Licensing_Examination.26.aspx)

<sup>8</sup> Brian E. Clauser and Ronald J. Nungester. Classification Accuracy for Tests That Allow Retakes. *Academic Medicine*, Vol. 76, No 10 / October Supplement 2001; S108-110.

<sup>9</sup> John J. Norcini, John R. Boulet, Amy Opalek, and W. Dale Dauphinee. The Relationship Between Licensing Examination Performance and the Outcomes of Care by International Medical School Graduates. *Academic Medicine*. 2014; 89(8):1157–62. doi: 10.1097/ACM.0000000000000310

**Summary**

The majority of medical licensing authorities (46:69 or 67%) have a time limit completion of the USMLE and/or COMLEX-USA examinations for licensure purposes. Most of these boards (31) have a 7-year time limit, although the limit can range from 5 to 7 years. Almost half of these boards (20) have an extended time limit for dual degree candidates. The time limit for completion of USMLE and/or COMLEX-USA for dual degree candidates ranges from 8 to 15 years, with 10 years being utilized most often (13 boards). Almost all of the boards provide a waiver of the time limit in other limited circumstances.

Additionally, the majority of boards (47:69 or 68%) also have an attempt limit for completion of all or parts of the USMLE and/or COMLEX-USA sequence for purposes of licensure. 30 boards have an attempt limit on all USMLE Steps, while 23 boards have a limit on all COMLEX-USA Levels. The most common attempt limit for both examinations is 3, with 19 boards stipulating a 3-attempt limit for exams on all USMLE Steps and 14 boards stipulating a 3-attempt limit for exams on all COMLEX-USA Levels. A handful of boards have adopted an attempt limit on USMLE Step 3 only (15 boards) or on COMLEX-USA Level 3 only (4 boards). Regardless of the attempt limit adopted, most boards allow for a waiver of the attempt limit requirement under some circumstances.

This report summarizes research that currently exists or is in progress regarding performance on USMLE or COMLEX-USA and future medical board disciplinary action and/or medical malpractice claims, and other measures of clinical aptitude. Future reports will provide updates on that and other research as available or requested.

**ITEM FOR ACTION:**

**This report is for information only.**

**ATTACHMENT 1****Count of boards with time and/or attempt limits on USMLE and/or COMLEX-USA**Time Limits for Completion of USMLE and/or COMLEX-USA (46 boards)

- 5-year limit: 1 board
- 7-year limit: 31 boards
- 10-year limit: 14 boards

Time Limits for Completion of USMLE and/or COMLEX-USA for Dual Degree Candidates (20 boards)

- 8-year time limit: 1 board
- 9-year time limit: 1 board
- 10-year time limit: 13 boards
- 12-year time limit: 1 board
- 15-year time limit: 1 board

Attempt limits on all USMLE Exams per Step (attempt limit is the same for all exams) (30 boards)

- 2 attempts: 2 boards
- 3 attempts: 19 boards
- 4 attempts: 3 boards
- 5 attempts: 2 boards
- 6 attempts: 4 boards

Attempt limits on all COMLEX-USA Exams per Level (attempt limit is the same for all exams) (23 boards)

- 2 attempts: 1 board
- 3 attempts: 14 boards
- 4 attempts: 3 boards
- 5 attempts: 3 boards
- 6 attempts: 2 boards

Attempt limits on USMLE Step 3 only (15 boards)

- 3 attempts: 9 boards
- 4 attempts: 3 boards
- 5 attempts: 2 boards
- 6 attempts: 1 board

Attempt limits on COMLEX-USA Level 3 only (4 boards)

- 3 attempts: 2 boards
- 4 attempts: 1 board
- 5 attempts: 1 board

## ATTACHMENT 2

### Exceptions and Waivers Allowed for USMLE and/or COMLEX-USA Time Limits

- Applicants who are ABMS or AOA board certified are not required to pass the examination within 7 years; however, they are limited to combined total of 10 attempts.
- Upon applicant's showing of good cause, the Board may waive the time requirements. Any such waiver shall be based upon the circumstances relating to the particular individual's application.
- In very limited & extraordinary circumstances, the board may grant exception to the 7-year rule on a case-by-case basis to those who demonstrate: 1) a verifiable and rational explanation for the failure to satisfy the regulation, 2) strong academic and post graduate record, and 3) a compelling totality of circumstances.
- The board may waive the time limit if the applicant is licensed to practice as a physician and surgeon in another state of the United States, the District of Columbia or Canada and the applicant has achieved a passing score on a licensing examination administered in a state or territory of the United States or the District of Columbia and no license issued to the applicant has been disciplined in any state or territory of the United States or the District of Columbia.
- Board may allow an exception to attempt and time limit rule if it finds that it is in the best interest of the state and the applicant: 1) is validly licensed in another state, 2) has practiced a minimum of 10 years, 3) has no disciplinary actions imposed by another state medical board, 4) is certified by a specialty board recognized by ABMS or the Royal College of Physicians and Surgeons of Canada, and 5) meets requirements regarding time limit for exam attempts.
- A waiver of this rule may be requested if one of the following applies to applicant:
  - Current certification by the ABMS or AOA-BOS,
  - Suffered from a documented significant health condition which delayed applicant's medical study,
  - Participated in a combined MD/DO/PhD program,
  - Completed continuous approved postgraduate training with equivalent number of years to an MD/DO/PhD program, or
  - Experienced other extenuating circumstances that do not indicate an inability to safely practice medicine as determined by the Board.
- Time frame waived if practicing in a medical underserved area (MUA) or Health Professional Shortage Areas (HPSA).
- 10 years if the applicant:
  - is specialty board certified by a specialty board that (a) is a member of the American Board of Medical Specialties; or (b) is a member of the Bureau of Osteopathic Specialists; or
  - has been issued a faculty temporary license, as prescribed by board rule, and has practiced under such a license for a minimum of 12 months and, at the conclusion of the 12-month period, has been recommended to the board by the chief administrative officer and the president of the institution in which the applicant practiced under the faculty temporary license.
- If the applicant does not meet the time limit, the applicant shall not be eligible for licensure unless or until they successfully complete either one-year post-graduate training in addition to

that already required for licensure, or one or more other comprehensive and suitably-rigorous assessment, training, and evaluation programs after passage of all parts of the examination.

- The amount of time an applicant has actively served while in continuous training and practice in the armed forces of the United States shall not be counted in calculating the ten (10) year limitation.
- The time limit will also not apply to applicants who: 1) are board certified by a board recognized by ABMS, or 2) have been & are at the time of application currently in active clinical practice in a state or territory for a period of at least one year and have held a full, unencumbered license in that state for at least one year since successfully completing USMLE; or 3) present satisfactory evidence of extraordinary circumstances as determined by the board which prevented the applicant from timely completing the examination.



### ATTACHMENT 3

#### **Stipulations on and Exceptions to USMLE and/or COMLEX-USA Attempt Limits**

- Further education and training.
- Minimum of 4 years continuous licensure in another state and ABMS certified.
- Hold a full unrestricted license in another US or Canadian jurisdiction; hold an active ABMS, RCPSC, or CFPC specialty certification; and have successfully completed an ACGME, RCPSC, CFPC approved post-graduate training program.
- After 3 failed attempts on Step 3, must complete one additional year ACGME- or AOA-approved graduate medical education before being eligible to take step 3 again.
- After 5 attempts, the board may require an applicant to complete additional remedial education or training. The board shall prescribe the additional requirements in a manner that permits the applicant to complete the requirements and be reexamined within 2 years after the date the applicant petitions the board to retake the examination a sixth or subsequent time.
- Applicants who have failed the USMLE Step 3 a total of three (3) times since January 1, 1994 must have one year of additional Board-approved clinical training. The training must be completed prior to taking USMLE Step 3 again.
- After 3 failed attempts, must appear before Board for approval to take a fourth or subsequent attempt. If additional attempts are required, applicant must complete additional educational requirements.
- An applicant who passes any of the required exams after having failed any part, step, level, or component three or more times must meet the requirements in numbers 1-3 or 4 below. (1) No disciplinary action pending and no disciplinary action taken against the applicant that would be grounds for discipline; and (2) Successful completion of 2 or more years of an ACGME or AOA-accredited residency or fellowship; and (3) A minimum of 5 years of clinical medicine experience in the U.S. or in Canada under a full unrestricted medical license with at least 3 of the 5 years having occurred within 5 years of the date of the application; or (4) Board certification.
- No candidate shall be permitted more than five attempts to pass Step 3 of USMLE without demonstration of additional education, experience or training acceptable to the Board.
- If an individual fails to secure a passing score on Step 3 in a third attempt, the individual shall repeat a year of graduate medical training at a first or second-year level before retaking Step 3. An applicant who did not have a year of Board approved training between third and fourth attempt to pass Step 3, or took more than four attempts to pass Step 3, may request a waiver based on current certification by the ABMS or AOA-BOS.
- A year of board approved postgraduate training between the 3rd and 4th (final) attempt to pass. An applicant who did not have a year of Board approved training between third and fourth attempt to pass Step/Level 3, or took more than four attempts to pass Step 3/Level, may request a waiver based on current certification by the ABMS or AOA-BOS.
- Applicants who do not pass Step 3 after three sittings within seven years after passing the first examination, either Step 1 or Step 2, or acceptable combination, shall demonstrate evidence satisfactory to the commission of having completed a remedial or refresher medical course approved by the board prior to being permitted to sit for the examination again. Applicants who do not pass Step 3 after the fourth sitting may not sit for another examination without

completing an additional year of postgraduate training or satisfying any other conditions specified by the board.

- If fail any step or component on second attempt, must complete supervised course of study acceptable to the board before permission to retake the step will be given.
- After 2 failed attempts at any Step, licensee may be interviewed or evaluated by the Board. If an applicant fails to pass the exam on 2 separate occasions, the applicant will not be eligible for re-examination for at least 1 year and before taking the examination again the applicant must make a showing to the board of successfully engaging in a course of study for the purpose of improving the applicants ability to engage in the practice of medicine.
- Waiver of 3 attempts can be granted if applicant can show documentation and proof that they suffered from significant health condition or personal problem that delayed medical education and successful completion of Step testing. Waiver will not exceed 4 attempts per Step. Waiver may also be granted on Step 3 to not exceed 4 attempts if applicant 1) has completed one year of approved GME after 3rd failed attempt or before 4th and final attempt and 2) can show proof is certified by ABMS specialty board. Limitation on number of attempts of the step exams may begin anew, if the applicant begins his or her entire medical school education anew.
- Four attempts are allowed if currently licensed in another state and currently certified by a specialty board of ABMS, AOABPE, RCPSC, or CFPC.
- After 3 failed attempts, 1 additional year of ACGME- or AOA-approved graduate medical education.
- The board may waive the provisions of this section if the applicant is licensed to practice as a physician and surgeon in another state of the United States, the District of Columbia or Canada and the applicant has achieved a passing score on a licensing examination administered in a state or territory of the United States or the District of Columbia and no license issued to the applicant has been disciplined in any state or territory of the United States or the District of Columbia.
- 3 attempts each section/step USMLE/COMLEX-USA - if not met, must start complete sequence over. Attempt limit may be waived by the board for those applicants who are board certified.
- The board shall raise the 3-attempt requirement if the applicant has been certified or recertified by an ABMS/CCFP/FRCP/FRCS/AOA/ABOMS or specialty board within the past 10 years.
- Board may allow an exception to attempt and time limit rule if it finds that it is in the best interest of the state and the applicant: 1) is validly licensed in another state, 2) has practiced a minimum of 10 years, 3) has no disciplinary actions imposed by another state medical board, 4) is certified by a specialty board recognized by ABMS or the Royal College of Physicians and Surgeons of Canada, and 5) meets requirements regarding time limit for exam attempts.
- After third failure, applicant must complete additional requirements as recommended by the Board on a case by case basis.
- If an applicant fails any step of the USMLE or FLEX examinations more than three (3) times, then the Board shall require proof of board-certification by an ABMS-recognized specialty board and proof of meeting requirements for Maintenance of Certification prior to application before consideration for licensure.
- Attempt limit does not apply an applicant who meets the following criteria: (A) holds a license to practice medicine in another state(s); (B) is in good standing in the other state(s); (C) has been licensed in another state(s) for at least five years; (D) such license has not been restricted, cancelled, suspended, revoked, or subject to other discipline in the other state(s); (E) has never

held a medical license that has been restricted for cause, canceled for cause, suspended for cause, revoked or subject to another form of discipline in a state or territory of the United States, a province of Canada, or a uniformed service of the United States; and (F) has passed all but one part of the examination approved by the board within three attempts and: (i) passed the remaining part of the examination within one additional attempt; or (ii) passed the remaining part of the examination within six attempts if the applicant: (I) is specialty board certified by a specialty board that: (-a-) is a member of the American Board of Medical Specialties; or (-b-) is approved by the American Osteopathic Association; and (II) has completed in this state an additional two years of postgraduate medical training approved by the board.

- Board review. An applicant that fails may request reexamination and may be reexamined not more than twice at not less than 4-month intervals. An applicant who fails after the 2nd reexamination may not be admitted to further examination until the applicant reapplies for licensure or certification and also presents to the board evidence of further professional training/education as the board may deem appropriate. If an applicant has been examined 4 or more times in another licensing jurisdiction in the United States or Canada before achieving a passing grade in written or computer-based examinations also required under this chapter, the board may require the applicant to submit evidence satisfactory to the board of further professional training or education in examination areas in which the applicant had previously demonstrated deficiencies. If the evidence provided by the applicant is not satisfactory to the board, the board may require the applicant to obtain further professional training or education as the board deems necessary to establish the applicant's fitness to practice medicine and surgery in this state. In order to determine any further professional training or education requirement, the board shall consider any information available relating to the quality of the applicant's previous practice, including the results of the applicant's performance on the oral examination.
- If an applicant failed Step 3/Level 3 on the 3rd attempt, he/she must complete a year of ACGME/AOA postgraduate training prior to his/her 4th attempt. The Board may, in certain circumstances, grant a waiver of this requirement.
- 1 additional year of post graduate training required if attempt limit is exceeded.
- A person who has failed any combination of steps 5 times must undergo remedial education.
- Ineligible for further examination and/or licensure until the Division is in receipt of proof that the applicant has completed, subsequent to his/her fifth failure: A) a course of clinical training of not less than 12 months in an accredited clinical training program in the United States or Canada in accordance with Section...; or B) a course of study of 9 months in length (one academic year) that includes no less than 25 clock hours per week of basic sciences as set forth in Section 1285.20(b) of this Part and no less than 40 clock hours per week of clinical sciences as set forth in Section...; or C) any other formal professional study or training in an accredited medical college or hospital, deemed by the Division to meet the requirements of subsection...
- After 3 failed attempts, 3 year of progressive GME are required.
- If the applicant has taken the three parts of the exam more than a total of 7 times, the applicant shall not be eligible for licensure unless or until they successfully complete either one-year post-graduate training in addition to that already required for licensure, or one or more other comprehensive and suitably-rigorous assessment, training, and evaluation programs after passage of all parts of the examination.

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- A candidate who fails any combination of the USMLE, FLEX, NBME and NBOME three times shall provide a narrative regarding the failure and may be requested to meet with the Board and Division.
- 4 attempts allowed with ABMS/AOA certification. Before the 4th attempt the applicant must submit special/compelling circumstances.

## REPORT OF THE BOARD OF DIRECTORS

**Subject:** Report on Resolution 19-4: Emergency Licensure Following a Natural Disaster (North Carolina Medical Board)

**Referred to:** Reference Committee

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### Introduction

During the 2019 Annual Business of the FSMB House of Delegates, Resolution 19-4: Emergency Licensure Following a Natural Disaster, submitted by the North Carolina Medical Board, was presented and the following substitute resolution was adopted:

*Resolved*, that the FSMB will evaluate the experiences and disaster readiness of state medical and osteopathic boards and develop recommendations to facilitate the interstate mobility of properly licensed physicians and other health care personnel in response to disasters, public health emergencies, and mass casualties, and issue a report to the House of Delegates in 2020.

The Board of Directors tasked the FSMB Advisory Council of Board Executives (Advisory Council) to complete the charge of Resolution 19-4 and report its findings and recommendations. The Advisory Council met in August 2019 and, in completing the charge, reviewed state and federal statutes, rules, and board policies currently in place regarding licensure following disasters and emergencies.

Because of the varied approaches that are currently in place, statutorily and otherwise, the Advisory Council did not recommend the development and dissemination of model legislation but rather, favored providing an informational report to include resources and examples for boards to use in determining an approach that best meets the needs of the residents and licensees in their respective states.

### Section 1. Overview

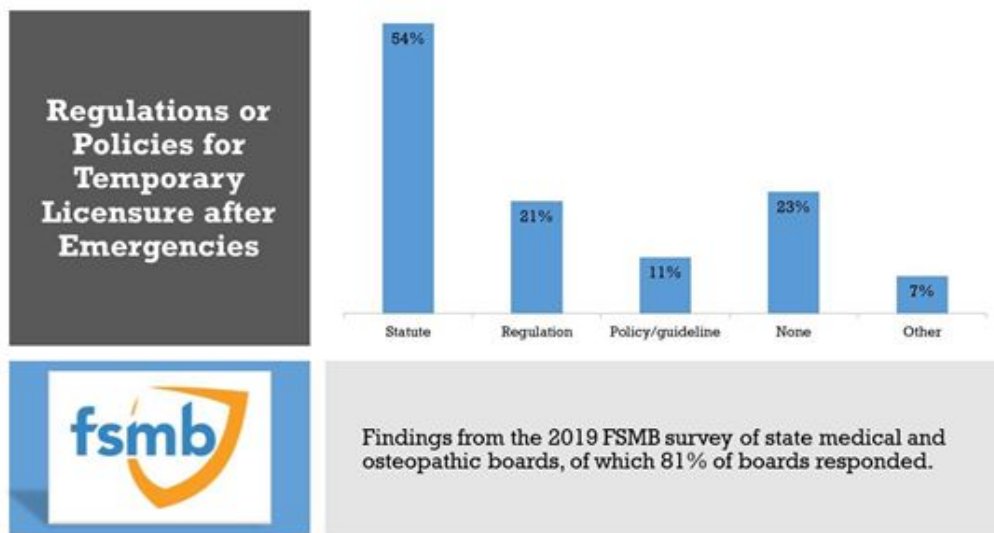
In 2019, there were 101 state-level major disaster, emergency, and fire management assistance declarations throughout the United States and its territories. Since 2010, there have been more than 1,100 declarations.<sup>1</sup> These declarations were issued in response to a wide range of disasters and emergencies, including, but not limited to, tropical storms and hurricanes, earthquakes, forest fires, and tornados. Each of these disasters required varying degrees of interstate and federal assistance.

States often differ on the statutory and regulatory framework in how to respond to natural disasters, but there are areas where they share commonalities, including mutually agreed upon interstate compacts. These compacts and programs provide frameworks for deploying and utilizing

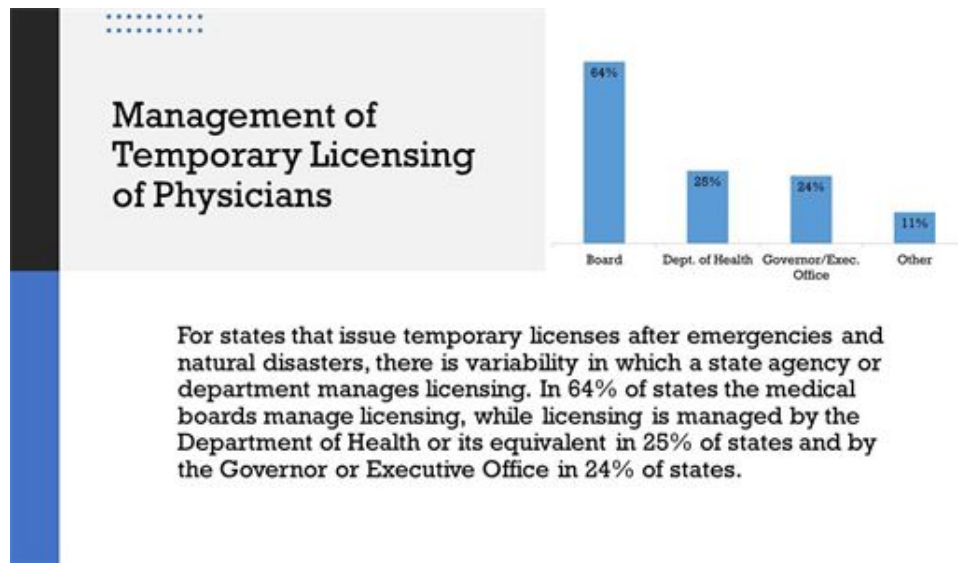
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<sup>1</sup> Disaster Declarations by Year. U.S. Department of Homeland Security, Federal Emergency Management Agency. <https://www.fema.gov/disasters/year/2019>

resources, including the use of physicians and other health professionals from other states to provide medical services. According to an FSMB survey of state medical and osteopathic boards conducted in 2019, of which 81 percent responded, 54 percent of boards have statutes in place for the temporary licensure of physicians after an emergency or natural disaster, while 21 percent have regulations and 11 percent have polices or guidelines for the temporary licensure after an emergency or natural disaster. Twenty-three percent of respondents stated that there are no statutes, regulations, or policies on the topic.<sup>[1]</sup> For states that issue temporary licenses after emergencies and natural disasters, there is no uniformity in which a state agency or department manages licensing. Sixty-four percent of boards manage licensing, while licensing is managed by the Department of Health, or its equivalent, in 25 percent of states. In 24 percent of states, licensing is managed by the Governor or Executive Office.



<sup>[1]</sup> Federation of State Medical Boards. "Annual Survey of State Medical and Osteopathic Boards," November 2019.



## Section 2. Interstate Compacts and Federal Assistance

When public policy issues cross jurisdictional boundaries, states may explore opportunities to establish interstate compacts that encourage multistate cooperation while maintaining state sovereignty. These Compacts can address critical issues by establishing uniform guidelines, standards, or procedures in the Member states. Historically, Compacts require the consent of the U.S. Congress when a power delegated to the federal government may be affected. Interstate compacts have been established and successfully utilized to support states in responding to natural disasters and emergencies.

### *Emergency Management Assistance Compact (EMAC)*

In 1996, Public Law 104-321 was signed into law, which granted the consent of the United States Congress for the Emergency Management Assistance Compact (“EMAC”).<sup>2</sup> EMAC provides a pathway for interstate recognition of licenses held by out-of-state health care professionals when responding to governor-declared states of emergency or disaster.. Since becoming law, all 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands have enacted legislation to become EMAC members.

Each state and territory that utilizes EMAC has done so through one of five enabling mechanisms. Those mechanisms, which can change over the course of time, include state legislation; memorandums of agreement/understanding; intergovernmental agreements; pre-disaster contracts; and governor executive orders.<sup>3</sup>

<sup>2</sup> Public Law 104-321 – Joint resolution granting the consent of Congress to the Emergency Management Assistance Compact. <https://www.govinfo.gov/app/details/PLAW-104publ321>

<sup>3</sup> Federation of State Medical Boards Roundtable Webinar. “When Disaster Strikes: the Emergency Management Assistance Compact.” August 28, 2019.

EMAC is comprised of 13 articles and standardized procedures, including its purpose and authority, implementation, state responsibilities, limitations, and licenses and permits, among other topics. Regarding licensure and permitting, Article V of EMAC states:

**“Article V: License and Permits**

Whenever any person holds a license, certificate, or other permit issued by any state party to the compact evidencing the meeting of qualifications for professional, mechanical, or other skills, and when such assistance is requested by the receiving party state, such person shall be deemed licensed, certified, or permitted by the state requesting assistance to render aid involving such skill to meet a declared emergency or disaster, subject to such limitations and conditions as the Governor of the requesting state may prescribe by executive order or otherwise.”

State licensing boards do not have the authority to set aside EMAC; only the governor of the state can set aside law through an executive order. Licensees that are deployed through EMAC should bring a copy of their license, certificate, or permit with them, as it may be needed for insurance purposes.

In cooperation with the Association of State & Territorial Health Officials and the National Association of County & City Health Officials, the National Emergency Management Association (NEMA) developed two webinars focused on EMAC and public health and medical professionals. These webinars, available on EMAC’s website, are intended to provide an overview about utilizing the Compact. The first webinar is titled “EMAC: A Basic Understanding & Use of the System by Public Health & Medical Professionals” and the second is titled “Use of the EMAC System by Public Health & Medical Professionals: A Discussion.”<sup>4</sup> On August 28, 2019, the FSMB hosted a Roundtable Webinar for state medical boards titled, “When Disaster Strikes: The Emergency Management Assistance Compact,” featuring Angela Coppel, Program Director for NEMA.

*Emergency System for the Advance Registration of Volunteer Health Professions (ESAR-VHP)*

In 2002, after authorities in New York City had difficulty distinguishing qualified volunteers responding to the September 11 terrorist attacks, the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Public Law 107-188, was signed into law and mandated the creation of the Emergency System for the Advance Registration of Volunteer Health Professions (“ESAR-VHP”).<sup>5</sup> The purpose of the electronic database system is to verify the credentials, licenses, accreditations, and hospital privileges of health professionals when, during public health emergencies, the professionals volunteer to provide health services in another state.

Initially administered by the Health Resources and Services Administration (HRSA) at the U.S Department of Health and Human Services (HHS), ESAR-VHP is now administered at the federal level by the Office of the Assistant Secretary for Preparedness and Response (ASPR) at HHS.

<sup>4</sup> Learn More About EMAC & Public Health and Medical Professionals from Past Webinars. Emergency Management Assistance Compact. <https://www.emacweb.org/index.php/training-education/learn-about-emac-your-discipline/public-health-medical>

<sup>5</sup> Public Law 107-188 - Public Health Security and Bioterrorism Preparedness and Response Act of 2002. <https://www.govinfo.gov/app/details/PLAW-107publ188>



ASPR leads the nation's medical and public health preparedness for, response to, and recovery from disasters and public health emergencies. ASPR assists each state and territory in establishing a standardized, volunteer registration program.<sup>6</sup> Each state and territory maintains their volunteer database, which allows health professionals in their state to register and have their credentials verified and stored for when an emergency arises (*See Appendix A*).

To maximize the use of health professionals with varying levels of clinical competency, ESAR-VHP developed a uniform process for classifying and assigning volunteers into one of four credential levels, based upon the provided and verified credentials. The credential levels are as follows:

Level 1: Volunteers who are clinically active in a hospital, either as an employee or by having hospital privileges.

Level 2: Volunteers who are clinically active in a wide variety of settings, such as clinics, nursing homes, and shelters.

Level 3: Volunteers who meet the basic qualifications necessary to practice in the state in which they are registered.

Level 4: Volunteers who have healthcare experience or education that would be useful for assisting clinicians and providing basic healthcare not controlled by the scope of practice laws (may include health professions students or retired health professionals who no longer hold a license).<sup>7</sup>

Once an emergency is declared and it is determined what resources are needed, ESAR-VHP state coordinators can work with the organizations to identify, match, and send notification to the best volunteer candidates. Those registered with ESAR-VHP are not required to deploy; it is up to the individual if they wish to assist.

#### *Pandemic and All-Hazards Preparedness and Advancing Innovation Act (PAHPA) of 2019*

Enacted into law on June 24, 2019, Public Law 116-22, the Pandemic and All-Hazards Preparedness and Advancing Innovation Act (PAHPA) of 2019, reauthorized certain programs under the Public Health Services Act and the Federal Food, Drug, and Cosmetic Act.<sup>8</sup> Included in the provisions of the law are several pertaining to licensure following an emergency.

The law seeks to improve hazard preparedness and response by making additional information available to states seeking to implement mechanisms to waive licensing requirements during emergencies after verifying that a volunteer professional's license is in good standing in another state. The law also adds a provision that includes making information available to professionals on how to register or enroll in volunteer services during a public health emergency. PAHPA also clarifies that when members of the Medical Reserve Corps or participants in ESAR-VHP are acting

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<sup>6</sup> Office of the Assistant Secretary for Preparedness and Response (ASPR), U.S. Department of Health and Human Services (HHS). <https://www.phe.gov/about/aspr/Pages/default.aspx>

<sup>7</sup> Health Professionals Registration, The Emergency System for Advance Registration of Volunteer Health Professionals. <https://www.phe.gov/esarvhp/Pages/registration.aspx>

<sup>8</sup> Public Law 116-22 – Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019. <https://www.congress.gov/bill/116th-congress/senate-bill/1379?r=51>

during an emergency, they are liable under the laws of the state in which they are acting with an exception with regard to licensure.

Included in PAHPA is a required Government Accountability Office (GAO) study on several emergency response factors including the:

- Number of health care providers who register under ESAR-VHP in advance to provide services during an emergency
- Number of health care providers credentialed to provide services during an emergency, including those through ESAR-VHP and authorities with the state
- Average time to verify credentials of a health care provider during the period of a public health declaration through ESAR-VHP and individuals verified by an authority within the state
- Whether states, including physician or medical groups, associations, or other relevant provider organization utilize ESAR-VHP for purposes of volunteering during public health emergencies.

As required by PAHPA, the GAO shall conduct the required review by no later than June 24, 2020.

### **Section 3. State Examples**

The process, as well as the eligibility, to be temporarily licensed during and after an emergency or natural disaster varies across individual states. These variations can be associated with, but not limited to, scope of practice, duration of licensure, and supervision requirements. The following are a few examples of approaches states have put in place and/or used during a natural disaster.

#### *Texas*

In Texas, in cases of declared emergency disasters, the executive director of the Texas Medical Board may issue a temporary permit to practice medicine to an applicant who intends to practice under the supervision of a licensed Texas physician, excluding trainees in postgraduate programs.<sup>9</sup> To be eligible for such permits, the applicant must have an active license in another state, territory, or country; must not have any action taken against their medical license; and must be supervised by a physician with an unrestricted medical license in Texas. Applicants must present verification to the Texas Medical Board from the supervising physician as to the purpose for the requested permit and an attestation that they will be continually supervised.

Visiting physicians seeking a temporary permit during a declared emergency disaster must complete the appropriate application (*See Appendix B*). If a visiting physician is granted a temporary permit in response to a declared emergency disaster, the permit is valid for 30 days and there is no licensure fee.

#### *North Carolina*

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<sup>9</sup> 22 Texas Admin. Code § 172.5

In 2018, the North Carolina Medical Board approved board rules regarding licensing after disasters and emergencies.<sup>10</sup> These rules were adopted in addition to the already established emergency provisions currently managed by the state's Office of Emergency Medical Services (NCOEMS), which has a network and process for bringing medical assistance into North Carolina.

The adopted rules allow for the following two pathways for out-of-state physicians to practice in North Carolina following a disaster or emergency:

#### Hospital to Hospital Credentialing

This pathway allows physicians holding a full, unlimited, and unrestricted license to practice medicine (in any U.S. jurisdiction), and has unrestricted hospital credentials and privileges to practice medicine in their home state, to practice at a hospital licensed by the North Carolina Department of Health and Human Services. Each licensed hospital shall verify physician credentials and privileges, keep a list of all out-of-state physicians practicing at the hospital, and provide that list to the Board within 10 days of beginning and ending practicing medicine at the hospital. Physicians are permitted to practice for either 30 days from the date the physician begins practicing at the hospital or until the emergency or disaster declaration is withdrawn or ended by the appropriate authority, whichever is shorter.

#### Limited Emergency License

Physicians who hold a full, unlimited, and unrestricted license to practice medicine in any state, territory, or district, but do not have credentials or privileges at a hospital in their home state may complete a limited emergency license application with the Board (*See Appendix C*). The Board must verify the physician's license and may limit the physician's scope of practice. Additionally, the Board shall have jurisdiction over all physicians practicing under this pathway, even after such physicians have stopped practicing medicine under the rule or the limited emergency license has expired. Physicians are permitted to practice for either 30 days from the date the license is issued or until the emergency or disaster declaration is withdrawn or ended, and at which time the issued license shall become inactive, whichever is shorter.

#### *District of Columbia*

The Public Health Emergency Law Manual was adopted in June 2017 by the Department of Health, in collaboration with representatives from the Office of the Chief Medical Examiner, the DC Office of the Attorney General, and the DC Courts. The Manual details the laws and regulations relevant to all sectors that may be engaged in emergency response. Included in the Manual is the framework for the scope of practice and license portability for volunteer health practitioners.

In DC, scopes of practice are defined by the Health Occupations Board. However, during disasters and emergencies, the Mayor may determine that it is necessary to modify scopes of practice to address demand. In such instances, the Mayor may issue an Order to expand health care

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<sup>10</sup> 21 NCAC 32B.1706 – Physician Practice and Limited License for Disasters and Emergencies.  
<http://reports.oah.state.nc.us/ncac/title%2021%20-%20occupational%20licensing%20boards%20and%20commissions/chapter%2032%20-%20north%20carolina%20medical%20board/subchapter%20b/21%20ncac%2032b%20.1706.pdf>

practitioners' ability to perform certain activities, such as permitting a physician assistant to provide certain services without the supervision of a physician.<sup>11</sup>

License portability during and after a disaster or emergency is addressed through the EMAC. Additionally, DC adopted portions of the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) which states that when an emergency declaration is in effect, volunteer healthcare practitioners who are licensed and in good standing in their state of licensure, and are registered with a qualified registrations, they may practice while located in DC. The provision further states that volunteers may only practice within their scope of practice in the state of licensure.<sup>12</sup>

The UEVHPA is model legislation developed in 2006 by the Uniform Law Commission in response to criticisms made after Hurricane Katrina regarding health practitioner licensure. Nineteen (19) states have enacted the UEVHPA.<sup>13</sup>

### *Louisiana*

Regulations for the Louisiana State Board of Medical Examiners authorize the board to issue emergency temporary permits to out-of-state individuals to practice as a physician or allied health care practitioner for upwards of 60 days to provide voluntary medical services in the state during a public health emergency.<sup>14</sup> In order to obtain an emergency temporary permit, individuals must complete an application (*See Appendix D*) and provide a copy of their current, unrestricted license in good standing from another state. For other healthcare professionals that require physician supervision by Louisiana state law, a physician must be designated on their application.

The Louisiana Department of Health and Hospitals may extend the temporary permit if it deems that emergency services are needed for more than 60 days. The Board may extend or renew an expired emergency temporary permit for one or two additional 60-day periods.

## **Section 4. Conclusion**

This informational report is intended to provide boards with resources and examples to assist in their efforts in assessing and/or enhancing the board's disaster readiness. In keeping with the intent of Resolution 19-4, the FSMB will continue to collect and maintain information, including state and federal legislation, rules, policies and procedures pertinent to the deployment of health personnel in response to disasters, public health emergencies, and mass casualties. State medical and osteopathic boards are encouraged to proactively share their experiences and best practices with FSMB to facilitate the collection of state specific information.

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<sup>11</sup> Public Health Emergency Law Manual. District of Columbia Department of Health. June 2017.  
[http://dclaw.dohcloudservices.com/sites/default/files/District%20of%20Columbia%20Public%20Health%20Emergency%20Law%20Manual\\_FINAL.pdf](http://dclaw.dohcloudservices.com/sites/default/files/District%20of%20Columbia%20Public%20Health%20Emergency%20Law%20Manual_FINAL.pdf)

<sup>12</sup> D.C. Code §§ 7-2361.01 – 7-2361.12

<sup>13</sup> Uniform Emergency Volunteer Health Practitioners Act.  
<https://www.uniformlaws.org/committees/community-home?CommunityKey=565933ce-965f-4d3c-9c90-b00246f30f2d>

<sup>14</sup> La. Admin. Code tit. 46, § 412

**ITEM FOR ACTION:**

**This report is for information only.**

**Appendix A.** State Healthcare Volunteer Registries

	Registry Name	Registry Link
AL	ALResponds	<a href="http://www.alabamapublichealth.gov/volunteer/">http://www.alabamapublichealth.gov/volunteer/</a>
AK	Alaska Respond	<a href="https://www.akrespond.alaska.gov/">https://www.akrespond.alaska.gov/</a>
AZ	Arizona ESAR-VHP	<a href="https://esar-vhp.health.azdhs.gov/">https://esar-vhp.health.azdhs.gov/</a>
AR	State Emergency Registry of Volunteers and Healthcare Personnel Arkansas (SERV Arkansas)	<a href="https://www.healthy.arkansas.gov/programs-services/topics/adh-volunteer-program">https://www.healthy.arkansas.gov/programs-services/topics/adh-volunteer-program</a>
CA	Disaster Healthcare Volunteers	<a href="https://healthcarevolunteers.ca.gov/">https://healthcarevolunteers.ca.gov/</a>
CO	Colorado Volunteer Mobilizer for Medical and Public Health Professionals	<a href="https://covolunteers.state.co.us/">https://covolunteers.state.co.us/</a>
CT	State of Connecticut Emergency Credentialing Program for Healthcare Professionals	<a href="http://www.ct-esar-vhp.org/">http://www.ct-esar-vhp.org/</a>
DE	State Emergency Registry of Volunteers and Healthcare Personnel for Delaware (SERVDE)	<a href="https://www.servde.org/">https://www.servde.org/</a>
DC	DC RESPONDS	<a href="https://www.dcreponds.org/">https://www.dcreponds.org/</a>
FL	State Emergency Responders & Volunteers of Florida (SERVFL)	<a href="http://servfl.com/">http://servfl.com/</a>
GA	Georgia Responds	<a href="https://www.servga.gov/">https://www.servga.gov/</a>
GU		
HI	Nā Lima Kāko'o	<a href="https://nlk.doh.hawaii.gov/">https://nlk.doh.hawaii.gov/</a>
ID	Volunteer Idaho	<a href="https://www.volunteeridaho.com/">https://www.volunteeridaho.com/</a>
IL	Illinois Helps	<a href="https://www.illinoishelps.net/">https://www.illinoishelps.net/</a>
IN	State Emergency Registry of Volunteers for Indiana (SERV-IN)	<a href="http://ser-in.org">http://ser-in.org</a>
IA	Iowa Statewide Emergency Registry of Volunteers (i-SERV)	<a href="http://iaserv.org">http://iaserv.org</a>
KS	Kansas System for the Early Registration of Volunteers (K-SERV)	<a href="http://www.kdheks.gov/it_systems/k-serve.htm">http://www.kdheks.gov/it_systems/k-serve.htm</a>
KY	Kentucky Helps	<a href="http://www.kentuckyhelps.com/">http://www.kentuckyhelps.com/</a>
LA	Louisiana Volunteers in Action (LAVA)	<a href="https://www.lava.dhh.louisiana.gov/">https://www.lava.dhh.louisiana.gov/</a>
ME	Maine Responds	<a href="https://www.maineresponds.org/">https://www.maineresponds.org/</a>
MD	Maryland Responds	<a href="https://mdresponds.health.maryland.gov/">https://mdresponds.health.maryland.gov/</a>
MA	MA Responds	<a href="https://maresponds.org/">https://maresponds.org/</a>
MI	MI Volunteer Registry	<a href="https://www.mivolunteerregistry.org/">https://www.mivolunteerregistry.org/</a>
MN	Minnesota Responds	<a href="https://www.mnresponds.org/">https://www.mnresponds.org/</a>
MS	Mississippi Responder Management System	<a href="https://www.signupms.org/">https://www.signupms.org/</a>
MO	Missouri Show-Me Response	<a href="https://www.showmeresponse.org/">https://www.showmeresponse.org/</a>
MP		
MT	Montana Volunteer Registry	<a href="https://dphhs.mt.gov/mtvr/volunteerresources">https://dphhs.mt.gov/mtvr/volunteerresources</a>
NE	Nebraska ESAR-VHP	<a href="https://volunteers.ne.gov/ESAR-VHP/faces/jsp/login.jsp">https://volunteers.ne.gov/ESAR-VHP/faces/jsp/login.jsp</a>
NV	State Emergency Registry of Volunteers-Nevada (SERV-NV)	<a href="http://servnv.org">http://servnv.org</a>
NH	New Hampshire Responds	<a href="https://www.nhresponds.org/">https://www.nhresponds.org/</a>
NJ	New Jersey ESAR-VHP	<a href="https://njmrc.nj.gov/hcpr/">https://njmrc.nj.gov/hcpr/</a>
NM	New Mexico Medical Reserve Corps	<a href="https://nmhealth.org/about/erd/bhem/mrc/">https://nmhealth.org/about/erd/bhem/mrc/</a>
NY	State Emergency Registry of Volunteers-New York (SERV-NY)	<a href="https://apps.health.ny.gov/pub/servny/">https://apps.health.ny.gov/pub/servny/</a>
NC	State Emergency Registry of Volunteers- North Carolina (SERV-NC)	<a href="https://www.servnc.org/">https://www.servnc.org/</a>

ND	North Dakota Public Health Emergency Volunteer Reserve/Medical Reserve Corps	<a href="http://www.ndhealth.gov/epr/hp/PHEVR/">http://www.ndhealth.gov/epr/hp/PHEVR/</a>
OH	Ohio Responds Volunteer Registry	<a href="https://www.ohioresponds.odh.ohio.gov/">https://www.ohioresponds.odh.ohio.gov/</a>
OK	Oklahoma Medical Reserve Corps	<a href="https://www.okmrc.org/">https://www.okmrc.org/</a>
OR	State Emergency Registry of Volunteers in Oregon (SERV-OR)	<a href="http://serv-or.org">http://serv-or.org</a>
PA	State Emergency Registry of Volunteers – Pennsylvania (SERV-PA)	<a href="https://www.serv.pa.gov/">https://www.serv.pa.gov/</a>
PR	Puerto Rico Medical Reserve Corps Registry	<a href="http://www.salud.gov.pr/Estadisticas-Registros-y-Publicaciones/Pages/Registros/Cuerpo-de-Reserva-Medica.aspx">http://www.salud.gov.pr/Estadisticas-Registros-y-Publicaciones/Pages/Registros/Cuerpo-de-Reserva-Medica.aspx</a>
RI	RI Responds	<a href="https://www.riresponds.org">https://www.riresponds.org</a>
SC	South Carolina Statewide Emergency Registry of Volunteers (SCSERV)	<a href="https://www.scserv.gov/UserRegistration.aspx">https://www.scserv.gov/UserRegistration.aspx</a>
SD	State Emergency Registry of Volunteers for South Dakota (SERV SD)	<a href="https://volunteers.sd.gov/">https://volunteers.sd.gov/</a>
TN	State of Tennessee Medical Reserve Corps (MRC) Volunteer Program	<a href="http://www.tnmrc.org/">http://www.tnmrc.org/</a>
TX	Texas Disaster Volunteer Registry	<a href="https://www.texasdisastervolunteerregistry.org/">https://www.texasdisastervolunteerregistry.org/</a>
UT	Utah Responds	<a href="https://www.utahresponds.org/">https://www.utahresponds.org/</a>
VT	Vermont Volunteer Responder Management System	<a href="https://rms.vermont.gov/">https://rms.vermont.gov/</a>
VI		
VA	Virginia Medical Reserve Corps	<a href="http://www.vdh.virginia.gov/mrc/">http://www.vdh.virginia.gov/mrc/</a>
WA	Washington State Emergency Registry of Volunteers	<a href="http://waserv.org">http://waserv.org</a>
WV	West Virginia Responder Emergency Deployment Information Site	<a href="http://wvredi.org">http://wvredi.org</a>
WI	Wisconsin Emergency Assistance Volunteer Registry	<a href="https://weavrwi.org/">https://weavrwi.org/</a>
WY	Wyoming Activation of Volunteers in Emergencies (WAVE)	<a href="https://volunteerwave.org/">https://volunteerwave.org/</a>

**Appendix B. Texas Medical Board – Visiting Physician Temporary Permit Application**



**TEXAS MEDICAL BOARD**

**INFORMATION NEEDED FOR VISITING PHYSICIAN TEMPORARY PERMIT  
(Except in emergency cases, applicants should allow 30 days for processing of a Visiting Physician Temporary Permit)**

**Visiting Physician’s Information**

Name: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
DOB: \_\_\_\_\_ Place of Birth (State/Province/Country): \_\_\_\_\_  
Medical School of Graduation: \_\_\_\_\_  
Date of Graduation (mm/dd/yy): \_\_\_\_\_  
Medical License Number(s) and State(s) held, or applied for  
\_\_\_\_\_

**Sponsoring Physician Information**

Name \_\_\_\_\_ Texas license number: \_\_\_\_\_  
(As imprinted on Texas medical license)

**Point of Contact for this Application (this will be the individual TMB staff will contact for additional information and purposes of sending the Visiting Physician Temporary Permit)**

Name: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Mailing Address:  
(Note – all correspondence, including the Visiting Physician Temporary Permit, will be sent to this address)  
\_\_\_\_\_

**Procedure Information**

Date(s) of procedure: \_\_\_\_\_  
Location of procedure - Hospital/Facility Name \_\_\_\_\_  
Location of procedure - Complete Address: \_\_\_\_\_  
\_\_\_\_\_ TX. \_\_\_\_\_  
Name of proposed procedure: \_\_\_\_\_  
Brief explanation of procedure: \_\_\_\_\_

Location Address:  
333 Guadalupe, Tower 3, Suite 610  
Austin, Texas 78701

Mailing Address  
P.O. Box 2029  
Austin, Texas 78768-2029

Phone 512.305.7030  
Fax 512.463-9416  
Licensure Fax 512.305.7009  
[www.tmb.state.tx.us](http://www.tmb.state.tx.us)



### DPS Computerized Criminal History (CCH) Verification

I, \_\_\_\_\_ have been notified that a computerized criminal history (CCH) verification check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB information I supply.

APPLICANT NAME (Please print)

Because the name based information is not an exact search and only fingerprint record searches represent true identification to criminal history, the organization (as listed below) conducting the criminal history check is not allowed to discuss any information obtained using this method, therefore the agency may offer the opportunity to have a fingerprint search performed to clear any misidentification based on the name search, if the search provides a criminal report I know could not be mine.

For the fingerprinting process I will be required to submit a full and complete set of my fingerprints for analysis through the Texas Department of Public Safety AFIS (automated fingerprint identification system). I have been made aware that in order to complete this process I must have the correct fingerprinting (FAST) form from this agency, make an online appointment, submit a full and complete set of my fingerprints, and pay a fee to the fingerprinting services company, L1Enrollment Services.

Once this process is completed and the agency receives the data from DPS, the information on my fingerprint criminal history record may be discussed with me.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Texas Medical Board  
Agency Name (Please print)


\_\_\_\_\_  
Agency Representative Name (Please print)


\_\_\_\_\_  
Signature of Agency Representative

\_\_\_\_\_  
Date

<b>Please: Check and Initial each Applicable Space</b>	
CCH Report Printed:	
YES _____ NO _____	_____ initial
Purpose of CCH: <u>Applicant background check</u>	
Date Printed: _____	_____ initial
Destroyed Date: _____	_____ initial
<b>Retain in your files</b>	

**Appendix C.** North Carolina Limited Emergency License for Disasters and Emergencies Application



Home   About the Board   Licensure   Resources & Information   Contact   

## Licensure

Licensure Overview

**Licensing**

- Physicians
- Residents
- Physician Assistants
- Other Applications
- Emergency Disaster License Application**

Renewals

Check Status

Reentry

### Limited Emergency License for Disasters and Emergencies

This process temporarily authorizes a **medical professional not licensed in the state of North Carolina** to practice medicine during a declared stated of emergency. There is no fee to submit this license application.

**NOTE: If you currently hold an active NC license you DO NOT need to obtain a disaster license to volunteer as a medical responder in NC. Under no circumstances should medical professionals self-report to any disaster site to provide assistance, as this may interfere with official emergency response efforts.**

Applicant Information

\* First Name:       \* Middle Name:

\* Last Name:

\* Address:

\* City       \* State       \* Zipcode

\* Email Address:       \* Phone/Cell Number  
 (Please provide a number that you can be reached at while assisting in North Carolina):

\* Social Security Number:

\* Date of Birth:  \* Place of Birth:

\* Name of Medical School:  \* Date of Graduation:

\* Medical License Number(s) and State(s) Held:

\* Volunteer Plans:  
 Please indicate how you plan to use your NC limited emergency license. If you will be working with a specific organization or at a specific practice site, please provide the name and location.

**Waiver**

I waive confidentiality, authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the NCMB any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit the NCMB or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges. I hereby release, discharge and exonerate the NCMB, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the NCMB.

**Appendix D.** Louisiana State Board of Medical Examiners Emergency Temporary Permit Application



**LOUISIANA STATE BOARD OF MEDICAL EXAMINERS**

630 CAMP STREET, NEW ORLEANS, LA 70130  
 PHONE (504) 568-6820 FAX (504) 599-0503  
 EMAIL: [LICENSING@LSBME.LA.GOV](mailto:LICENSING@LSBME.LA.GOV)  
 WEB SITE: [WWW.LSBME.LA.GOV](http://WWW.LSBME.LA.GOV)

**Emergency Temporary Permit Application**

**\*\* Complete this form PRIOR to printing\*\***

What category of licensure are you applying for:

Physician	Allied Health	Clinical Laboratory
<input type="checkbox"/> Physician <input type="checkbox"/> Osteopathy <input type="checkbox"/> Medical Psychologist <input type="checkbox"/> Physician Acupuncturist	<input type="checkbox"/> Acupuncture Detoxification Specialist <input type="checkbox"/> Athletic Trainer <input type="checkbox"/> Clinical Exercise Physiologist <input type="checkbox"/> Licensed Acupuncturist <input type="checkbox"/> Licensed Respiratory Therapist <input type="checkbox"/> Midwife <input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Occupational Therapy Assistant <input type="checkbox"/> Perfusionist <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Podiatrist <input type="checkbox"/> Polysomnography <input type="checkbox"/> Private Radiological Technology
		<input type="checkbox"/> CLS-Generalist <input type="checkbox"/> CLS-Specialist <input type="checkbox"/> CLS-Technician <input type="checkbox"/> Cytotechnologist <input type="checkbox"/> Laboratory Assistant <input type="checkbox"/> Phlebotomist

NAME: LAST	FIRST	MIDDLE	SUFFIX (SR, JR)	TITLE
SOCIAL SECURITY NUMBER:		DRIVER'S LICENSE # & STATE:		
HOME ADDRESS: STREET & NO.		CITY	STATE & ZIP CODE	
HOME PHONE:		CELL:	EMAIL:	
MAILING ADDRESS: STREET & NO.		CITY	STATE & ZIP CODE	
<b>FACILITY IN LOUISIANA WHERE YOU WILL BE PROVIDING HEALTHCARE SERVICES:</b>				
NAME OF FACILITY / STREET & NO.		CITY	STATE & ZIP CODE	
<b>IDENTIFICATION:</b>				
RACE: [ ] SEX: [ ] WEIGHT: [ ] HEIGHT: [ ]				
EYES: [ ] HAIR: [ ] MARKS: [ ]				
PLACE OF BIRTH: [ ] DATE OF BIRTH: [ ]				
<b>OTHER STATE LICENSES:</b> Have you ever been licensed to practice in any other state, territory, province, or country?				
STATE: [ ]	LICENSE #: [ ]	ISSUE DATE: [ ]	EXPIRATION DATE: [ ]	
STATE: [ ]	LICENSE #: [ ]	ISSUE DATE: [ ]	EXPIRATION DATE: [ ]	
STATE: [ ]	LICENSE #: [ ]	ISSUE DATE: [ ]	EXPIRATION DATE: [ ]	
STATE: [ ]	LICENSE #: [ ]	ISSUE DATE: [ ]	EXPIRATION DATE: [ ]	

Do you have a supervising physician:  Yes  No  
 If yes, list: [ ]

**Federation of State Medical Boards  
Report of the Nominating Committee  
January 23, 2020**

The Nominating Committee met on Thursday, January 23, 2020 at the FSMB Texas office in Euless, Texas at 8:30 am CST. FSMB Immediate Past Chair Patricia King, MD, PhD, FACP serves as Chair of the Committee. Other members of the Committee include Nathaniel Berg, MD; Ahmed Faheem, MD; Robert Giacalone, RPh, JD; Maroulla Gleaton, MD; Joy Neyhart, DO; and Kenneth Walker, MD. Providing staff support were FSMB President and CEO Humayun Chaudhry, DO, MACP; Chief Legal Officer Eric Fish, JD; Director of Leadership Services Pat McCarty, MM; and Governance Support Associate Pam Huffman.

Dr. King expressed her heartfelt appreciation for the Committee's dedication and emphasized the significance of their work in selecting highly qualified candidates for the elected office positions.

The Committee reviewed all submitted nomination materials; considered the results of the one-on-one interviews between the Committee members and nominees; and discussed the importance of selecting candidates who fulfill the qualifications for FSMB leadership positions as outlined in the Committee's charge. The Committee also shared ideas for strengthening the process of finding good candidates in the future. After thoughtful and careful deliberation throughout the vetting process, the Nominating Committee unanimously approved the following roster of candidates:

**Chair-elect** – 1 fellow, to be elected for three years: a one-year term as Chair-elect; a one-year term as Chair; and a one-year term as Immediate Past Chair

Assists the Chair in the discharge of the Chair's duties and performs the duties of the Chair at the Chair's request or, in the event of the Chair's temporary absence or incapacitation, at the request of the Board of Directors.

**Kenneth B. Simons, MD – Wisconsin**

With only one candidate for Chair-elect, Dr. Simons will be elected by acclamation. His current term on the FSMB Board of Directors expires on May 2, 2020.

**Board of Directors** – 3 fellows, each to be elected for a three-year term\*

Control and administration of the corporation is vested in the Board of Directors, which is the fiscal agent of the corporation; the Board acts for the FSMB between Annual Meetings.

**Jeffrey D. Carter, MD – Missouri  
Katie L. Templeton, JD – Oklahoma Osteopathic  
Barbara E. Walker, DO – North Carolina  
Richard A. Whitehouse, JD – Kentucky  
Sherif Z. Zaafran, MD – Texas**

\*In accordance with the FSMB Bylaws, “*At least three members of the Board, who are not Staff Fellows, shall be non-physicians, at least two of whom shall be a Member Medical Board public member.*” Two out of the three current non-physician public members on the Board will continue their service in FY 2021 (May 2020-April 2021); therefore, **at least one non-physician will need to be elected.**

**Nominating Committee** – 3 fellows, each to be elected for a two-year term\*\* / \*\*\*

Nominating Committee members select a roster of nominees for each of the elected positions to be filled at the annual business meeting of the House of Delegates.

**Alexander S. Gross, MD – Georgia**  
**Reverend Janet Harman – West Virginia Medical**  
**John “Jake” M. Manahan, JD – Minnesota**  
**J. Michael Wieting, DO – Tennessee Osteopathic**

\*\*In accordance with the FSMB Bylaws, “*At least one elected member of the Nominating Committee shall be a public member.*” The term of the Nominating Committee’s current public member will end on May 2, 2020; therefore, **at least one public member will need to be elected.**

\*\*\*No two Nominating Committee members shall be from the same member board. Continuing members of the Committee are from Alaska, Guam and Maine Medical.

Respectfully submitted,



Patricia A. King, MD, PhD, FACP  
Chair, Nominating Committee

# GUIDE TO THE FSMB HOUSE OF DELEGATES MEETING

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## **Preface**

The House of Delegates is the official public policy-making body of the FSMB. A “public policy” is defined in the FSMB Bylaws as *the official public position of the FSMB on a matter that may be reasonably expected to affect Member Boards when dealing with their licensees, other health care providers, health-related special interest groups, governmental bodies or the public*. At its Annual Meeting each spring, the House acts on numerous reports and resolutions and establishes policy to guide the organization and its members.

This *Guide* provides information about the House’s policy development process and is designed to help those attending the annual business meeting of the House of Delegates better understand and/or participate in that process.



## Chapter 1: FSMB's Governance Structure

Two characteristics distinguish the FSMB from most other nonprofit organizations: it is a membership association and it has a national scope. The FSMB Bylaws distribute the authority to govern across six levels. The organizational elements that participate in the FSMB's system of governance and policymaking process include: Member Medical Boards, House of Delegates, Board of Directors, Executive Committee, Standing and Special Committees/Workgroups, and the Executive Office. (see FSMB's Organizational Chart on page 4)

The roles and responsibilities of each of these components of the FSMB's governance structure are described below.

### I. Member Medical Boards

The term *Member Medical Board* as used in the FSMB's Articles of Incorporation and Bylaws, refer to *any board, committee or other group in any state, territory, the District of Columbia or possession of the United States of America that is empowered by law to pass on the qualifications of applicants for licensure to practice allopathic or osteopathic medicine or to discipline such licensees. If a state or other jurisdiction has more than one such entity and if each is an independent agency unrelated to the others, each is eligible for membership. Any eligible Medical Board may become a Member Medical Board upon approval of its application by the Board of Directors.*

A Member Medical Board's participation in the policymaking process of the FSMB takes place at the corporation's annual business meeting of the House of Delegates. The right to vote at meetings of the House of Delegates is vested in, and restricted to, Member Medical Boards. All classes of FSMB membership (Fellows, Honorary Fellows, Associate Members, Courtesy Members, Affiliate Member Boards and Official Observers) shall have the right of the floor at meetings of the House upon request of a delegate and approval of the presiding officer; however, the right to introduce resolutions for the House of Delegates to act upon is restricted to Member Medical Boards and the Board of Directors. Except as otherwise noted in the FSMB Bylaws, rights, duties, privileges and obligations of a member of the FSMB may be exercised only by a Member Medical Board.

### II. House of Delegates

A delegate is the president/chair of a Member Medical Board or his/her designated alternate (Board Member Fellow, Staff Fellow or Associate Member). Each Member Medical Board is entitled to one vote at the meetings of the House of Delegates, which is to be cast by the delegate of the Member Medical Board.

### **III. Board of Directors**

As the body responsible for the control and administration of the FSMB, the Board of Directors reports to the House of Delegates. The Board represents the interests of the House of Delegates and FSMB membership between Annual Meetings. The responsibilities of the Board include: providing leadership in the development and implementation of the FSMB's Strategic Plan; governing and conducting the business of the corporation, including supervising the President/Chief Executive Officer (President/CEO); and, under the leadership of the FSMB's Chair and President/CEO, representing the FSMB to the leadership of other organizations and speaking on behalf of the FSMB to promote recognition of the FSMB as the premier organization concerned with medical licensure and discipline.

### **IV. Executive Committee**

Under the leadership of the Chair, the Executive Committee, which also includes the Chair-elect, Treasurer, Immediate Past Chair and three Directors-at-Large, represents the Board of Directors between Board meetings. The members of the Executive Committee, either collectively or individually, provide leadership on behalf of the Chair in scheduling and conducting Board committee meetings; provide leadership on behalf of the Chair to the Directors-at-Large and Staff Fellows serving on the Board in the fulfillment of their responsibilities, including governing and conducting the business of the corporation and supervising the President/CEO; and, at the direction of the Chair, represent the FSMB to the leadership of other organizations, promoting recognition of the FSMB as the premier organization concerned with medical licensure and discipline.

### **V. Standing and Special Committees/Workgroups/Taskforces**

The Board of Directors governs by making decisions about goals and objectives, programs and services, personnel, finances, facilities and equipment and then seeing to it that those decisions are carried out. To assure that the Board conducts its business efficiently and democratically, assistance is provided through the FSMB's committee and workgroup structure. The Board oversees the work of two types of committees: standing and special.

Standing committees are permanent and assist the House of Delegates and Board of Directors with overseeing a specific aspect of governance such as finance. All standing committees are either specifically mentioned in the Bylaws or must be created by resolution of the FSMB and/or amendment to the Bylaws. Membership on standing committees is determined by the Bylaws (as approved by the House of Delegates) or Chair.

The FSMB standing committees include:

Audit Committee  
Bylaws Committee  
Editorial Committee  
Education Committee  
Ethics and Professionalism Committee  
Finance Committee  
Nominating Committee

Special committees, workgroups and taskforces are temporary and are created for some special purpose such as overseeing the development of a program or conducting research on a specific subject. The Chair determines the membership of these groups. Those for FY 2020 include:

Ad Hoc Task Force on Pandemic Response  
Artificial Intelligence Taskforce  
Special Committee on Strategic Planning  
Workgroup on Board Education, Service and Training (BEST)  
Workgroup on Physician Sexual Misconduct  
Workgroup on Physician Impairment  
Workgroup to Study Risk and Support Factors Affecting Physician Performance

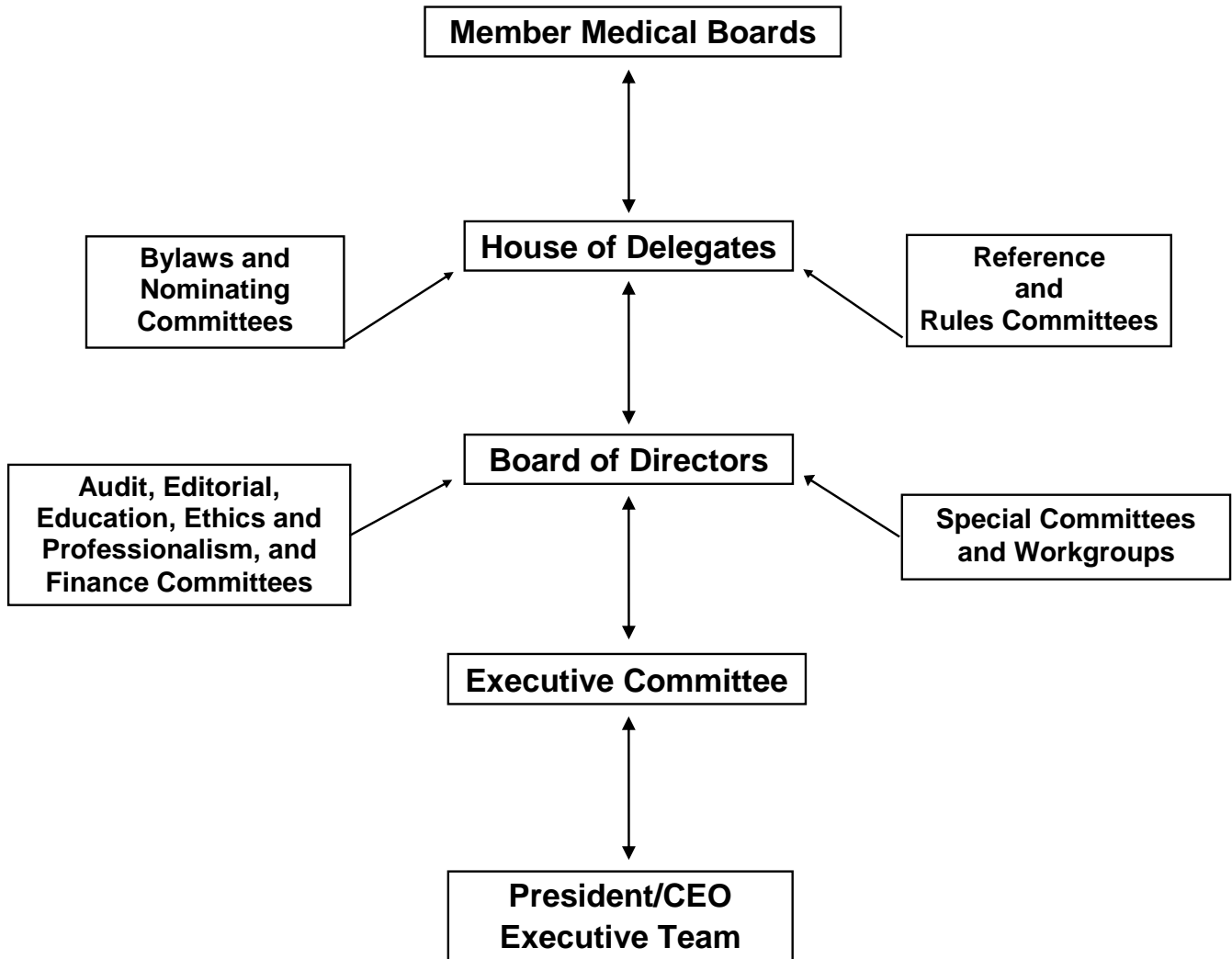
In addition to the existence of standing and special committees, workgroups and taskforces, a Rules Committee and Reference Committee(s) meet for each Annual Meeting to help facilitate the progress of business at the House of Delegates meeting.

## **VI. Executive Office**

The President/CEO reports to the Board of Directors. The President/CEO supports and assists the Board and its committees in the conduct of its corporate business and appraises the Board of the internal operations of the organization. Additionally, the President/CEO acts as the primary spokesperson for the FSMB to outside organizations, government authorities, special interest groups, the media and the public promoting recognition of the FSMB as the premier organization concerned with medical licensure and discipline.

Assisting the President/CEO are members of the Executive Team including the Chief Advocacy Officer, Chief Assessment Officer, Chief Financial Officer, Chief Legal Officer, and Chief Operating Officer.

# FSMB Organizational Chart



## Chapter 2: The House of Delegates Policy Development Process

### I. Reports and Proposals

Reports of the FSMB Board of Directors, Executive Office, committees, workgroups, taskforces and representatives to other organizations are transmitted to the House of Delegates for information or action. Informational reports provide highlights or an update on activities or projects that have been completed or are in progress, and do not require any decision-making on the part of the House. Action reports recommend a new or modified policy or that a particular action be carried out by the FSMB.

While the full text of reports and proposals is published, only the recommendations are subject to amendment, and only the recommendations adopted by the House become FSMB policy.

### II. Resolutions

Member Medical Boards may wish to submit resolutions for consideration at the annual business meeting of the House of Delegates. A resolution is a way to express an idea or to identify a problem or opportunity. Although resolutions may deal with complex issues, most resolutions begin simply when a problem is recognized, and a solution is suggested. Resolutions are structured to express the background of the problem and to lay out a course of action in a logical way so that the need for action on the issue is clear. To set the tone for discussion, each *Whereas* clause should carry a message and develop statements that require a solution. *Resolved* clauses should reflect what has just been stated and then go on to address what the FSMB should do or what position the FSMB should take on the identified topic.

Member Medical Boards wishing to submit resolutions are requested to forward all proposed resolutions to the FSMB's Executive Office. In order to streamline the processing of business for the meeting and increase the efficiency with which the House of Delegates agenda materials are produced, resolutions must be submitted in writing or via e-mail to the FSMB at least 60 days prior to the meeting. **The FSMB cannot accept resolutions after the published deadline.**

When drafting resolutions for submission:

- The title of the resolution should appropriately and concisely reflect the action for which it calls.

- The date on which the resolution was approved by the Member Medical Board should appear beneath the title.
- Information contained in the resolution should be checked for accuracy.
- The *Resolved* portions should stand alone, since the House adopts only the *Resolved* portions and the *Whereas* portions are not subject to adoption.

**III. Reference Committees** [in 2020, the Reference Committee will be meeting virtually on April 30 in place of a Reference Committee hearing – written testimony may be submitted by the Member Medical Boards for the Committee’s consideration by April 23. The report of the Reference Committee will be posted on the Member Portal on May 1.]

One or more Reference Committee hearings are scheduled prior to the House of Delegates annual business meeting. An agenda for the items to be heard by each Committee is posted with the Annual Meeting materials on the FSMB Member Portal, as well as on the Annual Meeting app.

All interested Annual Meeting participants may attend Reference Committee hearings and make statements on items being considered. Agenda items can include resolutions, Board reports, Bylaws amendments or other proposals that require a vote by the House of Delegates. All items heard in Reference Committee hearings will be voted upon by the full House of Delegates at the annual business meeting. Reference Committees are not empowered to take any action on items of business. Their role is to make recommendations to the House of Delegates. Only those items acted upon by the House of Delegates are considered official.

Each Reference Committee will be appointed by the Chair of the FSMB Board of Directors and will be composed of three to five members. However, the Chair may appoint additional members as needed. The Chair(s) of the Reference Committee(s) introduces each item of business, opens the floor for comment and recognizes individuals from the floor. While the purpose of the Reference Committee(s) is to hear as much testimony as necessary for a full discussion of each item, the Committee Chair(s) may set time limits on the testimony, as deemed necessary.

Members of the FSMB’s Board of Directors, standing committees, special committees, workgroups, taskforces and staff are present at Reference Committee hearings to provide any requested resources or information. The Reference Committee(s) is to listen and, if necessary, seek out any appropriate information and/or viewpoints on each item under discussion. Members of the Reference Committee(s) are not allowed to engage in debate or express their own opinions during the hearing(s), and they are not empowered to entertain motions or make decisions on items of business.

At the close of the hearing(s), Reference Committee members meet in Executive Session to formulate their recommendations on each item. These recommendations are based on what is in the best interest of the FSMB, and not on the amount of testimony for or against a particular proposal.

During the House of Delegates business meeting, the Chair(s) of each Reference Committee(s) presents the Committee's report. The Reference Committee(s) may recommend that a proposal be adopted, rejected, amended or otherwise disposed of, and give reasons, therefore. It may also recommend amendments to proposals that have been referred and/or make substitute proposals of its own. The Reference Committee(s) must forward a recommendation to the House of Delegates on each item of business, and the House must take action on these recommendations. Any "whereas" portions or preambles of resolutions before the Committee(s) are informational and explanatory, and only the "resolve" portions are considered by the House of Delegates. Recommendations of the Reference Committee(s) are advisory, and it is important that the House of Delegates has the opportunity to consider all proposals submitted to it and make the final decision on each.

The use of Reference Committee hearings allows for a more detailed and thorough discussion of items of business to come before the House of Delegates, thereby facilitating the progress of the annual House of Delegates business meeting.

#### **IV. Setting Policy**

A simple majority vote of the House is required for most items of business. Some actions, such as changes to the Bylaws, require a two-thirds majority vote of those voting.

The House of Delegates may act on items before it in one of the following ways:

- The House may **adopt** the recommendations of reports and resolves of resolutions or **not adopt** if a majority of the House votes against them.
- The House may **amend and then adopt** the amended recommendations of reports and resolves of resolutions.
- The House may **propose amendments by substitution and then adopt** the substitute amendments to recommendations of reports and resolves of resolutions.
- The House may **refer the items back to the Board** (or through the Board to the appropriate committee) **for further review**. If an item is referred for further study, then all pending information (i.e., amendments) relating to that item is referred as well. A specific time for reporting back to the House should be indicated.
- The House may **refer the items back to the Board for decision**, which gives the Board the authority and responsibility for making a determination on the matter.

- The House may **file an informational report** (acknowledging that a report has been received and considered, but that no action has been necessary or taken).
- The House may **table** a recommendation, which sets aside the recommendation for the current meeting unless the House votes to resume its consideration. A tabled recommendation is postponed to an undetermined time and may be proposed again, as a new recommendation at any future meeting; however, if a recommendation is tabled as a means of closing debate indefinitely, it would require a two-thirds majority vote.

## V. Elections

Elections for filling vacancies within the Board of Directors and Nominating Committee are conducted at the annual business meeting of the House of Delegates in accordance with the Bylaws of the FSMB, the process of which is described in Section VII of this chapter (Rules Committee). **Only individuals who are Board Member Fellows of the FSMB at the time of the election may run for elective office.** A Board Member Fellow is an individual member who as a result of appointment or confirmation is designated to be a member of a Member Medical Board. A Board Member Fellow shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of thirty-six months thereafter.

### a. Officers:

The Chair and Chair-elect may serve for terms of one (1) year or until their successors assume office. The Chair then serves one year as Immediate Past Chair, and the Chair-elect serves one year as Chair. The Treasurer may serve for a single term of three (3) years or until his/her successor assumes office. At each annual business meeting of the House of Delegates the Chair-elect will be elected and every third year at the Annual Meeting the Treasurer will be elected. (The position of Secretary is an ex-officio office, without vote, and the President/CEO serves as Secretary.) Officers assume office upon final adjournment of the Annual Meeting at which they were elected.

### b. Directors-at-Large and Staff Fellows serving on the Board

In addition to the Officers, the Board of Directors is comprised of nine (9) Directors-at-Large who are elected by the House of Delegates, and two Staff Fellows who are appointed by the Board of Directors. At least two members of the Board, who are not Staff Fellows, shall be non-physicians, at least one of whom shall be a public/consumer member. Directors-at-Large shall serve for a term of three (3) years and are eligible to be re-elected for one additional term. A partial term of one-and-a-half years or more counts as a full term. At least three (3) of the Directors-at-Large are to be elected each year at the Annual Meeting. Staff Fellows



shall serve for a term of two years and shall be eligible to be reappointed to one additional term. A partial term of one-and-a-half years or more counts as a full term.

c. Nominating and Other Standing Committee Members:

At least three Board Member Fellows are elected at each Annual Meeting to serve on the Nominating Committee, each for a two-year term. With the exception of the Immediate Past Chair, who chairs the Committee without vote, no two Nominating Committee members are to be from the same Member Medical Board.

With the exception of the Nominating Committee, chairs and members of all standing committees are appointed by the FSMB Chair, with the approval of the Board of Directors, for a term of one (1) year, unless otherwise provided for in the Bylaws. Reappointment, unless specifically prohibited, is permissible. Members of the Editorial Committee serve staggered three-year terms and are limited to two full terms. The Chair appoints the chair of the Audit, Bylaws, and Ethics and Professionalism Committees. The FSMB Treasurer serves as chair of the Finance Committee. The FSMB Chair serves as the chair of the Education Committee. The Immediate Past Chair serves as the chair of the Nominating Committee. The Editorial Committee elects its own chair, who serves as the Editor-in-Chief of the *Journal of Medical Regulation*. No officer or member of the Board of Directors shall serve on the Editorial Committee.

## VI. House of Delegates Meeting Materials

The House of Delegates business meeting materials include the agenda, minutes of the previous meeting, reports and resolutions, management notes (summaries of agenda items with any recommendations by FSMB management on appropriate actions to be taken by the House of Delegates), and reference information. **The House of Delegates business meeting materials will be posted on the FSMB Member Portal approximately one month prior to the Annual Meeting.** [This year, due to Covid-19, the posting of materials other than those going before the Reference Committee were delayed.]

## VII. Rules Committee [The 2020 Rules Committee drafted rules for ratification for conducting a virtual meeting of the House of Delegates]

The role of the Rules Committee is to develop the rules for conducting business during the House of Delegates annual business meeting and to develop a Report of the Rules Committee for ratification by the House of Delegates.

**The 2019 Report of the Rules Committee as ratified by the House of Delegates states the following:**

I. House Security:

Maximum security shall be maintained at all times to prevent disruptions of the Annual Business Meeting. Only those individuals with proper badges or secure log-in shall be permitted to attend or participate using an electronic platform. The presiding officer may appoint three (3) sergeants-at-arms to maintain order in the meeting room and escort any special guests to the podium.

II. Credentials:

Only properly registered voting representatives with marked badges shall be allowed to sit in the voting section at the Annual Meeting. Only those voting representatives registered as remote participants shall be allowed to cast votes using remote electronic means. Voting credentials cannot be transferred from the official voting delegate to another after the meeting is called to order.

III. Order of Business:

The agenda as published in the delegate's handbook shall be the official agenda for the Annual Business Meeting. This may be modified by the presiding officer or by majority vote of the House.

IV. Privilege of the Floor:

All classes of membership shall have the right of the floor at meetings of the House upon request of a delegate and approval of the presiding officer. The presiding officer shall have the discretion to structure and limit discussion, as needed for the orderly conduct of the meeting.

V. Procedures of the Annual Business Meeting:

The presiding officer shall appoint tellers for the purpose of assisting in the election process and certification of votes. Tellers shall not be designated voting delegates of the Annual Business Meeting.

The presiding officer shall appoint a parliamentarian to advise on all procedural questions using the Federation Bylaws and *American Institute of Parliamentarians Standard Code of Parliamentary Procedure*, current edition. The parliamentarian may not participate in the general discussion but only advise on procedural issues when there is a dispute or question.

All issues not decided by voice vote shall be decided by electronic balloting. In the event electronic balloting is not possible because of technical or other reasons, voting shall be conducted by written ballot. In the occurrence of such event, voting representatives participating using the remote electronic platform shall communicate their vote to the preassigned teller.

#### VI. Nominations:

The report of the Nominating Committee is presented as a list of candidates and does not require a second. At an appropriate time, the presiding officer shall introduce all nominations for office. Candidates for officers, directors, and the Nominating Committee must be Board Member Fellows at the time of election.

#### VII. Elections:

The elections shall be conducted in accordance with the Bylaws of the Federation. The presiding officer may call for a vote at any time during the meeting.

If there is only one candidate for office, then that individual shall be declared elected by acclamation.

Election to an officer/director slot requires a majority of the votes cast and all other elected positions shall be elected by a plurality vote. A majority is one more than one-half (1/2) of the number of delegates voting. A plurality vote is more votes than the number received by any other candidate.

In the event any slot on the Board of Directors is vacated by previous election or other reason, the full term at-large slots are to be filled first, concurrently, with the ballot including the names of all candidates running for the at-large positions. Following election of the full term at-large positions, the partial term at-large positions shall be filled individually, with the slate(s) including the remaining at-large candidates.

When it is necessary to meet the minimum Bylaws requirement for election of a non-physician director, election of a non-physician director from the field of non-physicians shall precede election of other at-large candidates to the Board of Directors. Non-physician candidates not elected to the required seat shall join the slate of physician candidates for the remaining at-large positions on the Board of Directors. The same procedures shall be used for election of the Nominating Committee.

If more than one seat on the Board of Directors is to be filled from a single list of candidates, and if one or more seats are not filled by majority vote on the first ballot, a runoff election shall be held with the ballot listing candidates equal in number to twice the number of seats remaining to be filled. These candidates shall be those remaining who

received the most votes on the first ballot. The same procedures shall be used for any subsequent runoff elections.

In the event of a deadlock, or tie for a single position, up to two additional runoff elections shall be held. Prior to each election, the presiding officer shall cast a sealed vote that shall be counted only to resolve a tie that cannot be decided by these additional runoff elections.

The top vote getters shall be elected until all positions are filled when the position requires election by a plurality vote.

A legal ballot shall be one that is 1) communicated electronically, 2) marked with the legible name of a qualified candidate(s) in that election, or 3) sent via text message by remote participant to a preassigned teller.

A ballot containing votes for more than the number of positions to be filled is invalid.

A ballot containing more than one vote for the same person is invalid.

Proxies - In accordance with *American Institute of Parliamentarians Standard Code of Parliamentary Procedure*, current edition, no proxies shall be accepted in the voting process.

The presiding officer shall announce the election results as soon as appropriate.

## **Chapter 3: Designated Annual Meeting Attendees [In 2020, due to COVID-19, the Annual Meeting was cancelled apart from the virtual meeting of the House of Delegates]**

### **I. Designation of Voting Delegates and Member Medical Board Senior Staff Representatives**

During the month of December prior to the Annual Meeting, the presidents/chairs (Board Member Fellows) and executive directors (Staff Fellows) of each Member Medical Board are sent an email communication requesting they begin the process of identifying the individuals who will participate in the FSMB House of Delegates meeting as their board's voting delegate (president/chair/another board member) and senior staff representative (executive director/another staff member). In the event the board president/chair cannot attend as voting delegate, an alternate member of the medical board may be identified by the board president/chair to attend as the designated voting delegate. In the event the chair/president nor alternate member of the medical board cannot attend, a Staff Fellow or Associate Member may be identified by the board chair/president to attend as their designated voting delegate. The designated attendee's name must be communicated to FSMB prior to the start of the Annual Meeting. Only board members, Staff Fellows or Associate Members of the FSMB may be designated as an alternate voting delegate. If the Staff Fellow cannot attend, another senior staff member may be identified by the board president/chair to attend in lieu of the Staff Fellow.

Scholarship and related Annual Meeting information is forwarded to the presidents/chairs (Board Member Fellows) and executive directors (Staff Fellows) of each Member Medical Board in early January to assist when identifying designated attendees.

### **II. Registration and Program Information**

Upon notification of a designated attendee, the FSMB will forward a confirmation email, Scholarship Registration Link, reimbursement policy and travel information to the selected individuals. The Annual Meeting registration fee is waived for scholarship recipients.

## **2019 FSMB BYLAWS**

### **ARTICLE I. NAME**

The corporation shall be known as the Federation of State Medical Boards of the United States, Inc. ("FSMB").

### **ARTICLE II. CLASSES OF MEMBERSHIP, ELECTION AND MEMBERSHIP RIGHTS**

#### **SECTION A. MEMBER MEDICAL BOARDS**

The term "Member Medical Board" as used in the Articles of Incorporation and in these Bylaws shall refer to any board, committee or other group in any state, territory, the District of Columbia or possession of the United States of America that is empowered by law to pass on the qualifications of applicants for licensure to practice allopathic or osteopathic medicine or to discipline such licensees. If a state or other jurisdiction has more than one such entity and if each is an independent agency unrelated to the others, each is eligible for membership. Any eligible Medical Board may become a Member Medical Board upon approval of its application by the Board of Directors.

#### **SECTION B. FELLOWS**

There shall be two categories of Fellow of the FSMB:

1. **BOARD MEMBER FELLOW.** A Board Member Fellow is an individual member who as a result of appointment or confirmation is designated to be a member of a Member Medical Board. A Board Member Fellow shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of thirty-six months thereafter, and
2. **STAFF FELLOW.** A Staff Fellow is an individual hired or appointed and who is responsible for the day-to-day supervision and performance of the administrative duties and functions for which a medical board is responsible. Each member board may denote only one individual to serve as a Staff Fellow of the FSMB. No individual shall continue as a Staff Fellow upon termination of employment by or service to the Member Medical Board.

#### **SECTION C. HONORARY FELLOWS**

A Board Member Fellow as defined in Section B, paragraph 1 shall become an Honorary Fellow of the FSMB thirty-six months after completion of service on a Member Medical Board. A Staff Fellow as defined in Section B, paragraph 2 shall become an Honorary Fellow of the FSMB upon

termination of employment by or service to the Member Medical Board. An Honorary Fellow of the FSMB may be appointed by the Chair to serve as a member of any committee or in any other appointive capacity.

#### **SECTION D. ASSOCIATE MEMBERS**

A Member Medical Board may designate one or more employees or staff members, other than an individual designated as a Staff Fellow, to be an Associate Member of the FSMB. No individual shall continue as an Associate Member upon termination of employment by or service to the Member Medical Board.

#### **SECTION E. COURTESY MEMBERS**

Any physician or physician assistant licensed by a Member Medical Board or an Affiliate Member Board and not eligible for any other type of membership may become a Courtesy Member of the FSMB upon approval of the candidate's application. A Courtesy Member may serve as a member of a committee and in any other capacity upon appointment by the Chair.

#### **SECTION F. AFFILIATE MEMBERS BOARDS**

A board or authority that is not otherwise eligible for membership may become an Affiliate Member Board of the FSMB upon approval of its application by the Board of Directors if the board or authority licenses either:

1. Allopathic or osteopathic physicians or physician assistants in the United States; or
2. Allopathic or osteopathic physicians if the board or authority is located in another country.

#### **SECTION G. OFFICIAL OBSERVERS**

An organization may apply for Official Observer status at meetings of the House of Delegates. The Board of Directors shall prescribe rules and procedures to govern the application for, the granting of and the exercise of Official Observer status.

#### **SECTION H. RIGHTS OF MEMBERS**

Except as otherwise provided in these Bylaws, rights, duties, privileges and obligations of a member of the FSMB may be exercised only by a Member Medical Board.

#### **SECTION I. METHODS OF NOMINATION TO ELECTED OFFICE**

Nomination by the Nominating Committee or Nomination by Petition pursuant to Articles III, IV, V and VIII shall be the sole methods of nomination to an elected office of the FSMB. A candidate

who runs for and is not elected to an elected office shall be ineligible to be nominated for any other elected office during the same election cycle.

### **ARTICLE III. OFFICERS: ELECTION AND DUTIES**

#### **SECTION A. OFFICERS OF THE FSMB**

1. OFFICERS. The officers of the FSMB shall be that of Chair, Chair-elect, Immediate Past Chair, Treasurer and Secretary.
2. Only an individual who is a Fellow as defined in Article II, Section B, paragraph 1 at the time of the individual's election or appointment shall be eligible for election or appointment as an Officer of the FSMB, except for the position of Secretary.
3. The position of Secretary shall be an ex-officio office, without vote, and the President of the FSMB shall serve as Secretary.

#### **SECTION B. ELECTION OF OFFICERS**

1. The Chair-elect shall ascend to the position of Chair at the Annual Meeting following the meeting in which the Chair-elect was elected.
2. The Chair-elect shall be elected at each Annual Meeting of the House of Delegates.
3. The Immediate Past Chair assumes that position upon the Chair-elect ascending to the position of Chair.
4. The Treasurer shall be elected every third year at the Annual Meeting of the House of Delegates.
5. Officers shall be elected by a majority of the members of the House of Delegates present and voting.
6. In any election, should no candidate receive a majority of the votes cast, a runoff election shall be held between the two candidates who receive the most votes for that office on the first ballot. Up to two additional runoff elections shall be held.
7. Prior to each election, the presiding officer shall cast a sealed vote that shall be counted only to resolve a tie that cannot be decided by the process set forth in this section.

#### **SECTION C. DUTIES OF OFFICERS**

1. The duties of the Chair shall be as follows:



- a. Preside at all meetings and sessions of the House of Delegates and the Board of Directors;
  - b. Perform the duties customary to the office of the Chair;
  - c. Make appointments to committees and define duties of committee members in accordance with these Bylaws, except as otherwise provided herein;
  - d. Serve, ex officio, on all committees except as otherwise provided herein; and
  - e. Exercise such other rights and customs as the Bylaws and parliamentary usage may require or as the FSMB or the Board of Directors shall deem appropriate.
2. The duties of the Chair-elect shall be as follows:
- a. Assist the Chair in the discharge of the Chair's duties; and
  - b. Perform the duties of the Chair at the Chair's request or, in the event of the Chair's temporary absence or incapacitation, at the request of the Board of Directors.
3. The duties of the Immediate Past Chair shall be as follows:
- a. Assist the Chair in the transition from Chair-elect to Chair;
  - b. Serve as chair of the Nominating Committee; and
  - c. Perform such other duties and responsibilities as the Chair shall determine.
4. The duties of the Treasurer shall be as follows:
- a. Perform the duties customary to that office;
  - b. Perform such other duties as the Bylaws and custom and parliamentary usage may require or as the Board of Directors shall deem appropriate;
  - c. Serve as an ex officio member of the Audit Committee; and
  - d. Serve as chair of the Finance Committee.
5. The duties of the Secretary shall be as follows:
- a. Administer the affairs of the FSMB; and
  - b. Such duties and responsibilities as the FSMB and the Board of Directors shall determine.

#### **SECTION D. TERMS OF OFFICE AND SUCCESSION**

1. The Chair and Chair-elect shall serve for single terms of one year or until their successors assume office.

2. The Immediate Past Chair shall serve until a successor to the current Chair assumes office.
3. The Treasurer shall serve for a single term of three years or until the Treasurer's successor assumes the office.
4. Officers shall assume office upon final adjournment of the Annual Meeting of the House of Delegates at which they were elected.
5. The term of the Secretary is co-terminus with that of the President.

#### **SECTION E. VACANCIES**

1. In the event of a vacancy in the office of the Chair, the Chair-elect shall assume the position of Chair for the remainder of the unexpired term, and shall then serve a full one-year term as Chair.
2. In the event of a vacancy in the office of the Chair-elect, the Board of Directors shall appoint a Director-at-Large to assume the duties, but not the office, of Chair-elect for the remainder of the unexpired term. At the next Annual Meeting of the House of Delegates, both a Chair and a Chair-elect shall be elected in accordance with the provisions in Section B of this Article.
3. In the event of a vacancy in the office of Immediate Past Chair, the office shall remain open until a new Chair assumes the office.
4. In the event of a vacancy in the office of the Treasurer, the Board of Directors shall elect one of the Directors-at-Large to serve as Treasurer, with one vote on the Board of Directors and one vote on the Executive Committee, until the next year's Annual Meeting of the House of Delegates, at which time a Treasurer shall be elected.

### **ARTICLE IV. BOARD OF DIRECTORS**

#### **SECTION A. MEMBERSHIP AND TERMS**

1. **MEMBERSHIP:** The Board of Directors shall be composed of the Officers, nine Directors-at-Large and two Staff Fellows. At least three members of the Board, who are not Staff Fellows, shall be non-physicians, at least two of whom shall be a Member Medical Board public member.
2. **NOMINATION OF STAFF FELLOWS:** Nominations for Staff Fellow positions shall be accepted from Member Boards, the Board of Directors and the Administrators in Medicine. Staff Fellows shall be appointed by the Board of Directors in staggered terms in accordance with policies and procedures established by the Board of Directors.

3. TERMS: Directors-at-Large shall each serve for a term of three years and shall be eligible to be reelected to one additional term. Staff Fellows shall serve for a term of two years and shall be eligible to be reappointed to one additional term. A partial term totaling one-and-a-half years or more shall count as a full term.

## **SECTION B. NOMINATIONS**

1. The Nominating Committee shall submit a roster of one or more candidates for each of the offices and positions to be filled by election at the Annual Meeting of the House of Delegates.
2. The Nominating Committee shall mail its roster of candidates to Member Boards not fewer than sixty days prior to the Annual Meeting of the House of Delegates.

## **SECTION C. ELECTION OF DIRECTORS-AT-LARGE**

1. At least three of the Directors-at-Large shall be elected each year at the Annual Meeting of the House of Delegates by a majority of the votes cast.
2. If no candidate receives a majority of the votes on the first ballot, and one seat is to be filled, a runoff election shall be held between the two candidates who received the most votes on the first ballot.
3. If more than one seat is to be filled from a single list of candidates, and if one or more seats are not filled by majority vote on the first ballot, a runoff election shall be held, with the ballot listing candidates equal in number to twice the number of seats remaining to be filled. These candidates shall be those remaining who received the most votes on the first ballot. The same procedure shall be used for any required subsequent runoff elections. In the event of a tie vote in a runoff election up to two additional runoff elections shall be held.
4. Prior to the election, the presiding officer shall cast a sealed vote, ranking each candidate in a list. The presiding officer's vote is counted for the candidate in the runoff election who is highest on the list. The presiding officer's vote is counted only to resolve a tie that cannot be decided by the process set forth in this section.
5. Directors shall assume office upon final adjournment of the Annual Meeting of the House of Delegates at which they were elected.
6. Only an individual who is a Board Member Fellow at the time of the individual's election shall be eligible for election as a Director of the FSMB.

## **SECTION D. DUTIES OF THE BOARD OF DIRECTORS**

1. The control and administration of the FSMB is vested in the Board of Directors and it shall act for the FSMB between Annual Meetings.
2. The Board of Directors shall carry out the mandates of the FSMB as established by the House of Delegates, and it shall have full and complete authority to perform all acts and to transact all business for and on behalf of the FSMB.
3. The Board of Directors shall conduct and manage all property, affairs, work and activities of the FSMB, subject only to the provisions of the Articles of Incorporation and these Bylaws and to resolutions and enactments of the House of Delegates.
4. The Board of Directors shall be the fiscal agent of the FSMB.
5. The Board of Directors shall establish rules for its operations and meetings.
6. The FSMB shall indemnify Directors, Officers and other individuals acting on behalf of the FSMB if such indemnification is in accordance with the laws of the State of Nebraska and the operational policies and procedures of the Board of Directors, as adopted. The Board shall report to the membership of the FSMB at the Annual Meeting of the House of Delegates.
7. The Board of Directors shall establish a strategic plan for the FSMB that states the FSMB mission and objectives and shall submit that plan to the House of Delegates for ratification, modification or rejection. The Board shall review the current strategic plan annually and propose any amendments to the Annual Meeting of the House of Delegates for ratification, modification or rejection. The President shall report to the Annual Meeting of the House of Delegates on the extent to which the FSMB's stated objectives have been accomplished in the preceding year.

## **SECTION E. REMOVAL FROM OFFICE**

1. REMOVAL: Any officer or member of the Board of Directors may be removed for any cause deemed sufficient by an affirmative vote of two-thirds of the total members of the Board of Directors entitled to vote and who are not subject to removal from office.
2. PROCEDURE: The procedure for removal shall be as follows:
  - a. The Board shall file with the Secretary of the Board and deliver a written statement of the cause for removal to the officer or board member in sufficient detail as to state the grounds

for the removal. Delivery to the officer or board member shall be by certified mail, return receipt requested, to the last address known to the Board.

- b. The officer or board member shall deliver a sworn written response to the Board no later than thirty calendar days after the written statement of the cause for removal is delivered to the officer or board member in question. Delivery to the Board shall be by certified mail, return receipt requested, directed to the Secretary of the Board at the FSMB corporate office.
  - c. At the Board meeting following the date the response is due, the Board shall determine whether or not to proceed with removal. Notice of the Board's action shall be delivered to the officer or board member by certified mail, return receipt requested. If the officer or board member does not file a written response, the Board shall proceed with a determination.
  - d. If the Board votes to proceed with removal of the officer or board member, at a Board meeting the board member shall be afforded the opportunity to address the Board on the merits of the allegations and produce any relevant information to the Board after which the Board shall make a determination. The Board meeting at which the officer or board member has the opportunity to address the Board shall be held no less than thirty days after delivery of the notice of removal.
3. **APPEAL:** Any officer or member of the Board of Directors removed by the Board of Directors may appeal to the House of Delegates at its next business meeting. The officer or member may be reinstated by a two-thirds vote of the House of Delegates.
  4. **DELIVERY:** For the purposes of this section, "Delivery" is effective upon mailing.

## **SECTION F. VACANCIES**

1. **DIRECTORS-AT-LARGE:** In the event of a vacancy in the membership of the Directors-at-Large, the Board of Directors may appoint a Fellow who meets the qualifications for the position to serve until the next annual meeting of the House of Delegates, at which time a Fellow shall be elected and shall serve the remainder of the unexpired term. In the event a Director-at-Large is elected to the office of Treasurer or Chair-elect, that vacancy shall be filled by an election at the same annual meeting of the House of Delegates.
2. **STAFF FELLOWS:** In the event of a vacancy of a Staff Fellow, the Board of Directors may appoint a substitute to complete the Staff Fellow's term in accordance with the policies established by the Board of Directors.

## **SECTION G. EXECUTIVE COMMITTEE OF THE BOARD**

1. **MEMBERSHIP:** The Board of Directors shall establish an Executive Committee of the Board, which shall consist of the Chair as Chair, Chair-elect, Treasurer, Immediate Past Chair and three Directors-at-Large. The Directors-at-Large shall be elected for a one-year term by majority vote of the Directors-at-Large and the Staff Fellows serving on the Board of Directors at the first regular meeting of the Board following the annual meeting of the House of Delegates. In the event of a vacancy in a Director-at-Large position, the Directors-at-Large and the Staff Fellows serving on the Board, by majority vote, shall choose another Director-at-Large to serve the remainder of the one-year term. A Staff Fellow may serve in one of the Director-at-Large positions. No more than one Staff Fellow may serve on the Executive Committee at any one time. In the event of vacancy in the position of Immediate Past Chair, this position shall remain vacant until the next annual meeting of the House of Delegates.
2. **DUTIES:** In intervals between Board meetings, the Executive Committee shall act for and on behalf of the Board in any matters that require prompt attention. It shall not modify actions previously taken by the Board unless additional information or a change of circumstances is presented and warrants additional action.
3. **MEETINGS:** The Executive Committee may meet as often as it deems necessary or appropriate, either in person, telephonically, electronically or by unanimous written consent, and at such times and places and manner as the Chair may determine. Minutes must be kept of all meetings.
4. **REPORTING:** The Executive Committee shall report in writing all formal actions taken by it to the Board of Directors within five working days of taking those actions. At each meeting of the Board, the Executive Committee shall present to the Board a written report of all its formal actions since the previous meeting of the Board.

## **SECTION H. PUBLIC POLICY STATEMENTS**

A “public policy” is defined as the official public position of the FSMB on a matter that may be reasonably expected to affect Member Boards when dealing with their licensees, other health care providers, health-related special interest groups, governmental bodies or the public. The House of Delegates is the official public policy-making body of the FSMB. When the interests of the FSMB require more immediate action, the Board of Directors, or the President in consultation with the Chair, if feasible, is authorized to issue statements on matters of public policy between Annual Meetings.

## **ARTICLE V. NOMINATION BY PETITION FOR BOARD OF DIRECTORS AND NOMINATING COMMITTEE**

### **SECTION A. SUBMISSION OF A PETITION**

1. At the time the Nominating Committee's roster of candidates is distributed to the Member Boards, the Boards will be informed that a Fellow who is qualified for nomination, but not otherwise nominated by the Nominating Committee, may seek to run for a position on the Board of Directors as an Officer or Director-at-Large, or for a position on the Nominating Committee.
2. In order to be placed on the ballot, the Fellow seeking nomination is required to present a petition to Administrative Staff that is signed by at least one Fellow from at least four Member Boards as well as a fellow from the Board of the member seeking nomination.
3. The deadline to submit petitions to the Administrative Staff is twenty-one days prior to the Annual Meeting.

### **SECTION B. VALIDATION AND PLACEMENT ON BALLOT**

1. The Administrative Staff shall verify that all signatures on the petition are valid. "Valid" is defined as the person who is seeking nomination and the persons who signed the petition are Fellows as defined in the FSMB Bylaws.
2. Once verified, the petitions are deemed valid and the candidate is placed on the ballot.
3. The names of those seeking to run by petition whose petitions are deemed valid shall be distributed to the Voting Delegates not fewer than fourteen days prior to the Annual Meeting.
4. Once a candidate seeking to run by petition is added to the ballot, the candidate shall be afforded the same privileges and be bound by the same rules in the campaign process as candidates who were nominated by the Nominating Committee.

## **ARTICLE VI. PRESIDENT**

The Board of Directors may, by a two-thirds majority vote of the full Board, appoint a President of the FSMB, who shall be a physician, to serve without term. The President shall administer the affairs of the FSMB and shall have such duties and responsibilities as the Board of Directors and the FSMB shall direct. The President shall serve as Secretary of the FSMB and shall be an ex-officio member, without vote, of the Board of Directors.

## **ARTICLE VII. MEETINGS**

### **SECTION A. ANNUAL MEETING OF THE HOUSE OF DELEGATES**

The annual meeting of the House of Delegates of the FSMB, which shall be called the House of Delegates, shall be held at such time and place as may be fixed by the Board of Directors. Written notice of the time and place of the meeting shall be given to all Member Medical Boards by mail not fewer than ninety days prior to the date of the meeting. Notice is effective upon mailing.

### **SECTION B. SPECIAL MEETINGS OF THE HOUSE OF DELEGATES**

Special meetings of the House of Delegates may be called at any time by the Chair, on the written request of ten Member Medical Boards or by action of the Board of Directors. Written notice of the time and place of such meetings shall be given to all Member Medical Boards by mail not fewer than thirty days prior to the date of the meeting. Notice is effective upon mailing.

### **SECTION C. RIGHT TO VOTE**

1. The right to vote at meetings of the House of Delegates is vested in, and restricted to, Member Medical Boards. Each Member Medical Board is entitled to one vote, said vote to be cast by the delegate of the Member Board. The delegate shall be the president of the Member Medical Board or the President's designated alternate. In order for a delegate to be permitted to vote, the delegate shall present a letter of appointment to the Secretary of the Board of Directors.
2. All classes of membership shall have the right of the floor at meetings of the House upon request of a delegate and approval of the presiding officer; however, the right to introduce resolutions is restricted to Member Medical Boards and the Board of Directors and the procedure for submission of such resolutions shall be in accordance with FSMB Policy.

### **SECTION D. QUORUM**

A majority of Member Medical Boards shall constitute a quorum at any meeting of the House of Delegates. A majority of the voting members of the Board of Directors or any committee or other constituted group shall constitute a quorum of the Board, committee or group.

### **SECTION E. RULES OF ORDER**

Meetings of the House of Delegates, Board of Directors and all committees shall be conducted in accordance with the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure*, current edition, except when in conflict with the Articles of Incorporation or these Bylaws, in which case the Articles of Incorporation or these Bylaws shall prevail.



## **ARTICLE VIII. STANDING AND SPECIAL COMMITTEES**

### **SECTION A. STANDING COMMITTEES**

1. The Standing Committees of the FSMB shall be:
  - a. Audit Committee
  - b. Bylaws Committee
  - c. Editorial Committee
  - d. Education Committee
  - e. Ethics and Professionalism Committee
  - f. Finance Committee
  - g. Nominating Committee
2. **ADDITIONAL STANDING COMMITTEES.** Additional standing committees may be created by resolution of the FSMB and/or amendment to the Bylaws. Chairs and members of all standing committees, with the exception of the Nominating Committee, shall be appointed by the Chair, with the approval of the Board of Directors, for a term of one year, unless otherwise provided for in these Bylaws. Reappointment, unless specifically prohibited, is permissible.
3. **MEMBERSHIP.** Honorary Fellows, Associate Members and Courtesy Members may be appointed by the Chair to serve on a standing committee in addition to the number of committee members called for in the following sections of this chapter. No more than one Honorary Fellow, Associate or Courtesy Member or non-member subject matter expert may be appointed by the Chair to serve in such a capacity on any standing committee unless otherwise provided for in these Bylaws. All committee members shall serve with vote. Honorary Fellows, Associate or Courtesy Members, and non-members appointed to standing committees by the Chair shall serve for a term concurrent with the term of the Chair. No individual shall serve on more than one standing committee except as specified in the Bylaws. With the exception of the Nominating Committee and the Editorial Committee, the Chair and the Chair-elect shall serve, ex-officio, on all committees.
4. **VACANCIES.** In the event a vacancy occurs in an elected position on a standing committee, the Chair, with the approval of the Board of Directors, shall appoint a Fellow to serve on the committee until the next meeting of the House of Delegates, at which time an election will be held to fill the vacant position for the remainder of the unexpired term. In the event a vacancy occurs in an appointed position on a standing committee, the Chair, with the approval of the

Board of Directors, shall appoint a Fellow to serve on the committee for the remainder of the unexpired term. In the event the Chairmanship of the Nominating Committee becomes vacant, the FSMB Chair, with the approval of the FSMB Board of Directors, shall appoint a Past Chair of the FSMB Board of Directors to serve in that capacity for the remainder of the unexpired term.

## **SECTION B. AUDIT COMMITTEE**

The Audit Committee shall:

1. Be composed of five Fellows, three of whom shall be members of the Board of Directors. The Treasurer of the FSMB shall serve ex-officio without vote. The Chair of the FSMB shall appoint the Chair of the Audit Committee from one of the three sitting Board Members.
2. Ensure that an annual audit of the financial accounts and records of the FSMB is performed by an independent Certified Public Accounting firm.
3. Recommend to the Board of Directors the appointment, retention or termination of an independent auditor or auditors and develop a schedule for periodic solicitation of audit firms consistent with Board policies and best practices.
4. Oversee the independent auditors. The independent auditors shall report directly to the Committee.
5. Review the audit of the FSMB. Submit such audit and Committee's report to the Board of Directors.
6. Report any suggestions to the Board of Directors on fiscal policy to ensure the continuing financial strength of the FSMB.
7. When the finalized committee report to the Board of Directors is made, suggestions and feedback will be forwarded to the Finance Committee.

## **SECTION C. BYLAWS COMMITTEE**

The Bylaws Committee, composed of five Fellows, shall continually assess the Articles of Incorporation and the Bylaws and shall receive all proposals for amendments thereto. It shall, from time to time, make recommendations to the House of Delegates for changes, deletions, modifications and interpretations thereto.

#### **SECTION D. EDITORIAL COMMITTEE**

1. An Editorial Committee, not to exceed twelve Fellows and three non-Fellows, at least two of whom shall be subject matter experts, shall advise the Editor-in-Chief on editorial policy for the FSMB's official publication, and shall serve as the editorial board of that publication and otherwise assist the Editor-in-Chief in the performance of duties as appropriate and necessary. No officer or member of the Board of Directors shall serve on this Committee.
2. Service on the Editorial Committee is by nomination and appointment by the FSMB Chair, subject to approval of the Board of Directors, immediately following the Annual Meeting of the House of Delegates. Candidates are allowed to express their interest in serving on the Committee through self-nomination. Committee members shall serve staggered three-year terms and shall be limited to two full terms.
3. The Editor-in-Chief shall be elected by the Editorial Committee to a three-year term beginning on the date of the annual Editorial Committee meeting, with the Editor-in-Chief's term on the Editorial Committee being automatically extended to allow the Editor-in-chief to serve for three years. A member of the Editorial Committee whose term is expiring shall continue to serve until the member's replacement meets at the next annual Editorial Committee meeting.
4. The Editorial Committee will elect its Chair, who will serve as the Editor-in-Chief of the *Journal of Medical Regulation*. The Editor-in-Chief will serve without compensation and will coordinate decisions on the *Journal* content, among other duties to be determined by the Bylaws Committee.

#### **SECTION E. EDUCATION COMMITTEE**

The Education Committee shall be composed of eight Fellows, to include the Chair as chair, the Immediate Past Chair and the Chair-elect. The Committee shall be responsible for assisting in the development of educational programs for the FSMB.

#### **SECTION F. ETHICS AND PROFESSIONALISM COMMITTEE**

The Ethics and Professionalism Committee shall be composed of up to five Fellows and up to two subject matter experts. The Ethics and Professionalism Committee shall address ethical and professional issues pertinent to medical regulation.

## **SECTION G. FINANCE COMMITTEE**

The Finance Committee shall be composed of five Fellows, to include the Treasurer as Chair. The Finance Committee shall review the financial condition of the FSMB, review and evaluate the costs of the activities and programs to be undertaken in the forthcoming year, present a budget for the FSMB to the Board of Directors for its recommendation to the House of Delegates at the Annual Meeting and perform such other duties as are assigned to it by the Board of Directors. Except for the Treasurer, no Fellow shall serve on both the Audit and Finance Committees.

## **SECTION H. NOMINATING COMMITTEE: PROCESS FOR ELECTION**

1. **MEMBERSHIP:** The Nominating Committee shall be composed of six Fellows and the Immediate Past Chair, who shall chair the Committee and serve without vote except in the event of a tie. At least one elected member of the Nominating Committee shall be a public member. With the exception of the Immediate Past Chair, no two Committee members shall be from the same member board and no officer or member of the Board of Directors shall serve on the Committee. A member of the Nominating Committee may not serve consecutive terms.
2. **ELECTION:** At least three Fellows shall be elected at each Annual Meeting of the House of Delegates by a plurality of votes cast, each to serve for a term of two years. Only an individual who is a Board Member Fellow at the time of the individual's election shall be eligible for election as a member of the Nominating Committee. In the event of a tie vote in a runoff election, up to two additional runoff elections shall be held. Prior to the election, the presiding officer shall cast a sealed vote, ranking each candidate in a list. The presiding officer's vote is counted for the candidate in the runoff election who is highest on the list. The presiding officer's vote is counted only to resolve a tie that cannot be decided by the process set forth in this section.
3. Members of the Nominating Committee are not eligible for inclusion on the roster of candidates for offices and positions to be filled by election at the Annual Meeting of the House of Delegates.

## **SECTION I. SPECIAL COMMITTEES**

Special committees may be appointed by the Chair, from time to time, as may be necessary for a specific purpose.

## **SECTION J. REPRESENTATIVES TO OTHER ORGANIZATIONS AND ENTITIES**

Appointment of all representatives of the FSMB to other official organizations or entities shall be made or nominated by the Chair, with the approval of the Board of Directors, as applicable, and shall serve for a term of three years unless the other organization shall specify some other term of appointment. Representatives to these organizations shall be Fellows, Honorary Fellows, Associate Members or Courtesy Members at the time of their appointment or nomination.

## **ARTICLE IX. UNITED STATES MEDICAL LICENSING EXAMINATION (USMLE)**

**SECTION A.** Except as otherwise set forth in this Article, the composition of committees and subcommittees for the USMLE are subject to agreements with and the advice and consent of the National Board of Medical Examiners (NBME) and/or the USMLE Composite Committee. The Chair, with the approval of the Board of Directors, shall make appointments to the following USMLE committees in appropriate numbers and at appropriate times as required by the FSMB/NBME Agreement establishing the USMLE and by other agreements as may apply:

1. USMLE Composite Committee, which shall be responsible for the development, operation and maintenance of policies governing the three-step USMLE. The President shall be one of the FSMB's representatives on this Committee.
2. USMLE Budget Committee, which shall be responsible for the development and monitoring of USMLE revenues and expenses, including the establishment of fees. FSMB representatives on the Committee will be the Chair, Chair-elect, Treasurer, President and the senior FSMB financial staff member.
3. The USMLE Management Committee shall be responsible for overseeing the design, development, scoring and standard setting for the USMLE Step examinations, subject to policies established by and reporting to the USMLE Composite Committee. Appointments to the Management Committee shall be made consistent with the FSMB/NBME Agreement Establishing the USMLE.

**SECTION B.** The President shall provide FSMB advice and consent to the NBME for NBME's appointments to the USMLE Management Committee and/or any appointments made jointly under the FSMB/NBME Agreement Establishing the USMLE.

## **ARTICLE X. POST-LICENSURE ASSESSMENT SYSTEM**

The Post-Licensure Assessment Governing Committee shall be responsible for the development, operation and maintenance of policies governing the Post-Licensure Assessment System (PLAS) established by joint agreement between FSMB and NBME. The Chair, with the approval of the Board of Directors, shall make appointments to the Post-Licensure Assessment Governing Committee and its program committees in appropriate numbers and at appropriate times as required by the FSMB/NBME joint agreement establishing the Post-Licensure Assessment System and by other agreements as may apply.

## **ARTICLE XI. FINANCES AND DUES**

### **SECTION A. SOURCES OF FUNDS**

Funds necessary for the conduct of the affairs of the FSMB shall be derived from but not be limited to:

1. Annual dues imposed on the Member Medical Boards, Affiliate Members, Courtesy Members and Official Observers;
2. Special assessments established by the House of Delegates;
3. Voluntary contributions, devices, bequests and other gifts;
4. Fees charged for examination services, data base services, credentials verification services and publications.

### **SECTION B. ANNUAL DUES, ELIGIBILITY TO SERVE AS A DELEGATE**

The annual dues for Member Medical Boards shall be established, from time to time, by a majority vote of the House of Delegates.

1. Annual dues for Member Medical Boards shall be the same for all Members regardless of their physician populations. Annual dues are due and payable not later than January 1.
2. Any Member Medical Board whose dues are in default at the time of the Annual Meeting of the House of Delegates shall be ineligible to have a seated delegate.

## **ARTICLE XII. DISCIPLINARY ACTION**

### **SECTION A. MEMBER**

For the purposes of this Article, a member shall be defined as a Member Medical Board, a Fellow, an Honorary Fellow, an Associate Member, an Affiliate Member, Courtesy Member or Official Observer.

### **SECTION B. AUTHORIZATION**

The Board of Directors, on behalf of the House of Delegates, may enforce disciplinary measures, including expulsion, suspension, censure and reprimand, and impose terms and conditions of probation or such sanctions as it may deem appropriate, for any of the following reasons:

1. Failure of the member to comply or act in accordance with these Bylaws, the Articles of Incorporation of the FSMB, or other duly adopted rules or regulations of the FSMB;
2. Failure of the member to comply with any contract or agreement between the FSMB and such member or with any contract or agreement of the FSMB that binds such member;
3. Failure of the member to maintain confidentiality or security, or the permitting of conditions that allow a breach of confidentiality or security, in any manner dealing with the licensing examination process or the confidentiality of FSMB records, including the storage, administration, grading or reporting of examinations and information relating to the examination process; or
4. The imposition of a sanction, judgment, disciplinary penalty or other similar action by a Member Medical Board that licenses the member or by a state or federal court, or other competent tribunal, whether or not related to the practice of medicine and including conduct as a member of a Member Medical Board.

### **SECTION C. PROCEDURE**

Any member alleged to have acted in such manner as to be subject to disciplinary action shall be accorded, at a minimum, the procedural protection set forth in the Manual for Disciplinary Procedures, which is available from the FSMB upon the written request of any member.

### **SECTION D. REINSTATEMENT**

In the event a member is suspended or expelled from the FSMB, the member may apply to the President for reinstatement after one year following final action on expulsion. The President shall review the application and the reason for the suspension or expulsion and forward a report to the

Board. The Board may accept application for reinstatement under such terms and conditions as it may deem appropriate, reject the application or request further information from the President. The Board's decision to accept or reject an application is final.

### **ARTICLE XIII. CORPORATE SEAL**

The Board of Directors shall adopt a corporate seal that meets the requirements of the state in which the FSMB is incorporated.

### **ARTICLE XIV. ADOPTION AND AMENDMENT OF BYLAWS, EFFECTIVE DATE**

#### **SECTION A. AMENDMENT**

These Bylaws may be amended at any annual meeting of the House of Delegates by two-thirds of those present and voting. Bylaws changes may be proposed only by the Board of Directors, Member Medical Boards or the Bylaws Committee and its members. All such proposals must be submitted in writing to the Bylaws Committee, in care of the Secretary of the FSMB. The Bylaws Committee shall inform the Member Medical Boards of its meeting dates not fewer than sixty days in advance of the meeting. The recommendations of the Bylaws Committee and the full texts of all proposed amendments recommended to the Committee shall be sent to each Member Medical Board not fewer than sixty days prior to the annual meeting of the House of Delegates at which they are to be considered.

#### **SECTION B. EFFECTIVE DATE**

These Bylaws and any other subsequent amendments thereto, shall become effective upon their adoption, except as otherwise provided herein.

Bylaws last amended in April 2019