
fsmb
FEDERATION OF
STATE MEDICAL BOARDS
House Of Delegates
Annual Business Meeting
Saturday, April 28
Charlotte, North Carolina

CHANGES IN DESIGNATED VOTING DELEGATES MUST BE MADE PRIOR TO 1:00 PM ON SATURDAY, APRIL 28, 2018.

PLEASE NOTIFY IN WRITING HUMAYUN J. CHAUDHRY, DO, MACP FSMB PRESIDENT/CEO, IF A CHANGE IN THE DESIGNATION OF VOTING DELEGATE IS REQUIRED.

HOUSE OF DELEGATES MEETING GUIDEBOOK

and

FSMB 2017 BYLAWS

are included under Tabs K and L

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.

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.

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.

2015-2020 Strategic Goals

Member State Medical and Osteopathic Boards

Alabama State Board of Medical Examiners

Alaska State Medical Board

Arizona Medical Board

Arizona Board of Osteopathic Examiners in Medicine and Surgery

Arkansas State Medical Board

Medical Board of California

Osteopathic Medical Board of California

Colorado Medical Board

Connecticut Medical Examining Board

Delaware Board of Medical Practice

District of Columbia Board of Medicine

Florida Board of Medicine

Florida Board of Osteopathic Medicine

Georgia Composite Medical Board

Guam Board of Medical Examiners

Hawaii Medical Board

Idaho State Board of Medicine

Illinois Department of Financial and Professional Regulation

Medical Licensing Board of Indiana

Iowa Board of Medicine

Kansas State Board of Healing Arts

Kentucky Board of Medical Licensure

Louisiana State Board of Medical Examiners

Maine Board of Licensure in Medicine

Maine Board of Osteopathic Licensure

Maryland Board of Physicians

Massachusetts Board of Registration in Medicine

Michigan Board of Medicine

Michigan Board of Osteopathic Medicine and Surgery

Minnesota Board of Medical Practice

Mississippi State Board of Medical Licensure

Missouri Board of Registration for the Healing Arts

Montana Board of Medical Examiners

Nebraska Board of Medicine and Surgery

Nevada State Board of Medical Examiners

Nevada State Board of Osteopathic Medicine

New Hampshire Board of Medicine

New Jersey State Board of Medical Examiners

New Mexico Medical Board

New Mexico Board of Osteopathic Medical Examiners

New York State Board for Medicine

New York State Office of Professional Medical Conduct

North Carolina Medical Board

North Dakota State Board of Medical Examiners

Northern Mariana Islands Medical Professional Licensing Board

State Medical Board of Ohio

Oklahoma State Board of Medical Licensure and Supervision

Oklahoma Board of Osteopathic Examiners

Oregon Medical Board

Pennsylvania State Board of Medicine

Pennsylvania State Board of Osteopathic Medicine

Puerto Rico Board of Medical Licensure and Discipline

Rhode Island Board of Medical Licensure and Discipline

South Carolina Board of Medical Examiners

South Dakota State Board of Medical and Osteopathic Examiners

Tennessee Board of Medical Examiners

Tennessee Board of Osteopathic Examiners

Texas Medical Board

Utah Physicians Licensing Board

Utah Osteopathic Physicians and Surgeons Licensing Board

Vermont Board of Medical Practice

Vermont Board of Osteopathic Physicians and Surgeons

Virgin Islands Board of Medical Examiners

Virginia Board of Medicine

Washington Medical Quality Assurance Commission

Washington Board of Osteopathic Medicine and Surgery

West Virginia Board of Medicine

West Virginia Board of Osteopathy

Wisconsin Medical Examining Board

Wyoming Board of Medicine

400 Fuller Wiser Rd., Suite 300 • Euless, TX 76039
Tel (817) 868-4000 • Fax (817) 868-4098 • www.fsmb.org

2017-18 Board of Directors

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Chair-elect	**Patricia A. King, MD, PhD, FACP** Vermont Board of Medical Practice
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Secretary	**Humayun J. Chaudhry, DO, MACP** FSMB President and CEO
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	Scott A. Steingard, DO Arizona Board of Osteopathic Examiners in Medicine and Surgery
	Cheryl L. Walker-McGill, MD, MBA North Carolina Medical Board
	Michael D. Zanolli, MD Tennessee Board of Medical Examiners

Welcome New Fellows

Alabama Board of Medical Examiners
Beverly F. Jordan, MD
Max Rogers, MD, FACOG
Ronnie L. Lewis, MD

Alabama State Medical Board
Catherine Hyndman, MD
Douglas Mertz
Timothy Olson, PA-C

Arizona Board of Osteopathic Examiners In Medicine & Surgery
Christopher Spiekerman, DO
Jonathan A. Maitem, DO

Arizona Medical Board
Bruce Bethancourt, MD, FACP

Arkansas State Medical Board
Don R. Phillips, MD

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Andrew Moreno

Colorado Medical Board
Juan Villaseñor, Esq
Robert Moghim, MD
Scott S. Strauss, DO, FAAFP

Connecticut Medical Examining Board
Marie C. Eugene, DO

Delaware Board of Medical Licensure & Discipline
Brian D. Villar, MD
Janice Truitt

District of Columbia Board of Medicine
Archie Rich
Joshua Wind, MD
Preetha Iyengar, MD

Florida Board of Medicine
Andre M. Perez
Robert A. London, MD
Stephanie Haridopolos, MD

Georgia Composite Medical Board
Rob Law, CFA
Thomas Harbin, Jr., MD

Hawaii Medical Board
Franklin V.H. Dao, MD
Geri Q. L. Young, MD

Idaho Board of Medicine
David A. McClusky, III, MD
Kedrick Wills
Mark S. Grajcar, DO
Robert Yoshida

Illinois Division of Professional Regulation - Medical Disciplinary Board
Garrick Hodge, JD
Henry Krasnow, JD

Iowa Board of Medicine
Teresa Garman
Warren Gall, MD

Kansas Board of Healing Arts
Thomas H. Estep, MD, FACS

Kentucky Board of Medical Licensure
Kenneth J. Payne, MD
Richard Whitehouse, Esq
Sandra R. Shuffett, MD
William Duncan Crosby, III, Esq

Louisiana State Board of Medical Examiners
Lester W. Johnson, MD

Maine Board of Licensure In Medicine
Michael P. Sullivan, MD
John Brewer, DO
Ryan Smith, DO

Maryland Board of Physicians
Alvin L. Helfenbein, Jr.
Ann Marie Stephenson, DO, MBA
Camille M. Williams, MD
Dalila Harvey-Granger, MD
Ira Kornbluth, MD
Jon S. Frank
Mark S. Dills, PA-C
Maxine E. Turnipseed
Scott J. Wiesenberger, MD

Massachusetts Board of Registration In Medicine
Julian N. Robinson, MD

Medical Licensing Board of Indiana
Michael Busk, MD

Michigan Board of Medicine
Eric Stocker
Michael Chafty, MD
Paul Sophiea, MBA

Michigan Board of Osteopathic Medicine & Surgery
Craig Glines, DO
Ronald Bradley, DO

Mississippi State Board of Medical Licensure
Michelle Y. Owens, MD

Missouri Board of Registration For the Healing Arts
Katherine J. Mathews, MD

Montana Board of Medical Examiners
Brian Reed
C. E. Abramson
Christine Emerson
James W. Guyer, MD

Nebraska Board of Medicine & Surgery
John R. Massey, MD

Nevada State Board of Medical Examiners
Michael C. Edwards, MD, FACS
Weldon Havins, MD, JD, LLM
Swadeep Nigam

Welcome New Fellows

New Hampshire Board of Medicine
David C. Conway, MD
Gilbert J. Fanciullo, MD
Michael Barr, MD
Nina C. Gardner

New Jersey State Board of Medical Examiners
Alexander C. Gellman, MD, FACS
Ansar Batool
Chul S. Hyun, MD, PhD
Donald M. Chervenak, MD, FACOG
John D. DiAngelo, DO, FACEP
Kathleen L. Gater, CNM, MS
Kathleen V. Greatrex, MD
Mahmoud Bader Aqel, MD
Michael H. Rieber, MD, FACS
Michael V. Verdi, DPM
Otto F. Sabando, DO, FACOEP, FACEP
Stephen Soloway, MD, FACP, FACR

New Mexico Board of Osteopathic Medical Examiners
John Cruickshank, DO

New Mexico Medical Board
Sebastian Dunlap, Esq

New York State Board For Medicine
Gregg Shutts, PA
JoAnn Marino, MPA, RN
Martha Grayson

New York State Office of Professional Medical Conduct
Amit M. Shelat, DO, FACP
Ashwani Chhibber, MD
Barry Rabin, MD, MPH, MBA
Bruce D. White, DO, JD
David M. Kirshy, MD
Elena M. Cottone, PA-C
Jeffrey Fudin, PharmD
Jerry R. Balentine, DO
JoAnn Marino, MPA, RN
Marian Goldstein, BA, MSW
Patricia E. Salkin, JD
Ramanathan Raju, MD
Richard S. Goldberg, Esq
Samantha Segal, BA, JD

North Carolina Medical Board
John W. Rusher, MD
Michaux R. Kilpatrick, MD, PhD

North Dakota Board of Medicine
Catherine Houle, MD
Gopal Chemiti, MD

State Medical Board of Ohio
Betty Montgomery

Oklahoma Board of Medical Licensure & Supervision
James Brinkworth, MD
Louis Cox, MD
Bret Langerman, DO, DPh

Oregon Medical Board
Andrew C. Schink, DPM
Chere Pereira
Kathleen Harder, MD
Saurabh Gupta, MD

Pennsylvania State Board of Medicine
Anna M. Moran, MD
Cary Cummings, III, MD
Ian Harlow

Rhode Island Board of Medical Licensure & Discipline
Alexios Carayannopoulos, MD
David Krieger, MPA, NHA

South Carolina Board of Medical Examiners
Christopher C. Wright, MD
George S. Dilts, MD
Richard R. Howell, MD
Ronald Januchowski, DO

South Dakota Board of Medical & Osteopathic Examiners
Corey W. Brown
Jennifer K. May, MD
Richard G. Hainje

Tennessee Board of Medical Examiners
John W. Hale, Jr., MD
Phyllis E. Miller, MD
Robert Ellis

Utah Physicians & Surgeons Licensing Board
Craig Davis, MD
Rebecca H. Moore, MD

Vermont Board of Medical Practice
Ryan Sexton, MD

Virginia Board of Medicine
Jacob W. Miller, DO
James L. Jenkins, RN
Martha Wingfield

Washington Medical Quality Assurance Commission
Jimmy Chung, MD
Patrick Espana, JD

West Virginia Board of Medicine
Rev. Janet Harman
Russell O. Wooton
Timothy Donatelli, DPM
Victoria Mullins, PA-C

Wisconsin Medical Examining Board
Alaa Abd-Elsayed, MD
David Bryce, MD

Wyoming Board of Medicine
Thor Hallingbye, MD
Valerie Goen, PA-C

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

HOUSE OF DELEGATES ANNUAL BUSINESS MEETING
CHARLOTTE, NORTH CAROLINA
APRIL 28, 2018

Agenda Item	**Tab**
1. Call to Order, *2:00 pm* *Gregory B. Snyder, MD, DABR, Chair*	
2. Roll Call of Member Boards *Humayun J. Chaudhry, DO, MACP, President/CEO*	
3. Approval of Agenda *Gregory B. Snyder, MD, DABR, Chair*	
4. Introduction of Parliamentarian and Tellers *Gregory B. Snyder, MD, DABR, Chair*	
5. Welcome New Fellows, Affiliate Members and Official Observers *Humayun J. Chaudhry, DO, MACP, President/CEO*	
6. Report of the Rules Committee *Patricia A. King, MD, PhD, FACP, Chair-elect*	A
7. Consent Agenda *Gregory B. Snyder, MD, DABR, Chair*	B
8. Approval of Minutes of April 2017 Business Meeting *Gregory B. Snyder, MD, DABR, Chair*	C
9. Chair's Report of the Board of Directors *Gregory B. Snyder, MD, DABR, Chair*	D
10. Report of the President-CEO *Humayun J. Chaudhry, DO, MACP, President/CEO*	E
11. Report on the FSMB 2015-2020 Strategic Plan *Humayun J. Chaudhry, DO, MACP, President/CEO*	F

FEDERATION OF STATE MEDICAL BOARDS
2018 ANNUAL HOUSE OF DELEGATES MEETING

Report of the Rules Committee

Presented by: Patricia A. King, M.D., Chair
Saturday, April 28, 2018

Attendees
Patricia A. King, M.D., Chair
Lyle R. Kelsey, MBA, CAE, CMBE
Ernest Miller, Jr., D.O.
Katie Templeton, JD

Linda Gage-White, M.D., Parliamentarian

Humayun J. Chaudhry, D.O., President and CEO
Michael Dugan, MBA, Chief Information Officer and SVP, Operations
Eric Fish, JD, SVP, Legal Services
Patricia McCarty, Director, Leadership Services
Lisa A. Robin, MLA, Chief Advocacy Officer

Sandra McAllister, Executive Administrative Associate

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

Your Committee on Rules recommends 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 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.

I want to thank the committee participants.

Respectfully submitted,

Patricia A. King, M.D.,
Chair

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 Educational Commission for Foreign Medical Graduates (ECFMG)
5. Report on the National Board of Medical Examiners (NBME)
6. Report on the National Commission on Certification of Physician Assistants (NCCPA)

ITEM FOR ACTION:

APPROVE the Consent Agenda for the April 28, 2018 House of Delegates meeting.

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

MANAGEMENT NOTE:

Jon V. Thomas, MD, MBA, is the FSMB representative to the American Board of Medical Specialties.

Attachment 1 contains an overview of ABMS initiatives since its last report to the FSMB House of Delegates in April 2017.

Attachment 2 provides an overview of the ABMS and its relationship with FSMB.

ITEM FOR ACTION:

No action required; report is for information only.

Attachment 1

American Board of Medical Specialties
Higher standards. Better care.®

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

American Board of Medical Specialties
Report to the Federation of State Medical Boards
April 2018

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 April 2017.

ABMS Names Richard E. Hawkins, MD, New President and CEO

Richard E. Hawkins, MD, assumed the position of ABMS President and Chief Executive Officer on Jan. 1, 2018 replacing Lois Margaret Nora, MD, JD, MBA, whose tenure ended last December. Dr. Hawkins brings more than 35 years of professional expertise, ranging from his service in the United States Navy as an officer in the Medical Corps to leadership positions at the National Board of Medical Examiners and the American Medical Association (AMA). Prior to joining ABMS, Dr. Hawkins served as the Vice President of Medical Education Outcomes at the AMA. Read the press release.

Board of Directors Update

The ABMS Board of Directors (BOD) met three times since April 2017 and approved the following items:

- Request from the American Board of Psychiatry and Neurology for a subspecialty certificate name change from Psychosomatic Medicine to Consultation-Liaison Psychiatry.
- Request from the American Board of Neurological Surgery for two Focused Practice Designations, one in Pediatric Neurological Surgery and one in Central Nervous System Endovascular Surgery.
- Request from the American Board of Obstetrics and Gynecology for a Focused Practice Designation in Pediatric and Adolescent Gynecology.
- Request from the American Board of Pathology for two Focused Practice Designations, one in Clinical Chemistry and one in Clinical Microbiology.

At its June 2017 retreat and meeting in San Diego, the BOD elected new officers and members to its BOD. Anne-Marie Irani, MD, was elected ABMS Secretary-Treasurer. She has served as an ABMS Board Member since 2010, and was elected to serve on the Executive Committee in 2015. To read about the other Board members elected at the meeting, which includes six new and six re-elected At-Large members plus two new and two current Board members to serve on the Executive Committee, click here. Topics discussed during the Board Retreat sessions included advancing professional self-regulation and Board Certification during a time of transformation, and ABMS governance.

ABMS Launches Continuing Board Certification Initiative, Names Commission Members

In September 2017, ABMS and its 24 Member Boards announced the launch of the Continuing Board Certification: Vision for the Future initiative (Vision Initiative). This is a multi-stakeholder effort to vision a system of continuing Board Certification that is meaningful, relevant, and of value to physicians, while remaining responsive to the patients, hospitals, and others who expect that physician specialists are maintaining their knowledge and skills to provide quality specialty care.

A Planning Committee composed of representatives from organizations across the continuum of physician regulation was tasked with developing the Commission's charge and composition. In February the Committee announced the members of the Vision Initiative Commission (Commission). The Commission will be responsible for assessing the status of continuing Board Certification and making recommendations to help enable the current process to become a system that demonstrates the profession's commitment to professional self-regulation, offers a consistent and clear understanding of what continuing certification means, and establishes a meaningful, relevant, and valuable program that meets the highest standard of quality patient care. As part of its comprehensive assessment of the current continuing certification system, the Commission will obtain feedback from various stakeholders through multiple methods beginning with this survey that is open until April 30. For more information about or updates on the work of the Commission, or to participate in the survey, please visit www.visioninitiative.org.

ABMS, State Medical and Specialty Societies Meet to Discuss MOC

Representatives from ABMS, the Specialty Society CEO Consortium, and state medical societies met on Dec. 4, 2017 to discuss ABMS Member Board Maintenance of Certification (MOC) programs. The meeting's agenda focused on physicians concerns about MOC, what the Member Boards are doing to resolve these concerns, and how the three communities can work together to create a future continuing Board Certification program that is relevant and valuable to all stakeholders, especially to Board Certified physicians and the patients they serve.

State medical society leaders expressed a desire to have ongoing input in the development of continuing certification programs, a commitment to action and transparency from the Member Boards Community, and improved communication. In addition, they seek more consistency across the Boards' continuing Board Certification programs in order to truly establish best practices that also indicate the programs' contribution to improved patient care.

National and state specialty societies, which are important partners in the development of Board Certification programs, have expressed similar concerns, in particular about physician fear of lost livelihood if they fail to maintain their certificates. ABMS' policy is that Board Certification should never be a requirement for licensure, nor should it be the sole criterion for hospital and insurance privileging.

ABMS Member Boards are already responding to these concerns. The majority of Boards are shifting away from the 10-year, high-stakes exam in favor of online assessment pathways that are more convenient, relevant, and more consistent with how people learn today. Additionally, other organizations, including the Boards, are conducting research into the value and patient/practice impact of continuing certification that will serve to inform and identify best practices and process models. The recently launched Vision Initiative is another opportunity to engage practicing physicians to address these issues and help envision a continuing certification system that is meaningful, contemporary, and relevant.

The three communities expressed a commitment to collaborate in developing solutions that address physician concerns about MOC's relevance, burden and cost, while upholding the principles of professional self-regulation.

On Dec. 5, representatives from the ABMS Boards Community met with their partner medical specialty societies from the Council on Medical Specialty Societies to examine the MOC innovations being implemented by ABMS Member Boards and to discuss ways to scale those innovations deemed high value. Meeting participants also spent time visioning what a future continuing certification system should

achieve and what needs to change in order to realize that future vision. The results of both meetings will be shared with the Vision Commission.

Report on MOC Activities
ABMS Member Boards are implementing changes to make their MOC programs more convenient, supportive, relevant, and cost-effective. For example, more than half of the Boards are introducing alternatives to the 10-year high-stakes examination that allow physicians to conveniently access practice-relevant assessments where and when they want on their desktop, tablet, and even smartphone. These assessments are more frequent, less burdensome, and provide immediate, focused feedback and guidance to resources for further study. They also eliminate the need for preparation courses, travel to exam centers, and time away from practice.

Each Board has taken its own approach to MOC programmatic improvements, within the context of the Standards for the ABMS Program for Maintenance of Certification and based on its study of the validity and psychometric rigor of the assessment options as well as preferences expressed by their diplomates. In addition to instituting online assessments, other examples of improvements being implemented include:

- Modularizing the content of continuing certification exams so assessments can be tailored to reflect specific practice areas, giving physicians more flexibility and control over the scope and frequency of assessment.
- Simulating real-life application of knowledge and decision making by permitting the use of reference materials during the exam.
- Assuring that knowledge assessments help participating physicians identify gaps in knowledge and guide their learning as well as provide timely, actionable feedback;
- Incorporating journal articles into their educational and assessment processes to help physicians acquire the latest evidence to use in their clinical practice.
- Broadening the range of approved activities that meet the *Improvement in Medical Practice* (IMP) requirements including those offered at the physician's institution and/or individual practices in order to address physician concerns about the relevance, cost, and burden associated with fulfilling the IMP requirements.
- Working with specialty societies to leverage registry data in the design of quality improvement (QI) activities that are customizable to the diplomate's practice.
- Assuring opportunities for remediation of knowledge gaps by providing multiple opportunities for physicians to retake the exam.
- Developing online practice assessment protocols that allow physicians to assess patient care using evidence-based quality indicators.
- Partnering with specialty societies to design quality and performance improvement activities for diplomates with population-based clinical focus.
- Implementing processes for individual physicians to develop their own improvement exercises that address an issue important to them, using data from their own practices, built around the Plan-Do-Study-Act (PDSA) process.

In an effort to expand MOC's utility for physicians serving in research or executive roles, some Boards have begun to give IMP credit for getting manuscripts published, writing peer-reviewed reports, giving presentations, and serving in institutional roles that focus on QI (provided that an explicit PDSA process is used). Physicians who participate in QI projects resulting from morbidity and mortality conferences and laboratory accreditation processes resulting in the identification and resolution of quality and safety issues also can receive IMP credit from some Boards.

In addition to the enhancements being made by individual Boards, the entire Boards Community has:

- Initiated a major redesign of ABMS governance to increase Board accountability and provide an ongoing opportunity for participating physicians to directly impact ABMS programs and policy.
- Initiated the development of organizational standards to increase operational consistency, transparency, and effectiveness across the Boards.
- Launched the Vision Initiative to gather broad input about continuing certification from a wide range of stakeholders (especially physicians who spend most of their time in practice), consider alternatives, and make recommendations for the future.

Increasing Access to Practice-Relevant MOC Activities

As part of its commitment to improve access to relevant MOC activities, the ABMS Continuing Certification Directory™ (Directory)—the new and improved version of the MOC Directory—was launched in January. It was developed to help diplomates find quality continuing medical education (CME) activities approved for MOC by one or more Member Boards. The new Directory's updated search and navigation capabilities greatly improves the user experience for diplomates as well as offers CME providers access to additional continuing certification information and resources. During the past two years, the Directory has increased its inventory and now indexes 600-plus activities from more than 60 CME providers nationwide. Activities in this online repository reflect the latest best practices, evidence-based guidelines, and educational initiatives designed to support the development of high functioning physicians. Indexed MOC activities award credit from one or more of the following CME credit systems: *AMA PRA Category 1 Credit*™, AAFP Prescribed Credit, ACOG Cognates, and or AOA Category 1-A. Additionally, four Member Boards – the American Board of Anesthesiology, American Board of Internal Medicine, American Board of Pathology, and American Board of Pediatrics – are collaborating with the Accreditation Council for Continuing Medical Education to expand the number and diversity of accredited CME activities that meet the Boards' MOC requirements for *Lifelong Learning and Self-Assessment* (Part II).

New ABMS Board Certification Report Features Infographics, Video Highlights

The newly released 2016-2017 *ABMS Board Certification Report* features new infographics highlighting the Board Certification process, professional development, practice areas, and physician characteristics. The report can be downloaded for free from the ABMS website, where an accompanying video that highlights the report's findings is posted.

ABMS Conference 2018

ABMS Conference 2018 will be held Sept. 24-26 in Las Vegas. This multi-track conference offers health care professionals and leaders from ABMS Member Boards, hospitals and health systems, academic medical centers, specialty societies, and continuing professional development/CME communities the opportunity to learn about and accelerate the implementation of best practices in assessment and medical education, QI, health policy initiatives, and improved patient care through Board Certification.

For more information on any topics outlined in this report, please contact Ruth Carol at (312) 436-2675 or rcarol@abms.org.

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Attachment 2

American Board of Medical Specialties (ABMS)

Jon V. Thomas, MD, MBA — Minnesota, 2nd term, Exp. 4/18

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.

Effective January 1, 2012, ABMS adopted a Board Eligibility Policy, which established time limits for achieving Board Certification. The policy establishes a window of three years to seven years between completion of training and achievement of initial certification. The maximum time allowed is established by the individual Member Boards.

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 Member Boards support the professional development of their diplomates throughout their career by providing them a structured approach to improve the effectiveness, safety, and efficiency of their practices through focused assessment, learning, and improvement activities. 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 2014, ABMS and its Member Boards approved updated standards for the ABMS Program for MOC. In 2017, ABMS launched the Vision Initiative (http://www.visioninitiative.org/) to vision a system of continuing Board Certification.

ABMS also maintains a website (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
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 currently serving her 1st term which will expire in December 2018, and Dr. Zanolli is serving his first full term on the Board which will also expire in December 2018.

A report from the ACCME's March 2018 meeting is provided as **Attachment 1**. An overview of the ACCME and its relationship with the FSMB is provided under **Attachment 2**.

ITEM FOR ACTION:

No action required; report is for information only.

Attachment 1

FSMB HOUSE OF DELEGATES

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

As the FSMB's representative to the ACCME Board of Directors, I attended the Board of Directors meeting in Chicago, Illinois at the office of the ACCME on March 22-23, 2018. The following is a summary of the meeting:

The meeting was convened by the current Chairman, Bill Rayburn, MD, professor and associate dean of CME and CPD at University of New Mexico, and Vice Chair, Hal Jenson, MD, MBA, founding dean of Western Michigan School of Medicine. The ACCME's Executive Administration includes Graham McMahon MD, CEO and President, and Ms. Kate Regnier, MBA, Executive Vice President.

New ACCME Board Members
Dr. Rayburn introduced the five new ACCME board members for this meeting, who will serve three year terms. They are:

- Ron Ben-Ari MD, Keck School of Med at USC
- Marilane Bond MEd, MBA , Associate Dean at Emory University
- Sandhya Malhortra MD, Past President of Queens Co. Medical Society, NY
- Jeffrey Mallin MD, Kaiser Permanente Div. of Med Ed
- Lewis Nelson MD, Professor and Chair Department of Emergency Medicine at Rutgers University

Routine Business was undertaken by the BOD including reports from the standing committees and a report from the President.

Special Topics
There was review and formal adoption of the Strategic Plan of the ACCME an ongoing collective effort by the BOD and the past two meetings and refined by staff in preparation for this meeting.

Mission Statement – Because the mission statement is so important in helping to define an organization to those unfamiliar with its function, the mission statement was reserved as a special topic for this meeting. An array of various phrases and ideas were assembled prior to discussion to help focus the efforts and input from the Board members and staff leadership. One aspect of the discussion was the difference between a mission statement and vision statement(s). A helpful generalization was offered during the discussion. It was: What we do – related to the mission statement. Why we do it – more often is related to the vision of the organization. The refinement of the discussion and centering of the final statement will take place during the interval between our next board meeting.

Discussion Session
The Discussion Session is a regular segment of the ACCME BOD meetings. There is a designated topic of discussion and the ACCME benefits from discussion and exchange of ideas with leaders from other organizations. The broad topic for this meeting was: Professional Development and the Transformation of American Healthcare. The special guests were:

- Richard Hawkins, President and CEO of ABMS
- Helen Burstin, CEO of CMSS
- Adrienne White-Faines, CEO of AOA
- Kate Goodrich MD, Div. of Clinical Standards and Quality and CME for CMS

Three hours were dedicated to interaction between the BOD and the guests in various formats including open discussion and smaller break out groups.

Member Organizations Updates
A standard segment of the second day of the BOD meeting is to receive updates and interact with member organization liaisons. This is an engaging session of all board meetings with the ability to ask questions to the representatives of the founding member organizations of the ACCME. The FSMB is well represented by Kelly Alford who has been a valuable resource to the ACCME and a respected voice for the FSMB.

Respectfully submitted,

Michael Zanolli, MD

Attachment 2

Accreditation Council for Continuing Medical Education (ACCME)

Linda Gage-White, MD, PhD, MBA	Louisiana, 1st full term, Exp. 12/18
Michael D. Zanolli, MD	Tennessee-Medical, 1st term, Exp. 12/18

ACCME Accreditation Review Committee (ARC)

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

Bruce Brod, MD (PA State Board of Medicine)	1st term, Exp. 12/19
Crystal Gyiraszin	2nd term, Exp. 12/19
Paul J. Lambiase (New York OPM)	2nd term, Exp. 12/18

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. The ACCME's mission is the identification, development and promotion of standards for quality CME utilized by physicians in their maintenance of competence and incorporation of new knowledge to improve quality medical care for patients and their communities. 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 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

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

Last Updated March 26, 2018

TAB B: Report of the Accreditation Council for Graduate Medical Education (ACGME)

MANAGEMENT NOTE:

Martin Crane, MD, is the FSMB representative to the Accreditation Council for Graduate Medical Education.

Dr. Crane's report on the ACGME Board of Directors Plenary Session held on February 5, 2018 in Chicago, Illinois can be found behind **Attachment 1**. **Attachment 2** contains an overview of the ACGME and its relationship with the FSMB.

ITEM FOR ACTION:

No action required; report is for information only.

Attachment 1

FSMB HOUSE OF DELEGATES

Report of the FSMB Representative to the
ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION
(ACGME)

APRIL 2018

As the FSMB Observer to the ACGME Board of Directors, I attended the Board's Plenary Session in Chicago, Illinois on February 5, 2018. The following is a summary of that meeting.

Executive Committee
The Executive Committee discussed:

- The ACGME's Policies and Procedures
- Revisions to the organization's Bylaws
- Relationship between the ACGME and its Member Organizations
- A title change for the CEO to "President"

Governance Committee
The Governance Committee is reviewing the Board Evaluation Meeting Assessments and adjusting the meetings accordingly, along with whether the assessments could be completed online.

Committee on Requirements
The Committee on Requirements continues to propose requirements on: Obtaining Public Comments, Assessment by Reviewers, Conference Calls and Open/Closed Discussions of the Issues.

Other discussion points included:

- Transitional Year Requirements will be effective on July 1, 2018.
- Institutional Requirements will be brought in line with Section 6 of the Common Program Requirements on July 1, 2018.
- Major changes for Pediatric Surgery will take place on July 1, 2018.
- The requirements for the Subspecialty Reviews Program are being reviewed.
- Reviewing of Core and Subspecialties that look at non-physicians in particular roles.

The Committee also reviewed how the mistreatment of residents is looked at in the requirements and considered that issue to be well addressed.

Finance Committee
The Finance Committee reviewed preliminary reports which showed that the ACGME had a "strong performance for the year."

Investment Committee
The Investment Committee adjusted some of the organization's investments.

Council on Review Committee Residents
The Council on Review Committee Residents received funding from the ACGME for approximately 30 projects, which are listed on the ACGME website. The majority of the projects involve Internal Medicine, Pediatrics and Family Medicine. The Committee's "Back to Bedside" venture is still progressing. The Committee is also interested in integrating leadership and experience into residency training.

Audit Committee
The Audit Committee is reviewing the implementation of policies on "Whistleblowing."

Monitoring Committee
The Monitoring Committee reviewed the Q1 Plan for the Committee for Neurological Surgery. The Committee discussed:

- The need for public members on most Review Committees
- The following programs are no longer under "oversight": Advanced Heart Failure and Transplant Cardiology, Female Pelvic Surgery, Complex General Surgical Oncology, Emergency Medical Services, Colorectal and Neurosurgery
- Multiple Core programs – the Committee is reaching to the Program Requirements Committee to see if things are "in good shape."
- How the Committee will review all of the Review Committees in view of the Single Accreditation System (SAS).

Education Committee
The Education Committee is looking at "Broadcast" capabilities and studying a Scholars and Residents Program. Committee members will be surveyed on themes and specific topic sessions for the ACGME's Annual Education Conference, which will focus on outreach. The Committee discussed three different approaches to distance learning to reach more people: Institutional Videos, Regional Hub Models and Pursuing Excellence Initiatives.

Journal Oversight Committee
The Journal Oversight Committee discussed:

- Transitioning from four to six issues per year
- Reducing print copies and going online, which will reduce the cost significantly. With the

"Going Green" Initiative, subscribers would have to "opt in" for a printed copy. ACGME-I is now online only. There will be an international supplement for 2019 to commemorate the 10th anniversary of ACGME-I.

- How and when to report confidential information, i.e., "Editorial Risk"

Policy Committee

The Policy Committee will be looking at multiple dimensions with respect to policy issues, such as GME Funding and Accountability to the Public, Work Force Distribution, Board Certification and Maintenance of Certification with respect to Program Directors.

Council on Review Committee Chairs

The Council on Review Committee Chairs changed its meeting format to encourage more dialog. It discussed the Single Accreditation System and Independent Subspecialty Programs that were not necessarily connected to a Core Program. The Committee also discussed producing a Common Program Guide for Common Program Requirements and further professionalizing the roles of Program Directors.

Council on Public Members

The Council on Public Members voted to extend the terms of the Chair and Vice Chair. The Council is reviewing how to orientate public members, enhance their effectiveness and define their roles and responsibilities in Committees and in the ACGME as a whole.

Reports of Federal Government Representatives

Health Resources Administration

The HHS has a new Secretary, Alex Azar. Priorities for the HHS include continued focus on Opioids, Drug Pricing, Health Insurance and Availability, and Health Outcomes.

HRSA Fellowship Programs

"Champions" in Leadership and Teaching are being trained.

GME

Health care center teaching GME programs support 57 primary care residency programs currently funded through the end of March 2018. The current three-month funding periods lead to instability.

Children's Hospital GME Programs are moving forward with the Quality Bonus System.

There is a push for identifying where GME trainees go and what they do. This may involve using National Provider Identifier (NPI) number to look at demographics.

CEO Report

Dr. Thomas Nasca, ACGME CEO, reported that ACGME governance accepted the Bylaws Committee revisions to allow extension of terms of Board Members. This would allow for opportunities for more Board Members to assume leadership roles. Dr. Nasca was grateful that Member Organizations are participating on the "Well-Being" Program.

I will be available to clarify anything contained in my report or to answer any questions to the best of my ability. It should be noted that I only attend the Plenary Sessions and do not hear the in-depth background discussions that go into the Plenary Reports. Thank you again for the opportunity to serve the FSMB as its representative to the ACGME. It has been an honor and a privilege.

Respectfully submitted,

Martin Crane, M.D., FACOG

Attachment 2

Accreditation Council for Graduate Medical Education (ACGME)

Martin Crane, MD — Massachusetts, 2nd term, Exp. 4/18

The ACGME is responsible for the accreditation of postgraduate medical training 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 us of PGT programs that have been closed or are closing. To date, FSMB has obtained the resident records from 72 PGT programs that have closed and is the Agent of Record for those programs. Finally, FSMB encouraged ACGME to assure accreditation of combined training programs or to discontinue combining these programs. As a result, the ACGME is developing program requirements and a system for accrediting combined PGT programs. Internal Medicine/Pediatrics combined training programs are now accredited by ACGME. The combined programs can be viewed on the ACGME Web site.

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
Web site: www.acgme.org

Tab B: Report on the Educational Commission for Foreign Medical Graduates (ECFMG)

MANAGEMENT NOTE:

Pamela Blizzard, MBA (North Carolina) and Ram Krishna, MD (Arizona Medical) are the FSMB representatives serving on the Educational Commission for Foreign Medical Graduates (ECFMG) Board of Trustees.

The ECFMG's 2018 Annual Report to the FSMB is provided as **Attachment 1.**

Attachment 2 offers a narrative description of the ECFMG and its services as well as its relationship with the FSMB.

ITEM FOR ACTION:

For information only; no action required

Attachment 1

The Educational Commission for Foreign Medical Graduates Annual Report to the Federation of State Medical Boards

The Educational Commission for Foreign Medical Graduates (ECFMG®) evaluates the qualifications of international medical graduates (IMGs). ECFMG's program of certification serves as the foundation for additional ECFMG services that support the training and assessment of IMGs who come to the United States. It also has enabled ECFMG to extend its services to enhance medical education and the assessment of physicians worldwide. This report highlights major activities across ECFMG's programs during the past year.

Strategic Planning Process Initiated

ECFMG has initiated a strategic planning process that will drive an evolving vision for both ECFMG and its Foundation for Advancement of International Medical Education and Research (FAIMER®). Led by ECFMG's CEO in collaboration with the organizations' executive and senior leadership teams, this process has resulted in a proposed plan anchored by core strategic priorities that will enhance our services in support of physicians, medical educators, the medical regulatory community, researchers, and patients worldwide. We have identified four strategic priorities:

- Diversify Business Model
- Expand Scope and Depth
- Thought Leadership
- Advocacy

Initiatives to implement these priorities have been approved by the Board of Trustees, and should strengthen ECFMG's ability to move forward and continue fulfilling its mission of promoting quality health care for the public.

Immigration Developments

In December 2017, the U.S. Supreme Court cleared the way for enforcement of President Trump's September 2017 Presidential Proclamation, "Enhancing Vetting Capabilities and Processes for Detecting Attempted Entry into the United States by Terrorists or other Public-Safety Threats," including enforcement of visa restrictions. In light of this development, ECFMG communicated directly with training programs, current J-1 physicians, Match applicants, and Step 2 CS examinees to reiterate ECFMG's original guidance on the Proclamation. These communications are available on ECFMG's web page, Resources on Presidential Proclamation.

With respect to the September 2017 Proclamation:

- **Restrictions are more likely to apply to physicians seeking visas to enter the United States for interviews or to take USMLE Step 2 CS on B-1/B-2 visas.**
- **The "enhanced vetting" processes had no material impact on J-1 applicants entering U.S. GME in July 2017.** For physicians from the six countries (Iran, Libya, Somalia, Sudan, Syria, and Yemen) listed in the March 2017 Executive Order (EO) Travel Ban who matched and applied for ECFMG J-1 sponsorship, the "enhanced vetting" mandated by the EO did not seem to have a material impact on physicians seeking entry to the United States in J-1 status. July 2017 J-1 status arrival rates for physicians from these countries were similar to those in recent years.

- **The Proclamation, which replaced the EO Travel Ban, allows for visa options for many foreign nationals to enter GME.** The September 2017 Presidential Proclamation replaced the EO Travel Ban and allows for J-1 and for some an H-1B visa for physicians from Iran, Libya, Somalia, Venezuela, and Yemen. Only Syria, North Korea, and certain governmental officials from Venezuela are restricted from the issuance of a J-1 and H-1B visa. (See https://www.ecfmg.org/annc/presidential-proclamation/#dio1208).

ECFMG Commentary on Immigration Developments

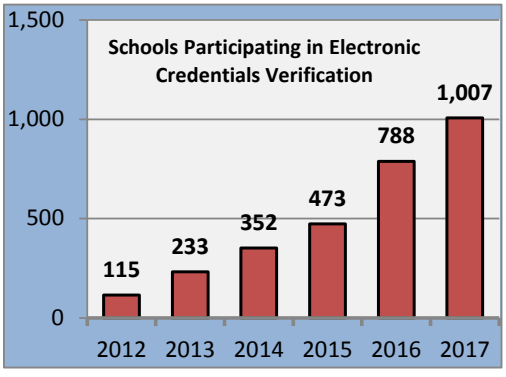
Dr. William W. Pinsky, MD, ECFMG's President & CEO, commented on "The Importance of International Medical Graduates in the United States" for the June 6, 2017 issue of the *Annals of Internal Medicine*.

Dr. Pinsky also was interviewed for the Association for Hospital Medical Education (AHME) publication, *AHME News.* He was asked to share his perspective on how recent immigration developments are affecting IMGs, U.S. graduate medical education, and U.S. health care. See "The Impact of Immigration Developments on U.S. Residency Recruitment and Health Care: A Perspective from the Educational Commission for Foreign Medical Graduates (ECFMG)" on page 3 of the Fall issue of *AHME News*.

Expansion of Primary-source Credential Verification Service

In 2017, ECFMG welcomed several new international medical regulatory authorities (MRAs) and organizations to its primary-source verification program called the Electronic Portfolio of International Credentials (EPIC℠). New medical regulatory authority clients include the Medical Council of New Zealand; the Sint Maarten Ministry of Education, Culture, Youth and Sports; and the Turks and Caicos Islands Hospital, InterHealth Canada. In early 2018, ECFMG began its collaboration with Doctors Without Borders/Médecins Sans Frontières (MSF) Canada to incorporate EPIC into its process for assessing the medical qualifications of internationally educated physicians who are applying to work with MSF Canada. In addition, we have initiated relationships and engaged in discussions with a number of other MRAs which may incorporate EPIC into their assessment processes.

Growth of Electronic Credentials Verification



ECFMG's electronic Credentials Verification enables medical schools to use the Internet to verify the authenticity of the medical education credentials they have issued to their students and graduates. Accessed through the ECFMG Medical School Web Portal (EMSWP), electronic Credentials Verification offers dramatic time-savings and greater efficiency compared to the traditional paper-based verification process by eliminating transit time and postal delays.
Security features ensure that only authorized medical school officials can verify credentials. By the end of 2017, there were more than 1,000 schools participating in Credentials Verification, an increase of 28% over 2016. Nearly 70% of credentials for ECFMG Certification are now verified electronically.

2023 Accreditation Requirement
ECFMG has continued working on the development of policies and procedures in connection with its 2023 Accreditation Requirement which states that physicians applying for ECFMG Certification must graduate from a medical school that has been appropriately accredited. The Board of Trustees has approved a plan to help guide us through the implementation of the accreditation requirement. We will begin to launch formal communications about 2023 to key constituencies.

An article about the evaluation and recognition of agencies that accredit medical education programs was authored by FAIMER Research Scientist Marta van Zanten. The article, titled "Recognition organisations that evaluate agencies accrediting medical education programmes: 'Quis custodiet ipsos custodes?'" was recently published on-line by the journal *Quality in Higher Education.*

The World Federation for Medical Education (WFME) has continued to evaluate accrediting agencies through its Recognition Programme. In 2017, recognition was granted to the Japan Accreditation Council for Medical Education (JACME). In early 2018, the Australian Medical Council (AMC) and the Independent Agency for Accreditation and Rating (IAAR), which operates in Kazakhstan, also were granted recognition, bringing to nine the number of accrediting agencies which have received WFME Recognition Status. A number of other agencies are presently working with WFME to obtain recognition.

Clinical Skills Evaluation Collaboration (CSEC) Step 2 CS Exam Administrations
In 2017, the Clinical Skills Evaluation Collaboration (CSEC) administered 34,876 exams, essentially unchanged from 2016. A collaboration of ECFMG and the National Board of Medical Examiners® (NBME®), CSEC has administered the Step 2 Clinical Skills (CS) component of the United States Medical Licensing Examination® since Step 2 CS was introduced in 2004. Through 2017, CSEC had administered more than 450,000 exams with nearly 5.4 million standardized patient encounters.

Expansion of GEMx$_{SM}$ Partnerships
ECFMG's program for global educational exchange in medicine and the health professions, GEMx, continues to welcome new partner institutions to its global network. Through 2017, nine institutions joined GEMx, bringing the total number of institutions to 48. Also, 79 student exchanges took place during 2017.

Throughout 2017, GEMx also supported five existing regional exchange networks in Africa and one in Latin America. These regional networks include a combined total of 34 institutions. By partnering with these networks, GEMx is striving to support their educational efforts by making elective exchanges more affordable and accessible to students in medicine and the health professions.

- End -

Attachment 2

Educational Commission for Foreign Medical Graduates (ECFMG)

Pamela Blizzard — North Carolina, 1st full term, Exp. 12/2021
Ram Krishna, MD — Arizona, 2nd full term, Exp. 12/2018

The ECFMG has the responsibility of evaluating qualifications of IMGs who seek entry into graduate medical education positions in the United States, and has an organizational commitment to promote excellence in international medical education. The ECFMG, through its program of certification, assesses the readiness of graduates of foreign medical schools to enter US residency or fellowship programs accredited by the ACGME. The purpose of ECFMG certification is to assure directors of ACGME-accredited residency and fellowship programs, and the people of the U.S., that graduates of foreign medical schools have met minimum standards of eligibility required to enter such programs. ECFMG certification is also an eligibility requirement for IMGs to take USMLE Step 3. Additionally, some state medical boards require graduates of medical education programs not approved by the Liaison Committee on Medical Education (LCME) to obtain ECFMG certification as a prerequisite for licensure to practice medicine.

The organizational members of the ECFMG are:

American Board of Medical Specialties	American Medical Association
Association of American Medical Colleges	Association for Hospital Medical Education
Federation of State Medical Boards	National Medical Association

The ECFMG participates in USMLE governance with three representatives on the Composite Committee. ECFMG is a partner with the NBME in administering the Step 2 Clinical Skills on behalf through the Clinical Skills Evaluation Collaboration (CSEC). CSEC maintains 5 regional testing sites. ECFMG is the registering entity for international medical graduates applying to take USMLE Steps 1 and 2.

FSMB and ECFMG work collegially to advance the missions of both organizations. FSMB collaborates with ECFMG on USMLE matters. The ECFMG collaborates with the Federation Credentials Verification Service (FCVS) to obtain primary source verification of medical school credentials for IMGs utilizing FCVS standards. The collaboration is part of an effort to ensure the quality and timeliness of verification processes for IMGs and to minimize duplication.

In fall 2010, ECFMG announced that effective in 2023, physicians applying for ECFMG certification must have graduated from an accredited medical school.

FSMB representative to the ECFMG, Dr. Ram Krishna, assumed the role of Chair, ECFMG Board of Trustees in December 2014. He completes his term as immediate past chair at the end of 2018.

Dr. William Pinsky assumed the role of ECFMG President/CEO in 2016.

The ECFMG is located at: 3624 Market Street, Philadelphia, PA, 19104-2685.
Phone: (215) 386-5900 Fax: (215) 386-9196
Email: info@ecfmg.org Web site: www.ecfmg.org
President and CEO: William Pinsky, MD Updated: February 2018

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

MANAGEMENT NOTE:

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

The report of the FSMB representatives to the NBME for the House of Delegates is provided as **Attachment 1.** An overview of the NBME and its relationship with the FSMB is provided under **Attachment 2**.

ITEM FOR ACTION:

For information only; no action required

Attachment 1

FSMB HOUSE OF DELEGATES

Report of the Representatives to the
NATIONAL BOARD OF MEDICAL EXAMINERS
April 2018

The Federation of State Medical Boards continues to enjoy a strong, collaborative relationship with the National Board of Medical Examiners (NBME). In addition to the following report, the FSMB House of Delegates should consult the 2017 NBME *Annual Report* which is available at www.nbme.org and contains updated information on many of the areas discussed below.

Leadership and Staff Changes

Dr. Peter J. Katsufrakis recently completed his first year as NBME president. Prior to his selection as president, Peter served as senior vice president of Assessment Programs at the NBME.

After more than a decade of service as a volunteer, **Dr. Michael Barone** joined the NBME as vice president of licensure programs. Mike oversees NBME's licensure programs such as USMLE and the Post-Licensure Assessment System (PLAS), which are collaborative programs with the FSMB, and the North American Veterinary Licensing Examination (in collaboration with the International Council for Veterinary Assessment).

Lisa Rawding, MBA, is NBME's new senior vice president for assessment programs, following a career as executive director of customer insights, strategy, and corporate marketing with the NEJM Group, publishers of the *New England Journal of Medicine*, and creators of many complementary continuing education and certification products. Lisa provides primary oversight for NBME's products and services, including domestic and international markets, licensure programs, among others.

United States Medical Licensing Examination® (USMLE®)

The USMLE is a three-step examination for medical licensure in the United States. Results of the USMLE are reported to medical licensing authorities in the United States for their use in granting the initial license to practice medicine. The USMLE is co-sponsored by the FSMB and the NBME. For the on-going delivery of USMLE, NBME has the primary responsibility for test development, scoring, reporting, and related research. Additional activities by NBME staff in the past year, done in conjunction with FSMB staff and USMLE committees, have included investigation of possible enhancements to the design of Step 1 and Step 2 Clinical Knowledge, the role of simulations in presenting physical findings in Step 2 Clinical Skills, and alternative approaches to providing examination results to examinees and schools.

As reported previously, the USMLE management function has shifted from what had been three separate Step committees to a single Management Committee. The Management Committee, which has been functioning for the last four years, is responsible for overall USMLE design and operations for all examinations, including changes in areas such as content, item formats, and

minimum passing standards. Members of the Management Committee are drawn from the academic, practice, and licensure communities.

Individuals who accept invitations to join USMLE test committees receive training in the development of USMLE-style test items and cases. Prior to their first committee meeting, these volunteers attend a two-day workshop at which they meet NBME staff and other new committee members, learn about issues related to content sampling, psychometric performance, and item difficulty and discrimination, and participate in a mock committee meeting during which test items they have written are discussed and edited. Members of the Step 3 Computer-based Case Simulation and the Step 2 CS committees attend a half-day of training and orientation prior to their first committee meeting. Every year, members of state medical licensing boards are invited to participate in a one-day workshop at the NBME headquarters to learn more about the program and the process of creating test materials. Usually one or more participants express an interest in joining test committees following this workshop. The USMLE is always interested in adding individuals with state licensure expertise to its pool of volunteers.

Services to Practicing Physicians

The Post-Licensure Assessment System (PLAS) is a joint activity of the FSMB and NBME. The PLAS was developed to assist medical licensing authorities in assessing physicians who have already been licensed. These include the Special Purpose Examination (SPEX®) and Resources for Clinical Competence Assessment.

In 2017, FSMB and NBME agreed to disband the prior governance and program committee structure for PLAS, and a new SPEX Oversight Committee (SOC) was formed. The SOC comprises four USMLE Composite Committee members and four USMLE Management Committee members, as SPEX exam design, standard setting and score reporting will benefit from closer linkage to USMLE operations. The Assessment Center Programs will be managed by PLAS staff. In April 2017, a pilot project was conducted that permitted a small number of individuals enrolled in the Physician Retraining and Re-entry program to sit for USMLE Step 2 CS.

Collaboration for Veterinary Assessments

The North American Veterinary Licensing Examination (NAVLE®), cosponsored and co-owned by the NBME and the International Council for Veterinary Assessment (ICVA), formerly the National Board of Veterinary Medical Examiners (NBVME), is a requirement for licensure to practice veterinary medicine in all licensing jurisdictions in North America. From 1998 until 2014, NAVLE development was governed by a series of contracts between the NBVME and the NBME. In February 2014, the NBVME entered into a collaborative relationship with the NBME with regard to the NAVLE. Since that time, the NAVLE has been overseen by the Collaboration for Veterinary Assessments (CVA) Governance Committee, comprising members appointed by the ICVA and the NBME. The purpose of the collaboration is to increase efficiency and facilitate NAVLE enhancements, drawing on the best of both organizations.

Services to Health Professions Organizations

The NBME has provided a wide variety of assessment services to healthcare organizations since the early 1960s, and the majority of NBME's client business is currently with the medical specialty boards and related medical societies. The NBME also provides testing services to a variety of other health professions for the purposes of licensure, certification, maintenance of certification, evaluation of special competence, and self-assessment. For most of these organizations, the NBME provides full services for multiple examinations.

Services to Medical Schools and Students

The NBME provides assessment services to medical schools and students through a number of programs. The NBME subject examination program includes the discipline-based basic and clinical science subject exams and the comprehensive basic science and clinical science exams. The NBME's web-based customized assessment services allow medical school faculty to create examinations tailored to local curriculum from a pool of test items covering topics commonly taught in basic science coursework. NBME's web-based self-assessments are designed for US and international medical students and graduates to highlight areas of strength and weakness in comprehensive basic science, comprehensive clinical science, and comprehensive clinical medicine.

The NBME's faculty services include item-writing workshops, and medical school liaison activities include the Advisory Committee for Medical School Programs.

Services to the International Community

The goal of the International Programs sub-unit 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. NBME approaches this goal in various ways – through NBME products such as subject examinations, self-assessments, and the International Foundations of Medicine program (IFOM); through the creation of exams tailored to specific schools' or countries' needs; through consulting services; and through other collaborations with international organizations. Recent international work includes:

- A collaboration with the Hospital Sirio Libanes in Sao Paulo, Brazil
- Meetings with the National Health and Family Planning Commission in China to discuss collaboration opportunities
- Workshops about standard setting, item development, the IFOM examinations and the USMLE with medical school representatives and regional assessment center representatives in Astana, Kazakhstan.
- Meetings with the Minister of Health of Kazakhstan to discuss NBME collaboration to develop quality assessments for healthcare professionals in Kazakhstan.
- Work with the Ministry of Health of Ukraine and the country's Testing Board to conduct the largest-ever administration of the Clinical Science Exam (CSE)
- IFOM CSE was used for the second year in Costa Rica as a nationwide internship selection exam and continues to be used in Panama for the same purpose.

Research and Discovery

To better fulfill its mission in the coming decades, NBME has been reviewing ways that it can advance and complement existing services, reach a broader global public, and leverage its capabilities as an assessment organization. That promise will be met through new ideas for assessment, in existing and new markets, both with traditional tests as well as novel assessments, and through high-quality research.

The NBME's research enterprise, broadly defined, underpins the NBME brand, reputation, current products, and future prospects. It comprises structures, processes, and individuals throughout the organization and connects with outside experts and institutions as colleagues and collaborators. This includes:

- Exploring influential and disruptive trends and technologies and their implications;
- Identifying needs and opportunities from our customers and stakeholders;
- Brainstorming opportunities for introducing novel assessment capabilities;
- Evaluating prospects for new products; and
- Prioritizing and driving a research agenda that strengthens the inferences made with existing products, contributes to knowledge in the field, and informs the most promising measurement opportunities that can serve stakeholders' needs.

Respectfully submitted,

Freda Bush, MD
Arthur Hengerer, MD
Ralph Loomis, MD
Cheryl Walker McGill, MD
Gregory Snyder, MD

Attachment 2

National Board of Medical Examiners (NBME)

Cheryl Walker-McGill, MD	North Carolina, 1st term, Exp. 3/21
Ralph Loomis, MD	North Carolina, 1st term, Exp. 3/21
Arthur Hengerer, MD	New York, 1st term, Exp. 3/21
Gregory Snyder, MD	Minnesota, 1st term, Exp. 3/21
Freda Bush, MD	Mississippi, 2nd term, Exp. 3/19

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. The NBME currently has five main strategic priorities as identified by their governance, several of which are being undertaken in concert with the FSMB: (1) the comprehensive review of the USMLE (CRU); (2) the Data Commons initiative; (3) maintenance of licensure (MOL); (4) international services; and (5) updating the organizations business architecture/infrastructure. NBME U co-hosted FSMB modules on medical regulation.

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
President/CEO: Peter Katsufrakis, MD

Updated: August 2017

TAB B: Report of 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.

Ms. Robinson's report can be found behind **Attachment 1**. **Attachment 2** provides an organizational summary of the NCCPA.

ITEM FOR ACTION:

No action required; report is for information only.

Attachment 1

Report of FSMB Representative to the
National Commission on Certification of Physician Assistants
Submitted March 2018

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.

Strategic Planning
During the November 2017 Board meeting, Board members finalized efforts in developing NCCPA's 5-year strategic plan. The Board of Directors confirmed the following vision statement and focus areas:

Vision: NCCPA is recognized as an innovative global leader in certification and recertification, promoting patient safety in the changing world of medicine. PAs, patients, and other stakeholders value certification. NCCPA is respected for its commitment to research and data-driven decision making.

Focus Areas: (1) product development and IT infrastructure, (2) value proposition, (3) international engagement, (4) research) and (5) environmental surveillance.

Update on Core Medical Knowledge and Alternative to PANRE Pilot
Work continues on efforts started in 2016 to identify the subset of the current PANRE content blueprint that represents core medical knowledge. Drawing on that extensive body of work, starting in 2019, the PA recertification exam (PANRE) will transition from the broad-based, general medical and surgical knowledge exam it is today – an exam based on analysis of the full breadth of PA practice – to a core medical knowledge exam focused on the essential foundational knowledge and cognitive skills all PAs should maintain, regardless of their area of practice.

In October 2017, NCCPA announced details of an alternative to PANRE, that we will pilot in 2019. This alternative approach to assessment is the culmination of more than two years of study and effort on the part of our Board and staff. It addresses many of the concerns we have heard from PAs about the time, cost and challenge of preparing for and taking today's PANRE. It also reflects our evolving technological capabilities, current trends in assessment and our responsibilities to those who rely on the PA-C credential.

The pilot will be conducted over two years (2019-2020), and participants will answer a set number of test questions each quarter, receiving immediate feedback on each question with additional educational information about the topic covered in that question. We hope this approach proves to be a less stressful, more impactful approach to gauging maintenance of knowledge over time.

Recertification assessments administered in 2019 for both the alternative to PANRE pilot and the secure PANRE will be based on a new core medical knowledge blueprint.

Two New Exam Blueprints — one for **initial certification (PANCE)** and one for **recertification (PANRE and the Alternative to PANRE Pilot)** — are now available for those certifying or recertifying beginning in 2019.

- PANCE will continue to cover broad general medical and surgical knowledge and skills deemed important for entry to PA practice. Changes include: slight modifications to the percentage allocations of the organ system categories; the renal diseases and disorders previously included in the genitourinary category have been moved to a separate renal category; and the portion of the exam that may be allocated to questions dealing with professional practice issues (formerly called legal and ethical) has been slightly increased.

- The new recertification (PANRE) content blueprint provides PAs with more granular information on which diseases and disorders will be included on the exams and to what level each disease and disorder will be tested, from recognizing signs and symptoms and referring the patient appropriately -- to making diagnosis and treatment plans with well-known comorbid conditions, standard contraindications, and standard complications. The content covered on the new blueprint is based on careful analysis of the feedback gathered through a multi-year initiative that was conducted in conjunction with PAs—with input from a profession-wide practice analysis, a profession-wide survey and multiple exam committee focus groups.

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 2017, NCCPA revoked certification in 43 cases and issued 53 letters of censure.

- The nccPA Health Foundation (www.nccpahealthfoundation.net) continues to pursue its mental health initiative. The Foundation also awarded dozens of grants in 2017 to support health equity and PA leadership.

- NCCPA continues to house and support the PA History Society (www.pahx.org) which celebrated its 15th anniversary in 2017. In celebration of the PA profession's 50th anniversary in 2017, the PA History Society honored U.S. Veterans and active duty PAs with the unveiling of a memorial garden at the Eugene A. Stead, Jr. Center for PAs 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) or NCCPA's president and CEO, Dawn Morton-Rias, Ed.D, PA-C (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 2018

Attachment 2

National Commission on Certification of Physician Assistants

Peggy Riley Robinson, MS, MHS, PA-C North Carolina, 1st 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). Work is underway to pilot an alternative to the PANRE that will allow eligible PAs to answer core medical knowledge questions over time, from any device. More than 123,000 PAs are certified today.

NCCPA is governed by a Board of Directors that includes PA 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
- American College of Physicians

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.

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).

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 Website: www.nccpa.net

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

DRAFT

MINUTES
Saturday, April 22, 2017
Fort Worth, TX

Call to Order

The annual business meeting of the House of Delegates was called to order at 2:04 p.m. on Saturday, April 22, 2017, at the Omni Fort Worth Hotel by FSMB chair Arthur S. Hengerer, M.D., FACS.

Roll Call

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

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

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

Agenda

The agenda of the April 22, 2017 House of Delegates annual business meeting was reviewed. No corrections to the agenda were noted.

ACTION: **APPROVED the agenda of the April 22, 2017 House of Delegates annual business meeting.**

Announcement of Parliamentarian and Tellers

Dr. Hengerer announced Linda Gage White, M.D. as parliamentarian. Mark Bowden, MPA, CMBE (Iowa Board of Medicine) and C. Grant La Farge, MD, FACP (New Mexico Medical Board) were appointed as tellers.

Welcome New Fellows, Courtesy Members, Affiliate Members and Official Observers

Dr. Chaudhry welcomed new FSMB Fellows, Courtesy Members, Affiliate Members and Official Observers in attendance.

Report of the Rules Committee

The House of Delegates was presented with the report of the Rules Committee, which met on Thursday, April 20, 2017 and was chaired by Gregory B. Snyder, MD, DABR. No changes were requested and the report was approved as presented.

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

Consent Agenda

The Consent Agenda was provided to the House of Delegates. No changes were noted and the Consent Agenda was approved as presented.

ACTION: **APPROVED the Consent Agenda.**

Minutes

Minutes of the April 30, 2016 House of Delegates annual business meeting were reviewed. No corrections to the minutes were noted.

ACTION: **APPROVED the minutes of the April 30, 2016 House of Delegates annual business meeting.**

Report of the FSMB Chair

Dr. Hengerer presented the Chair's Report highlighting the FSMB initiatives and programs during his year as chair of the FSMB board of directors. The board of directors were also recognized and Dr. Hengerer noted their hard work during the past year.

Report of the President

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

Report on the FSMB Strategic Plan

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

Treasurer's Report

Ralph C. Loomis, MD, FSMB Treasurer, provided the Treasurer's Report highlighting the activities of the Investment, Finance and Audit Committees this past year. The proposed FY 2018 budget was also discussed and presented for approval.

ACTION: **APPROVED the proposed FY 2018 FSMB budget as recommended.**

Report of the Reference Committee A

Marilyn J. Heine, MD, FACP, chair of the Reference Committee, presented the Committee's report. The Committee considered eight items of business being brought before the House of Delegates for action:

1. Report of the Bylaws Committee

The Bylaws Committee, chaired by Michael D. Zanolli, MD, met on December 15, 2016 and February 13, 2017 to consider the current Bylaws and proposed amendments thereto 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 included: Charles A. Castle, MD; Paul R. DeRensis, JD; Erich W. Garland, MD; Maroulla S. Gleaton, MD; and Joseph E. Fojtik, MD. Ex officio members included FSMB Chair Arthur S. Hengerer, MD; FSMB Chair-elect Gregory B. Snyder, MD; and FSMB President-CEO Humayun J. Chaudhry, DO.

The House of Delegates was asked to consider eight (8) proposed amendments to the Bylaws and one (1) proposed amendment to the Articles of Incorporation proposed by the Bylaws Committee.

PROPOSED BYLAWS AMENDMENT #1 is as follows:

Amend **Article II. Classes of Membership, Election and Membership Rights** as follows:

Section B. Fellows

An individual member who as a result of appointment ~~**holds full time membership on**~~ **or confirmation is designated to be a member of** a Member Medical Board shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of 36 months thereafter

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 ~~physician's~~ 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 Member~~s~~ **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.

The Chair of the 2017 Bylaws Committee presented the Bylaws Committee's recommendations and testified in favor of proposed Bylaws Amendment #1.

The Reference Committee heard no opposing testimony.

The Reference Committee recommended the House of Delegates ADOPT proposed Amendment #1 to the FSMB Bylaws.

ACTION: ADOPTED Amendment #1 to the FSMB Bylaws as recommended by the Reference Committee.

PROPOSED BYLAWS AMENDMENT #2 is as follows:

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

Section B. Nominations

1. The Nominating Committee shall submit a ~~**slate**~~ **roster** of one or more ~~**nominees**~~ **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 ~~**slate**~~ **roster** of candidates to Member Boards not fewer than 60 days prior to the Annual Meeting of the House of Delegates.

and

Amend **Article V. Nomination by Petition for Board of Directors and Nominating Committee** as follows:

Section A. Submission of a Petition

1. At the time the Nominating Committee's ~~**slate**~~ **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.

The Chair of the 2017 Bylaws Committee presented the Bylaws Committee's recommendations and testified in favor of proposed Bylaws Amendment #2.

The Reference Committee heard no opposing testimony.

The Reference Committee recommended the House of Delegates ADOPT proposed Amendment #2 to the FSMB Bylaws.

ACTION: ADOPTED Amendment #2 to the FSMB Bylaws as recommended by the Reference Committee.

PROPOSED BYLAWS AMENDMENT #3 is as follows:

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

Section D. Duties of the Board of Directors

6. The FSMB ~~**may**~~ **shall** indemnify Directors, Officers and other individuals acting on behalf of the FSMB~~**.**~~ **if S**such indemnification ~~**shall be subject to the approval of the Board of Directors and shall be**~~ **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.

The Chair of the 2017 Bylaws Committee presented the Bylaws Committee's recommendations and testified in favor of proposed Bylaws Amendment #3.

The Reference Committee heard no opposing testimony.

The Reference Committee recommended that the House of Delegates ADOPT proposed Amendment #3 to the FSMB Bylaws.

ACTION: As recommended by the Reference Committee, Amendment #3 to the FSMB Bylaws was ADOPTED.

PROPOSED BYLAWS AMENDMENT #4 is as follows:

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

Section F. Vacanc~~y~~**ies**

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 an individual shall be nominated and, if elected, shall serve for 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. ASSOCIATE MEMBERS: In the event of a vacancy of an Associate Member, the Board of Directors may appoint a substitute to complete the Associate Member's term in accordance with the policies established by the Board of Directors.

The Chair of the 2017 Bylaws Committee presented the Bylaws Committee's recommendations and testified in favor of proposed Bylaws Amendment #4.

The Reference Committee heard no opposing testimony.

The Reference Committee recommended the House of Delegates ADOPT proposed Amendment #4 to the FSMB Bylaws.

ACTION: ADOPTED Amendment #4 to the FSMB Bylaws as recommended by the Reference Committee.

PROPOSED BYLAWS AMENDMENT #5 is as follows:

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

Section G. Executive Committee of the Board

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**.

The Chair of the 2017 Bylaws Committee presented the Bylaws Committee's recommendations and testified in favor of proposed Bylaws Amendment #5.

The Reference Committee heard no opposing testimony.

The Reference Committee recommended that the House of Delegates ADOPT proposed Amendment #5 to the FSMB Bylaws.

ACTION: As recommended by the Reference Committee, Amendment #5 to the FSMB Bylaws was ADOPTED.

PROPOSED BYLAWS AMENDMENT #6 is as follows:

Amend **Article VIII. Standing and Special Committees** as follows:

Section H. Nominating Committee**~~: Process for Election~~**

1. **MEMBERSHIP:** The Nominating Committee shall be composed of **~~seven individuals,~~** 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 ~~non-physician~~ 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.** ***[moved from #4 with one change]***
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 Fellow at the time of the individual's election shall be eligible for election as a member of the Nominating Committee.** ***[moved from #6]*** 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.** ***[moved from #3]***
3. **~~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.~~** ***~~[moved to #2]~~***
4. **~~A member of the Nominating Committee may not serve consecutive terms. At least one elected member of the Nominating Committee shall be a non-physician. 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.~~** ***~~[moved to #1 with one change]~~***
5. **~~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. ~~for nomination by the Committee.~~**
6. **~~Only an individual who is a Fellow at the time of the individual's election shall be eligible for election as a member of the Nominating Committee.~~** ***~~[moved to #2]~~***

NOTE: The following is how Section H would read with all changes incorporated:

Section H. Nominating Committee

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 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.

The Chair of the 2017 Bylaws Committee presented the Bylaws Committee's recommendations and testified in favor of proposed Bylaws Amendment #6.

The Reference Committee heard no opposing testimony.

The Reference Committee recommended that the House of Delegates ADOPT proposed Amendment #6 to the FSMB Bylaws.

ACTION: ADOPTED Amendment #6 to the FSMB Bylaws as recommended by the Reference Committee.

PROPOSED BYLAWS AMENDMENT #7 is as follows:

Amend **Article XII. Disciplinary Action** as follows:

Section A. Member

For the purposes of this ~~Chapter~~ 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.

The Chair of the 2017 Bylaws Committee presented the Bylaws Committee's recommendations and testified in favor of proposed Bylaws Amendment #7.

The Reference Committee heard no opposing testimony.

The Reference Committee recommended the House of Delegates ADOPT proposed Amendment #7 to the FSMB Bylaws.

ACTION: ADOPTED Amendment #7 to the FSMB Bylaws as recommended by the Reference Committee.

PROPOSED BYLAWS AMENDMENT #8 is as follows:

Amend **Article XII. Disciplinary Action** as follows:

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, ~~such~~ the procedural protection ~~as satisfies the requirements of due process. All procedures shall be in accordance with~~ set forth in the Manual for Disciplinary Procedures, which is available from the FSMB upon the written request of any member.

The Chair of the 2017 Bylaws Committee presented the Bylaws Committee's recommendations and testified in favor of proposed Bylaws Amendment #8.

The Reference Committee heard no opposing testimony.

The Reference Committee recommended that the House of Delegates ADOPT proposed Amendment #8 to the FSMB Bylaws.

ACTION: As recommended by the Reference Committee, Amendment #8 was ADOPTED.

PROPOSED ARTICLES OF INCORPORATION AMENDMENT #1 is as follows:

Amend **Article V** as follows:

The corporation shall have members which will be classified as follows:

SEC. A. Medical Boards
SEC. B. Fellows
SEC. C. Honorary ~~**Members**~~ **Fellows**
SEC. D. Associate Members
SEC. E. ~~**Life Members**~~ **Courtesy Members**
SEC. F. Affiliate Member Boards

The Chair of the 2017 Bylaws Committee presented the Bylaws Committee's recommendations and testified in favor of proposed Articles of Incorporation Amendment #1.

The Reference Committee heard no opposing testimony.

The Reference Committee recommended the House of Delegates ADOPT proposed Amendment #1 to the FSMB Articles of Incorporation.

ACTION: ADOPTED Amendment #1 to the FSMB Articles of Incorporation as recommended by the Reference Committee.

2. Resolution 17-1: Mandatory Use of Prescription Drug Monitoring Programs

Resolution 17-1, offered by the Minnesota Board of Medical Practice, reads as follows:

Resolved, That the Federation of State Medical Boards (FSMB) will establish a task force to study PDMP use in the United States and its territories; and be it further

Resolved, That the FSMB task force will evaluate whether mandatory PDMP use positively impacts patient outcomes and prescribing practices; and

Resolved, That the FSMB task force will evaluate the feasibility of incorporating the PDMP into an electronic medical record system; and

Resolved, That the FSMB task force will develop recommendations regarding mandatory use of PDMP data by licensed prescribers and dispensers.

The Reference Committee heard testimony from a representative of the FSMB Board of Directors in support of Resolution 17-1 and its alignment with the FSMB's work with state medical boards in collaboration with Federal and State agencies, non-governmental organizations, and other stakeholders to develop recommendations on the mandatory use of prescription drug monitoring by prescribers and dispensers, and, as such, Resolution 17-1 should be adopted by the House of Delegates.

A representative from the Georgia Composite Medical Board testified in support of Resolution 17-1 and emphasized the timeliness and urgency of addressing PDMP usage and requested that the task force work expediently to accomplish its charge.

The American Society of Clinical Oncology (ASCO) also offered a letter in support of Resolution 17-1 and offered support to the FSMB as it considers this important issue.

The Reference Committee carefully considered the testimony it received and recommended that Resolution 17-1 be amended to include that the established task force report back to the House of Delegates at its 2018 Annual meeting. The resolution was amended as follows:

Resolved, That the Federation of State Medical Boards (FSMB) will establish a task force to study PDMP use in the United States and its territories; and be it further

Resolved, That the FSMB task force will evaluate whether mandatory PDMP use positively impacts patient outcomes and prescribing practices; and

Resolved, That the FSMB task force will evaluate the feasibility of incorporating the PDMP into an electronic medical record system; and

Resolved, That the FSMB task force will develop recommendations regarding mandatory use of PDMP data by licensed prescribers and dispensers ***and these recommendations will be presented at the FSMB 2018 annual meeting.***

The Reference Committee recommended that the House of Delegates ADOPT AS AMENDED the Resolution 17-1*: Mandatory Use of Prescription Drug Monitoring Program*

ACTION: As recommended by the Reference Committee, Resolution 17-1: *Mandatory Use of Prescription Drug Monitoring Program* was ADOPTED AS AMENDED.

3. Resolution 17-2: Advocacy for Professional Licensure of EMS Providers

Resolution 17-2, offered by the Montana Board of Medical Examiners, reads as follows:

Resolved, That the FSMB adopt a position supporting professional licensure of paramedics and other advanced life support EMS providers under the authority of state medical boards; and be it further

Resolved, That the FSMB coordinate and collaborate with individual state medical boards and other stakeholders to develop model statutory language for states to utilize in adopting a professional licensing process and standards for EMS providers.

A representative from the Montana Board of Medical Examiners testified in support of Resolution 17-2 as the scope EMS providers has expanded to include advance practices and technical procedures.

The Reference Committee heard testimony from a representative of the FSMB Board of Directors in opposition to Resolution 17-2 as the FSMB draft policy contained in BRD RPT 17-1: Report on Team Based Regulation, *Regulatory Strategies for Achieving Greater Cooperation and Collaboration Among Health Professional Boards* would apply and meet the intent of the resolution, and, as such, Resolution 17-2 should not be adopted by the House of Delegates. Further, the FSMB has not taken positions on which health professions should be under the purview of the medical board.

A representative from the Pennsylvania State Board of Medicine testified on his own behalf in support of referring Resolution 17-2 to an FSMB task force to further study how EMS providers are currently licensed or certified. He proposed that the matter may be better handled by individual states, rather than requiring an FSMB model policy.

The Reference Committee received a letter in opposition of Resolution 17-2 from the National Association of State Emergency Medical Services Officials articulating that agencies already exist with the statutory authority and responsibility to license EMS personnel at several levels (including paramedics).

The Reference Committee carefully considered the testimony it received and discussed the fluidity of emergency medical services and the volume of pending studies currently underway. Specifically, the Reference Committee was aware that the National Highway Traffic Safety

Administration had recently initiated a new project to revise the National EMS Scope of Practice Model, intended to promote consistency among the states and serve as a national foundation for EMS Practice.

The Reference Committee recommended that the House of Delegates REFER Resolution 17-2*: Advocacy for Profession Licensure of EMS* to the FSMB Board of Directors to study and examine this issue and make recommendations back to the House of Delegates in 2018 at its annual business meeting.

> **ACTION: As recommended by the Reference Committee, Resolution 17-2: *Advocacy for Profession Licensure of EMS* was REFERRED TO THE FSMB BOARD OF DIRECTORS FOR FURTHER STUDY AND REPORT BACK TO THE HOUSE OF DELEGATES IN 2018.**

4. <u>Resolution 17-3: Review of Model Guidelines for State Medical Boards Granting Licensure by Endorsement and Assessment of the Standards of ACGME – International</u>

Resolution 17-3, offered by the Pennsylvania State Board of Medicine, reads as follows:

> *Resolved, That the Federation of State Medical Boards perform a comprehensive review and update its model guidelines for licensure by endorsement; and be it further*
>
> *Resolved, That the Federation of State Medical Boards establish a workgroup to assess the standards of the Accreditation Council for Graduate Medical Education – International and whether they are recommended to be used by state medical boards to substantiate licensure by endorsement.*

The Reference Committee heard testimony from a representative from the Pennsylvania State Board of Medicine in support of Resolution 17-3 in an effort to address the lack of consistency among state medical board policies in this area. Currently, the Pennsylvania State Board of Medicine reviews licensure by endorsement requests on a case-by-case basis with an emphasis on postgraduate training, testing and practice experience of potential licensees. The Pennsylvania State Board of Medicine was seeking further guidance on licensure by endorsement of international medical graduates and information as to whether ACGME-I may impact the endorsement process.

A representative of the FSMB Board of Directors testified in opposition to Resolution 17-3 as written, as the intent of the resolution is already in the process of being met under existing FSMB policy initiatives. However, FSMB staff received questions from member boards regarding ACGME-I and therefore the FSMB Board of Directors requested the House of Delegates adopt a substitute resolution in lieu of Resolution 17-3 stating: The FSMB will work with ACGME-I to provide information to FSMB member boards on the status of programs that accredit graduate medical education outside the U.S. and Canada.

A representative from the Washington Medical Quality Assurance Commission testified in support of studying the issue as it is relevant to the Washington State Legislature and to many of the educational institutions and health care providers in their efforts to recruit competitive candidates.

A representative from the Wisconsin Medical Examining Board who serves as the Chair of the ACGME-I Review Committee for Surgical and Hospital Based Disciplines, testified as an individual that ACGME-I is not equivalent to ACGME due to cultural differences in meeting certain education program requirements.

The Reference Committee carefully considered the testimony it received. In recognition that licensure by endorsement is a well-established area of concern for medical boards and definitive recommendations and/or guidance have been requested, the Reference Committee recommended that Resolution 17-3: *Review of Model Guidelines for State Medical Boards Granting Licensure by Endorsement and Assessment of the Standards of ACGME – International* be adopted as written.

ACTION: As recommended by the Reference Committee, Resolution 17-3: *Review of Model Guidelines for State Medical Boards Granting Licensure by Endorsement and Assessment of the Standards of ACGME-International* was ADOPTED.

5. BRD RPT 17-1: Report of the Workgroup on Team-Based Regulation: *Regulatory Strategies for Achieving Greater Cooperation and Collaboration among Health Professional Boards*

The Workgroup on Team-Based Regulation, chaired by Ralph Loomis, MD, was convened in April 2015 by FSMB Chair J. Daniel Gifford, MD. The Workgroup was asked to identify best state-based practices and recommend regulatory strategies for achieving greater cooperation and collaboration among health professional boards in carrying out their shared responsibility to protect the public.

In completing its charge, the Workgroup met both remotely and in person over the course of 13 months. The Workgroup reviewed relevant laws, rules, and board policies, as well conducted an environmental scan and analysis of health care delivery models and methods that utilize interdisciplinary collaboration and team based-approaches to patient care, examined the defined roles and responsibilities of individual team members in such scenarios, and identified characteristics of a high functioning health care team.

The result of the Workgroup's work is *Regulatory Strategies for Achieving Greater Cooperation and Collaboration Among Health Professional Boards*. The draft model guidelines were distributed to state medical and osteopathic boards for comment in November 2016. Comments were considered and the report was finalized and submitted to the FSMB Board of Directors for approval in February 2017. The Board of Directors approved the *Regulatory Strategies for Achieving Greater Cooperation and Collaboration Among Health Professional Boards* and recommended that the recommendations in section four be adopted as policy by the House of Delegates, and the remainder of the report to be filed.

The Reference Committee heard testimony from a representative of the FSMB Board of Directors and Chair of the FSMB Workgroup Team-Based Regulation in support of Board Report 17-1.

The Reference Committee carefully considered the testimony it received.

The Reference Committee recommended that the House of Delegates ADOPT the recommendations contained in the report, *Regulatory Strategies for Achieving Greater Cooperation and Collaboration Among Health Professional Boards,* and the remainder of the report be filed.

ACTION: ADOPTED the recommendations contained in the report, *Regulatory Strategies for Achieving Greater Cooperation and Collaboration Among Health Professional Boards,* and the remainder of the report filed.

6. BRD RPT 17-2: Report of the Workgroup on FSMB's Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain: *FSMB Guidelines for the Chronic Use of Opioid Analgesics*

In April 2015, the FSMB House of Delegates adopted a resolution directing the FSMB to establish a workgroup to review the current science and revise the Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain. Accordingly, J. Daniel Gifford, MD, FACP, then FSMB Chair, appointed a workgroup comprised of a diverse group of medical and policy stakeholders that ranged from experts in pain medicine and addiction to government officials and other thought leaders.

To accomplish its charge, the Workgroup met on several occasions over the course of 12 months to examine and explore the key elements required to ensure FSMB's policy document remains relevant and is sufficiently comprehensive to serve as a prescribing guideline and resource for state medical and osteopathic boards and clinicians. The Workgroup conducted a thorough review and analysis of FSMB's 2013 policy document as well as other state and federal policies on the prescribing of opioids in the treatment of pain, including the March 2016 CDC Guideline for Prescribing Opioids for Chronic Pain.

The result of the Workgroup's work is the *FSMB Guidelines for the Chronic Use of Opioid Analgesics*, a policy document that includes relevant recommendations identified by the Workgroup, and is in keeping with recent releases of advisories issued by the CDC and FDA. A draft of the policy document was distributed to member boards and other key stakeholder organizations for comment in December 2016. Comments were considered and the report was finalized and submitted to the FSMB Board of Directors for approval in February 2017. The Board of Directors approved the *FSMB Guidelines for the Chronic Use of Opioid Analgesics* and recommends that the House of Delegates adopt the *FSMB Guidelines for the Chronic Use of Opioid Analgesics*, superseding the *FSMB Model Policy for Use of Opioid Analgesics in the Treatment of Chronic Pain (HOD 2013)*.

The Reference Committee heard testimony in support of BRD RPT 17-2 from a representative of the FSMB Board of Directors and Chair of the Workgroup on FSMB's Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain.

Reference Committee heard further testimony from the American Medical Association (AMA) in support of BRD RPT 17-2 with several suggested amendments.

The Reference Committee carefully considered the testimony it received and recommended that the model guidelines be adopted as amended as follows:

Recommendation A: Page 5, line 217-19: Tolerance is common in opioid treatment~~,~~ ~~**has been demonstrated following a single dose opioids,**~~ and is not the same as addiction.

Recommendation B: Page 8, lines 341-44: Treatment agreements outline the joint responsibilities of the clinician and patient, including the patient's agreement to periodic and unannounced drug testing for opioids and other medications when deemed appropriate by the clinician with potential for substance use disorder as well as ~~**permission to query the state's PDMP**~~ **discuss with the patient how and when the PDMP will be reviewed as part of the patient's care**.

Recommendation C: Page 9, lines 404-05: The concurrent use of benzodiazepines and opioids, recently added as a Black Box warning by the FDA, greatly increases the risk of adverse events including ~~**addiction and**~~ death.

Recommendation D: Page 10, lines 409-10: While there is clinical variation in response by patients to opioid therapy at any given dosage, the CDC and some states have ~~**set**~~ **recommended** specific dosing guidelines for opioids.

Recommendation E: Page 12, line 513: Evidence of misuse of prescribed opioids demands prompt ~~**intervention**~~ **evaluation** by the clinician . . . .

Recommendation F: Page 13, lines 560-61: Discontinuing or tapering of opioid therapy may be required for many reasons, and ideally, clinicians will have an end ~~**point**~~ **strategy** for patients receiving opioids at the outset of treatment.

Recommendation G: Page 15, lines 634-36: Opioids may be associated with substance use disorder~~**, chemical coping**~~ and other dysfunctional behavioral problems . . . .

The Reference Committee recommended the House of Delegates ADOPT AS AMENDED the *FSMB Guidelines for the Chronic Use of Opioid Analgesics*, superseding *FSMB Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain (HOD 2013)*

ACTION: As recommended by the Reference Committee, the *FSMB Guidelines for the Chronic Use of Opioid Analgesics* was ADOPTED AS AMENDED.

7. BRD RPT 17-3: Report on HOD Resolutions 15-1 and 15-2: Electronic Medical Records

In 2015, the FSMB House of Delegates combined Resolution 15-1: *Consistency in the Format of EMRs to Enhance Readability and Usability with Resolution* and 15-2: *Task Force to Study Access by Regulatory Boards to Electronic Medical Records*, and referred them to the FSMB Board of Directors to be studied and reported back to the HOD.

Resolution 15-1: *Consistency in the Format of EMRs to Enhance Readability and Usability*, offered by the Texas Medical Boards, states:

Resolved, That the Federation of State Medical Boards create a committee to consider recommended guidelines on electronic medical records that will provide an

understandable, longitudinal, patient centric, view of EMR data that will allow medical professionals to care for individual patients over time and for Medical Boards to oversee the process.

Resolution 15-2: *Task Force to Study Access by Regulatory Boards to Electronic Medical Records*, offered by the Minnesota Board of Medical Practice, states:

Resolved, That the Federation of State Medical Boards (FSMB) will establish a task force to review the format of an electronic medical records; and be it further
Resolved, That the FSMB task force will evaluate how information is entered into an electronic record and how information is compiled and released from an electronic format; and be it further

Resolved, That the FSMB task force will evaluate the feasibility of regulatory boards being allowed direct access to electronic medical records for the purpose of reviewing and downloading information necessary to a board process.

Following a comprehensive research study and analysis on the issue, and in considering the information contained in the report, the FSMB Board of Directors submitted this report for information only and did not offer specific recommendations.

The Reference Committee heard testimony from the FSMB Board of Directors, conveying that the FSMB will continue to seek opportunities to express the concerns of state medical boards related to the use of EMRs in both patient care and medical regulation. With the support of and coordination by the FSMB, state medical boards will continue to explore and share best practices as regards to the collection and maintenance of patient specific information to support their regulatory, investigative and adjudicative activities. A lack of clarity on the impact future health care policy will have on the access to and interpretation of EMR data would leave a newly formed task force or workgroup with little foundation with which to develop informed guidelines. Alternatively, the Board of Directors directed the FSMB Advocacy and Policy staff to maintain dialogue with the Administration, legislators and relevant stakeholders to express the concerns of state medical boards regarding access to and interpretation of EMRs in the investigation and adjudication process. Consequently, the FSMB Board of Directors approved BRD RPT 17-3 and recommended the report be filed for information.

ACTION: No action is required; report is for information only.

8. <u>BRD RPT 17-4: Interim Report of the Ethics and Professionalism Committee on Resolution 16-1 and BRD RPT 16-1(d): Physician Compounding</u>

This report summarized the FSMB's progress since April 2016 in addressing Resolution 16-1 and BRD RPT 16-1(d): *Physician Compounding*, submitted by the North Carolina Medical Board.

The interim report summarized the federal regulations that have been reviewed, the degree to which physicians are currently compounding medications, and the current state laws governing physician compounding. The report also details the partnerships FSMB has made with subject matter experts and outside organizations to study this issue. The FSMB Ethics and

Professionalism Committee also included questions in the 2016 FSMB Annual State Board Survey that relate to physician compounding in an office or clinic setting.

The FSMB continues to facilitate discussions with the U.S. Food and Drug Administration, Centers for Disease Control, United States Pharmacopeia, Government Accountability Office, National Association of Boards of Pharmacy, and Pew Charitable Trusts.

The Reference Committee heard testimony from the FSMB Board of Directors conveying that the FSMB will continue to seek opportunities to study physician compounding. While a great deal of progress has been made since April 2016, a final report or position statement on the compounding of medications by physicians would be premature in the absence of finalized federal guidance and standards from the FDA and USP. Consequently, the FSMB Board of Directors approved BRD RPT 17-4 and recommended the interim report be filed for information.

ACTION: No action was required; report was for information only.

Report of the Nominating Committee

J. Daniel Gifford, MD, FACP, Nominating Committee chair, presented the report of the Nominating Committee. Dr. Gifford read the roster of candidates.

Elections

Delegates were provided instructions on the wireless balloting process and the system was tested. Upon tally and verification of the votes by the tellers, the following individuals were declared to be duly elected:

Chair-elect:	**Patricia A. King, MD, PhD, FACP (2017-2018)**
Directors-at-Large:	**Jeffrey D. Carter, MD (2017-2020)**
	Jean L. Rexford (2017-2020)
	Kenneth B. Simons, MD (2017-2020)
Nominating Committee:	**Howard J. Falgout, MD (2017-2019)**
(by acclamation)	**Marilyn J. Heine, MD (2017-2019)**
	W. Michelle Terry, MD (2017-2019)

Concluding Remarks and Announcement of Future Annual Meeting Sites

Dr. Chaudhry thanked everyone in attendance and concluded the meeting by announcing the sites for the next two FSMB Annual Meetings: April 26-28, 2018 in Charlotte, North Carolina; and April 25-27, 2019 in Fort Worth, Texas.

Adjournment

There being no further business, the annual business meeting of the House of Delegates was adjourned at 3:32 pm.

Sandy McAllister
Pat McCarty
Recorders

CHAIR'S REPORT
APRIL 28, 2018
HOUSE OF DELEGATES

Dear delegates, friends and colleagues,

It has been my immense privilege and honor to serve as the 96th Chair of the Federation of State Medical Boards. Mostly, I cannot believe how quickly this year has flown by, but I do look back with a sense of pride and acknowledgement at the sheer volume of vital and meaningful work that we were able to accomplish in this short period of time. I will remain forever indebted and grateful to the incredible energy and support of my exemplary Board of Directors, vigilant Federation staff, guidance from our CEO and, most importantly, from the extreme effort and diligence that I was able to receive from each and every one of you who volunteered to participate in our multiple committees and workgroups. Frankly stated, it was *your* combined efforts that allowed us to achieve these meaningful goals.

This document will serve as my formal communication to the House of Delegates and as a summary of some of the past year's activities and outcomes that deserve to be highlighted. Additional information will be shared with you at the House of Delegates meeting via reports from the Board of Directors, as well as committees and workgroups that have all completed their tasks.

OPERATIONAL IMPROVEMENTS

Virtual Meetings

As I stood before you last year, I made several very specific commitments that I am pleased to say have been achieved. First, I was committed to update the way that the Federation's committees and workgroups communicated when not meeting in person. As you may recall during my Investiture speech, my 89-year-old father, Gerald Snyder (to whom I owe *EVERYTHING*) was able to be present virtually – in real time – by remote audio/video connection. This was a harbinger of great things to come within the FSMB. Embracing this technology, I am pleased to say that since our inaugural video conference call for the Nominating Committee under Dr. Art Hengerer's leadership last August, we have successfully held the majority of our telephone meetings using this new-to-us technology. Staff made a true commitment to finding the appropriate multi-platform technology and making this paradigm shift operational. I think that all of the participants agree that being able to interact visually as well as aurally has enhanced our remote meetings and I am hopeful that future Federation participants will continue to benefit from this approach.

New FSMB Website and Logo

Another commitment that I presented was my desire to enhance our digital presence. Last year, we collected user data and feedback to facilitate this change. I am pleased to announce that our Chief Information Officer, Michael Dugan, and his staff have completely re-vamped our website to allow for easier access and navigation, both on computers and handheld devices. This came with a logo revision and significant redesign of the website's formatting allowing for much easier access to relevant content. I am delighted at the work that has been done and encourage all of you to access it for your inspection and enjoyment.

Our online newsletter, *eNews,* under the guidance of Drew Carlson, continues to increase in its biweekly readership distribution and the number of people viewing the linked articles. Our Communications and Public Affairs expert, Joe Knickrehm, makes sure that the FSMB monitors all relevant social media venues and directs our participation on these platforms to ensure that our message is available in the right place at the right time.

ADVOCACY AND SUPPORT FOR STATE MEDICAL BOARDS

National Advocacy Headquarters

I discussed the desire to continue enhancing the influence of the Federation in both Washington, D.C. and throughout the nation. To that end, we have taken several bold steps. I am extremely pleased to announce that for the first time in Federation history, we have purchased a building in Washington, D.C. to serve as the National Advocacy Headquarters for the Federation and our state medical and osteopathic boards. As the lease on our current office space will expire soon, the Board of Directors reflected on the benefits of our D.C. presence. Realizing that our effectiveness as an organization in representing our member boards is greatly enhanced by our ability to participate in national discussions, inform lawmakers and influence policy, the Board agreed that our continued presence in D.C. is invaluable, and that it was appropriate to make arrangements for a permanent place of residence. I am confident that by the time of this year's Annual Meeting, specific requests we have made to optimize the property for our future use will have been approved by the D.C. zoning authorities. Establishing this advocacy headquarters in town sends a strong signal to those on the Hill that we are now a permanent fixture in DC, ready, willing and capable to advocate for patient safety through the state medical and osteopathic regulatory mechanism that has served our nation so well since its inception.

Regenerative & Stem Cell Therapy Practice

This approach is already proving to be successful as, for the first time in Federation history, we were approached by a U.S. Senator, Sen. Lamar Alexander (R-TN) (Chairman of the U.S. Senate Health, Education, Labor and Pensions Committee), for assistance in defining the appropriate regulatory guidelines for the use of stem cells in medicine. In response to his request, I convened our *Workgroup to Study Regenerative & Stem Cell Therapy Practice* (chaired by Board Member Dr. Scott Steingard), which took an in-depth look at this issue and provided the report that you will have for the House of Delegates' approval this year (BRD RPT 18-1). I am extremely proud of Dr. Steingard's efforts and the work that this group did in both answering Senator Alexander's concerns and being at the forefront of this evolving issue while providing guidance to our state medical and osteopathic boards.

Prescription Drug Monitoring Programs

Also new this year was the *Workgroup on Prescription Drug Monitoring Programs* (chaired by Board Member Dr. Anna Hayden) that I convened in response to the 2017 House of Delegates' adoption of Resolution 17-1, Mandatory Use of Prescription Drug Monitoring Programs (PDMPs) submitted by the Minnesota Board of Medical Practice. The workgroup was directed to 1) evaluate whether mandatory PDMP use positively impacts patient outcomes and prescribing practices; 2) evaluate the feasibility of incorporating the PDMP into an electronic medical record system; and 3) develop recommendations regarding mandatory use of PDMP data by licensed prescribers and dispensers. I commend Dr. Hayden for her excellent leadership of this group in their development of specific recommendations that are outlined in the report that will go before the House of Delegates (BRD RPT 18-2) and that may be used to provide guidance for state medical boards and other state agencies to maximize the effective use of PDMPs.

Physician Wellness and Burnout

In the midst of the multitude of issues affecting our Member Medical Boards, one that has been the focus of the FSMB's attention for the past two years is that of factors affecting physician well-being and resilience. Last year, then FSMB Chair Dr. Art Hengerer formed the *Workgroup on Physician Wellness and Burnout***.** As he reported in April 2017, during his career, he frequently observed situations that caused dysfunction and resulting burnout in many physicians, which were often denied or ignored due to the stigma or fear of adverse impact on their practices. "Physician burnout" has been publicized as affecting over 50% of the U.S. physicians and other health care providers with definite risks to public health. Dr. Hengerer made physician burnout his focus in order to draw attention to the impact the state medical boards play in this increasing problem. The workgroup he convened was charged with evaluating and making recommendations on how the FSMB could offer a means to improve wellness and decrease burnout with the physician population. The workgroup first met in December 2016 and has been receiving input from fourteen (14) different organizational experts. Most of the recommendations included in the workgroup's final report (BRD RPT 18-3) pertain to the licensing and license renewal processes of state medical boards. Underlying the importance of this issue, it is interesting to note that this report is the largest and most comprehensive report in FSMB history. A concurrent session on Physician Wellness and Burnout to discuss the recommendations of the workgroup will take place at this year's Annual Meeting

Dr. Hengerer continues to successfully represent the FSMB in this arena through his ongoing work with the National Academy of Medicine's (NAM's) Action Collaborative on Clinician Well-Being and Resilience. Launched in 2017, the Action Collaborative is a network of 55 organizations, including the FSMB, committed to reversing trends in clinician burnout, with the goals of raising the visibility of clinician burnout, improving the understanding of challenges to clinician well-being, and elevating evidence-based multidisciplinary solutions that will improve patient care by caring for the caregiver. Initial papers have been published and other projects completed, and a consensus statement on this issue is scheduled to be completed by 2020.

Potential Modification of FSMB Membership Class for Executive Directors

I am also happy to report that through the dedicated work of our Bylaws Committee, chaired by our Board Member Jerry Landau and informed extensively by Board Member Ian Marquand, we investigated a desire to allow the Federation to increase the ability to benefit from the wisdom and expertise of our state medical

and osteopathic board executive directors. These professionals work daily with (and have built their professional careers around) a commitment to patient safety; however, due to their current classification as Associate Members of the FSMB, there are several significant limitations to their collaboration on FSMB work products and position statements. After extensive deliberation and analysis of our sister organizations, we concluded that by modifying the membership class of the state board executive directors to Staff Fellows, we would be in a markedly improved position to directly benefit from their expertise, and at the same time, demonstrate the high regard in which we hold these professionals by elevating their status within our organization. I am hopeful and confident that our House of Delegates will embrace the logic and benefit in approving this historic change that will be presented to them for action in the Report of the Bylaws Committee.

FSMB Advisory Council of Board Executives

Illustrating the value and importance of the board executive directors, our Advisory Council of Board Executives was tasked with the laborious process of reviewing the *Essentials of a State Medical and Osteopathic Practice Act* and *Elements of a State Medical and Osteopathic Board,* and updating the documents for completeness and clarity. They ultimately decided that enhanced efficiency and reduced redundancy would be realized by combining the documents into our new, singular guidance document, the *Guidelines for the Structure and Function of a State Medical and Osteopathic Board.* I commend them on this fine piece of work.

Videoconference with Leadership of Member Boards Outside the Contiguous U.S.

On February 20th, I was joined by Board Members Jerry Landau and Dr. Ken Simons, along with CEO Dr. Hank Chaudhry, in a robust discussion via videoconference with the leadership of the FSMB Member Medical Boards located outside of the contiguous 48 states. This included Alaska, Guam, Hawaii, Northern Mariana Islands, Puerto Rico and the Virgin Islands. The purpose of the call was to discuss commonalities in the interests and concerns these boards may have as a result of the geographic distance separating them from the member boards within the contiguous states, and possible strategies the FSMB can use to address those topics. This was the first time that we convened as a unique group and this meeting allowed for a candid exchange of ideas, laying the foundation for several issues to be pursued in the future.

Interstate Medical Licensure Compact

The Interstate Medical Licensure Compact (IMLC) continues to be a very important endeavor for the FSMB with implications for all of us who support states' rights. To date, 23 states and territories have enacted the Compact and more than a thousand medical licenses have been issued through this alternative pathway. We continue to provide support when requested and collaborate with the IMLC Commission as it fulfills this important and novel role in license portability.

A Census of Actively Licensed Physicians in the United States, 2016

On a bi-annual basis, the Federation compiles the most accurate data available on the number of licensed physician throughout the United States (including some demographic data) and makes this information available to the public to help identify trends and inform policy decisions. 2016 data (released in 2017) represents the latest year in this effort, and due to the fine work of Dr. Aaron Young and his team, this information was presented early in 2017 to the regulatory community.

OTHER COMMITTEES AND WORKGROUPS

Workgroup on Education about Medical Regulation

FSMB Chair-elect Dr. Pat King is the chair of this workgroup that continues to develop a collection of video modules covering a variety of topics about medical regulation. The workgroup has completed three of the five planned modules, which are now available online to educate students and other interested parties. These videos include: 1) *The Role of State Medical Boards*, 2) *Understanding and Navigating the Medical Licensing Process*, and 3) *Medical Disciplinary Process*. To date, the modules have been very well received by the intended audience, and as the program has evolved additional topics are being considered for inclusion.

Workgroup on Board Education Service and Training (BEST)

FSMB Board Member Dr. Kenneth Simons is the chair of this workgroup, which was established to identify, study, develop and make available resources to support the roles and responsibilities associated with service on a state medical or osteopathic board. The goal is to assist our member boards with 'on-boarding' of new members by evaluating current best practices that can be shared and implemented by other states to improve and help standardize the regulatory process.

Ethics and Professionalism Committee

FSMB Board Member Dr. Claudette Dalton is the chair of this Committee whose major focus this year has been the issue of compounding of drug preparations, which gained attention several years ago following a series of serious incidents involving harm to patients from contaminated injectable compounded preparations. Congress responded to these incidents by enacting the Drug Quality and Security Act (DQSA) which addresses, among other issues, physician office-based compounding. The DQSA also clarifies and expands the powers and responsibilities of the U.S. Food and Drug Administration (FDA) which has since issued new guidance on compounding and is engaged in efforts to reconcile its definitions with those of the United States Pharmacopeia (USP), as the latter organization revises its compounding standards. After two years of careful study and several meetings with external stakeholders, the Committee agreed to delay a policy document pending final guidance from the FDA and USP and will draft a white paper, which will serve as an interim update to be distributed to our Member Medical Boards and posted on the FSMB website following the Annual Meeting.

STRATEGIC RELATIONSHIPS

Strengthening and expanding collaborative relationships with other organizations is one of the FSMB's strategic imperatives. It would be impossible to list here all of the organizations with whom we have important working relationships, so I will just highlight a few.

NBME, ECFMG Partnership

Two of the FSMB's closest partners are the National Board of Medical Examiners (NBME) and the Educational Commission for Foreign Medical Graduates (ECFMG), which are essential to the national system of testing and assessment for physicians. Working closely with our NBME colleagues, including NBME Chair Susanne Anderson and CEO Dr. Peter Katsufrakis, and our ECFMG colleagues, including ECFMG Chair Dr.

Ronald Blanck and CEO Dr. William Pinsky, we continue to look for ways to enhance each other through collaboration. The boards of our three organizations meet every several years and preparations are underway for our next meeting in 2019.

Tri-Regulator Collaborative

Twice yearly, the executives and board chairs of the organizations representing the three major parts of the health care team (Physicians, Nurses and Pharmacists) meet as a group known as the Tri-Regulator Collaborative to discuss topics of major importance to team-based care, and includes the FSMB, National Commission of State Boards of Nursing (NCSBN) and the National Association of Boards of Pharmacy (NABP). NCSBN President Katherine Thomas and CEO Dr. David Benton and NABP Chair Jeanne Waggener and Executive Director Carmen Catizone met with us on September 6 at the NABP headquarters in Chicago and on March 8 at the NCSBN Offices in Chicago. Additionally, the organizations hosted its 3rd invitation-only Tri-Regulator Symposium on July 25-26, also in Chicago. The alliance we have with these two prominent organizations has proved valuable for all involved by allowing us to become aware and understand the activities and concerns occurring in our particular fields of medicine.

TRAVEL

Over the course of my tenure as Chair, I have had the pleasure of representing the FSMB at meetings hosted by our state medical boards and external organizations, as well as meetings of various committees and workgroups. A few of the highlights include:

- May 8-9 – ASAE Exceptional Boards Workshop, Scottsdale, AZ
- June 10-11 – AMA House of Delegates and Annual Meeting, Chicago, IL
- June 24 – FSMB-NBOME Biennial Meeting, Chicago, IL
- June 25 – NBOME Liaison Committee, Chicago, IL
- July 29-August 1 – USMLE Management Committee Retreat, Annapolis, MD
- August 3-4 – Alaska State Medical Board Site Visit, Anchorage, AK
- August 21-25 – Association of Medical Councils of Africa (AMCOA), Stellenbosch, South Africa
- September 18 – Coalition for Physician Accountability, Washington, DC
- October 5-6 – IAMRA Symposium on Continued Competence, London, UK
- November 10-12 – Interim AMA House of Delegates, Honolulu, HI
- December 19 – UnitedHealth Group, Eden Prairie, MN
- March 22-23 – NBME Annual Meeting, Philadelphia, PA

SUMMARY

So as you can see from this lengthy report, we have been very busy this year promoting and enhancing issues relevant to medical regulation and our member boards. I cannot stress enough what an honor it has been to be allowed to represent this organization; one that I am sure will remain the pinnacle of my medical career.

As this document represents my final report as Chair, I would be remiss if I did not take a moment and

specifically thank and enter into the record many of the people who made this incredible year possible.

My current board members: Dr. Jeffrey Carter, Dr. Claudette Dalton, Ms. Kathleen Haley, Dr. Anna Hayden, Mr. Jerry Landau, Mr. Ian Marquand, Ms. Jean Rexford, Dr. Kenneth Simons, Dr. Scott Steingard, Dr. Cheryl Walker-McGill and Dr. Michael Zanolli. I thank each of you individually for your willingness to participate fully in the generative process of board governance and in the collegial environment of our meetings which allowed for thoughtful and sometimes spirited debate, but always with respect and a recognition of our common goals to create consensus and promote patient safety.

Past Chair Dr. Arthur Hengerer and Chair-Elect Dr. Patricia King, who always worked closely with me to ensure that the unbroken chain of leadership of the Federation continues to be as strong and vibrant as ever. Our camaraderie and support for one another formed the backbone of this most successful year.

Dr. Ralph Loomis, our treasurer, who not only continued to improve our Federation resources during his three-year term, but with the meticulous thoughtfulness of a neurosurgeon, was always available to provide careful contemplation and sage advice for me when difficult issues arose. His contribution to our organization in general and to me personally cannot be overstated. I will be forever grateful for your friendship and assistance.

CEO and President Dr. Humayun Chaudhry, who has become the welcome face of the Federation and continues to work collaboratively with all of our partners to enhance patient safety on a national and international level. We are indeed fortunate to have you at the helm. It has been a privilege to work with you this past year and all of our successes are in large part due to your exemplary skill, operational leadership and fabulous staffing decisions. Sandy McAllister (Dr. Chaudhry's executive administrative associate) did an outstanding job maintaining communication and coordinating our interdigitating schedules.

Ms. Lisa Robin and the Washington D.C. staff including Eric Fish, Shiri Hickman, John Bremer, Joe Knickrhem and Constance Moya for your tireless efforts and constant work.

Mr. Mark Staz for your multiple committees, responsibilities and commitments (and long commute).

The Texas C-suite staff including Michael Dugan, Todd Phillips and my hard rocking friend David Johnson for all of the innovations, hard work and continuous improvements that you three bring to the organization on a daily basis. Like the many Chairs before me, I have relied on you all every step of the way. You are simply the best.

Our unparalleled support staff including, but not limited to, Kelly Alfred, Drew Carlson, Deanne Dooley, Claudia Trejo, Kay Taylor and Dr. Aaron Young.

Finally, the Board's direct support staff without whom none of this would occur. I give my deepest and most sincere gratitude to Ms. Pamela Huffman and the unstoppable Ms. Patricia McCarty. Collectively you were my right and most of my left hand throughout this entire year. Every request, no matter how large or small,

was immediately filled or accomplished. Again, none of this would be possible without you. Thank you! Thank you! Thank you!

With the extensive time commitment to meetings, teleconferences and travel, the role of the chair can be quite demanding and has also required sacrifices from my family. I must acknowledge the constant support of my partner, Ms. Samnang Chhim and, of course, my three incredible and practically perfect-in-every-way children, Piper, Tavia and Grayson. You are my core and the reason why all of this is important. Thank you for allowing me all of the time away to pursue this opportunity. You three are incredibly intelligent and very good looking and I am proud to say that you take after your father!

In closing, I will reflect on what my colleague NBME President Suzanne Anderson said at the close of their recent annual meeting. NBME has a current initiative to address future development needs in a 12-year plan called NBME 2030. Ms. Anderson opined, “I don’t want to look 12 years into the future, I want to look 100 years into the future! I want to know what we do today will ensure that we remain a viable and meaningful organization long after people forget who we are.” What a wonderful sentiment and one that I can fully endorse! What we do today must not only be relevant to our current situation, but must be done with the foresight to be relevant well beyond our time here.

With our current trajectory, I am confident that the decisions that we have made this year will continue to propel us in the right direction into the future as we focus on our collective singular commitment to patient safety.

To commemorate this sentiment, in my travels I came upon a gavel fashioned from a piece of re-purposed roof timber that was an actual part of the White House from 1815 to 1927. I will leave this gavel as a gift from both myself and on behalf of the Minnesota Board of Medical Practice. It is my hope that this gavel will continue to be used to open and close our meetings, as I cannot think of a more fitting tribute to the durability of medical regulation and our organization (now 106 years old). This piece of wood is over 200 years old and was physically present in Washington D.C. during the advancement of allopathic and osteopathic medicine and the inception of medical regulation as we know it today.

I cannot think of a more fitting token with which to express my gratitude for the opportunities that I have been given by the House of Delegates, a token which will endure, along with our organization, long after people forget who we were.

Yours in Service,

Gregory B. Snyder, MD DABR

REPORT OF THE PRESIDENT-CEO
April 28, 2018
HOUSE OF DELEGATES

FROM THE CEO'S DESK

The fiscal year 2018, encompassing May 1, 2017 through April 30, 2018, has been the busiest year of my nine-year tenure as President and CEO of the FSMB. That is saying a lot, when you consider that my years of service thus far to the nation's state medical and osteopathic boards has included the FSMB's elaborate centennial celebrations in 2012, during which time I also had the honor and privilege to co-author, with Senior Vice President David Johnson, MA, a scholarly book about the history of medical licensure in the United States. What made this past year particularly busy and engaging? Let me count the ways.

Promotion and advocacy of the Interstate Medical Licensure Compact continued to grow by leaps and bounds this year, with 22 states and Guam having passed the statute into law and seven other jurisdictions poised to do so in 2018. The IMLC's Commission appointed an Executive Director, Marschall Smith, and worked diligently to help participating state medical and osteopathic boards – supplemented by monetary support from the FSMB, grants from the FSMB Foundation, and continuing federal grants from the Health Resources and Services Administration of the U.S. Department of Health and Human Services – implement the Compact and ease access to care concerns, in person and via telemedicine, while preserving state-based medical licensure across the land. More than a thousand medical licenses have been issued through this additional pathway for hundreds of interested and eligible physicians to practice medicine across the United States. The IMLC Commission has even started to facilitate medical licensure renewal for those physicians who obtained licenses from state medical boards under this pathway. The coming year will likely see more states and territories introduce legislative language in support of the Compact, more physicians licensed in more states, and the public directly benefitting from the facilitated licensure portability of physicians across a number of medical and surgical specialties.

Ever since the 2015 U.S. Supreme Court decision in North Carolina State Board of Dental Examiners versus Federal Trade Commission, we have been working diligently with state medical and osteopathic boards and our board of directors to play a leading role alongside state regulators in other professions to seek federal legislation to help offset some of the unintended consequences of that court decision. While every Supreme Court decision has a range of intended and unintended consequences, few imagined that one of the outcomes would be more than a score of lawsuits across the country by physicians and others against state medical boards, including those employed by them and the countless physicians, physician assistants, attorneys and public members who voluntarily serve on them, citing antitrust grounds and the 2015 decision. While the majority of those cases didn't go anywhere, nobody likes to see their name listed on a lawsuit and risk their livelihood and personal assets, which is actually what is at stake in jurisdictions where the state or territory does not automatically grant state-protected immunity

to the actions of individuals serving on state medical boards. This story is not over and after more than a year of diligent efforts, there may be some bipartisan federal legislation coming our way in the months ahead that addresses these concerns and protects patient safety and promotes public protection.

Perhaps the biggest series of activities this past year revolved around various FSMB Committees and Workgroups, including those established under the leadership of our tireless board chair, Gregory Snyder, MD. The FSMB's Advisory Council of Board Executives once again reviewed our policy documents that guide state and territorial medical practice acts, wisely deciding this year to consolidate our *Essentials* and *Elements* documents into one monograph, now known as the *Guide for the Structure and Function of a State Medical and Osteopathic Board*. Our pre-existing workgroup looking at best practices in medical regulation, aptly named the Board Education, Service and Training (BEST) Workgroup, continued its efforts under FSMB board member Kenneth Simons, MD. So did the Workgroup for Education on Medical Regulation, chaired by FSMB Chair-Elect Pat King, MD, PhD, which has successfully developed several important online educational modules for medical students, residents and practicing physicians about the value and meaning of a medical license and state-based medical regulation.

Our Ethics and Professionalism Committee, under the capable leadership of board member Claudette Dalton, MD, continued to diligently and thoughtfully study the compounding of medications and planted seeds for future discussions on a wide range of topics, including the physician's duty to report and the ethics of concurrent surgeries. The FSMB's Editorial Committee continued to provide masterful guidance and oversight of the premier journal for state-based medical regulation in the United States, the Journal of Medical Regulation, and is actively pursuing indexing of with the National Library of Medicine's MEDLINE database. Other advisory councils supported the USMLE program, a partnership between the FSMB and the National Board of Medical Examiners (NBME), with input provided not only by state medical boards members served by the examination but also by medical students and residents through a new advisory panel that had its first meeting at our offices in Euless, Texas. The FSMB and NBME co-hosted the 11th Annual USMLE Orientation for current and former members of state medical boards to identify individuals interesting in participating in the program.

The FSMB's Workgroup on Physician Wellness and Burnout, chaired by FSMB Immediate Past Chair Art Hengerer, MD, completed two years of thoughtful discussions and deliberations to create what is now the largest series of recommendations the FSMB has ever issued through a workgroup on any one topic. Physician safety and health, as the report points out, is also a patient safety issue. The Workgroup's many recommendations include suggestions for better compliance by state medical and osteopathic boards with federal laws, including updates to the Americans with Disability Act, and recommendations for the education and training of physicians across the entire continuum of medical education and into practice. The FSMB was also delighted to partner with the prestigious National Academy of Medicine, created by an Act of Congress under the administration of President Abraham Lincoln, to develop an action collaborative on the issue, which will soon be entering its third year of insightful deliberations

Dr. Snyder, with the support of the FSMB's board of directors, created a timely workgroup devoted to studying the nation's prescription drug monitoring programs and mitigating against the nation's prescription opioid epidemic, which was ably chaired by board member Anna

Hayden, DO. Dr. Snyder also created a workgroup looking at regenerative medicine and stem cell therapy practices, which was ably chaired by FSMB board member Scott Steingard, DO. The latter workgroup was created specifically in response to a request to the FSMB from the offices of U.S. Senator Lamar Alexander (R-TN), signaling the very first time that a Member of Congress has asked the FSMB to study an issue on behalf of the nation.

The FSMB, this year more than ever before, has ramped up its use of social media, communications and messaging. Our FSMB Spotlight now showcases online video interviews with newsmakers in medical regulation. Our eNews and Advocacy Alert E-Newsletter serve growing audiences. Joe Knickrehm, who was promoted to FSMB's Director of Communications and Public Affairs, has done a masterful job in seeking opportunities to help the FSMB share the views and concerns of state medical and osteopathic boards to members of the media and to various branches of the federal and state governments with whom we interact on behalf of our member boards. The USMLE program also hired Shana Griffith as our social media specialist and she is based at our Washington, DC office.

For those members of our state medical and osteopathic boards who may have visited our Euless, Texas offices recently, you might not have recognized the offices after you entered our doors. This is because of a carefully considered and deliberative effort that has been underway for a few years and is now bearing fruit in terms of substantive changes to how office space is structured to support the functions of our organization. The biggest addition of late has been the creation of an auditorium space in Euless by which the FSMB's employees can all meet in one location for "All Staff Meetings" and which can also be used for various meetings that would otherwise take place in a nearby hotel at a much greater expense. The USMLE's Composite Committee, which is a large committee with members and staff representing the FSMB, NBME and Educational Commission for Foreign Medical Graduates (ECFMG), had a very successful meeting in this space a few months ago. A small space for the use of physical fitness equipment in Euless also should be made available soon, supporting the organization's efforts to promote the health and well-being of our employees. Additional renovations, both structural and functional, are planned for the near future.

Recognizing that the lease on our office space in Washington, DC, was set to expire in a couple of years, the FSMB's board of directors – with Dr. Snyder's strong support – decided to purchase a property near our current office that should serve the needs of both the organization and our member boards for years to come. The FSMB's presence in Washington, DC on behalf of our member boards formally began in January of 2010, just a few months after I joined the organization as President and CEO, and since that time we have grown in size, activity and advocacy of the value and need for state-based medical regulation. By the time of the FSMB's annual meeting in Charlotte, North Carolina, we should have a better idea about whether certain requests we have made to optimize the property for our future use have been approved by the zoning authorities for the District of Columbia.

In other developments, the FSMB launched a new website and new logo, which was approved by the FSMB's board of directors. Such changes from time to time are a best practice among dynamic organizations like ours and enable us to stay fresh and current as we meet the current and future needs of our member boards. We also improved efficiencies and customer satisfaction for many of our services, especially our *Federation Credentials Verification Service (FCVS)* and our *Physician Data Center (PDC)*. Our FCVS 3.0 initiative has led to substantial improvements

in how the service, which has produced more than 530,000 physician profiles since the program's inception in 1996, continues to meet the needs of physician and physician assistants, as well as state and territorial medical and osteopathic boards. Our growing research department complied data for our 2017 Census of Actively Licensed Physicians in the United States, a biennial effort that generates a critically important document that is distributed to all Members of Congress and is now quoted very frequently in the news and in discussions about the nation's physician workforce. Our *Uniform Application for Medical Licensure (UA)* has now been adopted by 27 states boards and more than 101,000 physicians have submitted their applications for licensure using the UA. We have now also expanded the UA to incorporate the medical licensure of physician assistant, an effort that is currently in place in Oklahoma with more states planned in the future.

This year has been busier for several staff at the FSMB, as well, in part because of my role as Chair of the International Association of Medical Regulatory Authorities (IAMRA), which ends formally in October 2018. I will then resume my peripatetic duties as permanent Secretary of IAMRA, a position that the FSMB President and CEO has held since the organization's establishment in 2000. I am thankful that the FSMB's board of directors formally approved and supported by involvement with IAMRA as Chair in 2016 and I have been delighted to serve in this leadership role during the last two years or so, which has enabled me to better appreciate the many strengths of what we do in the United States at our member boards and to better understand the opportunities afforded by innovations in medical regulation that are being talked about or implemented at medical regulatory authorities around the world. One such exciting opportunity is likely to be generated through the efforts of IAMRA's Physician Information Exchange (PIE) Workgroup, currently chaired by Heidi Oetter, MD, of British Columbia, Canada, which has empowered the medical regulators of the United States, the United Kingdom and Australia to work together on the technical and policy end to consider a practical and cost-free means by which the world's medical regulators may be able to share, consistent with each country's laws and regulations, critical disciplinary information about physicians who may pose a risk to the general public. The Medical Board of California is a valued member of this effort, which is now in a pilot phase, and the FSMB hopes that more state medical and osteopathic boards will consider joining IAMRA as members and as contributors of their wisdom, experience and expertise. IAMRA has grown by leaps and bounds in recent years, I am happy to report, and now represents more than 108 organizations from 48 countries around the world.

The FSMB continues to play a leadership role in the Coalition for Physician Accountability, which was formally established in 2011 following years of discussions and meetings hosted by the FSMB, beginning in 2005. I am delighted to serve on the Coalition's Management Committee, where we have supported discussions within the house of medicine related to professional self-regulation. We also continue to work with our Tri-Regulator Collaborative partners, the National Council of State Boards of Nursing and the National Association of Boards of Pharmacy, with whom we are planning a Fourth Tri-Regulator Symposium in 2019 for state-based regulators in medicine, nursing and pharmacy. Previous meetings have generated wonderful conversations about the value and meaning of licensure and discipline, including team-based regulation. I am also delighted to serve as a non-voting member of the FSMB Foundation under its President, FSMB Past Chair Janelle Rhyne, MD. The FSMB Foundation has matured and grown in recent years, giving out research and project grants to support licensure portability and, more recently, physician wellness and resilience.

I am grateful for the outstanding staff at the FSMB who make all our efforts on behalf of state medical and osteopathic boards possible in the first place. I would particularly like to recognize our senior staff in Euless and in Washington, DC: Lisa Robin, MLA, Chief Advocacy Officer; David Johnson, MA, Senior Vice President for Assessment Services; Todd Philips, MBA, Chief Financial Officer; Michael Dugan, MBA, Chief Information Officer and SVP for Operations; and Eric Fish, JD, Senior VP for Legal Services. I am also grateful for the efforts of our growing cadre of Assistant Vice Presidents: Aaron Young, PhD, AVP for Research and Data Integration, Frances Cain, MPA, AVP for Assessment Services, and Cyndi Streun, MS, AVP for Information Services. I am also grateful to Sandy McAllister, my Executive Administrative Associate, for all her diligent and consistent support behind the scenes of all my activities, domestic and international; to Patricia McCarty, Director of Leadership Services, for her thoughtful and exceptional diligence on behalf of our board of directors; and to Roxanne Huff, IAMRA's Operation Officer and *diplomat extraordinaire*, who also functions part-time as Executive Administrative Associate for Mr. Johnson.

Finally, I am very thankful and grateful to the FSMB's board of directors, as a whole, and to Dr. Snyder, in particular, for their gracious understand and support, and for their wise guidance and recommendations that, in my view, have masterfully guided the efforts of our organization on behalf of our state medical and osteopathic boards. Ultimately, that enables us to better support our member boards and their mission to protect the public, promote patient safety and assure quality health care. We look forward to working with FSMB Chair-Elect Patricia King, MD, PhD, and the board of directors in place for 2018-19, in the year ahead!

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 antitrust liability, Veteran's Administration, Interstate Medical Licensure Compact, patient safety, telemedicine, and the opioid epidemic.

The FSMB works directly with 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.

Professional Licensing Coalition: The FSMB launched and served as a founding member of the Professional Licensing Coalition (PLC), comprised of approximately a dozen organizations representing state occupational and licensing boards. The PLC is advocating in Congress for the introduction and enactment of federal legislation that would eliminate the potential for antitrust damage liability against state boards, their members, and employees for conduct within the scope of their official duties. The legislation also seeks to protect persons acting at the direction of state medical boards, while permitting injunctive relief by government enforcers and private parties. 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 2018, Twenty-three (23) states have enacted the compact, while the IMLC has been introduced for the 2018 Legislative Session in the District of Columbia, Georgia, Indiana, Maryland, Michigan, New York, Rhode Island, and Vermont. FSMB staff has supported state legislative efforts by submitting written testimony, assisting boards with testimony, and coordinating technical and legal assistance.

In June 2016, the FSMB was awarded a three 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 Commission in implementing the administrative and technical infrastructure necessary to fully operationalize the IMLC. The grant also supports outreach activities toward the goal of expanding the number of participating states. The FSMB continues to be engaged with HRSA to provide status reports on the project.

Congressional Activity: The FSMB Board of Directors hosted its annual Capitol Hill Advocacy Day in February 2018, meeting with the offices of more than 40 members of the U.S. House of Representatives and U.S. Senate.

The FSMB successfully advocated for modifying *The Comprehensive Addiction and Recovery Act* to include "State Medical Boards" as representatives to an inter-agency task force to review, modify, and update best practices for pain management and prescribing pain medication.

The FSMB led the effort that successfully ensured the removal of a controversial provision within *The National Defense Authorization Act (NDAA*) that would have, for the purposes of reimbursement, licensure, and professional liability, redefined the practice of medicine as occurring at the location of the provider, rather than the patient for services provided via telehealth to TRI-CARE beneficiaries.

In November 2017, FSMB President and CEO, Humayun Chaudhry, DO, MACP, testified before the House Committee on Veterans Affairs Subcommittee on Oversight and Investigations, on the issue of "Examining VA's Failure to Address Provider Quality and Safety Concerns." Based on conversations with several member boards, Dr. Chaudhry testified that the VA does not always alert state boards in a timely fashion about violations, disciplinary actions, or suspected violations of a state's Medical Practice Act. He stressed that the primary mission of every state medical board is public protection, and it is imperative that boards are provided with disciplinary

information so that they can carry out their critically important work. In response to the GAO report and testimony before the committee, the VA is in the process of rewriting and updating its policies and taking at least three major steps to improve clinical competency and reporting. These steps include reporting more clinical occupations (beyond medicine) to the NPDB, improving the timeliness of reporting, and enhancing oversight to ensure that no settlement agreements wave VA's ability to report to NPDB and state medical boards.

Collaborating with the Administration and Congress: The FSMB regularly collaborates with Administration officials to support the work of state medical boards, including: the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC), Federal Trade Commission, Office of the National Coordinator for Health Information Technology (ONC), Food and Drug Administration (FDA), Substance Abuse and Mental Health Services Administration (SAMHSA), Office of National Drug Control Policy (ONDCP), Department of Defense, and Drug Enforcement Administration (DEA).

At the request of Senator Lamar Alexander (R-TN), the FSMB addressed best practices for state medical boards in the regulation of stem cell clinics, particularly as related to promotion and communication practices. The FSMB has also included representatives from the CDC and FDA as subject matter experts on this year's workgroup on Prescription Drug Monitoring Programs.

FSMB Advocacy Network: The FSMB Advocacy Network has approximately 200 participants and efforts to grow the Network are being explored. Its e-newsletter is distributed regularly by the FSMB's Washington D.C. Office and provides updates on pertinent federal and state legislative and regulatory activity of interest to state medical and osteopathic boards and includes a "call to action," requesting targeted advocacy efforts of state medical board participants when necessary.

State Legislative and Regulatory Activity: The FSMB assists its member boards in achieving their legislative priorities. In doing so, 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 2017, the FSMB monitored more than 4,000 legislative bills, including 1,510 related to pain management, opioid abuse and prevention, and controlled substances. Additionally, 489 related to state health-professional licensing/disciplinary boards, including board investigations, board composition and oversight, reporting requirements, and funding. Furthermore, 1,446 related to physician scope of practice and 205 related to telemedicine. The FSMB also submitted official letters and testimony in response to legislation in Michigan, Texas, and the District of Columbia.

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 2017 included:

Continuing Medical Education; Criminal Background Checks; Medical Marijuana; Office Based Surgery; Pain Management; Physician Profiling; Standard of Proof; 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 updating the FSMB's companion documents that provide state medical and boards a useful blueprint for their structure and function as stated in their medical practice acts, Guide to the Essentials of a Modern Medical Practice Act and Elements of a State Medical and Osteopathic Board, the Council agreed to condense the companion documents into one document, Guidelines for the Structure and Function of a State Medical and Osteopathic Board. The proposed document incorporates the contents of the prior policies, containing the principles of state medical board responsibility, duty, empowerment, and accountability that the initial documents outlined, as well as detailing the essential components for the structure and function of a state medical board.

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. The Workgroup's efforts included conducting a thorough analysis of various orientation and training materials shared by the state board community, as well as identifying appropriate content and educational approaches to board member training. Over the next year, customizable educational training modules specifically designed for board members will be released. These will likely include educational modules on the roles and responsibilities of board members, what it means to be an effective board member, the purposes of medical licensure and discipline, and individual modules on specific regulatory topics.

Workgroup on Education on Medical Regulation: Chaired by Dr. Patricia King, the Workgroup on Education on Medical Regulation has released three 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," and "Understanding and Navigating the Medical Licensing Process." In March 2018, the FSMB released a module on the medical disciplinary process which orients the learner to medical discipline, a key function of state medical boards. All three modules are available at http://www.fsmb.org/education/ with additional modules to be released through 2018.

Workgroup on Physician Wellness and Burnout: The Workgroup, chaired by FSMB past chair, Dr. Arthur Hengerer, began its work in November 2016 over the course of two year drafted a report that will be considered by the House of Delegates this year. The draft report includes suggested language for state medical board licensing applications and recommendations for a shared accountability approach to better support physician wellness and combat burnout.

The Ethics and Professionalism Committee: The Committee continued work started in 2015 on compounding of medications by physicians and developed a white paper on Compounding Medications by Physicians that will be distributed to state medical boards for information.

Workgroup on Prescription Drug Monitoring Programs: In April 2017, FSMB Chair, Gregory B. Snyder, MD, DABR, appointed a Workgroup on Prescription Drug Monitoring Programs (PDMP) in accordance with FSMB Resolution 17-1: Mandatory Use of Prescription Drug Monitoring Programs, which directed the FSMB to establish a task force to study PDMP use in the United States and its territories. The Workgroup, chaired by Anna Z. Hayden, DO, was charged with evaluating the impact of mandatory PDMP query on patient outcomes and the prescribing of controlled substances; evaluating challenges to increasing PDMP utilization, including, but not limited to: a) authority to access; b) currency of data; c) Electronic Medical Record (EMR) integration; and d) interoperability; and developing recommendations to state medical boards regarding physician utilization of PDMPs, including a recommendation regarding mandatory query. The Workgroup drafted its report and recommendations, *Prescription Drug Monitoring Programs*, for consideration by the House of Delegates this year.

Workgroup to Study Regenerative and Stem Cell Therapy Practices: The Workgroup, convened in May 2017 by FSMB Chair Gregory B. Snyder, MD, DABR, in response to a letter from US Senator Lamar Alexander (R-TN), Chairman of the US Senate Health, Education, Labor, and Pensions (HELP) Committee, urging the FSMB to develop best practices for state medical boards in regulating the promotion, communication, and practices of treatments received at stem cell clinics in the US. The Workgroup drafted the *Report of the FSMB Workgroup to Study Regenerative and Stem Cell Therapy Practices* for consideration by the House of Delegates. The guidance document that addresses the regulation of the provision of stem cell and regenerative therapies, as well as their promotion and communication to patients, and documentation of treatments provided.

COMMUNICATIONS AND PUBLIC AFFAIRS

FSMB is regularly sought for comment by the nation's news media to provide insight and national perspective on issues of relevance to the medical regulatory community. FSMB facilitated interviews and provided background information to numerous media outlets, including The New York Times, Wall Street Journal, Washington Post, the Associated Press, CNN, USA Today, and the Toronto Star, as well as numerous health care-related publications and regional and local news outlets. In 2017, the communications team brought on a new media tracking service called "Meltwater" that provides real-time notifications each time the FSMB or a specific state board is mentioned, as well as comprehensive analytics that have demonstrated a healthy increase in media attention for the FSMB.

Additionally, the team provided media relations assistance to medical boards for both state and national stories on a variety of issues, such as the duty to report, information sharing and physician burnout. 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 physician census, the efforts of FSMB Workgroups to support member boards, announcing free

education modules for medical students and residents, and the FSMB's desire to improve information sharing between the U.S. Department of Veterans Affairs and state medical boards. Over the past year, the communications team played a significant role in helping increase FSMB's presence online. Through the redesign of FSMB.org as well as the creation of a new logo for the organization, the FSMB has helped deliver a more intuitive and easy-to-navigate experience for its users. In an effort to further expand its social media capabilities, the FSMB hired a full-time Social Media Specialist in its Washington D.C. office to help promote the USMLE program and increase engagement with medical students and residents.

STATUS OF RESOLUTIONS TO THE HOUSE OF DELEGATES

Resolution 16-1; Task Force to Study the Need for State Board Regulation of Physician Compounding: The 2016 The House of Delegates referred to the Board of Directors Resolution 16-1, submitted by the North Carolina Medical Board, together with the position statement of the Ethics and Professionalism Committee, entitled, The Compounding of Medications by Physicians, contained in BRD RPT 16-1(d). In response to the referral, the Board tasked the Ethics and Professionalism Committee to address both the resolution and the position statement. The Board provided an interim informational report of the Ethics and Professionalism Committee to the 2017 House of Delegates in which the board stated its agreement with the Committee that a final report or position statement on compounding of medications by physicians was premature in the absence of finalized federal guidance and standards from the Food and Drug Administration (FDA) and United States Pharmacopeia (USP). In February 2018, the Board of Directors approved the a white paper on Compounding of Medications by Physicians. Once the FDA and USP have finalized their respective guidance and standards, development of a final position statement may be considered.

Resolution 17-1; Mandatory Use of Prescription Drug Monitoring Programs (PDMP): Resolution 17-1 was submitted by the Minnesota Board of Medical Practice and resolved that 1) the FSMB establish a task force to study PDMP use in the U.S. and its territories; 2) the FSMB task force evaluate whether mandatory PDMP use positively impacts patient outcomes and prescribing practices; 3) the task force evaluate the feasibility of incorporating the PDMP into an electronic medical record system; and 4) the task force develop recommendations regarding mandatory use of PDMP data by licensed prescribers and dispensers. The 2017 House of Delegates adopted the resolution as amended by requesting that the recommendations of the task force be presented at the FSMB 2018 Annual Meeting. A Workgroup on Prescription Drug Monitoring Programs was established and charged with developing the requested recommendations. The Workgroup completed its charge and its report containing the recommendations, included in BRD RPT 18-2, will be considered by the 2018 House of Delegates.

Resolution 17-2; Advocacy for Professional Licensure of EMS Providers: Resolution 17-2 was submitted by the Montana Board of Medical Examiners and resolved that the FSMB 1) adopt a position supporting professional licensure of paramedics and other advanced life support EMS providers under the authority of state medical boards; and 2) coordinate and collaborate with individual state medical boards and other stakeholders to develop model statutory language for

state to utilize in adopting a professional licensing process and standards for EMS providers. The 2017 House of Delegates referred the resolution to the Board of Directors to study and examine this issue and make recommendations back to the 2018 House of Delegates. An informational report from the Board (BRD RPT 18-5) will be submitted to the 2018 House of Delegates.

Resolution 17-3; Review of Model Guidelines for State Medical Boards Granting Licensure by Endorsement and Assessment of the Standards of ACGME-International: Resolution 17-3 was submitted by the Pennsylvania State Board of Medicine and resolved that the FSMB 1) perform a comprehensive review and update its model guidelines for licensure by endorsement; and 2) establish a workgroup to assess the standards of the Accreditation Council for Graduate Medical Education (ACGME)-International and whether they are recommended to be used by state medical boards to substantiate licensure by endorsement. The resolution was adopted by the 2017 House of Delegates. Because the *Essentials of a State Medical and Osteopathic Practice Act* and *Elements of a State Medical and Osteopathic Board* policy documents were scheduled for revision by the FSMB Advisory Council in FY 2018, the Board of Directors asked that Resolution 17-3 be evaluated in the review of the *Essentials* section on licensure by endorsement. The Advisory Council discussed the ACGME-I program, its purpose and intended use, and recommended no policy change regarding programs accredited via ACGME-I for licensure by endorsement.

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 Euless, 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 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.

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. Over the past year, staff have continued efforts to educate state medical boards about the SPEX. Additionally, the SPEX application system was updated to allow applicants to submit their application and fees online via the FSMB website, rather than having to mail in a paper application and check.

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. 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 2017. Representatives from the California-Medical, Illinois, Montana, Nevada-Medical, North Carolina, Pennsylvania-Medical, Tennessee-Medical and Tennessee-Osteopathic, Virginia, Wisconsin and Wyoming boards participated.

Current and former representatives (members or executive directors) of multiple state medical boards actively participated in the USMLE program in 2017. Boards represented include the following: California-Medical, District of Columbia, Florida-Medical, Guam, Hawaii, Illinois, Iowa, Minnesota, Montana, Nevada-Medical, North Carolina, North Dakota, Pennsylvania-Medical, South Dakota, Tennessee-Medical, Tennessee-Osteopathic, Texas, Utah-Medical, Vermont-Medical, Virginia, Washington-Medical, Wisconsin and Wyoming. In 2016-17, 40 individuals with experience as members or staff of a medical board served on a USMLE committee, task force, advisory or standard setting panel. This recent activity reflects the long-standing tradition of medical board participation in the USMLE. Since the program's inception, more than 202 individuals from 58 medical and osteopathic boards have participated on a USMLE committee, panel, workgroup, etc.

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. Other physician members of

state medical boards are involved in the process of test item development for the USMLE. FSMB is actively working to increase numbers in this area and hosts an annual orientation workshop for state board members. The most recent workshop took place in fall 2017. To date, over 100 physician members representing 50 state medical and osteopathic boards have participated in these workshops. Approximately 40% of the individuals have gone on to serve subsequently on a USMLE committee, workgroup or standard-setting panels.

In 2017, the USMLE program increased its presence on social medial as a way to supplement and strengthen USMLE communication and outreach via the USMLE website. The newly implemented 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.

Education Services

2018 FSMB Annual Meeting – April 26-28, 2018: Over the last year, the Education Committee has worked very hard to identify timely and relevant topics that are of importance to the work of the state medical board community. Using data collected from the post-2017 Annual Meeting evaluation, the 2017-2018 Education Committee, chaired by Gregory B. Snyder, MD, held its first planning meeting in Chicago, Illinois, on July 24, 2017. During this meeting the Education Committee discussed potential topics and sessions for the 2018 meeting including issues in physician wellness and burnout, the aging physician, sexual boundary violations and the duty to report, artificial intelligence in health care, and the current environment's impact on occupational licensing and professional regulation. We are also very pleased with this year's lineup of keynote speakers including Thomas P. Nichols, PhD, author of *The Death of Expertise: The Campaign Against Established Knowledge and Why It Matters,* who will deliver the *Dr. Herbert Platter Lecture Luncheon* on Thursday, April 26; and Kevin Fong, MD, astrophysicist, medical specialist and a natural storyteller, who will discuss "Life, Death and Mistakes" during this year's *Dr. Bryant L. Galusha Lecture* on Saturday, April 28.

2017 New Directors and New Executive Directors Orientations: The FSMB held its New Directors and New Executive Directors Orientations on June 25-26, 2017, in the Texas office. The purpose of this 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. Six (6) new Executive Directors and/or senior medical board attended the event in addition to six (6) members of FSMB's Board of Directors, including Dr. Greg Snyder, Chair, and Dr. Pat King, Chair-elect. 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 24-25, 2018 at the Euless, Texas office.

2017 Tri-Regulator Symposium: On July 24-26, the FSMB, the National Council for State Boards of Nursing (NCSBN), and the National Association of Boards of Pharmacy (NABP) hosted the 2017 Tri-Regulator Symposium at the Loew's Chicago Hotel in Chicago. The theme of this year's Symposium was *Addressing Challenges Together, Increasing Impact*, with particular focus on the opiate crisis in health care. Throughout the two days, attendees were engaged in discussions of diversion schemes, prescription drug monitoring programs, education, alternative modalities to opioids, opioid legislation and preventing opioid deaths.

2017 Fall Board Attorneys Workshop: The FSMB held its 11th annual fall Board Attorneys Workshop on November 8-9, 2017, at the Kimpton Solamar Hotel in San Diego. This year's workshop drew 70 participants representing 26 different state boards. Feedback has been extremely positive, suggesting attendees greatly benefited from the program and found the workshop quite meaningful.

Sessions offered during the workshop included the federal and state legislative impact of the NCBDE vs. FTC case, prosecuting opioid prescribing cases, understanding trauma's impact on the brain and the use of trauma-informed interviewing techniques, cross-examining the licensee expert witness, and use of social media/electronic media in administrative hearings. The workshop was accredited by the State Bar of California for 10 regular hours of continuing legal education (CLE) including 1.5 hours of legal ethics credit.

FSMB CME Program and Accreditation Services: In 2015, after a long process, the FSMB received provisional accreditation status from the Accreditation Council of Continuing Medical Education (ACCME) as an accredited CME provider. In March 2017, the ACCME extended the FSMB's status beyond provisional, providing full accreditation for a four-year period through March 2021. The purpose of FSMB's CME program is to focus on the enhancement of public health, safety and welfare while recognizing the value of professional development and supporting lifelong learning by providing relevant and effective CME opportunities. As such, the FSMB is available to assist its membership with accredited educational program development and management that will assure a successful CME program.

Drug Enforcement Administration CME Collaboration
Starting this spring, the DEA will host multiple regional Practitioner Diversion Awareness Conferences throughout the United States. The first of these conferences is scheduled for May 5-6, 2018 in Orlando, Florida. Designed to assist health care practitioners identify and prevent diversion activity, the one-day conferences are open to all DEA registered practitioners and prescribers including physicians, nurses, pharmacists, dentists and veterinarians. FSMB will serve as the CME accredited provider for each of the live activities where physicians will be eligible to earn up to 6.5 *AMA PRA Category 1 Credits™.*

National Board of Medical Examiners (NBME)
On May 7-8, 2018, the National Board of Medical Examiners (NBME) will host its live activity titled "NBME Invitational Conference for Educators (NICE)" in Philadelphia, PA. This meeting is geared towards medical educators who are involved in assessment and evaluation in medical education. The content presented during this two-day event will closely resemble *NBME U,* an online collection of learning modules relevant to high-quality assessment and will include topics such as developing rating scales and checklists, strategies for organizing question writing and

review, and test score reliability. The NBME expects 200-300 attendees, and the FSMB will serve as the CME provider for this event.

JMR Journal-Based CME
The FSMB is working with the *Journal for Medical Regulation (JMR)* to host journal-based CME for its readers. Journal-based CME will offer credit for peer-reviewed articles that have been accredited by the FSMB for *AMA PRA Category 1 Credit™* prior to publication. Learners will be required to read an article and complete a pre-determined set of questions or tasks related to the content of the material as part of the learning process. Currently in development is a special issue of *JMR* that will include multiple articles on the topic of physician burnout and wellness. Projected publication date for the special issue is summer of 2018.

Operational Update

During the past twelve months, continued progress has been made in improving the services provided to our member boards and our physician user community. Improvements discussed in previous reports related to USMLE and the Physician Data Center (PDC) are now available throughout our online systems and include the Uniform Application (UA) and the Federation Credential Verification Service (FCVS).

FCVS: The FCVS team has successfully completed implementation of our next generation FCVS infrastructure/application. All FCVS physician applications are now using this new application. As of this report, the new application and corresponding processes have improved cycle time to less than 30 days for the past five consecutive months compared to an average of 40+ days in prior comparable years. A corresponding trend has delivered Customer Satisfaction scores at 90% or better in the same time period.

FCVS continues to look for both technology and process improvements. One of the current technology and process improvement projects is the implementation of DocuSign as part of the credentials verification process. DocuSign provides a streamlined and secure electronic process for programs to provide education credentials verification, using electronic signatures. Initial pilot results provided important feedback from programs to improve the product for use. At this report more than 60 programs are using the DocuSign process to provide electronic verifications for medical and graduate medical education.

Uniform Application for Medical Licensure (UA): The UA has been adopted by twenty-seven (27) state boards. More than 101,000 physicians have submitted their applications for licensure using the UA. The use of the UA by Physician Assistants is currently being used by the Oklahoma state medical board, with other boards already expressing an interest in adopting this process as well.

Closed Residency Programs: 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. Without this service, many physicians would have difficulty providing verification of their training. FSMB now has a total of 239 closed programs accounting for 48,000+ physicians. During this past calendar year, a

total of 1,875 credentialing verifications were sent from the FSMB for physicians that attended a now closed residency training program.

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

- American Association of Colleges of Osteopathic Medicine (AACOM)
- American Association of Physicians of Indian Origin (AAPI)
- Association of American Medical Colleges (AAMC)
- Accreditation Council for Graduate Medical Education (ACGME)
- National Association of Medical Staff Services (NAMSS)
- The Credentialing School

Marketing: In addition to the exhibitions and outreach referenced above, the FSMB marketing department utilizes strategic content marketing to promote FSMB activities. This is accomplished primarily through the distribution of relevant content to targeted groups having a professional interest in medical regulatory topics. Within the recently released FSMB website, special areas are designated for distribution of dynamic content in an effort to create an industry specific hub for the credentialing community.

Physician Data Center – (PDC): As part of the PDC, the FSMB has a dedicated team in the Data Integration Department, leveraging the value of the FSMB's Master Data Management System. A score of 100% from NCQA for verifying and reporting license and discipline data demonstrates FSMB's continued commitment to increased data volume and improved quality. During 2017, FSMB's Data Integration Department loaded 1,385 files (an increase of 5% from 2016) with more than 75 million license records (an increase of 11% from 2016). The FSMB is committed to data quality and some records require hands on review. In 2017, the department manually reviewed and matched, on average, approximately 10,000 license records each month.

The FSMB PDC is also 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 states 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 109,822 time in 2017. 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 2017, state boards received 15,147 alerts from the FSMB's DAS.

Research: In a national survey of state medical board executive directors conducted by the FSMB in 2017, directors ranked what they consider the five most important topics to the regulatory community. Resources related to opioid prescribing and telemedicine tied as the most important topic, followed by physician stress and burnout, medical marijuana and the Interstate Medical Licensure Compact. The survey results were reported by various U.S. media outlets.

The Research Department compiled data for the 2017 *A Census of Actively Licensed Physicians in the United States*. The census, released every two years in the *Journal of Medical Regulation*, uses data received by the FSMB from the nation's state medical and osteopathic licensing boards. FSMB's 4th census provides a useful and current snapshot of the physicians licensed to practice medicine in the United States.

In addition, the Research Department published articles in peer-reviewed medical journals. The FSMB worked with the NBME to analyze the relationship between USMLE scores and the likelihood of being disciplined by a state board. The results show that even when controlling for jurisdiction and medical specialty, USMLE scores predict future disciplinary actions. The manuscript was published in *Academic Medicine*.

A collaborative effort between the American Board of Anesthesiology and the FSMB which looks at how the risk of a disciplinary action against a physician is lower in those who pass both examinations than those who pass only the written examination. This manuscript was published in *Anesthesiology* and provides support that an oral examination (during initial certification) assesses domains important to physician performance (e.g., discipline) that are not fully captured in a written examination.

Using FSMB's data, the Research Department examined first-time licenses issued between 1990 and 2014 to female physicians to better understand the physician pipeline and physicians' transition from medical school to practice in the United States. The manuscript was published in the *Journal of Medical Regulation*.

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 *2017 Annual Report*: *Thinking Forward,* highlighting progress the FSMB has made over the last year on many its key initiatives. The report, which was officially released at the 2017 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 2017, FSMB distributed 100 issues of the bi-weekly *FSMB eNews* e-mail bulletin to more than 5,500 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. Scholarly articles and commentaries included in the *JMR* in 2017 included contributions from state medical board authors and articles of interest to the medical regulatory community, including:

- Personal Drug Diversion of Narcotics by Physicians: The Role of Medical Regulation and Physician Health Programs
- The Rise of Female IMGs and their Contribution to Physician Supply in the United States
- A Census of Actively Licensed Physicians in the United States, 2016
- Quality Assurance and MOC Assessment Mechanisms in the Professions
- Mandated Self-Reporting of Workforce Data Collected During Medical License Application or Renewal
- State Continuing Education Requirements for Physicians and Dentists, Including Requirements Related to Pain Management and Controlled Substance Prescribing
- Extended Release and Long-Acting Opioids Analgesics Risk Evaluation and Mitigation Strategy (REMS): Educating Providers on the FDA's Approved Risk Management Program
- Addressing the Novel Dilemmas Provided by the Modernization of Health Care
- Part-time Pediatric Practice: Demographic and Medical Practice Characteristics and Implications for State Medical Boards
- The Changing Dynamics of Professional Regulation: A Perspective from Medicine, Nursing and Pharmacy

FSMB Editorial Committee: Under the leadership of Editor-in-Chief Heidi Koenig, MD, the Committee met in June 2017 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.

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 for 2017-18 Roundtables included:

- An Update on the Interstate Medical Licensure Compact
- Duty to Report: Sharing Information to Protect Patients
- Ohio Medical Board's New e-Licensing System
- Joint Accreditation for Health Care Teams
- An Update on ACGME-International
- Immigration Issues and the Impact of Executive Orders on IMGs
- Physician Burnout and the Licensing Process

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; Hedy L. Chang, of California; as Treasurer; Humayun J. Chaudhry, DO, MACP, President and Chief Executive Officer of the FSMB, *ex officio*, as Secretary; Kathleen Haley, JD, of Oregon, as a Director; Arthur Hengerer, MD, FACS, of New York, as a Director; Stephen Heretick, JD, of Virginia, as a Director; and Ralph Loomis, MD, of North Carolina, as a Director; and Gregory B. Snyder, MD, DABR, of Minnesota, Chair of FSMB, *ex officio*, as a Director.

Through generous support of the FSMB and its member boards, the FSMB Foundation has been able to help fund various projects and initiatives. Most recently, the FSMB Foundation has supported projects with major grants to advance projects such as the Interstate Medical Licensure Compact, to support physician health and wellness, and to address the U.S. opioid prescribing epidemic. The FSMB Foundation has also widened its grantmaking, including launching a program that will make it possible to support the work of a more diverse range of research and educational projects through "mini-grants."

With an eye toward wider impact and long-term sustainability, the FSMB Foundation recently updated its strategic plan and vision for the future. The Foundation's new plan puts a strong emphasis on partnership, collaboration and organizational effectiveness – in close alignment with the FSMB's overall strategic initiatives undertaken in recent years.

Additionally, during FSMB's 2018 Annual Meeting, the FSMB Foundation will host its sixth annual luncheon on Friday, April 27, 2018, beginning at noon. The keynote speaker for this year's event is Archelle Georgiou, MD, a nationally recognized physician, advocate, advisor and author.

INTERNATIONAL ORGANIZATIONS

IAMRA

IAMRA is a membership organization whose purpose is to encourage best practices among medical regulatory authorities worldwide in the achievement of their mandate – to protect, promote and maintain the health and safety of the public by ensuring proper standards for the profession of medicine. IAMRA membership currently consists of 110 organizations from 48 countries, including the FSMB, a founding member. The FSMB continues to serve as the secretariat for IAMRA.

2017 IAMRA Symposium on Continued Competence: IAMRA held the 4th Symposium on Continued Competence in London, United Kingdom October 5-6, 2017. The Symposium was hosted by the General Medical Council. The theme of the Symposium was *Continued Competence Systems – Measuring Their Impact and Value.*

2018 IAMRA Conference: IAMRA will hold its 13th International Conference on Medical Regulation in Dubai, United Arab Emirates October 6-9, 2018. The Conference is being hosted

by Dubai Health Authority. The theme of the Conference is *Empowering Regulation with Innovation and Evidence*.

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

The *IAMRA Management Committee* is comprised of 3 officers and 8 Members-at-Large. With the recent passing of IAMRA Chair-elect, Dr. Margaret Mungherera, the committee is comprised as follows, (a Chair and a Chair-elect will be elected at the 2018 IAMRA Members General Assembly in Dubai):

Chair and Secretary: Dr. Humayun Chaudhry, President and Chief Executive Officer, Federation of State Medical Boards of the United States
Acting Chair-elect: Dr. Joanna Flynn, Chair, Medical Board of Australia

Members-at-Large:
Ms. Susan Goldsmith, Chief Operating Officer, General Medical Council (U.K.)
Prof. Dr. Shabir Ahmed Lehri, President, Pakistan Medical and Dental Council
Dr. Tebogo Kgosietsile Solomon Letlape, President, Health Professions Council of South Africa
Dr. Heidi Oetter, Registrar, College of Physicians and Surgeons of British Columbia (Canada)
Mrs. Joan Simeon, Chief Executive, Medical Council of New Zealand
Dr. Carlos Vital, President, Brazilian General Medical Council
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 *Membership Committee's* primary focus is to develop strategies to increase and sustain membership in the organization. The Membership Committee is also responsible for publishing IAMRA's quarterly electronic newsletter *IAMRA eNews*.

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 23, 2017 through April 28, 2018

DATE	MEETING/EVENT	BOD/EXEC
April 23, 2017	FSMB Board of Directors – Fort Worth, TX	*A. Hengerer* *J. Carter* *C. Dalton* *K. Haley* *A. Hayden* *P. King* *J. Landau* *R. Loomis* *I. Marquand* *J. Rexford* *K. Simons* *G. Snyder* *S. Steingard* *C. Walker-McGill* *M. Zanolli* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
April 24, 2017	AAMC 2017 GRA Spring Meeting – Washington, DC	*L. Robin*
April 25, 2017	Meeting with Dr. Kgosietsile Letlape, President, Health Professions Council of South Africa – Washington, DC FSMB Office	*H. Chaudhry* *D. Johnson*
April 25, 2017	Meeting with Dr. Bankowitz, Americas's Health Insurance Plans (AHIP) – Wahington, DC	*H. Chaudhry*
April 25, 2017	AMA Multi-Stakeholder Conference on Joy in Medicine – Chicago, IL	*A. Hengerer*
April 26, 2017	AACOM/AODME Joint Annual Meeting – Baltimore, MD	*H. Chaudhry*
April 26, 2017	Teleconference with Dr. Greg Snyder, FSMB Chair	*H. Chaudhry*
April 26, 2017	National Academy of Medicine (NAM) Conceptual Model Working Group Pre-briefing Teleconference	*A. Hengerer*
April 26, 2017	National Academy of Medicine (NAM) Conceptual Model Working Group Teleconference	*A. Hengerer*
April 28, 2017	National Academy of Medicine (NAM) Conceptual Model Working Group De-briefing Teleconference	*A. Hengerer*
April 30-May 1, 2017	World Health Care Congress – Washington, DC	*H. Chaudhry*
May 1, 2017	USMLE Committee on Individualized Review – Philadelphia, PA	*D. Johnson*

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DATE	MEETING/EVENT	BOD/EXEC
May 2, 2017	Teleconference with Dr. Graham McMahon, CEO, ACCME and Mark Staz, FSMB Director, Continuing Professional Development	*H. Chaudhry*
May 2, 2017	Address Telemedicine at MIT- Cambridge, MA	*L. Robin*
May 2, 2017	Meeting with USP and AMA Staff – Washington, DC	*C. Dalton*
May 3, 2017	FSMB-Yelp Staff Meeting – FSMB Washington, DC office	*H. Chaudhry* *M. Dugan*
May 3, 2017	World Health Care Congress – Washington, DC	*H. Chaudhry*
May 3, 2017	NEHI Health Care without Walls Panel Teleconference	*H Chaudhry*
May 3, 2017	Teleconference with Dr. Greg Snyder, FSMB Chair	*H. Chaudhry*
May 3, 2017	PDMP Meeting at AMA Headquarters – Chicago, IL	*A. Hayden*
May 4-6, 2017	American Association for the History of Medicine (AAHM) Conference – Nashville, TN	*D. Johnson*
May 8-9, 2017	ASAE Exceptional Boards Workshop – Scottsdale, AZ	*G. Snyder* *H. Chaudhry*
May 9, 2017	FARB Advocacy Committee Teleconference	*E. Fish*
May 9-10, 2017	FDA Meeting on Opioid Prescriber Education – Silver Spring, MD	*L. Robin*
May 10, 2017	Network for Excellence in Healthcare Convening – Washington, DC	*H. Chaudhry*
May 10, 2017	Rhode Island Board of Medical Licensure & Discipline Board Site Visit – Providence, RI *Presentation: FSMB Update*	*A. Hengerer*
May 10-11, 2017	NBME Leadership Visit – Philadelphia, PA	*G. Snyder*
May 11, 2017	National Academy of Medicine Workgroup (Opioid Paper) Teleconference	*H. Chaudhry*
May 11, 2017	Unity Healthcare – Washington, DC	*L. Robin*
May 11, 2017	Video Conference Testing with FSMB Staff	*G. Snyder*
May 12, 2017	CSEC Strategic Planning Meeting – Philadelphia, PA	*D. Johnson*
May 12, 2017	National Academy of Medicine (NAM) Conceptual Model Working Group Pre-briefing Teleconference	*A. Hengerer*
May 12-13, 2017	CMSS Spring Meeting/Educational Session: Clinician Burnout, Resiliency and Regaining Joy in Medicine – Rosement, IL *Keynote Presentation: Duty to Report or Prevent – the Challenge to Professional Self-regulation in Medicine*	*A. Hengerer*

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DATE	MEETING/EVENT	BOD/EXEC
May 15, 2017	Teleconference with Dr. Graham McMahon, CEO, ACCME	*H. Chaudhry*
May 15, 2017	FSMB Workgroup on Physician Wellness and Burnout Pre-briefing Teleconference with Mark Staz	*A.Hengerer* *H. Chaudhry*
May 15-18, 2017	KNOW Identity Conference – Washington, DC	*E. Fish*
May 16, 2017	Examining Bipartisan Medicare Policies that Improve Care for Patients with Chronic Conditions – Washington, DC	*L. Robin*
May 16-17, 2017	Coalition for Physician Accountability Meeting – Chicago, IL	*G. Snyder*
May 17, 2017	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
May 18, 2017	Colorado Medical Board Site Visit – Denver, CO *Presentation: FSMB Update*	*A. Hengerer* *L. Robin*
May 18, 2017	NAMSS 2017 Roundtable – Alexandria, VA	*M. Dugan* *E.Fish*
May 18, 2017	PLAS Governing Committee Teleconference	*G. Snyder* *H. Chaudhry* *D. Johnson* *T. Phillips*
May 18, 2017	FSMB Roundtable Webinar Topic: *"An Update on the Interstate Medical Licensure Compact"*	*H. Chaudhry* *D. Johnson*
May 18, 2017	Teleconference with Dr. Greg Snyder, FSMB Chair	*H. Chaudhry*
May 19, 2017	Heritage College of Osteopathic Medicine (HCOM) Spring Clinical Education Network Summit – Dublin, OH *Keynote Speaker: The Disruptive Physician – Impact Upon Patient Safety and the Learning Environment*	*S. Steingard*
May 20-23, 2017	NABP 113th Annual Meeting – Orlando, FL	*C. Dalton* *L. Robin*
May 21, 2017	NYIT Commencement – Old Westbury, NY	*H. Chaudhry*
May 22, 2017	NYIT College of Ostepathic Medicine Hooding Ceremony – New York, NY	*H. Chaudhry*
May 22-24, 2017	USMLE Management Committee Meeting – Philadelphia, PA	*D. Johnson*
May 23, 2017	National Academy of Medicine (NAM) Conceptual Model Working Group Teleconference	*A. Hengerer*
May 24, 2017	Teleconference with Dr. Lois Nora, CEO, ABMS	*H. Chaudhry*
May 24, 2017	Federal Trade Commission Meeting – Washington, DC	*H. Chaudhry* *E. Fish* *L. Robin*
May 26, 2017	Visit and Meeting with Dr. Peter Katsufrakis, CEO, NBME and Suzanne Andersion, Chair, NBME – Euless, TX office	*H. Chaudhry* *M. Dugan* *D. Johnson*

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DATE	MEETING/EVENT	BOD/EXEC
		T. Phillips *L. Robin*
May 30, 2017	NBME-FSMB Advocacy Opportunities Teleconference	*H. Chaudhry* *L. Robin*
May 30, 2017	National Acadmey of Medicine Workgroup Teleconference	*H. Chaudhry*
May 30, 2017	Coalition Management Committee Teleconference	*H. Chaudhry*
June 1-4, 2017	USMLE Composite Committee Retreat – Meadows of Dan, VA	*P. King* *H. Chaudhry* *D. Johnson* *E. Fish*
June 2, 2017	National Academy of Medicine (NAM) Conceptual Model Working Group De-briefing Teleconference	*A. Hengerer*
June 2, 2017	New York State Board for Medicine Board Site Visit – New York City, NY *Presentation: FSMB Update & Interstate Compact*	*C. Walker-McGill* *L. Robin*
June 5, 2017	Professional Licensing Coalition Summit – Washington, DC	*H. Chaudhry* *L. Robin*
June 5, 2017	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
June 5, 2017	FSMB Awards Teleconference	*A. Hengerer* *H. Chaudhry* *T. Phillips* *L. Robin*
June 6, 2017	Professional Licensure Coalition Teleconference	*H. Chaudhry*
June 6, 2017	IAMRA Management Committee Teleconference	*H. Chaudhry*
June 6, 2017	FDA's Stakeholder Listening Sessions on Compounding – Silver Spring, MD	*C. Dalton* *L. Robin*
June 7-11, 2017	ASAE Conference – Vancouver, British Columbia, Canada	*D. Johnson*
June 8, 2017	FSMB Workgroup on Physician Wellness and Burnout Teleconference	*G. Snyder* *K. Haley* *A. Hengerer* *P. King* *J. Rexford* *S. Steingard* *H. Chaudhry* *L. Robin*

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DATE	MEETING/EVENT	BOD/EXEC
June 8, 2017	Teleconference with Dr. David Benton, CEO, NCSBN	*H. Chaudhry*
June 9, 2017	FSMB Workgroup to Study Regenerative and Stem Cell Therapy Practices Teleconference Teleconference	*S. Steingard* *L. Robin*
June 9, 2017	FSMB Workgroup on Physician Wellness and Burnout De-briefing Teleconference with Mark Staz	*A. Hengerer* *H. Chaudhry*
June 9, 2017	AMA Council on Medical Education (CME) Stakeholder's Forum – Chicago, IL	*P. King* *H. Chaudhry* *L. Robin*
June 10, 2017	AMA Senior Physician Section Assembly and Educational Meeting – Chicago, IL	*G. Snyder* *P. King* *H. Chaudhry*
June 10-11, 2017	AMA House of Delegates Meeting – Chicago, IL	*G. Snyder* *C. Dalton* *P. King* *H. Chaudhry* *L. Robin*
June 10-12, 2017	FMRAC Board of Directors Meeting and Annual Meeting – Winnipeg, Manitoba	*R. Loomis*
June 12, 2017	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
June 12, 2017	FSMB Spotlight Interview – Washington, DC	*G. Snyder* *H. Chaudhry*
June 12, 2017	Public Members Paper Teleconference	*H. Chaudhry* *D. Johnson*
June 13, 2017	International Academy of Continuous Professional Development (IACPD) Webinar	*H. Chaudhry*
June 13, 2017	Professional Licensing Coalition Teleconference	*H. Chaudhry*
June 13, 2017	C-Suite Meeting – DC and TX FSMB offices	*H. Chaudhry* *M. Dugan* *E. Fish* *T. Phillips* *L. Robin*
June 13, 2017	FARB Advocacy Committee Teleconference	*E. Fish*
June 15, 2017	FSMB Governance Committee Teleconference	*G. Snyder* *K. Haley* *A. Hayden* *P. King*

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DATE	MEETING/EVENT	BOD/EXEC
		K. Simons *S. Steingard* *M. Zanolli* *H. Chaudhry* *L. Robin*
June 16, 2017	Mercy Medical Graduation Presentation – Rockville Center, NY	*H. Chaudhry*
June 19, 2017	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
June 19, 2017	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
June 19, 2017	Future of PLAS Teleconference	*H. Chaudhry* *D. Johnson*
June 19, 2017	FSMB-Personas Teleconference	*L. Robin*
June 20, 2017	Teleconference with Dr. Marwan	*H. Chaudhry*
June 20, 2017	Teleconference with Dr. Heidi Oetter	*H. Chaudhry*
June 21-22, 2017	AAPI Annual Convention – Atlantic City, NJ	*H. Chaudhry*
June 22, 2017	Workgroup on Prescription Drug Monitoring Programs Pre-briefing Strategy Teleconference	*A. Hayden* *L. Robin*
June 23, 2017	Teleconference with Dr. Graham McMahon, CEO, ACCME	*H. Chaudhry*
June 23, 2017	FSMB Editorial Committee Meeting – Dallas/Fort Worth, TX	*D. Johnson*
June 24, 2017	FSMB-NBOME Biennial Meeting – Chicago, IL	*G. Snyder* *A. Hengerer* *H. Chaudhry*
June 25, 2017	NBOME Liaison Committee Meeting – Chicago, IL	*G. Snyder* *H. Chaudhry*
June 25-26, 2017	FSMB New Directors and New Executives Orientation – FSMB Euless, TX Office	*G. Snyder* *J. Carter* *K. Haley* *P. King* *I. Marquand* *K. Simons* *H. Chaudhry* *M. Dugan* *D. Johnson* *T. Phillips* *L. Robin*

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DATE	MEETING/EVENT	BOD/EXEC
		E. Fish
June 26, 2017	National Academy of Medicine (NAM) Conceptual Model Working Group Teleconference	*A. Hengerer*
June 26, 2017	National Academy of Medicine (NAM) Conceptual Model Working Group De-briefing Teleconference	*A. Hengerer*
June 27, 2017	C-Suite Meeting – DC and TX FSMB offices	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
June 27, 2017	Coalition Management Committee Teleconference	*H. Chaudhry*
June 29, 2017	FSMB Board of Directors Teleconference RE: DC Advocacy Office Opportunity	*G. Snyder* *J. Carter* *K. Haley* *A. Hayden* *A. Hengerer* *P. King* *J. Landau* *R. Loomis* *I. Marquand* *K. Simons* *S, Steingard* *M. Zanolli* *H. Chaudhry* *T. Phillips* *L. Robin* *E. Fish*
June 29-30, 2017	FSMB Ethics and Professionalism Committee Meeting – Washington, DC	*G. Snyder* *J. Carter* *C. Dalton* *P. King* *H. Chaudhry* *L. Robin*
June 30, 2017	National Academy of Medicine (NAM) Conceptual Model Reactionary Speaker Pre-briefing with Matthew McHugh RE: July 14th Meeting	*A. Hengerer*
July 7, 2017	CCCE Meeting – Silver Spring, MD	*L. Robin*
July 11-12, 2017	FDA/Duke University Initiative on Mobile Clinical Trials CTTI – Silver Spring, MD	*L. Robin*

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DATE	MEETING/EVENT	BOD/EXEC
July 12, 2017	FSMB Compensation, Executive and Investment Committee Meetings – New York City, NY	*G. Snyder* *A. Hengerer* *P. King* *R. Loomis* *C. Walker-McGill* *M. Zanolli* *H. Chaudhry*
July 12-15, 2017	FSMB Board of Directors Meeting – New York City, NY	*G. Snyder* *J. Carter* *C. Dalton (via cc)* *K. Haley* *A. Hayden* *A. Hengerer* *P. King* *J. Landau* *R. Loomis* *I. Marquand* *J. Rexford* *K. Simons* *S, Steingard* *C. Walker-McGill* *M. Zanolli* *H. Chaudhry* *M. Dugan* *D. Johnson* *T. Phillips* *L. Robin* *E. Fish*
July 13-14, 2017	National Academy of Medicine (NAM) Action Collaborative on Clinician Well-being and Resilience Meeting – Washington, DC	*A. Hengerer* *(returned to BOD meeting)*
July 18, 2017	FSMB Roundtable Webinar RE: Duty to Report: Sharing Information to Protect Patients *Presenter: Kenneth B. Simons, MD*	*K. Simons* *L. Robin*
July 18, 2017	New DC Office Closing – Washington, DC	*H. Chaudry*
July 19, 2017	HealthCare Regulatory Research Meeting – Washington, DC	*H. Chaudhry*
July 19-21, 2017	ACCME Board Meeting – Chicago, IL	*M. Zanolli*
July 20, 2017	AOA Council of Osteopathic Student Government Presidents (COSGP) Council – Chicago, IL *Presentation: United States Medicial Licensing Examination (USMLE)*	*H. Chaudhry*
July 20, 2017	AOA Council of Osteopathic Student Government Presidents (COSGP) Global Health Committee Meeting – Chicago, IL	*H. Chaudhry*

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DATE	MEETING/EVENT	BOD/EXEC
July 20, 2017	IAMRA Management Committee Teleconference	*H. Chaudhry*
July 20, 2017	American Association of Osteopathic Examiners (AAOE) Business Meeting – Chicago, IL	*H. Chaudhry*
July 21-22, 2017	Annual AOA House of Delegates Meeting – Chicago, IL	*A. Hengerer* *H. Chaudhry*
July 24, 2017	FSMB Education Committee Meeting – Chicago, IL	*G. Snyder* *A. Hengerer* *P. King* *H. Chaudhry* *L. Robin*
July 24, 2017	NBME Branding Taskforce Meeting – Philadelphia, PA	*D. Johnson*
July 25, 2017	USMLE Social Media Planning Meeting – Philadelphia, PA	*D. Johnson*
July 24-26, 2017	Intouch Health Telehealth Innovation Forum – Santa Barbara, CA *Presentation: Regulatory Aspects of Innovation*	*E. Fish*
July 25-26, 2017	FSMB/NABP/NCSBN Tri-Regulator Symposium – Chicago, IL	*G. Snyder* *A. Hengerer* *P. King* *C. Walker-McGill* *M. Zanolli* *H. Chaudhry* *L. Robin*
July 26, 2017	Committee for Individualized Review Meeting – Philadelphia, PA	*D. Johnson*
July 27, 2017	IAMRA 2018 Program Planning Committee Teleconference	*H. Chaudhry*
July 27, 2017	AAP-FSMB Teleconference	*H. Chaudhry*
July 27, 2017	FTC First Economic Liberty Public Roundtable – Washington, D.C	*H. Chaudhry* *E. Fish* *L. Robin*
July 27, 2017	Teleconference with Dr. Alison Reid, Executive Director, IAMRA and Roxanne Huff, Operations Officer, IAMRA	*H. Chaudhry*
July 28, 2017	Meeting with Senator Claire McCaskill (D-MO)	*J. Carter*
July 28, 2017	Moving to IMIS 20- Strategic Review of Priorities Teleconference	*L. Robin*
July 29-August 1, 2017	USMLE Management Committee Retreat – Annapolis, MD	*G. Snyder* *H. Chaudhry* *D. Johnson*
August 3, 2017	Alaska State Medical Board Site Visit – Anchorage, AK *Presentation: FSMB Update*	*G. Snyder* *H. Chaudhry*
August 4, 2017	Teleconference with Legislative Counsel to Senator Claire McCaskill (D-MO) Janelle McClure, JD	*J. Carter*

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DATE	MEETING/EVENT	BOD/EXEC
August 7, 2017	AMA-FSMB Staff Teleconference	*H. Chaudhry*
August 7, 2017	FSMB Work Group on Education for Medical Regulation Teleconference	*G. Snyder* *A. Hayden* *A. Hengerer* *P. King* *H. Chaudhry* *D. Johnson*
August 8, 2017	IAMRA 2018 Program Planning Committee Teleconference	*H. Chaudhry*
August 8, 2017	Professional Licensing Coalition Teleconference	*H. Chaudhry*
August 10, 2017	Teleconference with Dr. William Pinsky, CEO, ECFMG	*H. Chaudhry*
August 8, 2017	FSMB Foundation Nominating Committee Teleconference	*K. Haley*
August 9, 2017	FSMB Roundtable Webinar Speaker: Michael Miller, Dep Director, State Medical Board of Ohio Topic: Overview of Ohio board's new e-licensing system, which includes real time integration with FSMB data	*P. King* *M. Dugan* *D. Johnson* *L. Robin*
August 9, 2017	FSMB Nominating Committee Videoconference	*G. Snyder observe)* *A. Hengerer* *H. Chaudhry*
August 11, 2017	Kansas Board of Healing Arts Board Site Visit and 60th Anniversary Celebration – Topeka, KS *Presentation: FSMB Update*	*R. Loomis* *H. Chaudhry*
August 11-12, 2017	Resident Retreat: Physician Burnout – Rochester, NY	*A. Hengerer*
August 14, 2017	New York Institute of Technology Teleconference with Hank Foley, PhD, President/CEO	*A. Hengerer*
August 14, 2017	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *E. Fish* *D. Johnson* *L. Robin*
August 14, 2017	Teleconference with Kevin Bohnenblust, President, AIM	*H. Chaudhry*
August 14, 2017	Mississippi Medical Board Audit Team Teleconference	*K. Haley* *A. Hengerer* *L. Robin*
August 15, 2017	Mississippi Medical Board Audit Team Teleconference	*K. Haley* *A. Hengerer* *L. Robin*
August 16, 2017	National Academy of Medicine (NAM) Action Collaborative on Clinician Well-Being and Resilience July Meeting Co-Lead Debriefing Teleconference	*A. Hengerer*

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DATE	MEETING/EVENT	BOD/EXEC
August 16-18, 2017	2017 NCSBN Annual Meeting – Chicago, IL	*M. Zanolli*
August 17, 2017	FSMB Advisory Council of Board Executives Teleconference	*K. Haley* *L. Robin* *E. Fish*
August 18, 2017	American Osteopathic Association Meeting – Chicago, IL	*M. Dugan*
August 22-25, 2017	Association of Medical Councils of Africa (AMCOA) Conference Stellenbosch, South Africa *Presentation: Technology in Regulation (Chaudhry)* *Presentation: Assessment within the Framework of Medical Regulation in the United States (Snyder/Johnson)*	*G. Snyder* *H. Chaudhry* *D. Johnson*
August 24, 2017	FSMB and BU Collaboration Teleconference	*L. Robin*
August 24, 2017	Telemedicine in Clinical Trials (FSMB and CTTI) Teleconference	*L. Robin*
August 25, 2017	Practitioner Diversion Awareness Conference Planning Teleconference	*L. Robin*
August 24, 2017	Health Professions Council of South Africa (HPCSA) Medical and Dental Boards-USMLE Meeting – Stellenbosch, South Africa	*G. Snyder* *H. Chaudhry* *D. Johnson*
August 28, 2017	Federation of State Medical Boards Guidelines Discussion Teleconference	*L. Robin*
August 29-September 1, 2017	NASCLA Annual Meeting – Denver, CO	*L. Robin*
August 29-30, 2017	American Academy of Family Physicians Meeting – Washington, DC	*M. Dugan*
August 30, 2017	Teleconference with Kevin Bohnenblust, President, AIM	*H. Chaudhry*
August 30, 2017	AAFP-FSMB Staff Meeting – Washington, DC	*H. Chaudhry* *M. Dugan*
August 31, 2017	Teleconference with Timothy Brigham, MD, Chief Of Staff and Senior Vice President, Department of Education, ACGME	*H. Chaudhry*
September 5, 2017	IAMRA Continued Competence Symposium Panel Teleconference	*H. Chaudhry*
September 5, 2017	Professional Licensing Coalition Teleconference	*H. Chaudhry*
September 5, 2017	IAMRA Management Committee Teleconference	*H. Chaudhry*
September 6, 2017	FSMB/NABP/NCSBN Tri-Regulator Collaborative Meeting – Chicago, IL	*G. Snyder* *P. King* *H. Chaudhry*

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September 6, 2017	Guam Board of Medical Examiners Board Site Visit – Mangilao, Guam *Presentation: FSMB Update*	*J. Landau* *M. Dugan*
September 7, 2017	Commonwealth of the Northern Mariana Islands Health Care Professions Licensing Board Site Visit – Saipan, MP *Presentation: FSMB Update*	*J. Landau* *M. Dugan*
September 7, 2017	FSMB Workgroup to Study Regenerative and Stem Cell Therapy Practices Meeting – Washington, DC	*G. Snyder* *P. King* *S. Steingard* *H. Chaudhry* *L. Robin*
September 7, 2017	ECFMG-NBME-FSMB CEO Teleconference	*H. Chaudhry*
September 7, 2017	Commonwealth of the Northern Mariana Islands Health Care Professions Board Site Visit – Saipan, Northern Mariana Islands *Presentation: FSMB Update*	*J. Landau* *M. Dugan*
September 8, 2017	FSMB Workgroup on Prescription Drug Monitoring Programs Meeting – Washington, DC	*G. Snyder* *A. Hayden* *P. King* *J. Rexford* *H. Chaudhry* *L. Robin*
September 9, 2017	New DC Office Meeting	*R. Loomis* *T. Phillips*
September 9, 2017	FSMB Foundation Board of Directors Meeting – Washington, DC	*G. Snyder* *K. Haley* *A. Hengerer* *R. Loomis* *H. Chaudhry* *L. Robin*
September 11, 2017	USMLE Composite Committee Teleconference	*P. King* *H. Chaudhry* *E. Fish* *D. Johnson*
September 11, 2017	Review Team for Mississippi Medical Board Audit Teleconference	*K. Haley* *A. Hengerer* *L. Robin*
September 12, 2017	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *E. Fish* *D. Johnson*
September 12, 2017	VA Health Roundtable on Telemedicine – Washington, DC	*H. Chaudhry*

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September 12, 2017	Teleconference with Dr. Alison Reid, Executive Director, IAMRA and Roxanne Huff, Operations Officer, IAMRA	*H. Chaudhry*
September 13, 2017	Diligent Overview Session	*A. Hengerer*
September 13, 2017	Health Policy Fellowship Orientation – Washington, DC *Presentation: The Role of the Physician in Health Policy*	*H. Chaudhry*
September 13, 2017	Teleconference with Dr. William Pinsky, CEO, ECFMG	*H. Chaudhry*
September 13, 2017	Teleconference with Dr. Stacy Lankford, Past FSMB Chair, Board of Directors	*H. Chaudhry*
September 13, 2017	Discuss Physician Compact Maryland Campaign with FSMB Teleconference	*L. Robin*
September 13-15, 2017	CliftonLarsonAllen Coference – Chicago, IL	*T. Phillips*
September 14, 2017	FSMB Governance Committee Videoconference	*G. Snyder* *K. Haley* *A. Hayden* *P. King* *J. Rexford observer* *K. Simons* *S. Steingard* *M. Zanolli* *H. Chaudhry* *L. Robin*
September 14-15, 2017	ACEP Inventing Social Emergency Medicine Consensus Conference – Irving, TX *Presentation: Physician Wellness & Socialization*	*A. Hengerer*
September 14-16, 2017	AMA ChangeMedEd™ 2017 National Conference – Chicago, IL	*P. King*
September 14-16, 2017	AAVSB Annual Meeting – San Antonio, TX	*L. Robin*
September 15, 2017	NYIT 40th Anniversary Celebration Symposium – Old Westbury, NY *Presentation: Innovations in Satee Medical Regulation: Are You Ready?*	*H. Chaudhry*
September 18, 2017	Coalition for Physician Accountability Meeting – Washington, DC	*G. Snyder* *A. Hengerer* *H. Chaudhy*
September 18-19, 2017	NABP Task Force on Definition of a Patient-Pharmacist Relationship – Chicago, IL	*R. Loomis*
September 19, 2017	Professional Licensing Coalition Teleconference	*H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
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DATE	MEETING/EVENT	BOD/EXEC
September 19, 2017	Teleconference with Dr. Jeffrey Flier, Former Dean, Harvard Medical School	*H. Chaudhry*
September 19, 2017	NBME-FSMB Advocacy Opportunities Follow-up – Washington DC	*L. Robin*
September 20, 2017	Diligent Overview Session	*G. Snyder* *H. Chaudhry*
September 20, 2017	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H.. Chaudhry*
September 20, 2017	Teleconference with Dr. Marty Crane, Past FSMB Chair, Board of Directors	*H. Chaudhry*
September 21, 2017	FSMB Roundtable Webinar Speakers: *Dr. Graham McMahon, CEO and Kate Regnier, ACCME* Topic: *New Joint Accreditation for Interprofessioal Contining Education*	*H. Chaudhry*
September 21, 2017	Diligent Overview Session	*E. Fish*
September 21, 2017	Kentucky Board of Medical Licensure Board Site Visit – Louisville, KY *Presentation: FSMB Update*	*K. Haley* *L. Robin*
September 22, 2017	Diligent Overview Session	*L. Robin*
September 22, 2017	National Academy of Medicine (NAM) Conceptual Model Writing Group Outline Teleconference	*A. Hengerer*
September 23, 2017	Washingtonton College Presidential Inauguration – Chestertown, MD	*H. Chaudhry*
September 24, 2017	ACGME Board of Directors Meeting – Chicago, IL	*H. Chaudhry*
September 25, 2017	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
September 25-26, 2017	FSMB Leadership Review of Board Operations with Mississippi State Board of Medical Licensure – Jackson, MS	*A. Hengerer* *K. Haley*
September 25-26, 2017	Distributed: Health 2017 – Nashville, TN Healthcare Innovation Through Blockchain	*M. Dugan*
September 26, 2017	CSEC Operations Oversight Group Meeting – Philadelphia, PA	*H. Chaudhry*
September 26, 2017	Diligent Overview Session	*A. Hayden* *D. Johnson*

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September 26-27, 2017	2017 FDA Intergovernmental Working Meeting on Pharmacy Compounding – Silver Spring, MD	*C. Dalton* *L. Robin*
September 27, 2017	DC Board of Medicine Meeting – Washington, DC	*H. Chaudhry*
September 27, 2017	Tri-Regulator CEO-HHS/CMS Leadership Teleconference	*H. Chaudhry*
September 27, 2017	Diligent Overview Session	*J. Rexford* *M. Dugan* *T. Phillips*
September 27-28, 2017	FSMB Bylaws Committee Meeting – Washington, DC	*G. Snyder* *P. King* *J. Landau* *I. Marquand* *H. Chaudhry* *E. Fish* *L. Robin*
September 28, 2017	Professional Licensing Coalition Teleconference	*H. Chaudhry*
September 28, 2017	Coalition Teleconference	*H. Chaudhry*
September 28, 2017	FSMB Liaison Director/State Board Liaison Representative Teleconference with Diana Shephard, Executive Director, West Virginia Board of Osteopathic Medicine	*J. Carter*
September 28, 2017	Diligent Overview Session	*J. Carter* *R. Loomis* *M. Zanolli*
September 28, 2017	USMLE Orientation for State Board Members – Philadelphia, PA	*D. Johnson*
September 29, 2017	Interview with “The DO” Journal	*H. Chaudhry*
September 29, 2017	Teleconference with Dr. Jim Thompson, Former FSMB CEO	*H. Chaudhry*
September 29, 2017	National Academy of Sciences GME Worskhop Panel Teleconference	*H. Chaudhry*
September 29, 2017	Diligent Overview Session	*K. Simons* *S. Steingard*
September 29, 2017	National Academy of Medicine (NAM) Conceptual Model Working Group WebEx	*A. Hengerer*
September 29, 2017	National Academy of Medicine (NAM) Conceptual Model Working Group Co-Lead Debriefing WebEx	*A. Hengerer*
September 29, 2017	DNC Breakfast Roundtable – Washington D.C.	*L. Robin*

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October 3-4, 2017	International Society for Quality in Health Care (ISQua) Conference – London, UK	*A. Hengerer*
October 4, 2017	Pennsylvania State Board of Osteopathic Medicine Board Site Visit – Harrisburg, PA *Presentation: FSMB Update*	*C. Dalton* *M. Dugan*
October 4, 2017	Meeting with ANC Commissioners regarding 2118 Leroy Property	*E. Fish*
October 4, 2017	Diligent Overview Session	*K. Haley*
October 4, 2017	Audit Committee Pre-Briefing with Committee Chair and FSMB Treasurer	*R. Loomis* *C. Walker-McGill* *T. Phillips*
October 5, 2017	Diligent Overview Session	*C. Dalton* *P. King* *J. Landau* *I. Marquand* *C. Walker-McGill*
October 5, 2017	Michigan Board of Osteopathic Medicine and Surgery Board Site Visit – Lansing, MI *Presentation: FSMB Update*	*J. Rexford*
October 5-6, 2017	IAMRA Continued Competence Symposium 2017 - London, UK	*G. Snyder* *A. Hengerer* *H. Chaudhry* *D. Johnson* *L. Robin*
October 8, 2017	American Osteopathic College of Occupational and Preventitive Medicine (AOCOPM) Meeting – Philadelphia, PA *Presentation: Physician Licensure What's New? What's Relevant*	*H. Chaudhry*
October 8-12, 2017	2017 Annual Congress of Neurological Surgeons Meeting – Boston, MA	*R. Loomis*
October 9-10, 2017	NBME Timing Imapct on Measurement in Education (TIME) Conference – Philadelphia, PA	*D. Johnson*
October 10, 2017	FARB Advocacy Committee Teleconference	*E. Fish*
October 10-11, 2017	National Academy of Sciences GME Workshop – Washington, DC	*H. Chaudhry*
October 11, 2017	FSMB Audit Committee Teleconference	*G. Snyder* *P. King* *R. Loomis* *J. Rexford* *S. Steingard* *C. Walker-McGill* *H. Chaudhry*

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October 12, 2017	World Medical Association Meeting – Chicago, IL *Presentation: The International Asccocation of Medical Regulatory Authorities (IAMRA) Statement on Accreditation of Medical Education Programs*	*H. Chaudhry*
October 13, 2017	Meeting with Dr. David Benton, CEO, NCSBN – Chicago, IL	*H. Chaudhry*
October 13, 2017	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
October 13-14, 2017	NY Board of Professional Medical Conduct Annual Board Training Session – Albany, NY *Presentation: Burnout & Wellness: Importance to the BPMC* *Presentation: The Prescription Opioid Epidemic: The Crisis in Perspective*	*A. Hengerer*
October 14, 2017	MS State Board of Medical Licensure Retreat – Raymond, MS *Presentation: FSMB Update*	*A. Hayden*
October 16, 2017	Natinal Academy of Medicine (NAM) Annual Meeting – Washington, DC	*H. Chaudhry*
October 16, 2017	SMU Big Data Advisory Board Meeting	*M. Dugan*
October 16, 2017	National Academy of Medicine (NAM) 2017 Annual Meeting – Washington, DC	*A. Hengerer*
October 17, 2017	IAMRA 2018 Planning Committee Teleconference	*H. Chaudhry*
October 17, 2017	Teleconference with Marschall Smith, Executive Director, Interstate Medical Licensing Compact Commission	*H. Chaudhry*
October 17, 2017	Professional Licensing Coalition Teleconference	*H. Chaudhry*
October 17, 2017	National Academy of Medicine (NAM) Conceptual Model Co-Leads Pre-Call WebEx	*A. Hengerer*
October 18, 2017	AAMC-NBME-FSMB Liaison Committee Meeting – Philadelphia, PA	*H. Chaudhry*
October 18, 2017	2017 International Medical Education Leaders Forum (IMELF) & 10th Anniversary Meeting – Quebec, Ontario, Canada	*C. Walker-McGill*
October 18, 2017	NBME Branding Taskforce Meeting – Philadelphia, PA	*D. Johnson*
October 18, 2017	Tidewater Otolaryngology Society – Norfolk, VA *Presentation: Physician Burnout & Wellness*	*A. Hengerer*
October 19, 2017	FSMB Spotlight Taping with Victor Dzau, MD, President of the National Academy of Medicine – Washington, DC	*H. Chaudhry*
October 19, 2017	Teleconference with Dr. Alison Reid, Executive Director, IAMRA and Roxanne Huff, Operations Officer, IAMRA	*H. Chaudhry*
October 20, 2017	State Board Advisory Panel to USMLE Meeting – Euless, TX	*D. Johnson*
October 23, 2017	National Academy of Medicine (NAM) Conceptual Model Working Group WebEx	*A. Hengerer*
October 23, 2017	National Academy of Medicine (NAM) Conceptual Model Post Call WebEx	*A. Hengerer*

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DATE	MEETING/EVENT	BOD/EXEC
October 24, 2017	Coalition Management Committee Teleconference	*H. Chaudhry*
October 24, 2017	Teleconference with Dr. Regina Benjamin, Past FSMB Chair, Board of Directors	*H. Chaudhry*
October 25, 2017	FSMB Executive & Investment Committee Meetings – Dallas, TX	*G. Snyder* *P. King* *A. Hengerer* *R. Loomis* *C. Walker-McGill* *M. Zanolli* *H. Chaudhry* *T. Phillips*
October 25-28, 2017	FSMB Board of Director Meetings – Dallas, TX	*G. Snyder* *J. Carter* *C. Dalton* *K. Haley* *A. Hayden* *A. Hengerer* *P. King* *J. Landau* *R. Loomis* *I. Marquand* *J. Rexford (videoconference)* *K. Simons* *S. Steingard* *C. Walker-McGill* *M. Zanolli* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
October 27, 2017	National Academy of Medicine (NAM) Conceptual Model Working Group De-Briefing Teleconference	*A. Hengerer*
October 27, 2017	Joint FSMB Board of Director & FSMB Foundation Board of Director Meeting – Dallas, TX	*G. Snyder* *J. Carter* *C. Dalton* *K. Haley* *A. Hayden* *A. Hengerer* *P. King* *J. Landau*

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		R. Loomis *I. Marquand* *J. Rexford (by cc)* *K. Simons* *S. Steingard* *C. Walker-McGill* *M. Zanolli* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
October 28, 2017	FSMB Foundation Board of Directors – Dallas, TX	*G. Snyder* *K. Haley* *A. Hengerer* *R. Loomis* *H. Chaudhry* *L. Robin*
October 30, 2017	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
October 30, 2017	Teleconference with Dr. Ana Pujols McKee, Executive Vice President and Chief Medical Officer, Joint Commission	*H. Chaudhry*
October 30, 2017	Bi-weekly Professional Licensing Coalition Teleconference	*H. Chaudhry*
October 31,2017	Update on Single GME Accreditation Hill Activity (ACGME) Teleconference	*L. Robin*
October 31, 2017	American College of Emergency Physicians (ACEP) Education Steering Committee Meeting – Washington, DC *Verbal Update Summary: FSMB & the ACEP*	*J. Carter*
November 1, 2017	Teleconference on Opioid Workgroup with Dr. Dan Gifford	*H. Chaudhry* *L. Robin*
November 1, 2017	Associate Member Bylaws Changes Teleconference with Kevin Bohnenblust, President, AIM	*G. Snyder* *K. Haley* *I. Marquand* *H. Chaudhry*
November 1, 2017	NBME Branding Task Force: Brand Platform Workshop – Philadelphia, PA	*D. Johnson*
November 2, 2017	WNDC Democratic Woman of the Year Award – Washington DC	*L. Robin*

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November 2-5, 2017	AAMC Annual Meeting – Boston, MA	*D. Johnson*
November 6, 2017	Regulating Telemedicine Follow-up Teleconference with the General Medical Council	*H. Chaudhry* *L. Robin*
Novembr 7, 2017	Teleconference with Dr. Alison Reid, Executive Director and Roxanne Huff, Operations Officer, IAMRA	*H. Chaudhry*
November 7, 2017	FTC Economic Liberty Task Force Roundtable - Washington, DC	*H. Chaudhry* *L. Robin*
November 7, 2017	iGIANT Roundtable – Washington, DC	*L. Robin*
November 7, 2017	Klobuchar Meeting - Washington, DC	*L. Robin*
November 8, 2017	CSEC Strategy Videoconference	*D. Johnson*
November 8-9, 2017	FSMB Board Attorney Workshop – San Diego, CA	*L. Robin*
Hovember 9, 2017	Meeting with Dr. Jone Flanders Geimer – Honolulu, HI	*G. Snyder* *H. Chaudhry*
November 10, 2017	AMA Council on Medical Education Meeting – Honolulu, HI	*G. Snyder* *H. Chaudhry*
November 11-14, 2017	Interim AMA House of Delegates Meeting – Honolulu, HI	*G. Snyder* *C. Dalton* *K. Simons*
November 14, 2017	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
November 14, 2017	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
November 14, 2017	Bi-weekly Professional Licensing Coalition Teleconference	*H. Chaudhry*
November 14, 2017	FSMB Roundtable Webinar Speaker: Dr. Thomas Nasca, CEO, ACGME Topic: ACGME-International Accreditation and U.S. Licensure	*P. King* *H. Chaudhry*
November 14, 2017	Awards Committee Videoconference	*G. Snyder* *J. Carter* *C. Dalton* *A. Hengerer* *P. King* *I. Marquand* *H. Chaudhry*

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		L. Robin
November 16, 2017	CMSS Patient and Family Engagement Summit – Arlington, VA	*H. Chaudhry*
November 17-19, 2017	Litchfield CEO Meeting – New York, NY	*H. Chaudhry*
November 18, 2017	Arizona Board of Osteopathic Examiners in Medicine & Surgery Board Site Visit – Scottsdale, AZ *Presentation: FSMB Update*	*J. Landau* *D. Johnson*
November 20, 2017	Presentation on new DC Advocacy Office with Advisory Neighborhood Commission – Washington, DC	*H. Chaudhry*
November 20, 2017	National Academy of Medicine (NAM) Conceptual Model Working Group Co-Leads PreCall Teleconference	*A. Hengerer*
November 27, 2017	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
November 27, 2017	Teleconference with Joint Commission Staff	*H. Chaudhry*
November 27, 2017	National Academy of Medicine (NAM) Conceptual Model Working Group WebEx	*A. Hengerer*
November 27, 2017	National Academy of Medicine (NAM) Conceptual Model Post Call Teleconference	*A. Hengerer*
November27, 2017	FDA-FSMB Teleconference	*H. Chaudhry* *M. Dugan* *L. Robin*
November 29, 2017	House Veteran's Affairs Committee Hearing – Washington, DC	*H. Chaudhry*
November 29-30, 2017	2017 ACGME Symposium on Physician Well-Being – Chicago, IL *Keynote Speaker: FSMB Efforts on Physician Wellness and Burnout*	*A. Hengerer*
November 29-30, 2017	USMLE Management Committee Meeting – Philadelphia, PA	*D. Johnson*
November 30, 2017	Hard Hat Tour of Idaho College of Osteopathic Medicine – Boise, ID	*P. King* *H. Chaudhry*
December 1, 2017	Idaho Board of Medicine Board Site Visit – Boise, ID *Presentation: FSMB Update*	*P. King* *H. Chaudhry*
December 4, 2017	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *M. Dugan* *E. Fish*

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		D. Johnson *T. Phillips* *L. Robin*
December 4, 2017	FSMB Chair and CEO Teleconference	*G. Snyder* *H. Chaudhry*
December 4, 2017	Planning Committee Videoconference	*G. Snyder* *P. King* *R. Loomis* *C. Walker-McGill* *H. Chaudhry* *L. Robin*
December 4, 2017	Staff Committee for the Review of Anomalous Performance (SCRAP) Videoconference	*D. Johnson*
December 5, 2017	Teleconference with Dr. Alison Reid, Executive Director, IAMRA	*H. Chaudhry*
December 6, 2017	Public Hearing Bill 22-77 Interstate Medical Licensure Compact Approval Act Hearing – Washington, DC	*H. Chaudhry*
December 6, 2017	IAMRA Management Committee Teleconference	*H. Chaudhry*
December 6, 2017	New Jersey State Board of Medical Examiners Board Site Visit – Trenton, NJ *Presentation: FSMB Update*	*C. Walker-McGill* *L. Robin*
December 6, 2017	FSMB-United Health Group Pre-briefing Teleconference	*G. Snyder* *P. King* *H. Chaudhry* *M. Dugan* *D. Johnson* *L. Robin*
December 7, 2017	FSMB Spotlight Taping with Tara Koslov	*H. Chaudhry*
December 7, 2017	Education Committee Videoconference	*G. Snyder* *A. Hengerer* *P. King* *H. Chaudhry*
December 11, 2017	C-Suite Meeting – TX and DC Offices	*H. Chaudhry* *M. Dugan* *T. Phillips* *L. Robin*
December 11, 2017	Workgroup to Study Regenerative & Stem Cell Therapy Practices Videoconference	*G. Snyder* *P. King* *S. Steingard* *H. Chaudhry* *L. Robin*

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December 12, 2017	Healthcare Regulatory CEO Meeting – Washington, DC	*H. Chaudhry*
December 12, 2017	POLITICO Outside/In Event – Washington, DC	*H. Chaudhry*
December 12, 2017	Nevada State Board of Osteopathic Medicine Board Site Visit – Henderson, NV	*J. Landau* *L. Robin*
December 12, 2017	Committee on Individualized Review Meeting – Philadelphia, PA	*D. Johnson*
December 13, 2017	FSMB-VA Meeting – Washington, DC and Euless, TX (via videoconference)	*H. Chaudhry* *M. Dugan*
Dece,ber 13, 2017	CSEC Strategy Meeting – Philadelphia, PA	*D. Johnson*
December 14, 2017	FSMB Roundtable Webinar Speakers: Jon Thomas, MD, Chair and Marschall Smith, MPA Executive Director, Interstate Medical Licesnure Compact Commission Topic: An Update on the Interstate Medical Licensure Compact	*G. Snyder* *H. Chaudhry* *M. Dugan* *L. Robin*
December 14, 2017	Workgroup on Prescription Drug Monitoring Programs Videoconference	*G. Snyder* *A. Hayden* *P. King* *J. Rexford* *H. Chaudhry* *L. Robin*
December 14, 2017	National Advisory Council (NAC) for the Alliance of Independent Academic Medical Center's (AIAMC's) National Initiative VI: Stimulating a Culture of Well-Being in the Clinical Learning Environment Teleconference	*A. Hengerer*
December 14, 2017	AMA Treatment and Parity fly-in – Washington, DC	*L. Robin*
December 14, 2017	NBME Branding Task Force: Brand Design Workshop – Philadelphia, PA	*D. Johnson*
December 14-15, 2017	National Academy of Medicine (NAM) Action Collaborative on Clinician Well-Being and Resilience Steering Committee Meeting – Washington, DC	*A. Hengerer*
December 15, 2017	FSMB Holiday Party and Staff Recognition Awards Celebration – Euless, TX	*G. Snyder* *H. Chaudhry* *M. Dugan* *D. Johnson* *T. Phillips*
December 18, 2017	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
December 19, 2017	United Health Group-FSMB Meeting– Eden Prairie, MN	*G. Snyder* *P. King*

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		H. Chaudhry *M. Dugan* *D. Johnson* *L. Robin*
December 20, 2017	Teleconference with Dr. Graham McMahon, CEO, ACCME	*H. Chaudhry*
January 3-4, 2018	American College of Emergency Physicians (ACEP) Education Steering Committee Meeting – Irving, TX	*J. Carter*
January 4, 2018	Oregon Medical Board Site Visit – Portland, OR *Presentation: FSMB Update*	*A. Hengerer* *K. Haley* *L. Robin*
January 8, 2018	NAM-Aspen Institure Meeting on Opioid Epidemic – Washington, DC	*H. Chaudhry*
January 8, 2018	Teleconference with Dr. Steve Shannon, CEO, AACOM	*H. Chaudhry*
January 9, 2018	Coalition Communications Committee Teleconference	*H. Chaudhry*
Janaury 9, 2018	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
January 9, 2018	Bi-weekly Professional Licensing Coalition Teleconference	*H. Chaudhry*
January 9, 2018	Bylaws Committee Videoconference	*G. Snyder* *P. King* *J. Landau* *H. Chaudhry* *L. Robin*
January 11-12, 2018	ASAE Symposium for Chief Executives & Chief Elected Officers – Naples, FL	*P. King* *H. Chaudhry*
January 15, 2018	National Academy of Medicine (NAM) Conceptual Model Co-Leads Pre-Call WebEx	*A. Hengerer*
January 16, 2018	Awards Committee Videoconference	*G. Snyder* *J. Carter* *C. Dalton* *A. Hengerer* *P. King* *I. Marquand* *H. Chaudhry* *L. Robin*

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January 17, 2018	Teleconference with Dr. Paul Wallach, Vice-Chair, NBME	*H. Chaudhry*
Janaury 17, 2018	Coalition Management Committee Teleconference	*H. Chaudhry*
January 17, 2018	FSMB Rountable Webinar Speakers: Lisa Cover, MHA, SVP Business Development and Operations, ECFMG and John (Jack) Boulet, PhD, VP, Rsearch and Data Resources, FAIMER Topic: Immigration Issues and the Impacts of Executive Orders on IMG's	*G. Snyder* *H. Chaudhry* *L. Robin*
January 17, 2018	Planning Committee Videoconference	*G. Snyder* *P. King* *J. Landau* *R. Loomis* *J. Rexford* *C. Walker-McGill* *H. Chaudhry* *L. Robin*
January 17, 2018	Joint FSMB-ECFMG Operations Meeting – FSMB Euless, TX Office	*M. Dugan*
January 18, 2018	AOA LEAD Conference Panel Teleconference	*H. Chaudhry*
January 18, 2018	FSMB Chair and CEO Teleconference	*G. Snyder* *H. Chaudhry*
January 19, 2018	Nominating Committee Meeting – Irving, TX	*A. Hengerer* *H. Chaudhry*
January 22, 2018	Finance Committee Meeting – FSMB Euless, TX Office	*G. Snyder* *K. Haley* *P. King* *R. Loomis* *K. Simons* *M. Zanolli* *H. Chaudhry* *T. Phillips*
Janaury 22, 2018	SPEX Oversight Committee Pre-briefing Meeting	*H. Chaudhry* *D. Johnson*
January 22, 2018	National Academy of Medicine (NAM) Conceptual Model Co-Leads Pre-Call WebEx	*A. Hengerer*
January 23, 2018	IAMRA 2018 Conference Planning Committee Teleconference	*H. Chaudhry*
January 24, 2018	Monroe County Medical Society – Rochester, NY Presentation on Burnout and Misconduct	*A. Hengerer*
January 24, 2017	CSEC Strategy Videoconference	*D. Johnson*

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January 25-26, 2018	AOA LEADS Conference – Austin, TX *Panel Presentation: Globalization of Osteopathic Medicine*	*H. Chaudhry*
January 26, 2018	National Academy of Medicine (NAM) Conceptual Model Working Group WebEx	*A. Hengerer*
January 26, 2018	National Academy of Medicine (NAM) Conceptual Model Working Group Post Call Teleconference	*A. Hengerer*
January 26, 2018	National Academy of Medicine (NAM) Public Webinar Rehearsal Teleconference	*A. Hengerer*
January 27, 2018	AAOE Business Meeting – Austin, TX *Presentation: FSMB Update*	*H. Chaudhry*
January 29, 2018	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
January 29, 2018	SPEX Oversight Committee Meeting – FSMB Euless, TX Office	*H. Chaudhry* *D. Johnson*
January 29, 2018	Meeting with Mark Jackson, Executive Director, Medical Association of Alabama – Washington, DC	*L. Robin*
January 30, 2018	USMLE Composite Committee Meeting – FSMB Euless, TX Office	*P. King* *H. Chaudhry* *D. Johnson*
February 1, 2018	Teleconference with Drs. Anu Ashok and Foster Gesten	*H. Chaudhry*
February 1, 2018	AMA-FSMB Staff Teleconference	*H. Chaudhry* *L. Robin*
February 1-2, 2018	National Credentialing Forum – San Diego, CA	*M. Dugan*
February 2, 2018	National Academy of Medicine (NAM) Collaborative Public Webinar *Presentation: NAM Conceptual Model Working Group*	*A. Hengerer*
February 5-9, 2018	Reception followed by Tour of the Capitol; Hill Visits; FSMB Executive/Invstment Committee Meetings; Board of Director Meetings – Washington, DC	*G. Snyder* *J. Carter* *C. Dalton* *K. Haley* *A. Hayden* *A. Hengerer* *P. King* *J. Landau* *R. Loomis* *I. Marquand* *J. Rexford*

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		K. Simons *S. Steingard* *C. Walker-McGill* *M. Zanolli* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
February 9-12, 2018	Weill Cornell Medical College – Qatar Education City, Al Luqta St., Ar-Rayyan *Presentation*: *Well-Being and Resilience of Medical Students*	*A. Hengerer*
February 12, 2018	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
February 12, 2018	ECFMG-FSMB-NBME CEO Quarterly Meeting – Washington,DC	*H. Chaudhry*
February 12, 2018	ABMS Commission Webinar Orientation Series: Medical Self Regulation Across the Continuum	*H. Chaudhry*
February 12-14, 2018	AMA National Advocacy Conference – Washington D.C	*L. Robin*
February 12-15, 2018	Interview Architecture Firms for new DC Office – Washington, DC	*H. Chaudhry* *T. Phillips* *L. Robin*
February 13, 2018	Meeting with Thorn Run Partners LLP - Washington D.C	*L. Robin*
February 14, 2018	Meeting with Mehlman Castagnetti Rosen & Thomas LLP – Washington D.C	*L. Robin*
February 15, 2018	Virginia Board of Medicine Board Site Visit – Henrico, VA *Presentation: FSMB Update (limited to subject matter)*	*C. Dalton*
February 16, 2018	University Club of DC International Committee Presentation by Journalist Nirmal Ghosh – Washington,DC	*H. Chaudhry*
February 20, 2018	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF ACTIVITY SUMMARY

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DATE	MEETING/EVENT	BOD/EXEC
February 20, 2018	Lunch Meeting with Dr. Richard Hawkins, CEO, ABMS – Irving, TX	*H. Chaudhry*
February 20, 2018	Highland Hospital – Rochester, NY Grand Rounds on Burnout and State Board Issues	*A. Hengerer*
February 20, 2018	FSMB Non-Contiguous U.S. Member Boards Videoconference with Debora Stovern, Executive Administrator (AK); Esther Fleming, Executive Director & Theodore Parker, RPh, MPH, Chair (CNMI); Nathaniel Berg, MD, Chair, & Marlene Carbullido, Acting Administrator (GU); Jone Geimer-Flanders, DO, Chair & Ahlani Quiogue, Executive Officer (HI); Veronica Rodriquez, MD, Secretary (PR); Frank Odlum, MD, Chair & Deborah Richardson-Peter, MPA, Director (VI)	*G. Snyder* *J. Landau* *K. Simons* *H. Chaudhry* *L. Robin*
February 21, 2018	FSMB Roundtable Webinar Speaker: Arthur S. Hengerer, MD, FACS Topic: Physician Burnout and the Licensing Process	*A. Hengerer* *H. Chaudhry*
February 21, 2018	Bylaws Committee Videoconference	*G. Snyder* *P. King* *J. Landau* *I. Marquand* *H. Chaudhry* *E. Fish* *L. Robin*
February 22, 2018	Workgroup on Board Education Service and Training (BEST) Videoconference	*G. Snyder* *P. King* *K. Simons* *H. Chaudhry* *L. Robin*
February 22, 2018	CSEC Oversight Committee Videoconference	*H. Chaudhry* *D. Johnson* *T. Phillips*
February 22, 2018	FARB Outreach Teleconference	*H. Chaudhry*
February 23, 2018	USMLE Medical Student and Resident Advisory Panel Meeting – TX FSMB Office	*H. Chaudhry* *D. Johnson*
February 25-27, 2018	Gartner CIO Forum – Phoenix, AZ	*M. Dugan*
February 26, 2018	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *E. Fish* *T. Phillips* *L. Robin*
February 26, 2018	Subcommittee on Future of AOGME Collegium of Fellows Teleconference	*H. Chaudhry*

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DATE	MEETING/EVENT	BOD/EXEC
February 26, 2018	IAMRA Management Committee Teleconference	*H.Chaudhry*
February 26, 2018	Meeting with Brownstein Hyatt Farber Schreck, LLP	*L. Robin*
February 26, 2018	Coalition Kick-Off Meeting Teleconference	*L. Robin*
February 26, 2018	FSMB Leadership Teleconference	*G. Snyder* *P. King* *H. Chaudhry* *L. Robin*
February 26, 2018	USMLE Social Media Training – Philadelphia, PA	*D. Johnson*
February 27, 2018	Lunch Meeting with Dr. Helen Burstin, CEO, CMSS – Washington, DC	*H. Chaudhry*
February 27, 2018	FSMB-AIM Leadership Teleconference with Kevin Bohnenblust	*H. Chaudhry*
February 27, 2018	Interview with the Toronto Star	*H. Chaudhry*
February 27, 2018	Physician Wellness Taskforce Meeting – Philadelphia, PA	*D. Johnson*
February 28, 2018	FSMB Leadership Teleconference	*G. Snyder* *P. King* *R. Loomis* *H. Chaudhry* *E. Fish*
February 28, 2018	NAM Conceptual Model Co-Leads Pre-Call WebEx	*A. Hengerer*
February 28, 2018	NAM Conceptual Model Working Group WebEx	*A. Hengerer*
February 28, 2018	NAM Conceptual Model Working Group Post Call Teleconference	*A. Hengerer*
March 1, 2018	Teleconference with Dr. Janelle Rhyne, Chair, FSMB Foundation	*H. Chaudhry*
March 1, 2018	Committee Appointments Review Meeting – FSMB DC Office	*P. King* *H. Chaudhry* *L. Robin*
March 2, 2018	Teleconference with Dr. William Burdick, VP for Education, FAIMER	*H. Chaudhry*
March 2, 2018	Committee for Individualized Review (CIR) Meeting – Philadelphia, PA	*D. Johnson*
March 5, 2018	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *E. Fish* *D. Johnson*

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		T. Phillips *L. Robin*
March 5, 2018	Meeing with Raine Richards, Director, AOA State Government Affairs, - FSMB DC Office	*H. Chaudhry*
March 5, 2018	Nominating Committee Teleconference	*A. Hengerer* *R. Loomis*
March 6, 2018	AAFP-FSMB Staff Teleconference	*H. Chaudhry*
March 6, 2018	Interview with the Washington Post	*H. Chaudhry*
March 6, 2018	Coalition Management Committee Teleconference	*H. Chaudhry*
March 7, 2018	Illinois Medical Disciplinary and Medical Licensing Boards Board Site Visit – Chicago, IL *Presentation: FSMB Update*	*I. Marquand* *M. Dugan*
March 7, 2018	NAM Action Collaborative Steering Committee Teleconference	*A. Hengerer*
March 8, 2018	Tri-Regulator Collaborative Meeting – Chicago, IL	*G. Snyder* *H. Chaudhry*
March 9, 2018	Annual Meeting Galusha Lecture Pre-briefing Teleconference with Dr. Kevin Fong	*H. Chaudhry*
March 9, 2018	Ethics and Professionalism Committee Teleconference	*G. Snyder* *J. Carter* *C. Dalton* *P. King* *H. Chaudhry* *L. Robin*
March 12, 2018	Louisiana State Board of Medical Examiners – New Orleans, LA *Presentaton: Physician Wellness and Suicide*	*A. Hengerer*
March 13, 2018	FSMB Foundation Board of Directors Teleconference	*G. Snyder* *K. Haley* *A. Hengerer* *R. Loomis* *H. Chaudhry* *L. Robin*
March 13, 2018	FSMB Foundation Grants Committee Teleconference	*R. Loomis*
March 14, 2018	Public Roundtable Discussion: Regulation & Antitrust Law - Washington D.C	*L. Robin*
March 19, 2018	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *E. Fish* *D. Johnson* *T. Phillips*

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		L. Robin
March 19, 2018	FSMB-FSPHP Annual Meeting Pre-briefing Teleconference	*G. Snyder* *H. Chaudhry*
March 21, 2018	NAM Conceptual Model Co-Lead Pre-Call WebEx	*A. Hengerer*
March 22, 2018	FSMB Roundtable Webinar Speakers: Jama Ball and Julie Briscoe Topic: Streamlining Licensure: The Uniform Application for Physician Assistants	*H. Chaudhry*
March 22, 2018	ECFMG-FSMB-NBME CEO Teleconference	*H. Chaudhry*
March 22, 2018	NYS Medical Society Annual Meeting – Buffalo, NY *Presentation: Update on NAM Project and Burnout Efforts*	*A. Hengerer*
March 22-23, 2018	NBME Annual Meeting – Philadelphia, PA	*G. Snyder* *P. King* *R. Loomis* *C. Walker-McGill*
March 23, 2018	Hashed Health Use Case Strategy Workshop – Nashville, TN	*M. Dugan* *E. Fish*
March 26, 2018	AMA-ABMS Conference – Chicago, IL	*H. Chaudhry*
March 26-28, 2018	KNOW Identity Conference – Washington D.C.	*M. Dugan*
March 27, 2018	IAMRA 2018 Conference Planning Committee Teleconference	*H. Chaudhry*
March 27, 2018	Teleconference with Dr. Victor Dzau, President, National Academy of Medicine (NAM)	*H. Chaudhry*
March 27, 2018	Teleconference with Dr. Alison Reid, Executive Director, IAMRA and Roxanne Huff, Operations Officer, IAMRA	*H. Chaudhry*
March 27, 2018	Rules Committee Teleconference	*P. King* *H. Chaudhry* *L. Robin*
March 28, 2018	USMLE Composite Committee WebEx	*P. King* *H. Chaudhry* *D. Johnson*
March 28, 2018	TRP Influencer Series Session – Washington, DC	*H. Chaudhry* *L. Robin*
March 28, 2018	NAM Conceptual Model Working GroupWebEx	*A. Hengerer*
March 28, 2018	NAM Conceptual Model Working Group Post Call Teleconference	*A. Hengerer*

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March 29, 2018	Meeting with Dr. Jay Bhatt, Senior VP and Chief Medical Officer, American Hospital Association – Washington, DC	*H. Chaudhry*
March 30, 2018	Annual Meeting Regenrative & Adult Stem Cell Therapy Session Panelist Pre-briefing Teleconference	*G. Snyder* *P. King* *S. Steingard* *L. Robin*
April 4, 2018	Reference Committee Chairs Pre-briefing Teleconference	*G. Snyder* *H. Chaudhry* *E. Fish* *L. Robin*
April 6, 2018	ECFMG/FAIMER Stakeholder's Session – Philadelphia, PA	*S. Steingard*
April 6, 2018	NBME Branding Taskforce Meeting – Philadelphia, PA	*D. Johnson*
April 6-7, 2018	NBCOT OT State Regulatory Leadership Forum	*L. Robin*
April 9, 2018	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
April 9, 2018	Tri-Regulator CEO Teleconference	*H. Chaudhry*
April 10, 2018	Bi-weekly Professional Licensure Coalition Teleconference	*H. Chaudhry*
April 10, 2018	Coalition Management Committee Teleconfernece	*H. Chaudhry*
Aril 11, 2018	Teleconference with Dr. Thomas Nasca, CEO, ACGME	*H. Chaudhry*
April 11, 2018	Greater New York Hospital Association (GNYHA): Building a Resilient and Compassionate Workforce – New York City, NY *Presentation: NAM Update*	*A. Hengerer*
April 11, 2018	United States Pharmacopeia 797 Committee on Physician Compounding – Washington, DC	*C. Dalton*
April 13, 2018	Leadership Meeting with Dr. Peter Katrufrakis, President, NBME – Philadelphia, PA	*P. King*
April 13, 2018	New York State Board of Medicine – Albany, NY *Presentation: "Which is the Licensing Part of the State Board about Burnout and Wellness Issues?"*	*A. Hengerer*
April 16, 2018	USMLE Budget Committee Meeting – Philadelphia, PA	*G. Snyder* *P. King* *R. Loomis* *H. Chaudhry*

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DATE	MEETING/EVENT	BOD/EXEC
		D. Johnson *T. Phillips*
April 17, 2018	C-Suite Meeting – DC and TX FSMB Offices	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
April 18, 2018	AACOM Annual Meeting – Washington, DC *Presentation: Leaders and Leadership: It's Not Complicated*	*H. Chaudhry*
April 18-20, 2018	Groningen Declaration Network – Paris, France *Presentation: The Use of Digital Credentials in U.S. Medical Licensing*	*M. Dugan*
April 19-21, 2018	American College of Physicians (ACP) Internal Medicine Meeting – New Orleans, LA	*P. King* *H. Chaudhry*
April 20-23, 2018	Master in Health Care Management Alumni Program – Boston, MA *Presentation: The Licensure Compact: Bipartianship in a Partisan Age*	*H. Chaudhry*
April 23, 2018	State Society Leaders Webinar on Professional Regulation Across the Continuum of Medical Training and Practice	*H. Chaudhry*
April 23, 2018	NAM Conceptual Model Co-Leads Pre-Call WebEx	*A. Hengerer*
April 24-28, 2018	FSMB Investment and Compensation Committee Meeetings; FSMB-AIM Reception/Dinner; FSMB Board of Directors Meeting; Annual Meeting – Charlotte, NC	*G. Snyder* *J. Carter* *C. Dalton* *K. Haley* *A. Hayden* *A. Hengerer* *P. King* *J. Landau* *R. Loomis* *I. Marquand* *J. Rexford* *K. Simons* *S, Steingard* *C. Walker-McGill* *M. Zanolli* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips*

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DATE	MEETING/EVENT	BOD/EXEC
		L. Robin

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 the introduction of federal legislation that would limit antitrust liability for state licensing boards, creating a balanced approach that is now necessary as states determine how best to actively supervise their state licensing boards, entrusted to simultaneously protect the public and allow for competition in the marketplace for consumers. 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 approximately a dozen organizations representing state occupational and licensing boards, the FSMB hosts bi-weekly conference calls with coalition members and communicates regularly with Congressional staff. The PLC is advocating in Congress for the introduction and enactment of federal legislation that would eliminate the potential for antitrust damage liability against state boards, their members, and employees for conduct within the scope of their official duties, as well as for persons acting at their direction, while permitting injunctive relief by government enforcers and private parties.
- The FSMB worked closely with the Minnesota Board of Medical Practice's Policy & Planning Committee in drafting a letter to U.S. Senator Amy Klobuchar, Ranking Member of the Senate Judiciary Subcommittee on Antitrust, Competition Policy and Consumer Rights, urging her to sponsor the bipartisan legislation.

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 2018, 23 states and territories have enacted the Compact, and seven states and the District of Columbia are currently considering adopting the model legislation.
- In June 2016, the FSMB, on behalf of the Interstate Medical Licensure Compact Commission, was awarded a three-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 its Commission in implementing the administrative and technical infrastructure necessary to fully operationalize the IMLC, as well as outreach activities to expand the number of participating states.

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

- *Advisory Council of Board Executives:* Charged with updating the FSMB's companion documents that provide state medical and boards a useful blueprint for their structure and function as stated in their medical practice acts, *Guide to the Essentials of a Modern Medical Practice Act* and *Elements of a State Medical and Osteopathic Board*, the Council recommended condensing the companion documents into one new document, *Guidelines for the Structure and Function of a State Medical and Osteopathic Board.* The proposed document incorporates the contents of the prior policies, containing the principles of state medical board responsibility, duty, empowerment, and accountability that the initial documents outlined, as well as detailing the essential components for the structure and function of a state medical board.

- *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's efforts have included conducting a thorough analysis of various orientation and training materials shared by the state board community, as well as identifying appropriate content and educational approaches to board member training. Products of the workgroup will include brief educational modules on the roles and responsibilities of board members, what it means to be an effective board member, the purposes of medical licensure and discipline, and individual modules on specific regulatory topics.
- *Workgroup for Education on Medical Regulation*: The Workgroup has released three individual online educational modules about medical regulation primarily designed for medical students and residents: "The Role of State Medical Boards," "Understanding and Navigating the Medical Licensing Process," and a module on the medical disciplinary process which orients the learner to medical discipline, a key function of state medical boards. Other modules are planned to be released over the next year.
- *Workgroup on Physician Wellness and Burnout*: Over the course of two years, the Workgroup examined the issue of physician burnout from a broad perspective, reviewing existing research, resources, and strategies for addressing it. The Workgroup has drafted the *Report of the FSMB Workgroup on Physician Wellness and Burnout* that includes recommendations, most of which pertain to the licensing and license renewal processes of state medical boards, as well as suggestions for external organizations that aim to address physician burnout.
- *Workgroup on Prescription Drug Monitoring Programs:* FSMB Chair Gregory B. Snyder, MD, DABR, appointed the Workgroup on Prescription Drug Monitoring Programs (PDMP) in response to House of Delegates Resolution 17-1, Mandatory Use of Prescription Drug Monitoring Programs. The Workgroup's report is intended to serve as a guidance document for state medical boards and other state agencies to maximize the effective use of PDMPs.
- *Workgroup to Study Regenerative and Stem Cell Therapy Practices:* The Workgroup, convened in May 2017 by FSMB Chair Gregory B. Snyder, MD, DABR, in response to a request from U.S. Senator Lamar Alexander (R-TN), Chairman of the US Senate Health, Education, Labor, and Pensions (HELP) Committee, urging the FSMB to develop best practices for state medical boards in regulating the promotion, communication, and practices of treatments received at stem cell clinics in the U.S. The Workgroup drafted the *Report of the FSMB Workgroup to Study Regenerative and Stem Cell Therapy Practices* for consideration by the House of Delegates. The guidance document addresses the regulation of the provision of stem cell and regenerative therapies, as well as their promotion and communication to patients, and documentation of treatments provided.
- *Ethics and Professionalism Committee*: The Committee continued work started in 2015 on compounding of medications by physicians and drafted the White Paper on Compounding Medications by Physicians. The White Paper will be distributed to state medical boards and will be posted on the FSMB website.
- *Editorial Committee:* The Committee provided guidance to *Journal of Medical Regulation* staff on potential manuscript topics and authors, reviewed manuscript submission policies and editorial processes, and received an update on efforts underway to pursue *JMR* indexing with the National Library of Medicine's MEDLINE database.

The FSMB followed up a special summit meeting it hosted in Washington, D.C., in February 2017, titled "Duty to Report: Sharing Information to Protect Patients," by communicating recommendations from the summit's participants to FSMB membership, the public and other stakeholders. The summit included a broad cross-section of stakeholders from various medical organizations, government agencies and patient safety groups that are impacted by the current environment for reporting. The meeting's goal was to begin a dialogue that will lead to new thinking and approaches to improving the reporting of unprofessional conduct and information sharing.

- Recommendations for action were summarized in a special report released to state medical boards, the public and stakeholders.
- FSMB engaged state medical boards in a discussion of the summit's recommendations during a Roundtable webinar.
- The FSMB will continue to address the issue in future stakeholder forums, including sessions at its Annual Meeting.

The FSMB works directly with state medical boards to achieve their individual legislative and policy priorities. In 2017, 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.
- 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 2017 included: Continuing Medical Education, Medical Marijuana, Pain Management, Physician Profiling, Standard of Proof, 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.

- In June 2017, the Mississippi State Board of Medical Licensure requested and accepted a proposal from the FSMB to conduct a review of the Board's operations, processes, and policies. The FSMB subsequently assembled a review team of state medical board representatives and FSMB staff, which conducted an on-site review of the board and a report outlining recommendations for improving various processes and policies.
- The FSMB began preparations for the 2018 *U.S. Medical Regulatory Trends and Actions Report*, which provides the nation's most comprehensive and current information about the make-up, policies and work of the 70 state medical boards. The report, which is published every two years, offers valuable information for consumers, aimed at helping them gather information about physicians, file complaints and utilize the services of their state medical board.
- The report provides updated data on each state medical board, as well as national aggregated data on physician licensure and discipline.

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

- The Physician Data Center (PDC) encompasses multiple software tools to load, analyze, audit, research and match incoming licensure file transmissions from state medical boards. During 2017, FSMB's Data Integration Department loaded 1,385 files with more than 75 million license records.
- The Physician Data Center notifies querying states of other states in which the applicant is licensed, and alerts them if an applicant has been disciplined in another jurisdiction. State boards queried the PDC 109,822 times in 2017.
- State boards continue to successfully collaborate in using the FSMB's Disciplinary Alert Service to prevent disciplined physicians with multiple licenses from resuming practice undetected in new locations. The FSMB sent 15,147 disciplinary alerts to state boards in 2017.

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 11th annual USMLE orientation for current and former members of state medical boards to identify individuals interested in participating with the USMLE. More than 100 individuals have attended these orientations with approximately 40% of

attendees subsequently participating in one form or another in the operations or management of the USMLE program.
- The State Board Advisory Panel to USMLE, which consists of representatives from 11 state boards, provided guidance to FSMB and NBME staff on issues impacting the program.
- Representatives from 23 state medical boards participated in the USMLE program in 2017, including service on item-writing committees, standard setting panels, governance committees, and special committees.
- The FSMB hired a new Social Media Specialist to help promote the USMLE program's social media channels and improve its proactive outreach to examinees, medical educators, medical regulators and the public. The specialist reports to the FSMB Director of Communications and Public Affairs and will work directly with FSMB Assessment Services and USMLE staff at NBME and ECFMG.

The Post-Licensure Assessment System is a collaborative initiative of the FSMB and the National Board of Medical Examiners. Through this system, the FSMB offers services to assist member boards with evaluating the current medical knowledge and clinical competence of currently or previously licensed physicians.
- Representatives from eight state medical and osteopathic boards served on PLAS committees in 2017.

The FSMB distributes electronic and print communications to inform state medical boards of trends in medical regulation and facilitate intra-board communications.
- The *FSMB eNews* is distributed twice-weekly to more than 5,500 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 2017 that illuminated various issues of interest to medical boards, including. Personal Drug Diversion of Narcotics by Physicians: The Role of Medical Regulation and Physician Health Programs; A Census of Actively Licensed Physicians in the United States, 2016; and Extended Release and Long-Acting Opioids Analgesics Risk Evaluation and Mitigation Strategy (REMS): Educating Providers on the FDA's Approved Risk Management Program.
- The *FSMB Advocacy Alert* E-Newsletter provides monthly updates on federal and state legislative and regulatory activity related to medical regulation and includes occasional "calls to action" in support/opposition to legislation.
- 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 Board of Directors hosted its annual Capitol Hill Advocacy Day in February 2018 in Washington, D.C., meeting with the offices of 40 U.S. House Representatives and Senators to discuss issues critical to state medical boards, including continued efforts to address and respond to the *FTC v. North Carolina State Board of Dental Examiners* decision.
- FSMB CEO Humayun Chaudhry, DO, MACP, testified before the U.S. House Veterans Affairs Subcommittee on Oversight and Investigations at a hearing entitled *Examining VA's Failure to*

Address Provider Quality and Safety Concerns. The hearing was called after the release of a Government Accountability Office (GAO) report that found significant deficiencies in VA medical facility reporting procedures. Dr. Chaudhry urged the U.S. Department of Veterans Affairs to improve its information sharing processes, especially in terms of alerting state licensing boards in a timely fashion of disciplinary actions taken by the VA against a clinician.

- The FSMB, along with the National Council of State Boards of Nursing (NCSBN), successfully negotiated with Senate staff and the Department of Veterans Affairs (VA) to remove language from the *Veterans E-Health and Telemedicine Support Act of 2017* that would have extended and expanded state licensure exceptions to personal services contractors.
- The FSMB submitted comments in response to the Federal Trade Commission (FTC) Economic Liberty Task Force Roundtable, *Streamlining Licensing Across State Lines: Initiatives to Enhance Occupational License Portability*, highlighting that the successful development and implementation of the Interstate Medical Licensure Compact serves as a prime example of state innovation and cooperation, and further achieves the goals of the FTC in reducing barriers to entry and enhancing competition through interstate mobility and practice, while ensuring the protection of the public.
- FSMB coordinated a pilot FDA-FSMB Data Research Project with the U.S. Food and Drug Administration to evaluate the value of general/targeted electronic communications from the FDA and/or FSMB with licensed physicians. The FDA has initiated the pilot communications plan with the Medical Board of California and the Oklahoma Board of Medical Licensure and Supervision.
- The FSMB electronically distributed its *Census of Actively Licensed Physicians in the United States, 2016* to the U.S. House of Representatives and U.S. Senate.
- 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: Maintenance of Certification (MOC) legislation, Doctor of Medical Science legislation, Physician Burnout, the FSMB's *Model Guidelines for the Recommendation of Marijuana in Patient Care*, state regulatory trends, opioid prescribing limits, and continuing medical education requirements.
- The FSMB responded to information requests from the American Medical Association, Council of Medical Specialty Societies, DC Board of Medicine, Florida Attorney General's Office, Florida Board of Medicine, the Federation of Podiatric Medical Boards, Massachusetts Medical Society, Minnesota Board of Medical Practice, Mississippi State Board of Medical Licensure, National Association of Boards of Pharmacy, New Jersey Office of Attorney General, and Washington Medical Quality Assurance Commission.

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

- *Department of Veterans Affairs Provider Accountability Act*, which would require the Under Secretary of Health to report major adverse personnel actions involving health care employees to the NPDB and to applicable state licensing boards. This legislation was introduced in response to a *USA Today* investigative report.
- *The Ethical Patient Care for Veterans Act of 2017*, which directs the Department of Veterans Affairs to ensure that each VA physician is informed of the duty to report any covered activity

committed by another physician that the physician witnesses, or otherwise directly discovers, to the applicable state licensing authority within five days.

- *Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2017*, which would expand the use of telehealth and remote patient monitoring (RPM) services in Medicare.
- *The Health for Each American Less Fortunate Through Help from Medical Professionals in Every Rural and Impoverished Area Act of 2017 (HEALTHIER Act)*, which directs the Secretary of Health and Human Services to establish a grant program for states that provide flexibility in licensing for health care providers who offer services on a volunteer basis.
- *Teaching Health Centers Graduate Medical Education Extension Act of 2017* and *Training the Next Generation of Primary Care Doctors Act of 2017*, which take an important step towards addressing the nation's primary care physician shortage by reauthorizing the Teaching Health Center Graduate Medical Education Program for three years.

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 membership of the 70 state medical and osteopathic boards of 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.

- To enhance communications between FSMB and its member boards, the Board of Directors' State Medical Boards Liaison Program visited 17 state medical boards in 2017 and engaged in more than 60 one-on-one communications with board liaison representatives.
- 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 third Symposia in July 2017 in Chicago. The theme of this year's Symposium was *Addressing Challenges Together, Increasing Impact*, with particular focus on the opiate crisis in health care.
- FSMB periodically participates in trilateral meetings with the National Board of Medical Examiners (NBME) Executive Board and Educational Commission for Foreign Medical Graduates (ECFMG) Board of Trustees to discuss issues pertinent to each organization. Preparations are underway for the next tri-lateral meeting in 2018.
- 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) and the Post-Licensure Assessment System (PLAS), which supports the Special Purpose Examination (SPEX) for physicians who are already licensed. FSMB continues to promote *NBME U*, introduced in 2015-16 as a resource to medical educators and others interested in the more technical aspects of physician assessment.
- 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 National Governors Association (NGA), 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 (FSPHP) 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 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 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 2018, IAMRA has 112 members from 48 countries.
- FSMB President and CEO Dr. Humayun Chaudhry is completing his term as Chair of IAMRA through the IAMRA Members General Assembly in October 2018. He will continue as Secretary of IAMRA.
- The Physician Information Exchange (PIE) Working Group, in which the FSMB participates, is conducting a pilot project for a system designed to enable proactive disciplinary information exchange about physicians. Data is currently being shared among participating jurisdictions and feedback from the pilot project will be used to establish an ongoing system which will be available to IAMRA members around the world.
- Representatives of the FSMB attended and presented at the IAMRA Symposium on Continued Competence in London in October 2017. The focus of the symposium was *Continued Competence Systems - Measuring their Impact and Value.*
- 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. In 2017, *JMR* published an article about the rise of female international medical graduates and their contribution to the U.S. physician workforce, as well as a series of international briefs.

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 Continuing Medical Education (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 participated on the program planning committee for IAMRA's Continued Competency Symposium, co-sponsored by the General Medical Council (UK) and presented on a variety of topics at the Symposium.

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 will hold its 106th Annual Meeting in Charlotte, North Carolina, in April 2018. 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 workshop included the federal and state legislative impact of the *NCBDE vs. FTC* case, prosecuting opioid prescribing cases, cross-examining the licensee expert witness, and the use of social media/electronic media in administrative hearings.

The FSMB, an accredited continuing medical education (CME) provider through the Accreditation Council of Continuing Medical Education (ACCME), is available to assist state medical boards with accredited educational program development and management. FSMB's recent CME activities include:

- Beginning in the spring of 2018, the DEA will host regional one-day Practitioner Diversion Awareness Conferences throughout the United States. Designed to assist health care practitioners identify and prevent diversion activity, each one-day conference will be open to all DEA registered practitioners and prescribers, including physicians, nurses, pharmacists, dentists and veterinarians. FSMB will serve as the CME accredited provider for each of the live activities in which physicians will be eligible CME credit.
- FSMB staff is evaluating offering journal-based CME within select issues of the *Journal for Medical Regulation,* and anticipates accrediting its first journal-based CME activity in the summer of 2018.

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 FSMB manages and maintains the widely used Board Attorney listserv, which allows participants to submit inquiries and solicit responses on a wide array of legal matters of relevance to state 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 addressed issues of interest to the medical board community, including:
    - In response to a 2017 House of Delegates' Resolution, the FSMB hosted ACGME's CEO Tom Nasca, MD, to discuss ACGME-International and clarify the purpose and appropriate use of ACGME-I as related to licensure in the U.S.
    - Representatives from the Educational Commission for Foreign Medical Graduates discussed the impact of the Executive Orders on immigration signed by President Trump on the 2017-18 residency recruitment season.
    - FSMB hosted a discussion with medical boards on the recommendations from the "Duty to Report: Sharing Information to Protect Patients" summit hosted by FSMB in 2017.

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. During 2017, progress has continued in improving the services provided to FSMB member boards and FSMB's physician user community.

- FSMB launched a newly redesigned website to deliver a more intuitive and easy-to-navigate experience for its users. The new FSMB.org design was guided by feedback gathered from multiple focus groups, listening sessions and surveys completed by state medical boards and thousands of FSMB's diverse group of constituents. Key features of the new site include an enhanced search function, audience-based site navigation, social media integration and a modern responsive design on all mobile devices.
- FSMB improved efficiencies and customer satisfaction by implementing a series of system enhancements throughout its technical infrastructure, including:

  - Assessment Services Transcript Rewrite
  - FCVS 3.0 finalization
  - FCVS ECFMG API
  - Microsoft Office Upgrade
  - Exchange Online Migration
  - IAMRA Data Sharing System
  - Business Intelligence Reporting and Forecasting
  - Diligent Board Software
  - Integration of NPDB to FCVS

- The Research Department worked closely with FSMB leadership and staff to develop a set of questions to assist with the needs of workgroups, committees and topics referred to the FSMB Board of Directors and fielded its third annual survey to state board executive directors in 2017. The survey gathered valuable information on these topics: licensee impairment, reporting by hospitals and health systems, malpractice judgments, investigations related to stem cells, physician suicide, board composition, state board inactions with media, antitrust and assessment.
- The Research Department compiled data for the 2017 *A Census of Actively Licensed Physicians in the United States*. The census, released every two years in the *Journal of Medical Regulation*, uses data received by the FSMB from the nation's state medical and osteopathic licensing boards. FSMB's fourth census provides a useful and current snapshot of the physicians licensed to practice medicine in the United States.

The Federation Credentials Verification Service (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.

- With the full implementation of its next generation FCVS application, overall cycle times have been trending at 30 days or less since October 2017. This new system takes advantage of automation and focuses on electronic verifications.
- In line with the improved overall cycle times, Customer Satisfaction scores have reached 90% or better for the past five months, peaking at 96% in January 2018.
- From 1996 to 2017, FCVS has produced 529,684 physician profiles.

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, and more than 101,000 physicians have submitted their applications for licensure using the UA.
- The UA has now also been enhanced to support licensure applications for Physician Assistants. This functionality is now available and in use by the Oklahoma State Board of Medical Licensure and Supervision. Other boards have expressed an interest in adopting this process.

FSMB's Closed Residency Programs service provides ongoing storage of training records for physicians who attended a training program that no longer exists.

- FSMB now maintains the records of 239 closed programs accounting for more than 48,000 physicians; in 2017, FSMB issued 1,875 credentialing verifications for physicians who attended a now closed program.

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.
- The FSMB continued to make major investments in technology and a system-wide integration of its previously diverse data systems into a single, integrated enterprise. This effort has changed the way FSMB works internally in many ways, adding to its effectiveness.
- 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.

TAB G: Treasurer's Report

Management Note:

The Report of the Treasurer is included under **Attachment 1**.

A copy of the Auditor's "Report and Financial Statements for Fiscal Years (FY) ended April 30, 2017 and 2016" is provided under **Attachment 2**. The accounting firm, Clifton Larson Allen, issued an audit report with no significant findings or deficiencies.

FY2018 year-to-date performance compared to budget through the third quarter (May 1, 2017–January 31, 2018) is included under **Attachment 3**.

Following the Finance Committee's review and recommendation of the proposed FY2019 Operating and Capital Budget (for the period May 1, 2018–April 30, 2019), the Board of Directors moved to recommend to the FSMB House of Delegates that the proposed FY2019 Budget be approved. The proposed FY2019 Budget is included under **Attachment 4.**

ITEM FOR ACTION:

APPROVE the proposed FY 2019 Budget as recommended by the FSMB Board of Directors.

Attachment 1

Treasurer's Report
April 2018

The Treasurer's functions are carried out at Board meetings, Committee meetings, and through interaction with FSMB staff. The Treasurer chairs the Finance Committee, the Investment Committee and serves on the Audit, Executive, and Compensation Committees. Committee Members are noted in the report included in the House of Delegate Materials. Committee functions and highlights for Fiscal Year 2018 are noted in the sections that follow.

Finance Committee

Finance Committee responsibilities noted in the Bylaws include the following:

- Review the financial condition of the Federation.
- Review and evaluate the costs of the activities and programs to be undertaken in the forthcoming year.
- Present a budget to the Board of Directors for its recommendation to the House of Delegates at the Annual Meeting.
- Perform such other duties as assigned to it by the Board of Directors.

Fiscal Year 2018 highlights of the Finance Committee

- Orientation and Education of Committee Members
- Met on January 22, 2018 at FSMB's Texas office. The Finance Committee received a detailed presentation of FSMB budget setting process, an overview of the organization's operation as related to finances and the proposed FY2019 Budget.
- The Committee voted to recommend the budget for presentation to the Board of Directors. This budget is presented to the House of Delegates ***for action*** following the Treasurer's Report.

Investment Committee

The Investment Committee monitors investments and provides status reports to the BOD, explores investment options, recommends changes in investments as needed, and considers/recommends policy changes.

Fiscal Year 2018 highlights of the Investment Committee

- The Investment Committee held four meetings throughout the course of the year.
- The committee reviewed the investment strategies and policies in relation to the organization's strategic plan.

Audit Committee

The Audit Committee reviews the financial statement and audit of the corporation, and advises the Board of Directors on fiscal policy to ensure the company's continued financial strength.

Fiscal Year 2018 highlights of the Audit Committee

- Audit field work performed by audit firm, Clifton Larson Allen, in June 26-30 2017.
- Audit Committee reviewed Auditor's Report in October 2017.
- The auditors determined the consolidated financial statements are free from material misstatement.
- Accepted the Auditor's Report and recommended it for approval by Board of Directors at the October 2017 BOD meeting.

Conclusion

In addition to these narrative comments, I refer you to the detailed attachments, which follow. In closing, I would like to thank each member of the Finance, Investment, and Audit Committees, FSMB management, and the House of Delegates for allowing us to serve you.

Respectfully submitted,

Ralph C. Loomis, MD
FSMB Treasurer

Attachment 2

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

CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEARS ENDED APRIL 30, 2017 AND 2016

FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC. AND SUBSIDIARY
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YEARS ENDED APRIL 30, 2017 AND 2016

CliftonLarsonAllen

CliftonLarsonAllen LLP
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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, 2017 and 2016, 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, 2017 and 2016, 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 11, 2017

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
CONSOLIDATED STATEMENTS OF FINANCIAL POSITION
APRIL 30, 2017 AND 2016

	2017	2016
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	$ 14,305,261	$ 11,175,456
Accounts Receivable:		
Disciplinary Searches	271,835	172,566
Other	338,326	483,177
Prepaid Expenses	492,737	490,059
Other Assets	50,309	40,514
Total Current Assets	15,458,468	12,361,772
NONCURRENT ASSETS		
Investments	28,998,103	26,455,124
Prepaid Expenses	37,756	-
Property and Equipment, Net	5,251,762	5,447,349
Total Noncurrent Assets	34,287,621	31,902,473
Total Assets	$ 49,746,089	$ 44,264,245
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable	$ 7,956,968	$ 6,711,051
Unearned Revenue - USMLE and SPEX	9,428,274	9,695,198
Deferred Compensation	1,242,579	1,159,348
Capital Lease Payable	16,975	15,549
Total Current Liabilities	18,644,796	17,581,146
NONCURRENT LIABILITIES		
Capital Lease Payable	31,820	48,795
Total Noncurrent Liabilities	31,820	48,795
NET ASSETS		
Unrestricted:		
Board-Designated Endowment	2,251,295	1,954,087
Undesignated	28,818,178	24,680,217
Total Net Assets	31,069,473	26,634,304
Total Liabilities and Net Assets	$ 49,746,089	$ 44,264,245

See accompanying Notes to Consolidated Financial Statements.

FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC. AND SUBSIDIARY
CONSOLIDATED STATEMENTS OF ACTIVITIES
YEARS ENDED APRIL 30, 2017 AND 2016

	April 30, 2017			April 30, 2016		
		Unaudited			Unaudited	
			Variance Favorable			Variance Favorable
	Unrestricted	Budget	(Unfavorable)	Unrestricted	Budget	(Unfavorable)
REVENUES AND GAINS						
Examination Revenue - USMLE	$ 27,326,680	$ 26,728,000	$ 598,680	$ 24,289,385	$ 26,307,360	$ (2,017,975)
Examination Revenue - PLAS	188,500	243,000	(54,500)	237,250	200,000	37,250
Transfer Fees - USMLE	(20,092,999)	(19,511,440)	(581,559)	(17,578,737)	(19,467,446)	1,888,709
Transfer Fees - PLAS	(101,600)	(225,000)	123,400	(130,400)	(200,000)	69,600
Subtotal	7,320,581	7,234,560	86,021	6,817,498	6,839,914	(22,416)
Examination History Reports	6,363,986	5,816,000	547,966	6,099,520	5,620,000	479,520
Other Exam Revenue	855,505	549,320	306,185	749,517	689,900	59,617
Physician Data Center	1,567,277	1,418,961	148,316	1,446,442	1,600,000	(153,558)
Public Access Revenue	-	-	-	16,133	-	16,133
Registration Fees	142,183	134,000	8,183	136,673	170,700	(34,027)
FCVS Revenue	8,769,859	9,031,944	(262,085)	8,898,368	9,288,432	(390,064)
Member Dues	176,950	172,375	4,575	175,350	170,200	5,150
Shipping and Handling Fees	83,400	82,500	900	84,050	82,500	1,550
Grants and Contributions	273,763	-	273,763	268,193	88,750	179,443
Interest and Dividends	672,666	250,000	422,666	677,401	250,000	427,401
Net Investment Gain (Loss)	2,013,739	-	2,013,739	(1,358,286)	-	(1,358,286)
Other Revenue	231,666	112,220	119,446	463,963	90,400	373,563
Total Revenues and Gains	28,471,555	24,801,880	3,669,675	24,474,822	24,890,796	(415,974)
EXPENSES						
Salary and Benefits	15,510,939	16,259,184	748,245	15,579,698	16,315,992	736,294
Data Processing	935,493	1,027,558	92,065	979,734	939,248	(40,486)
General Office	2,915,933	3,024,616	108,683	3,106,001	3,327,994	221,993
Travel and Program	1,680,690	1,823,181	142,491	1,759,701	1,265,211	(494,490)
Occupancy	642,852	576,951	(65,901)	632,167	591,570	(40,597)
Professional Services and Dues	902,332	603,143	(299,189)	614,829	975,089	360,260
Legislative and Legal	316,987	315,000	(1,987)	261,529	240,000	(21,529)
Total Expenses	22,905,226	23,629,633	724,407	22,933,659	23,655,104	721,445
CHANGES IN NET ASSETS BEFORE DEPRECIATION	5,566,329	$ 1,172,247	$ 4,394,082	1,541,163	$ 1,235,692	$ 305,471
Depreciation	1,131,160			1,632,466		
CHANGE IN NET ASSETS	4,435,169			(91,303)		
Net Assets - Beginning of Year	26,634,304			26,725,607		
NET ASSETS - END OF YEAR	$ 31,069,473			$ 26,634,304		

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, 2017 AND 2016

	2017	2016
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in Net Assets	$ 4,435,169	$ (91,303)
Adjustments to Reconcile Change in Net Assets to Net Cash Provided by Operating Activities:		
Depreciation	1,131,160	1,632,466
Net Investment (Gain) Loss	(2,013,739)	1,358,286
Change in:		
Accounts Receivable	45,582	71,610
Accrued Interest	-	3,351
Prepaid Expenses	(40,434)	118,145
Other Assets	(9,795)	19,899
Accounts Payable	1,245,917	3,297,570
Unearned Revenue - USMLE and SPEX	(266,924)	1,532,125
Deferred Compensation	83,231	111,495
Net Cash Provided by Operating Activities	4,610,167	8,053,644
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from Sales and Maturities of Marketable Securities	19,744,204	13,689,824
Purchase of Marketable Securities	(20,273,444)	(16,673,377)
Purchases of Property and Equipment	(935,573)	(983,914)
Net Cash Used by Investing Activities	(1,464,813)	(3,967,467)
CASH FLOWS FROM FINANCING ACTIVITIES		
Payments on Capital Lease Obligation	(15,549)	(14,242)
NET CHANGES IN CASH AND CASH EQUIVALENTS	3,129,805	4,071,935
Cash and Cash Equivalents - Beginning of Year	11,175,456	7,103,521
CASH AND CASH EQUIVALENTS - END OF YEAR	$ 14,305,261	$ 11,175,456

See accompanying Notes to Consolidated Financial Statements.

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
YEARS ENDED APRIL 30, 2017 AND 2016

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, 2017 and 2016.

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
YEARS ENDED APRIL 30, 2017 AND 2016

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, 2017, 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
YEARS ENDED APRIL 30, 2017 AND 2016

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

Net Assets

The Federation and the Foundation report their net assets as unrestricted or temporarily restricted. The purposes of each class of the net assets are as follows:

Unrestricted Net Assets

Undesignated – Represents net assets available for program and supporting services for both organizations.

Board Designated – Represents unrestricted net assets designations by the Foundation board for specific purposes.

Temporarily Restricted Net Assets

The Federation and the Foundation did not have any temporarily restricted net assets or related activity for the years ended April 30, 2017 and 2016.

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.

All contributions are considered to be available for unrestricted use unless specifically restricted by the donor. Unconditional promises to give are recorded as received. Conditional promises to give are not included as support until the conditions are 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.

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.

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
YEARS ENDED APRIL 30, 2017 AND 2016

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

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.

Subsequent Events

In preparing these consolidated financial statements, the Federation has evaluated events and transactions for potential recognition or disclosure through October 11, 2017, the date the consolidated financial statements were available to be issued. On July 18, 2017, the Federation closed on the purchase of a building in Washington, D.C. for $4.15 million in cash. There were no other events or transactions subsequent to year-end requiring recognition or disclosure.

NOTE 2 INVESTMENTS

Investments are comprised of the following at April 30:

	2017	2016
Mutual Funds - Fixed Income	$ 8,098,184	$ 6,607,093
Mutual Funds - Equity	13,651,572	8,630,832
Stocks	5,299,662	9,035,091
Absolute Return Investments	57,998	1,162,888
Private Equity	1,890,687	1,019,220
Total	$ 28,998,103	$ 26,455,124

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
YEARS ENDED APRIL 30, 2017 AND 2016

NOTE 2 INVESTMENTS (CONTINUED)

Investment earnings consist of the following for the years ended April 30:

	2017	2016
Interest and Dividends	$ 672,666	$ 677,401
Net Unrealized/Realized Gain (Loss)	2,013,739	(1,358,286)
Total Investment Earnings (Loss)	$ 2,686,405	$ (680,885)

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
YEARS ENDED APRIL 30, 2017 AND 2016

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:

	2017			
	Level 1	Level 2	Level 3	Total
Mutual Funds - Fixed Income	$ 8,098,184	$ -	$ -	$ 8,098,184
Mutual Funds - Equity	13,651,572	-	-	13,651,572
Stocks	5,299,662	-	-	5,299,662
Total	27,049,418	-	-	27,049,418
NAV Funds	-	-	-	1,948,685
Total with NAV Funds	$ 27,049,418	$ -	$ -	$ 28,998,103

	2016			
	Level 1	Level 2	Level 3	Total
Mutual Funds - Fixed Income	$ 6,607,093	$ -	$ -	$ 6,607,093
Mutual Funds - Equity	8,630,832	-	-	8,630,832
Stocks	9,035,091	-	-	9,035,091
Total	24,273,016	-	-	24,273,016
NAV Funds	-	-	-	2,182,108
Total with NAV Funds	$ 24,273,016	$ -	$ -	$ 26,455,124

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:

	2017		
	Net Asset Value	Unfunded Commitments	Redemption Frequency
Absolute Return Investments	$ 57,998	$ -	Quarterly
Private Equity Funds	1,890,687	-	Quarterly
Total	$ 1,948,685	$ -	

	2016		
	Net Asset Value	Unfunded Commitments	Redemption Frequency
Absolute Return Investments	$ 1,162,888	$ -	Quarterly
Private Equity Funds	1,019,220	-	Quarterly
Total	$ 2,182,108	$ -	

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:

	2017	2016
Land	$ 690,151	$ 690,151
Buildings	4,679,545	4,473,017
Furniture, Fixtures, and Equipment	1,370,594	1,370,594
Computer Systems	23,314,887	22,585,840
Total	30,055,177	29,119,602
Less: Accumulated Depreciation and Amortization	(24,803,415)	(23,672,253)
Total Property and Equipment	$ 5,251,762	$ 5,447,349

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. 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.

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, 2017 and 2016 is as follows:

	Unrestricted Net Assets
Endowment Fund Balance, April 30, 2016	$ 1,954,087
Additions	221,000
Earnings and Expenses:	
Investment Income	24,364
Investment Expenses	(13,469)
Unrealized and Realized Gains	81,800
Total Earnings and Expenses	92,695
Appropriations	(16,487)
Endowment Fund Balance, April 30, 2017	$ 2,251,295

	Unrestricted Net Assets
Endowment Fund Balance, April 30, 2015	$ 2,036,551
Additions	-
Earnings and Expenses:	
Investment Income	34,121
Investment Expenses	(21,158)
Unrealized and Realized (Losses)	(79,287)
Total Earnings and Expenses	(66,324)
Appropriations	(16,140)
Endowment Fund Balance, April 30, 2016	$ 1,954,087

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
YEARS ENDED APRIL 30, 2017 AND 2016

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:

	2017	2016
Equipment	$ 83,063	$ 83,063
Less: Accumulated Depreciation	(38,687)	(22,075)
Assets Under Capital Lease, Net	$ 44,376	$ 60,988

Included in depreciation expense for the years ended April 30, 2017 and 2016 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, 2017:

Year Ending April 30,	Amount
2018	$ 20,597
2019	20,597
2020	13,732
Total Future Minimum Lease Payments	54,926
Less: Amounts Representing Interest	(6,131)
Present Value of Future Minimum Annual Lease Payments	48,795
Less: Current Portion of Capital Lease Obligations	(16,975)
Capital Lease Obligations, Net	$ 31,820

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. Future minimum rental payments due under the lease are as follows:

Year Ending April 30,	Amount
2018	$ 121,356
2019	127,424
2020	89,197
Total	$ 337,977

Rental expense totaled $116,059 for the year ended April 30, 2017.

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
YEARS ENDED APRIL 30, 2017 AND 2016

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, 2017. 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 $1,441,270 during 2017 and $1,324,552 during 2016, 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 $2,611 and $93,406 during 2017 and 2016, 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, 2017, the potential liability to the Federation is approximately $449,000 for meetings contracted through fiscal year 2019. Based on prior performance, management believes the likelihood of cancellations to be remote.

NOTE 11 FUNCTIONAL EXPENSES

Expenses were incurred for the following functional areas of the Federation for the years ended April 30:

	2017											
			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	$ 15,510,939	$ 4,916,937	$ 253,560	$ -	$ -	$ 1,009,691	$ 160,386	$ 5,469,642	$ 1,140,653	$ 2,540,070	$ -	$ 10,594,002
Data Processing	935,493	82,878	14,859	363	-	21,576	1,800	34,519	6,143	771,555	-	852,615
General Office	2,915,933	646,866	38,385	200,484	803	843,780	12,992	1,013,652	99,087	43,433	16,648	2,269,247
Travel and Program	1,680,690	232,321	736,512	385,043	139,076	94,040	-	27,797	13,965	29,937	21,999	1,448,369
Occupancy	642,852	401,835	4,461	-	-	13,642	3,409	137,002	25,642	56,661	-	241,017
Professional Services and Dues	902,332	313,368	259,420	29,975	39,000	3,975	-	121,295	972	86,780	47,546	588,964
Legislative and Legal	316,987	276,056	40,931	-	-	-	-	-	-	-	-	40,931
Depreciation	1,131,160	350,883	59,251	-	-	102,317	10,217	350,408	56,366	181,718	-	780,277
Total	$ 24,036,386	$ 7,220,964	$ 1,417,382	$ 615,865	$ 178,879	$ 2,089,021	$ 208,804	$ 7,154,316	$ 1,355,008	$ 3,710,154	$ 86,193	$ 16,815,422

	2016											
			Program									
	Total	Administration	Member Services	Governance	Other Initiatives	Examination Services	Uniform Application	FCVS	Physician Data Center	Information Services	FSMB Foundation	Total Program
Salary and Benefits	$ 15,579,698	$ 4,831,331	$ 1,297,779	$ -	$ 157,523	$ 924,369	$ 188,627	$ 5,501,764	$ 379,600	$ 2,298,704	$ -	$ 10,748,366
Data Processing	979,734	122,534	10,713	-	447	36,497	991	9,915	14,698	783,939	-	857,200
General Office	3,106,001	677,137	149,410	183,198	8,244	803,302	10,095	1,073,180	86,695	87,654	26,696	2,428,864
Travel and Program	1,759,701	161,405	768,936	432,010	262,954	75,089	-	22,782	2,252	13,389	20,584	1,598,296
Occupancy	532,167	346,267	22,647	-	-	44,684	2,887	154,372	22,825	38,485	-	285,900
Professional Services and Dues	614,829	202,347	196,588	3,050	74,444	3,657	455	56	788	121,510	11,933	412,482
Legislative and Legal	261,529	187,685	-	9,800	52,826	11,218	-	-	-	-	-	73,844
Depreciation	1,632,466	508,212	135,745	-	16,477	96,687	19,730	575,471	39,705	240,439	-	1,124,254
Total	$ 24,586,125	$ 7,036,918	$ 2,581,818	$ 628,058	$ 572,915	$ 1,995,503	$ 222,785	$ 7,337,520	$ 546,764	$ 3,584,130	$ 59,713	$ 17,529,206

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
CONSOLIDATING STATEMENT OF FINANCIAL POSITION
APRIL 30, 2017
(SEE INDEPENDENT AUDITORS' REPORT)

	FSMB	Foundation	Eliminations	Consolidated
ASSETS				
CURRENT ASSETS				
Cash and Cash Equivalents	$ 13,972,545	$ 332,716	$ -	$ 14,305,261
Accounts Receivable:				
Disciplinary Searches	271,835	-	-	271,835
Other	335,326	14,100	(11,100)	338,326
Prepaid Expenses	492,737	-	-	492,737
Other Assets	49,809	500	-	50,309
Total Current Assets	15,122,252	347,316	(11,100)	15,458,468
NONCURRENT ASSETS				
Investments	26,503,912	2,494,191	-	28,998,103
Prepaid Expenses	37,756	-	-	37,756
Property and Equipment, Net	5,251,762	-	-	5,251,762
Total Noncurrent Assets	31,793,430	2,494,191	-	34,287,621
Total Assets	$ 46,915,682	$ 2,841,507	$ (11,100)	$ 49,746,089
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Accounts Payable	$ 7,955,457	$ 12,611	$ (11,100)	$ 7,956,968
Unearned Revenue - USMLE and SPEX	9,428,274	-	-	9,428,274
Deferred Compensation	1,242,579	-	-	1,242,579
Capital Lease Payable	16,975	-	-	16,975
Total Current Liabilities	18,643,285	12,611	(11,100)	18,644,796
NONCURRENT LIABILITIES				
Capital Lease Payable	31,820	-	-	31,820
Total Noncurrent Liabilities	31,820	-	-	31,820
NET ASSETS				
Unrestricted:				
Board-Designated Endowment	-	2,251,295	-	2,251,295
Undesignated	28,240,577	577,601	-	28,818,178
Total Net Assets	28,240,577	2,828,896	-	31,069,473
Total Liabilities and Net Assets	$ 46,915,682	$ 2,841,507	$ (11,100)	$ 49,746,089

FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC. AND SUBSIDIARY
CONSOLIDATING STATEMENT OF ACTIVITIES
YEAR ENDED APRIL 30, 2017
(SEE INDEPENDENT AUDITORS' REPORT)

	FSMB	Foundation				Consolidated		
	Unrestricted	Unrestricted	Temporarily Restricted	Total	Consolidating Eliminations	Unrestricted	Temporarily Restricted	Total
REVENUES AND GAINS								
Examination Revenue - USMLE	$ 27,326,680	$ -	$ -	$ -	$ -	$ 27,326,680	$ -	$ 27,326,680
Examination Revenue - PLAS	188,500	-	-	-	-	188,500	-	188,500
Transfer Fees - USMLE	(20,092,999)	-	-	-	-	(20,092,999)	-	(20,092,999)
Transfer Fees - PLAS	(101,600)	-	-	-	-	(101,600)	-	(101,600)
Subtotal	7,320,581	-	-	-	-	7,320,581	-	7,320,581
Examination History Reports	6,363,966	-	-	-	-	6,363,966	-	6,363,966
Other Exam Revenue	855,505	-	-	-	-	855,505	-	855,505
Physician Data Center	1,567,277	-	-	-	-	1,567,277	-	1,567,277
Registration Fees	142,183	-	-	-	-	142,183	-	142,183
FCVS Revenue	8,769,859	-	-	-	-	8,769,859	-	8,769,859
Member Dues	176,950	-	-	-	-	176,950	-	176,950
Shipping and Handling Fees	83,400	-	-	-	-	83,400	-	83,400
Grants and Contributions	261,112	12,651	-	12,651	-	273,763	-	273,763
Interest and Dividends	642,291	30,375	-	30,375	-	672,666	-	672,666
Net Investment Gain	1,848,246	165,493	-	165,493	-	2,013,739	-	2,013,739
Other Revenue	231,666	-	-	-	-	231,666	-	231,666
Total Revenues and Gains	28,263,036	208,519	-	208,519	-	28,471,555	-	28,471,555
EXPENSES								
Salary and Benefits	15,510,939	-	-	-	-	15,510,939	-	15,510,939
Data Processing	935,493	-	-	-	-	935,493	-	935,493
General Office	2,899,285	16,648	-	16,648	-	2,915,933	-	2,915,933
Travel and Program	1,658,691	21,999	-	21,999	-	1,680,690	-	1,680,690
Occupancy	642,852	-	-	-	-	642,852	-	642,852
Professional Services and Dues	854,786	47,546	-	47,546	-	902,332	-	902,332
Legislative and Legal	316,987	-	-	-	-	316,987	-	316,987
Total Expenses	22,819,033	86,193	-	86,193	-	22,905,226	-	22,905,226
CHANGES IN NET ASSETS - BEFORE DEPRECIATION	5,444,003	122,326	-	122,326	-	5,566,329	-	5,566,329
Depreciation	1,131,160	-	-	-	-	1,131,160	-	1,131,160
CHANGE IN NET ASSETS	4,312,843	122,326	-	122,326	-	4,435,169	-	4,435,169
Net Assets - Beginning of Year	23,927,734	2,706,570	-	2,706,570	-	26,634,304	-	26,634,304
NET ASSETS - END OF YEAR	$ 28,240,577	$ 2,828,896	$ -	$ 2,828,896	$ -	$ 31,069,473	$ -	$ 31,069,473

Attachment 3

FEDERATION OF STATE MEDICAL BOARDS
VARIANCE REPORT
Through 3rd QUARTER ENDED January 31, 2018

Unrestricted Revenues and Gains from Operations	YTD Actuals	Budget	Variance $ Favorable (Unfavorable)	Variance % Favorable (Unfavorable)	Comments
USMLE					
Examination Revenue	5,359,108.00	5,226,829	132,279	2.53%	Overall, USMLE rev. is within 0.3% (3/10th of 1%) of budget
Examination History Reports	4,390,142.05	4,607,025	(216,883)	(4.71%)	Actual rev. projected to exceed Budget at year-end
Elig bility Extension Fees	313,145.00	262,890	50,255	19.12%	
Other Exam Revenue	96,330	95,690	640	0.67%	
Physician Data Center:					
PDC Profile (formerly "disciplinary searches")	870,030	862,500	7,530	0.87%	
Disciplinary Alert, PDC Monitoring & ABMS services	435,362	274,500	160,862	58.60%	New customers, improved product mix
Data Licensing Revenue	204,518	191,250	13,268	6.94%	
FCVS	6,229,178	6,137,371	91,807	1.50%	Slight uptick above prior periods
Uniform Application	318,420	299,700	18,720	6.25%	
Other Revenue					
Publication Revenue	640	375	265	70.67%	
Registration & Exhibitor Fees	(1,640)	25,500	(27,140)	(106.43%)	Registration refunds in this FY
Member Dues	170,550	174,775	(4,225)	100.00%	
Grant Revenue-Federal	185,706	-	185,706	100.00%	
Grant Revenue-Other		-	-	-	
Other Revenue	673	-	673	100.00%	
Total Unrestricted Revenues and Gains from Operations	18,572,162	18,158,405	413,758	(2.28%)	

FEDERATION OF STATE MEDICAL BOARDS
VARIANCE REPORT
Through 3rd QUARTER ENDED January 31, 2018

Unrestricted Expenses and Losses	Actuals	Budget	Variance $ Favorable (Unfavorable)	Variance % Favorable (Unfavorable)	Comments
General Office Expense	2,075,710	2,086,066	10,356	0.50%	
Chair/Chair Elect / Past Chair Stipend	153,188	153,188	-		
Occupancy Expense	505,691	471,753	(33,938)	(7.19%)	HVAC & Plumbing Issues
Salary Expense					
Exempt	5,218,559	5,257,699	39,140	0.74%	
Non-Exempt	2,874,136	2,952,251	78,115	2.65%	
Temporary	268,153	239,300	(28,853)	(12.06%)	
Benefits Expense	2,502,250	2,504,065	1,815	0.07%	
Data Processing Expense	584,142	786,906	202,764	25.77%	Timing: Maintenance contracts and other expenses expected to be incurred in last quarter
Travel and Program Expense					
Annual Meeting	20,703	150	(20,553)	(100.00%)	Annual Mtg-April 2017 expenses came in late
Board Meetings	205,216	225,568	20,352	9.02%	Numerous meetings coming in under budget
Other Meetings	632,902	761,625	128,723	16.90%	
Licensure Compact	54,677	75,000	20,323	27.10%	
Legal Expense (External)	10,353	106,250	95,897	90.26%	
Government Relations	23,161	135,000	111,839	82.84%	Govt Relations efforts brought back "in house"
Professional Services / Consulting / Dues	455,994	421,225	(34,769)	(8.25%)	
Total Unrestricted Expenses	15,584,835	16,176,045	591,210	3.65%	Lower than budgeted expenses across multiple categories, some of which are related to timing.
Change in Net Assets-Unrestricted before depreciation and investment gains	2,987,327	1,982,359	1,004,967		Greater revenue and lower expenses combine for a healthy bottom line thru the 3rd quarter
Depreciation	858,338	900,000	41,662		
Investment Gain	3,173,233	187,500	2,985,733		We continue to benefit from an up market and well-performing portfolio
Change in Net Assets-Unrestricted	**5,302,222**	**1,269,859**			

Attachment 4

FEDERATION OF STATE MEDICAL BOARDS
FY 2019 PROPOSED BUDGET
VS FY 2018 ADOPTED BUDGET AND FY2017 ACTUAL RESULTS

Unrestricted Revenues and Gains from Operations	2017 Actual Results	2018 Adopted Budget	2019 Proposed Budget	**Variance $ Favorable (Unfavorable)**	**Variance %**
USMLE					
Examination Revenue	7,233,681	6,728,605	7,137,936	**409,331**	**6.08%**
Examination History Reports	6,328,476	6,100,000	6,300,000	**200,000**	**3.28%**
Exam Eligibility Extension Fee	365,330	350,000	350,000	**0**	**0.00%**
Other Exam Revenue	261,995	186,220	176,520	**(9,700)**	**-5.21%**
Physician Data Center					
PDC Profile (formerly "disciplinary searches")	1,156,846	1,150,000	1,137,855	**(12,145)**	**-1.06%**
Disciplinary Alert, PDC Monitoring, & ABMS services	410,431	366,000	498,093	**132,093**	**36.09%**
Data Licensing Revenue	128,813	255,000	300,000	**45,000**	**17.65%**
FCVS	8,776,659	8,972,297	9,029,496	**57,199**	**0.64%**
Uniform Application	431,920	474,000	450,107	**(23,893)**	**-5.04%**
Other Revenue					
Publication Revenue	1,873	500	500	**0**	**0.00%**
Registration Fees/Exhibitor Fees	161,383	146,500	146,300	**(200)**	**-0.14%**
Member Dues	170,400	168,000	168,000	**0**	**0.00%**
Grant Revenue-Federal	261,112	0	0	**0**	**0.00%**
Grant Revenue-Other	76,227	0	0	**0**	**0.00%**
Other Revenue	7,354	7,275	7,275	**0**	**0.00%**
Total Unrestricted Revenues and Gains from Operations	25,772,499	24,904,397	25,702,082	**797,685**	**3.20%**

FEDERATION OF STATE MEDICAL BOARDS
FY 2019 PROPOSED BUDGET
VS FY 2018 ADOPTED BUDGET AND FY2017 ACTUAL RESULTS

Unrestricted Expenses and Losses	2017 Actual Results	2018 Adopted Budget	2019 Proposed Budget	Variance $ Reduced Increased	Variance %	Comments
General Office Expenses	2,591,396	2,694,264	3,085,757	***391,494***	**14.53%**	Incr. costs: ECFMG verifs; software as a service; cc processing; DC lodg & trav 4 bldg
Chair/Chair Elect / Past Chair Stipend	190,000	204,250	204,250	***0***	**0.00%**	
Texas Occupancy	642,852	626,445	618,700	***(7,745)***	**-1.24%**	
DC Rent	116,059	*115,584*	*121,380*	***5,796***	**5.01%**	
DC Building	0	0	112,200	***112,200***	**0.00%**	
Salary Expense						
Salaries-Exempt	7,245,227	7,200,871	7,675,959	***475,088***	**6.60%**	New Positions; last year's budget too aggressive
Salaries-Non-exempt	3,902,444	4,017,443	4,214,832	***197,389***	**4.91%**	New Positions; last year's budget too aggressive
Temporary Help	937,538	313,800	312,000	***(1,800)***	**-0.57%**	Continued FCVS focus on Perm. EE's vs Temps
Salaries Expenses	12,085,209	11,532,113	12,202,791	***670,677***	**5.82%**	Represents a 0.96% increase over 2017 Actuals
Benefits Expenses	3,425,729	3,490,568	3,990,661	***500,093***	**14.33%**	Aggress. FY18 Budg; Improved deductible for EE's
Data Processing Expense	923,068	927,244	1,045,337	***118,092***	**12.74%**	Continued focus on FSMB's role as a Data org.
Travel and Program Expense				***0***		
Annual Meeting	516,563	659,650	626,400	***(33,250)***	**-5.04%**	
Board Meetings	255,306	370,451	369,088	***(1,363)***	**-0.37%**	
Other Meetings	818,866	960,833	1,043,215	***82,381***	**8.57%**	
Licensure Compact	283,703	100,000	100,000	***0***	**0.00%**	
Legal Expense (External)	70,196	135,000	150,000	***15,000***	**11.11%**	
Governmental Relations	216,166	180,000	120,000	***(60,000)***	**-33.33%**	
Professional Services & Dues	683,920	534,050	741,972	***207,922***	**38.93%**	Represents a 7.8% increase over 2017 Actuals
Total Unrestricted Expenses	22,819,033	22,530,453	24,531,750	***2,001,297***	**8.88%**	
Change in Net Assets-Unrestricted before depreciation and investment gains	2,953,466	2,373,945	1,170,332	***(1,203,612)***	**-50.70%**	
Depreciation Expenses	1,131,160	1,200,000	1,200,000	***0***	**0.00%**	
Investment Gains/(Losses)	2,490,537	250,000	500,000	***250,000***	**100.00%**	
Change in Net Assets-Unrestricted	4,312,843	1,423,945	470,332			

FSMB Fiscal Year 2019
Request for Capital

Project Name

IT Initiatives

Description

IT projects for FY2019 have been planned in support of the following goals:

1) Improved customer experience
2) Enhanced performance for improved staff efficiency
3) Greater research capabilities

While a few minor remnants of legacy systems remain to be upgraded in FY19, the vast majority of the work to be funded by the requested budget will support enhancements that will benefit our physician and state medical board users, as well as explore potential uses and benefits of current tech advancements.

This request is lower than requests made in previous years due to regular investments in improved infrastructure and flexible systems that have eliminated the need for more substantial investment during FY2019.

Project Management

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.

Business Unit(s)

Assessment Services
Physician Data Center
FCVS
Uniform Application
Accounting and Finance
Information Technology

Capital Costs

$	405,000	- External Resources
$	0	- Hardware
$	0	- Software
$	405,000	- Total

FSMB Fiscal Year 2019
Previously Approved Capital Project

Project Name	DC Building
Description	Redesign and remodel of Building purchased in 2017 in support of the following goals: 1) Permanent Washington, DC home for Advocacy and other Departments 2) Improved functionality for staff, committees, and workgroups 3) Tool for recruiting and retaining great staff
Project Management	This project will be completed with substantial external resources including architects, general contractors, interior and landscape designers, and others. Current or specialized staff will manage external resources throughout this 2 year project.
Business Unit(s)	Advocacy Executive Office Legal Assessment Services Governance
Capital Costs	$ 1,750,000 - External Resources

TAB H: Report of Reference Committee A

MANAGEMENT NOTE:

The following reports and resolutions will be submitted to Reference Committee A. Following testimony at the Reference Committee hearing, a report containing the Reference Committee's recommendations will be presented to the House of Delegates:

1. Report of the Bylaws Committee

2. Resolution 18-3: Permitting Out-of-State Practitioners to Provide Continuity of Care in Limited Situations (WA-M)

3. BRD RPT 18-4: Guidelines for the Structure and Function of a State Medical and Osteopathic Board

4. BRD RPT 18-5: Report on Resolution 17-2: Advocacy for Professional Licensure of EMS Providers

5. Resolution 18-4: Interprofessional Continuing Education (IPCE) (FSMB BOD)

REPORT OF THE BYLAWS COMMITTEE

SUBJECT: **PROPOSED AMENDMENTS TO THE FEDERATION BYLAWS**

REFERRED TO: **REFERENCE COMMITTEE**

The Bylaws Committee, chaired by Jerry G. Landau, JD, met on September 27-28, 2017 in Washington, D.C. and extended its discussion on January 9 and February 21, 2018 via videoconference to consider the current Bylaws and proposed amendments thereto 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: Charles A. Castle, MD; Erich W. Garland, MD; Eric R. Groce, DO; W. Reeves Johnson, Jr., MD; and Ian Marquand. Ex officio members include FSMB Chair Gregory B. Snyder, MD; FSMB Chair-elect Patricia A. King, MD, PhD; and FSMB President-CEO Humayun J. Chaudhry, DO.

The Bylaws Committee is presenting twenty-six (26) proposed amendments for consideration. Proposed amendments #1-7 are contained in **Bylaws Proposal #1**; proposed amendments #8-24 are contained in **Bylaws Proposal #2**; proposed amendment #25 is contained in **Bylaws Proposal #3**; and proposed amendment #26 is contained in **Bylaws Proposal #4**. Each Bylaws Proposal will be addressed separately.

The Bylaws may be amended at any annual meeting of the House of Delegates by *two-thirds* of those present and voting.

BYLAWS PROPOSAL #1/ PROPOSED AMENDMENTS #1-7 (PROPOSED BY THE FSMB BOARD OF DIRECTORS)

In July 2017, the FSMB Board of Directors approved a resolution directing the Bylaws Committee to explore changes to the Bylaws that would *enhance the role of state medical board executive directors in FSMB governance.* The catalyst prompting the resolution was the FSMB's commitment to enhancing its effectiveness in supporting its state medical and osteopathic boards (SMBs) and its awareness that the institutional knowledge, historical perspective and political savvy of SMB executive directors are invaluable to the creation of FSMB work products and positions statements.

The Board of Directors acknowledges that since the inception of the FSMB there has been ongoing review and periodic revisions to the bylaws to allow for appropriate evolution of the organization. In its current form, executive directors as 'Associate Members' cannot be utilized to their full potential to benefit the organization.

After extensive discussion and careful consideration, the concept of creating a new category of Fellow was advanced which would allow for both appropriate recognition of the significant contribution that executive directors provide to medical regulation as well as allow the organization to more fully benefit from their expertise on our various committees, work groups and task forces.

In September 2017, the Bylaws Committee met to develop a draft Bylaws proposal for the Board's consideration, as well as to consider other potential amendments to the Bylaws. At this time, the Bylaws Committee determined that potential amendments designed to create a new category of Fellow could be drafted within the structure of the Bylaws and were feasible to consider. The Committee began to draft recommended revisions. In furtherance of this effort, the Bylaws Committee also sought input from Administrators in Medicine (AIM). In December 2017, the Bylaws Committee distributed proposed revisions to the FSMB Member Medical Boards for comment.

In January 2018, the Bylaws Committee discussed the feedback received from the Member Medical Boards and AIM, all of which was favorable, and the draft proposal was then forwarded, with no additional changes, to the Board of Directors for final review at its February 2018 meeting. On February 21, the Bylaws Committee discussed the Board's feedback and finalized its position on the proposal.

Bylaws Proposal #1 can be found in its entirety behind **Attachment 1** and contains seven (7) proposed amendments (#1-7) within **Article II. Classes of Membership, Election and Membership Rights; Article III. Officers: Election and Duties; and Article IV. Board of Directors.** The Bylaws Committee recommends the House of Delegates **ADOPT proposed Amendments #1-7 as follows:**

PROPOSED AMENDMENT #1

Article II. Classes of Membership, Election and Membership Rights
Section B. Fellows

There shall be two categories of Fellow of the FSMB:

1. Board Member Fellow. A Board Member Fellow is ~~A~~**a**n 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 36 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.

PROPOSED AMENDMENT #2

Article II. Classes of Membership, Election and Membership Rights
Section C. Honorary Fellows

~~**Thirty six months after completion of service on a Member Medical Board, a**~~ **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** ~~**and**~~ may be appointed by the Chair to serve as a member of any committee or in any other appointive capacity.

PROPOSED AMENDMENT #3

Article II. Classes of Membership, Election and Membership Rights
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 ~~**Associate Member**~~ **individual** shall continue ~~**in that capacity**~~ **as an Associate Member** upon termination of employment by or service to the Member Medical Board.

PROPOSED AMENDMENT #4

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, 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.

PROPOSED AMENDMENT #5

Article IV. Board of Directors
Section A. Membership and Terms

1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, the Immediate Past Chair, nine Directors-at-Large and two ~~**Associate Members**~~ **Staff Fellows**. At least

two members of the Board, who are not ~~Associate Members~~ **Staff Fellows**, shall be non-physicians, at least one of whom shall be a public/consumer member.

2. NOMINATION OF ~~ASSOCIATE MEMBERS~~ **STAFF FELLOWS**: Nominations for ~~Associate Member~~ **Staff Fellow** positions shall be accepted from Member Boards, the Board of Directors and **the** Administrators in Medicine ~~(AIM).~~ ~~Associate Members~~ **Staff Fellows** shall be ~~elected~~ **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. ~~Associate Members shall each serve for a term of two years. Associate Members shall not be eligible to serve consecutive terms.~~

PROPOSED AMENDMENT #6

Article IV. Board of Directors
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 an individual shall be nominated and, if elected, shall serve for 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. ~~ASSOCIATE MEMBERS~~ **STAFF FELLOWS**: In the event of a vacancy of ~~an Associate Member~~ **a Staff Fellow**, the Board of Directors may appoint a substitute to complete the ~~Associate Member's~~ **Staff Fellow's** term in accordance with the policies established by the Board of Directors.

PROPOSED AMENDMENT #7

Article IV. 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 ~~two~~ **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 ~~Associate Members of~~ **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 ~~Associate Members of~~ **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.

BYLAWS PROPOSAL #2/ PROPOSED AMENDMENTS #8-23 (PROPOSED BY THE BYLAWS COMMITTEE)

Bylaws Proposal #2 can be found in its entirety behind **Attachment 2** and contains sixteen (16) proposed amendments (#8-24) within **Article II. Classes of Membership, Election and Membership Rights; Article III. Officers: Election and Duties; Article IV. Board of Directors; Article V. Nomination by Petition for Board of Directors and Nominating Committee; and Article VII. Meetings.** For discussion purposes, these proposed amendments are divided into three sections.

1) Proposed Amendments #8-13 to **Articles III and IV** address the Bylaws Committee's recommendation that the Bylaws be changed so that the FSMB Immediate Past Chair is considered an Officer of the corporation given that when a Fellow is elected Chair-elect, the individual is expected to serve for three years: one year as Chair-elect; one year as Chair: and one year as Immediate Past Chair. The individual is also a standing member of the Executive Committee during those three years.

Accordingly, the Bylaws Committee recommends the House of Delegates **ADOPT proposed Amendments #8-13 as follows:**

PROPOSED AMENDMENT #8

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.

PROPOSED AMENDMENT #9

Article III. Officers: Election and Duties
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.**

~~3~~4. The Treasurer shall be elected every third year at the Annual Meeting of the House of Delegates.

~~4~~5. Officers shall be elected by a majority of the members of the House of Delegates present and voting.

~~5~~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.

~~6~~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.

PROPOSED AMENDMENT #10

Article III. Officers: Election and Duties

Section C. Duties of Officers

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.

~~3~~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.

~~4~~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.

PROPOSED AMENDMENT #11

Article III. Officers: Election and Duties

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.

~~2~~3. The Treasurer shall serve for a single term of three years or until the Treasurer's successor assumes the office.

~~3~~4. Officers shall assume office upon final adjournment of the Annual Meeting of the House of Delegates at which they were elected.

~~4~~5. The term of the Secretary is co-terminus with that of the President.

PROPOSED AMENDMENT #12

Article III. Officers: Election and Duties
Section E. Vacancies

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.

~~3~~**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.

PROPOSED AMENDMENT #13

Article IV. Board of Directors
Section A. Membership and Terms

1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, ~~**the Immediate Past Chair,**~~ nine Directors-at-Large and two Associate Members. At least two members of the Board, who are not Associate Members, shall be non-physicians, at least one of whom shall be a public/consumer member.

2) Proposed Amendment #14 to **Article IV** addresses the Bylaws Committee's recommendation that the Bylaws be changed to offer greater clarity about the process for removing an individual from the Board of Directors. Accordingly, the Bylaws Committee recommends the House of Delegates **ADOPT proposed Amendment #14 as follows:**

PROPOSED AMENDMENT #14

Article IV. Board of Directors
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 ~~**and is effective upon mailing**~~.
   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 ~~filed with the Secretary of the Board~~ **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. ~~**Delivery is effective upon mailing.**~~

c. At the ~~**next**~~ 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 ~~**B**~~**b**oard member by certified mail, return receipt requested. If the officer or board member ~~**did**~~ **does** not file a written response the Board shall proceed with a determination. ~~**Delivery is effective upon mailing**~~.

d. If the Board votes to proceed with removal of the officer or ~~**B**~~**b**oard member, at a Board meeting ~~**held no less than thirty days after delivery of the notice,**~~ the ~~**B**~~**b**oard 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.

3) Proposed Amendments #15-24 to **Articles II, IV, V and VII** address the Bylaws Committee's recommendation that the Bylaws be changed to reflect an increase in the Executive Committee from two to three Directors-at-Large, minor editorial improvements. Accordingly, the Bylaws Committee recommends the House of Delegates **ADOPT proposed Amendments #15-24 as follows:**

PROPOSED AMENDMENT #15

Article II. Classes of Membership, Election and Membership Rights
Section B. Fellows

An individual member who as a result of appointment or confirmation is designated to be a member of a Member Medical Board shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of ~~**36**~~ **thirty-six** months thereafter.

PROPOSED AMENDMENT #16

Article IV. Board of Directors
Section B. Nominations

2. The Nominating Committee shall mail its roster of candidates to Member Boards not fewer than ~~**60**~~ **sixty** days prior to the Annual Meeting of the House of Delegates.

PROPOSED AMENDMENT #17

Article IV. Board of Directors
Section D. Duties of the Board of Directors

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 ~~**power and**~~ authority to perform all acts and to transact all business for and on behalf of the FSMB.

PROPOSED AMENDMENT #18

Article IV. Board of Directors
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 ~~**an individual**~~ **a Fellow** shall be ~~**nominated and, if**~~ elected~~**,**~~ **and** shall serve ~~**for**~~ 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.

PROPOSED AMENDMENT #19

Article IV. 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 ~~**two**~~ **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 Associate Members of 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 Associate Members of the Board, by majority vote, shall choose another Director-at-Large to serve the remainder of the one-year term. 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.

PROPOSED AMENDMENT #20

Article V. Nomination by Petition for Board of Directors and Nominating Committee
Section A. Submission of a Petition

3. The deadline to submit petitions to the Administrative Staff is ~~**21**~~ **twenty-one** days prior to the Annual Meeting.

PROPOSED AMENDMENT #21

Article V. Nomination by Petition for Board of Directors and Nominating Committee
Section B. Validation and Placement on 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 ~~14~~ **fourteen** days prior to the Annual Meeting.

PROPOSED AMENDMENT #22

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 ~~90~~ **ninety** days prior to the date of the meeting. **Notice is effective upon mailing.**

PROPOSED AMENDMENT #23

Article VII. Meetings
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 ~~30~~ **thirty** days prior to the date of the meeting. **Notice is effective upon mailing**.

PROPOSED AMENDMENT #24

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 ~~60~~ **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 ~~60~~ **sixty** days prior to the Annual Meeting of the House of Delegates at which they are to be considered.

BYLAWS PROPOSAL #3/ PROPOSED AMENDMENT #25 (PROPOSED BY THE BYLAWS COMMITTEE)

Bylaws Proposal #3 can be found in its entirety behind **Attachment 3** and contains one (1) proposed amendment (#25) within **Article VIII. Standing and Special Committees.**

The Bylaws Committee proposes that **Article VIII** be changed to allow the FSMB Chair an opportunity to appoint an Associate Member to the Editorial Committee should the Chair so choose. Accordingly, the Bylaws Committee recommends the House of Delegates **ADOPT proposed Amendment #25 as follows:**

PROPOSED AMENDMENT #25

Article VIII. Standing and Special Committees
Section D. Editorial Committee

1. An Editorial Committee, not to exceed twelve Fellows and three ~~**non-member subject matter experts**~~ **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.

BYLAWS PROPOSAL #4/ PROPOSED AMENDMENT #26 (PROPOSED BY THE TENNESSEE BOARD OF MEDICAL EXAMINERS)

Bylaws Proposal #4 can be found in its entirety behind **Attachment 4** and contains one (1) proposed amendment (#26) within **Article IV. Board of Directors.**

The Tennessee Board of Medical Examiners proposes that **Article IV** be changed to allow the inclusion of two (2) public/consumer members, who are not Associate Members, to serve on the Board of Directors as follows:

PROPOSED AMENDMENT #26

Article IV. Board of Directors
Section A. Membership and Terms

1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, the Immediate Past Chair, nine Directors-at-Large and two Associate Members. At least two members of the Board, who are not Associate Members, shall be ~~**non-physicians, at least one of whom shall be a**~~ public/consumer member**s**.

The Tennessee Board suggests that this modification to the Bylaws makes clear that the public/consumer members' participation and perspective on the Board is valued and aligned with

the Member Medical Boards of the FSMB, and notes that non-physician members can still be elected to the Board if they are Fellows of the FSMB.

The Bylaws Committee considered the Tennessee Board's position and discussed the current process for electing Fellows to the Board of Directors, which begins with the election of the requisite number of non-physicians and public/consumer members and a ballot that only includes the non-physician and public/consumer member candidates. After those positions are filled, any non-physician or public/consumer member candidate not elected at that time is included on the next ballot with the physician candidates.

The Bylaws Committee opined that while it is true that the Tennessee Board's proposed change to the Bylaws would still provide an opportunity for non-physicians (who are not public/consumer members because of their nexus to healthcare) to be elected to the Board, they would not have the added benefit of being considered independently of physicians, which might discourage a non-physician, such as a physician assistant, from running for election because of a perception that voting delegates would likely favor the physicians.

Given the importance of this issue, the Bylaws Committee agreed that additional discussion is needed to consider all of the possible ramifications of this proposed change as well as how it might affect the rest of the Bylaws. The Committee also concurred that because of the significance of the changes being presented to the House of Delegates in Proposal 1, it would be best to act on Proposal 4 in 2019. Therefore, the Bylaws Committee recommends the House of Delegates **TABLE proposed Amendment #26 until the Bylaws Committee can make its final recommendation to the House in 2019.**

Attachment 1

2018 FSMB BYLAWS

PROPOSED AMENDMENTS

PROPOSAL #1

(to enhance role of state medical board executive directors in FSMB governance)

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 ~~A~~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 36 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

~~**Thirty six months after completion of service on a Member Medical Board, a**~~ **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** ~~**and**~~ 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 ~~**Associate Member**~~ **individual** shall continue ~~**in that capacity**~~ **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, 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 Treasurer shall be elected every third year at the Annual Meeting of the House of Delegates.
4. Officers shall be elected by a majority of the members of the House of Delegates present and voting.
5. 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.

6. 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 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.
4. 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 Treasurer shall serve for a single term of three years or until the Treasurer's successor assumes the office.
3. Officers shall assume office upon final adjournment of the Annual Meeting of the House of Delegates at which they were elected.
4. 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 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, the Immediate Past Chair, nine Directors-at-Large and two ~~**Associate Members**~~ **Staff Fellows**. At least two members of the Board, who are not ~~**Associate Members**~~ **Staff Fellows**, shall be non-physicians, at least one of whom shall be a public/consumer member.
2. NOMINATION OF ~~**ASSOCIATE MEMBERS**~~ **STAFF FELLOWS**: Nominations for ~~**Associate Member**~~ **Staff Fellow** positions shall be accepted from Member Boards, the Board of Directors and **the** Administrators in Medicine ~~**(AIM).**~~ ~~**Associate Members**~~ **Staff Fellows** shall be ~~**elected**~~

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. ~~**Associate Members shall each serve for a term of two years. Associate Members shall not be eligible to serve consecutive terms.**~~

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 60 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 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 power and 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 member shall be by certified mail, return receipt requested, to the last address known to the Board and is effective upon mailing.

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 is filed with the Secretary of the Board. Delivery to the Board shall be by certified mail, return receipt requested, directed to the Secretary of the Board at the FSMB corporate office. Delivery is effective upon mailing.

c. At the next Board meeting, 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 did not file a written response the Board shall proceed with a determination. Delivery is effective upon mailing.

d. If the Board votes to proceed with removal of the officer or Board member, at a Board meeting held no less than thirty days after delivery of the notice, 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.

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.

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 an individual shall be nominated and, if elected, shall serve for 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. ~~**ASSOCIATE MEMBERS**~~ **STAFF FELLOWS**: In the event of a vacancy of ~~**an Associate Member**~~ **a Staff Fellow**, the Board of Directors may appoint a substitute to complete the ~~**Associate Member's**~~ **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 ~~two~~ **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 ~~Associate Members of~~ **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 ~~Associate Members of~~ **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 21 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 14 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 90 days prior to the date of the meeting.

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 30 days prior to the date of the meeting.

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-member 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 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. 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 60 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 60 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 2017

Attachment 2

2018 FSMB BYLAWS

PROPOSED AMENDMENTS

PROPOSAL #2

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

An individual member who as a result of appointment or confirmation is designated to be a member of a Member Medical Board shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of ~~**36**~~ **thirty-six** months thereafter.

SECTION C. HONORARY FELLOWS

Thirty-six months after completion of service on a Member Medical Board, a Fellow shall become an Honorary Fellow of the FSMB and 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 to be an Associate Member of the FSMB. No Associate Member shall continue in that capacity 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 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.

~~3~~ **4**. The Treasurer shall be elected every third year at the Annual Meeting of the House of Delegates.

~~4~~ **5.** Officers shall be elected by a majority of the members of the House of Delegates present and voting.

~~5~~ **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.

~~6~~ **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.

~~3~~ **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.

~~4~~ **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.

~~2~~ **3.** The Treasurer shall serve for a single term of three years or until the Treasurer's successor assumes the office.

~~3~~ 4. Officers shall assume office upon final adjournment of the Annual Meeting of the House of Delegates at which they were elected.

~~4~~ 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.**

~~3~~ 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, **~~the Immediate Past Chair,~~** nine Directors-at-Large and two Associate Members. At least two members of the Board, who are not Associate Members, shall be non-physicians, at least one of whom shall be a public/consumer member.

2. NOMINATION OF ASSOCIATE MEMBERS: Nominations for Associate Member positions shall be accepted from Member Boards, the Board of Directors and Administrators in Medicine (AIM). Associate Members shall be elected 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. A partial term totaling one-and-a-half years or more shall

count as a full term. Associate Members shall each serve for a term of two years. Associate Members shall not be eligible to serve consecutive terms.

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 ~~60~~ **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 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 ~~**power and**~~ 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 ~~**and is effective upon mailing**~~.

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 ~~filed with the Secretary of the Board~~ **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. ~~**Delivery is effective upon mailing.**~~

c. At the ~~**next**~~ 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 ~~**B**~~**b**oard member by certified mail, return receipt requested. If the officer or board member ~~**did**~~ **does** not file a written response the Board shall proceed with a determination. ~~**Delivery is effective upon mailing**~~.

d. If the Board votes to proceed with removal of the officer or ~~**B**~~**b**oard member, at a Board meeting ~~**held no less than thirty days after delivery of the notice,**~~ the ~~**B**~~**b**oard 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 ~~**an individual**~~ **a Fellow** shall be ~~**nominated and, if**~~ elected~~**,**~~ **and** shall serve ~~**for**~~ 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. ASSOCIATE MEMBERS: In the event of a vacancy of an Associate Member, the Board of Directors may appoint a substitute to complete the Associate Member'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 ~~**two**~~ **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 Associate Members of 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 Associate Members of the Board, by majority vote, shall choose another Director-at-Large to serve the remainder of the one-year term. 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 ~~**21**~~ **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 ~~**14**~~ **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 ~~**90**~~ **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 ~~**30**~~ **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-member 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 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 ~~60~~ **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 ~~60~~ **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.

Attachment 3

2018 FSMB BYLAWS

PROPOSED AMENDMENTS

PROPOSAL #3

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 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.

Attachment 4

2018 FSMB BYLAWS

PROPOSED AMENDMENT

PROPOSAL #4

ARTICLE IV. BOARD OF DIRECTORS

SECTION A. MEMBERSHIP AND TERMS

1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, the Immediate Past Chair, nine Directors-at-Large and two Associate Members. At least two members of the Board, who are not Associate Members, shall be ~~**non-physicians, at least one of whom shall be a**~~ public/consumer member**s**.

TN Board Comment:
This simple modification of the FSMB Bylaws makes clear that the Public/Consumer members' participation and perspective on the Board of Directors is valued and aligned with the member medical boards of the FSMB.

It should be noted that non-physician members can be elected to the Board of Directors if they are fellows of the FSMB. This proposed change to the Bylaws would not alter that status.

There are nine Directors-at-Large and two Associate Members on the FSMB Board of Directors in addition to the Officers of the Board of Directors and the Immediate Past Chair. The Secretary (President) of the Board of Directors is ex officio and does not vote.

Resolution 18-3

Federation of State Medical Boards
House of Delegates Meeting
April 28, 2018

Subject: Permitting Out-of-State Practitioners to Provide Continuity of Care in Limited Situations

Introduced by: Washington State Medical Commission

Approved: January 2018

Whereas, state medical boards are responsible for protecting the citizens of their states by ensuring that physicians are qualified and competent; and

Whereas, state medical boards determine, within the context of their enabling statutes, under what circumstances a license is required for a physician to treat a patient in their states; and

Whereas, many states have license reciprocity and/or the Interstate Medical License Compact which establishes reliance on sister state licensing processes; and

Whereas, due to **r**apid changes in telemedicine technology, the practice of medicine is occurring more frequently across state lines; and

Whereas, telemedicine is a tool that has the potential to increase access, lower costs, and improve the quality of healthcare; and

Whereas, the historic practice of medicine has prioritized the continuity of care delivery to established patients over recognition of jurisdictional boundaries; and

Whereas, continuity of care is an essential element in consistently delivering high quality health care; and

Whereas, physicians can promote continuity of care by using telemedicine to provide follow-up care to established patients who travel outside the physician's state of licensure. For example, a physician at a major academic medical center who treats a patient who then returns home, can maintain a connection with the patient by providing follow-up care, including having access to timely and accurate data from the patient; and

Whereas, permitting physicians who are duly licensed in another jurisdiction to provide follow-up care to established patients, and to engage in peer-to-peer consultations, will result in better outcomes and lower costs;

Therefore, be it hereby

Resolved, that the Federation of State Medical Boards (FSMB) will encourage state medical boards to interpret their licensing laws, or work to change their licensing laws if

necessary, to permit physicians duly licensed in another jurisdiction to provide infrequent and episodic continuity of care by providing follow-up care to established patients or a peer-to-peer consultation without the need to obtain a license in the state in which the patient is located at the time of the interaction.

BRD RPT 18-4

REPORT OF THE BOARD OF DIRECTORS

Subject: **Guidelines for the Structure and Function of a State Medical and Osteopathic Board**

Referred to: **Reference Committee A**

Since 1988, the FSMB's *Guide to the Essentials of a Modern Medical Practice Act* and *Elements of a State Medical and Osteopathic Board* have functioned as companion documents to provide state medical boards a useful blueprint for their structure and functions as stated in their medical practice act. These policies have served as a highly effective stimulus to medical boards and state legislatures for periodic review and revision of their statutes. The policies are revised every three years. The Advisory Council of Board Executives is charged with updating the policies to ensure currency and recommending the revisions to the Board of Directors. The 2017 Advisory Council includes Kimberly Kirchmeyer, Micah T. Matthews, MPA, Maegan Martin, JD, Frank B. Meyers, JD, Kathleen Selzler Lippert, JD, Kevin D. Bohnenblust, JD, Mark E. Bowden, MPA, Kathleen Haley, JD, and Ian Marquand.

The Advisory Council of Board Executives met on August 17, 2017 in Washington, DC, to revise the *Elements* and *Essentials* for consideration by the FSMB House of Delegates at its Annual Meeting in April 2018. At this meeting the Council considered a full agenda in meeting its charge to conduct a review and revision of the *Essentials* and *Elements of a State Medical and Osteopathic Act*. As part of its meeting, the Council conducted a thorough review of the licensure by endorsement provisions in accordance with Resolution 17-3, Review of Model Guidelines for State Medical Boards Granting Licensure by Endorsement and Assessment of the Standards of ACGME International.

As a result of in person discussions and in response to feedback from member state boards, the Council agreed to condense the *Elements* and *Essentials* into one document, *Guidelines for the Structure and Function of a State Medical and Osteopathic Board* (**Attachment 1**). The Council determined that a singular guidance document on state medical board structure would reduce redundancies inherent in the original two documents and allow for a more dynamic and user-friendly resource for member state boards. The Council recommended that existing FSMB policy regarding licensure by endorsement not be amended to include reference to ACGME-International.

Guidelines for the Structure and Function of a State Medical and Osteopathic Board incorporates the contents of prior *Elements* and *Essentials*, containing the principles of state medical board responsibility, duty, empowerment, and accountability that the initial documents outlined, as well as detailing the essential components for the structure and function of a state medical board. This

guidance document reflects not only relevant characteristics of effective modern medical boards, but also a number of innovative concepts not yet widely implemented. Though presented for consideration as an integrated whole, the guidelines offer significant approaches to a variety of issues that concern many boards, including: funding and budgeting, confidentiality, board authority, personnel and staffing, administration, emergency powers, training of board members, immunity and indemnity, standards of evidence, and the public's right to know.

Recognizing the differences among jurisdictions, this document is designed with the flexibility to accommodate as many of those differences as possible, while maintaining the integrity of the overall concept. Some sections empower boards to adopt alternatives of their choice, provided they are in accord with other state statutes, while other sections are phrased loosely to allow boards necessary discretionary authority. These guidelines may thus be seen not as one proposal but as various proposals.

A draft of the *Guidelines for the Structure and Function of a State Medical and Osteopathic Board* was distributed to FSMB member boards and other key stakeholder organizations in December 2017 with comments due January 31, 2018. There were no suggestions for modification received. No comments were received. The FSMB Board of Directors considered the draft *Guidelines for the Structure and Function of a State Medical and Osteopathic Board* at its meeting on February 7, 2018 in Washington D.C. and discussed clarifications to the document.

ITEM FOR ACTION:

The Board of Directors recommends that:

The House of Delegates ADOPT *Guidelines for the Structure and Function of a State Medical and Osteopathic Board,* superseding *Guide to the Essentials of a Modern Medical Practice Act (HOD 2015)* and *Elements of a State Medical and Osteopathic Board (HOD 2015).*

Attachment 1

Guidelines for the Structure and Function of a State Medical and Osteopathic Board

Introduction

As early as 1914, the Federation of State Medical Boards (FSMB), which now represents 70 state and territorial medical and osteopathic licensing and disciplinary boards (hereafter referred to as "state medical board(s)" or "Board(s)"), recognized the need for a guidance document supporting U.S. states and territories in their development, and updating as needed, of their medical practice acts, and the corresponding structures and functions of their medical boards.

Following extensive consultations with members and staff of state medical boards, and a review of emerging best practices, the FSMB first issued *A Guide to the Essentials of a Modern Medical Practice Act* in 1956. The stated purposes of this guidance document were:

1. To serve as a guide to those states that may adopt new medical practice acts or may amend existing laws; and
2. To encourage the development and use of consistent standards, language, definitions, and tools by boards responsible for physician and physician assistant regulation.

Over the years, dynamic changes in medical education, in the practice of medicine, and in the diverse responsibilities that face medical boards have necessitated frequent revision of a state or territory's medical practice act. *The Essentials* has since undergone numerous revisions to respond to these changes and assist member boards to be consistent with best practices in the interests of public protection and patient safety.

In 1988, the Division of Medicine of the Bureau of Health Professions, Health Resources and Services Administration (HRSA), in the U.S. Department of Health and Human Services, requested proposals for the development of a parallel document on a state medical board's structure and function. The FSMB proposed a new guidance document in response, called the *Elements of a State Medical and Osteopathic Board*. The Bureau of Health Profession and HRSA accepted the FSMB's proposal, and the document was soon developed and made available for consideration by the public, state medical boards, medical organizations, and other relevant groups.

The primary focus of the *Elements* document was to develop a blueprint of the structure and function of a modern state medical board. It detailed the powers, duties, and protections that are basic to a state medical board's structure and function. In that context, it reflected the understanding, concepts, opinions, knowledge and experience of the individuals comprising the work panel, which included members, attorneys and staff of state medical boards. The *Elements* presented a blueprint that was consistent with the principles expressed in the *Essentials*, and was offered as a stimulus for discussion of several issues vital to improving the regulation of the medical profession in the United States.

The *Elements* and *Essentials* have, since 1988, functioned as companion documents to provide state

medical boards a useful blueprint for their structure and functions as stated in their medical practice act. Revised by the FSMB's Advisory Council of Board Executives every three years to remain current, the model policies have served as a highly effective stimulus to medical boards and state legislatures for periodic review and revision of their statutes.

In 2017, the Advisory Council met to revise the *Elements* and *Essentials* for consideration by the FSMB House of Delegates at its Annual Meeting in April 2018. At this meeting and in response to feedback from member state boards, the Advisory Council considered and agreed to condense the two model policies into one document. The Advisory Council determined that a singular guidance document on state medical board structure would reduce redundancies inherent in the original two documents and allow for a more dynamic and user-friendly resource for member state boards.

The guidance document that follows incorporates the contents of prior *Elements* and *Essentials* documents, containing the principles of state medical board responsibility, duty, empowerment, and accountability that the initial documents outlined, as well as detailing the essential components for the structure and function of a state medical board.

This guidance document reflects not only relevant characteristics of effective modern medical boards, but also a number of innovative concepts not yet widely implemented. The result is a document worthy of consideration for adaptation to the requirements of any state or territorial jurisdiction. Although it could hardly be expected that any one jurisdiction would accept every component of this model, it should lead every jurisdiction to assess its present board structure and function. Does the status quo provide maximum potential for protection of the public interest? Though presented for consideration as an integrated whole, the guidelines offer significant approaches to a variety of issues that concern many boards, including: funding and budgeting, confidentiality, board authority, personnel and staffing, administration, emergency powers, training of board members, immunity and indemnity, standards of evidence, and the public's right to know.

Recognizing the differences among jurisdictions, this document is designed with the flexibility to accommodate as many of those differences as possible, while maintaining the integrity of the overall concept. Some sections empower boards to adopt alternatives of their choice, provided they are in accord with other state statutes, while other sections are phrased loosely to allow boards necessary discretionary authority. These guidelines may thus be seen not as one proposal but as various proposals. Each is applicable in one form or another to a diversity of settings, and all are aimed at increasing or refining the ability of state medical boards to better protect the health, safety and welfare of the public.

The Federation urges member boards to consider including any recommendations contained herein in their respective medical practice acts, rules, or their own guidance documents.

The following guidelines apply equally to boards that govern physicians who have acquired the M.D. or D.O. degree, and the terms used herein should be interpreted throughout with this understanding.

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Section I. Definitions

The following terms have the following meanings:

"Assessment Program" means a formal system to examine or evaluate a physician's competence within the scope of the physician's practice.

"Competence" means possessing the requisite abilities and qualities (cognitive, non-cognitive, and communicative) to perform effectively within the scope of the physician's practice while adhering to professional ethical standards.

"Dyscompetence" means failing to maintain acceptable standards in one or more areas of professional physician practice. (HOD 1999)

"Impairment" means a physician's inability to practice medicine with reasonable skill and safety due to:

1. Mental, psychological, or psychiatric illness, disease, or deficit;
2. Physical illness or condition, including, but not limited to, those illnesses or conditions that would adversely affect cognitive, motor, or perceptive skills; or
3. Habitual, excessive, or illegal use or abuse of drugs defined by law as controlled substances, illegal drugs, alcohol, or of other impairing substances.

"Incompetence" means lacking the requisite abilities and qualities (cognitive, non-cognitive, and communicative) to perform effectively in the scope of the physician's practice.

"License" means any license, certificate, or other practice authorization granted by the Board pursuant to the medical practice act, or any other applicable statute.

"Licensee" means the holder of any license, certificate, or other practice authorization granted by the Board.

"Licensed physician" means a physician licensed to practice medicine in the jurisdiction.

"Medical Practice Act" means the statute that determines the structure and function of a state medical or osteopathic board. Section II below addresses categories that the medical practice act does not typically apply to.

"Physician assistant" means a skilled person who by training, scholarly achievements, submission of acceptable letters of recommendations, and satisfaction of other requirements of the Board has been licensed for the provision of patient services under the supervision and direction of a licensed physician who is responsible for the performance of that person.

"Physician Assistant Council" means a council appointed by the Board or other means that reviews matters relating to physician assistants, reports its findings to the Board, and makes recommendations for action.

"Practice of medicine" is consistent with the following:

1. Advertising, holding out to the public, or representing in any manner that one is authorized to practice medicine in the jurisdiction;
2. Offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other person;
3. Offering or undertaking to prevent or to diagnose, correct, and/or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of any person, including the management of pregnancy and parturition;
4. Offering or undertaking to perform any surgical operation upon any person;
5. Rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient within a state by a physician located outside the state as a result of transmission of individual patient data by electronic or other means from within a state to such physician or the physician's agent;
6. Rendering a determination of medical necessity or a decision affecting the diagnosis and/or treatment of a patient; and
7. Using the designation Doctor, Doctor of Medicine, Doctor of Osteopathic Medicine/Doctor of Osteopathy, Physician, Surgeon, Physician and Surgeon, Dr., M.D., D.O., or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition unless such a designation additionally contains the description of another branch of the healing arts for which one holds a valid license in the jurisdiction where the patient is located.

The definition of the practice of medicine may also include several exceptions, which exempt certain activities from the categorization of the practice of medicine.

The practice of medicine is determined to occur where the patient is located in order that the full resources of the state are available for the protection of that patient.

"Remediation" means the process whereby deficiencies in physician performance identified through an examination or assessment program are corrected, resulting in an acceptable state of physician competence.

"Supervising physician" means a licensed physician in good standing in the same jurisdiction as the physician assistant who the Board approved to supervise the services of a physician assistant, and who has in writing formally accepted the responsibility for such supervision.

"Telemedicine" means the practice of medicine using electronic communications, information technology, or other means between a licensee in one location, and a patient in another location, with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient. (HOD 2014)

Section II. The Medical Practice Act

The structure and function of each of the 70 medical regulatory boards (allopathic, osteopathic and composite) within the United States and its territories are determined by a unique state statute (or group of statutes), usually referred to as a medical practice act. The differences among these statutes are related to the general administrative structure of each jurisdiction and to the needs of the public as they are perceived by each responsible legislative body.

The following section is not intended to encourage movement toward total uniformity among these statutes. Given the diversity of administrative structures and the variations in perceived needs, that would be a futile exercise. The existing differences do have a positive creative value, allowing the evolution and testing of a range of new approaches in a number of jurisdictions concurrently. Rather, it is intended to nurture that creativity by encouraging the public, state legislators, medical boards, medical societies, and others who have an interest in the regulation of the medical profession to reexamine existing practice acts as they relate to the composition, structure, functions, responsibilities, powers, and funding of medical boards.

The medical practice act should provide for a separate state medical board, acting as a governmental agency to regulate the practice of medicine, in order to protect the public from unlawful, incompetent, unqualified, impaired, or unprofessional practitioners of medicine, through licensure, regulation, and rehabilitation of the medical profession in the state.

Generally, the medical practice act should authorize Boards to promulgate rules and regulations to facilitate the enforcement of the act. Boards should be authorized to adopt and enforce rules and regulations to carry out the provisions of the medical practice act and to fulfill their duties under the act. Boards should adopt rules and regulations in accord with administrative procedures established in the respective jurisdiction.

Statement of purpose

The medical practice act should be introduced by a statement of policy specifying the purpose of the act. This statement should include language expressing the following concepts:

- The practice of medicine is a privilege granted by the people acting through their elected representatives.
- In the interests of public health, safety, and welfare, and to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent, and/or deceptive practice of medicine, it is necessary for the government to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine.
- The primary responsibility and obligation of the state medical board is to act in the sovereign interests of the government by protecting the public through licensing, regulation and education as directed by the state government.

Sample Statement of Purpose:

As a matter of public policy, the practice of medicine is a privilege granted by the people of the State acting through their elected representatives by their adoption of the Medical Practice Act. It is not a natural right of individuals. Therefore, in the interests of public health, safety and welfare, and to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent, and/or deceptive practice of medicine, it is necessary to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine and to ensure, as much as possible, that only qualified and fit persons hold that privilege. The Board's primary responsibility and obligation is to protect the public, and any license, certificate or other practice authorization issued pursuant to this statute shall be a revocable privilege and no holder of such a privilege shall acquire thereby any irrevocable right.

Exemptions

The medical practice act should not apply to:

1. Students while engaged in training in a medical school approved or recognized by the state medical board, unless the board licenses the student;
2. Those providing service in cases of emergency where no fee or other consideration is contemplated, charged or received by the physician or anyone on behalf of the physician;
3. Commissioned medical officers of the armed forces of the United States and medical officers of the United States Public Health Service or the Veterans Administration of the United States in the discharge of their official duties and/or within federally controlled facilities, provided that such persons who hold medical licenses in the jurisdiction should be subject to the provisions of the act and provided that all such persons should be fully licensed to practice medicine in one or more jurisdictions of the United States. Further, the military physician should be subject to the Military Health System Clinical Quality Assurance (CQA) Program 10 U.S.C.A. § 1094; Regulation DOD 6025.13-R;
4. Those practicing dentistry, nursing, optometry, psychology, or any other of the healing arts in accord with and as provided by the laws of the jurisdiction;
5. Those practicing the tenets of a religion or ministering religious based medical procedures or ministering to the sick or suffering by mental or spiritual means in accord with such tenets;
6. Those administering a lawful domestic or family remedy to a member of one's own family;
7. Those fully licensed to practice medicine in another jurisdiction of the United States who briefly render emergency medical treatment or briefly provide critical medical service at the specific lawful direction of a medical institution or federal agency that assumes full responsibility for that treatment or service and is approved by the state medical board; and
8. Those fully licensed to practice medicine in another jurisdiction of the United States who is employed or formally designated as the team physician by an athletic team visiting the jurisdiction for a specific sporting event, and the physician limits the practice of medicine in the jurisdiction to medical treatment of the members, coaches, and staff of the sports entity that employs (or has designated) the physician.

Unlawful Practice of Medicine

The medical practice act should provide a definition of the unlawful practice of medicine and penalties for such unlawful practice. These provisions of the act should implement or be consistent with the following:

1. It should be unlawful for any person, corporation, or association to perform any act constituting the practice of medicine as defined in the medical practice act without first obtaining a medical license in accord with that act and the rules and regulations of the Board. Other licensed health care professionals may provide medical services within the scope of their authorizing license.
2. The Board should be authorized to issue a cease-and-desist order[1] and/or obtain injunctive relief against the unlawful practice of medicine by any person, corporation, or association.
3. It should be a felony for any person, corporation, or association that performs any act constituting the practice of medicine as defined in the medical practice act, or causing or aiding and abetting such actions.
4. A physician located in another state practicing within the state by electronic or other means without a license (full, special purpose or otherwise) issued by the Board should be deemed guilty of a felonious offense.

Section III. State Medical Board Duty, Responsibility, and Power

In some states, responsibility for licensing and disciplinary functions is divided between two separate Boards. In others, Boards are subject to supervision or, in some cases, complete control by larger administrative or umbrella agencies. In a few states, the Board is simply an advisory body. In most states, the Board regulates both allopathic and osteopathic physicians; in others, separate boards exist. And in some states, narrow constitutional restrictions inhibit effective Board funding. Clearly, the following section proposes a true working board with real and effective power and support, a proposal some states are much better prepared to implement than others. But it is also a reflection of those principles the authors consider to be basic to the operation of any accountable medical board, regardless of the administrative structure of the state, the size or distribution of the physician population being regulated, the form of legislation required for funding, or the title of the body to which responsibility and power for regulation have been entrusted. It may be drawn upon by both allopathic and osteopathic boards, making appropriate adaptations in the area of Board membership. Larger administrative agencies can use it to better assess their own structures and functions and to explore the broader roles their medical boards might play in meeting public expectations.

It is necessary that Boards have the responsibilities and powers necessary to fulfill the duties conferred on the Board by the medical practice act. These duties, responsibilities, and powers are to be liberally construed to protect the health, safety, and welfare of the people of the Board's State. It is the duty of Boards to determine a physician's initial and continuing qualification and fitness for the practice of medicine. Boards should be empowered to initiate proceedings against the unprofessional, improper,

[1] In light of the recent U.S. Supreme Court case, *North Carolina Board of Dental Examiners v. Federal Trade Commission*, it is currently unclear whether the reliance on cease-and-desist orders to regulate the unlicensed practice of medicine by state medical boards is a best practice.

incompetent, unlawful, fraudulent, deceptive, or unlicensed practice of medicine, and enforce the medical practice act and related rules. Boards should discharge these duties and responsibilities in accord with the medical practice act and other governing laws.

In addition to any other duty, responsibility, and power provided to the Board in the medical practice act, the Board, acting in accord with its medical practice act and the requirements of due process, should:

1. Enforce the provisions of the medical practice act;
2. Develop, adopt and enforce rules and regulations to affect the provisions of medical practice act and to fulfill the Boards duties there under;
3. Select and/or administer licensing examination(s);
4. Employ or contract with one or more organizations or agencies known to provide acceptable examinations for the preparation, administration, and scoring of required examinations;
5. Prepare, select, conduct, or direct the conduct of, set passing requirements for, assure security of, and impose conditions for (e.g., time or attempt limits) successful completion of the licensing and other required examinations;
6. Impose conditions, sanctions, deny licensure, levy fines, seek appropriate civil and/or criminal penalties, or any combination of these, against those who violate or attempt to violate examination security, those who obtain or attempt to obtain licensure by fraud or deception, and those who knowingly assist in such activities;
7. Acquire information about and evaluate medical education and training of applicants;
8. Determine which professional schools, colleges, universities, training institutions, and educational programs are acceptable relating to licensure under the medical practice act and are appropriately preparing physicians for the practice of medicine, and to accept the approval of such facilities and programs by Board-recognized accrediting bodies in the United States and Canada;
9. Develop and use applications and other necessary forms and related procedures it finds appropriate for purposes of the medical practice act;
10. Require supporting documentation or other acceptable verifying evidence of any information provided the Board by an applicant or licensee;
11. Require information on and evaluate an applicant's or a licensee's fitness, qualification, and previous professional record and performance from recognized data sources, including, but not limited to, the Federation of State Medical Boards' Federation Physician Data Center, other national data repositories, licensing and disciplinary authorities of other jurisdictions, professional education and training institutions, liability insurers, health care institutions, and law enforcement agencies;
12. Issue, condition, or deny initial or endorsement licenses;
13. Maintain secure and complete records on individual licensees including, but not limited to license application, verified credentials, disciplinary information, and malpractice history;
14. Provide the public with a profile of all licensed physicians;
15. Process and approve or deny applications for license renewal and review of a licensee's

activities for that time period;

16. Develop and implement methods to identify physicians who are in violation of the medical practice act;
17. Require the self-reporting by applicants or licensees of any information the Board determines may indicate possible deficiencies in practice, performance, fitness, or qualification.
18. Require all licensees, healthcare professionals, healthcare facilities, and medical societies and organizations to report to the Board information that appears to show another licensee is, or may be, professionally incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in licensed practice, and to report to the Board and/or to an agency designated by the Board a licensee's possible dependence on alcohol or other addictive substances which have the potential to impair. Require licensees, malpractice insurance companies, attorneys, and healthcare facilities to report any payments on a demand, claim, settlement, arbitration award or judgment by or on behalf of a licensee;
19. Develop and implement methods to identify and rehabilitate, if appropriate, physicians with an alcohol, drug, and/or psychiatric illness;
20. When deemed appropriate by the Board to do so, require professional competency, physical, mental or chemical dependency examination, and evaluations of any applicant or licensee, including withdrawal and laboratory examination of bodily fluids;
21. Establish a mechanism, which at the Board's discretion, may involve cooperation with and/or participation by one or more Board-approved professional organizations, for the identification and monitored treatment of licensees who are dependent on or abuse alcohol or other addictive substances which have the potential to impair;
22. Establish a mechanism by which licensees who believe they abuse or may be dependent on or addicted to alcohol or other addictive substances which have the potential to impair, and who have not been identified by the Board through other sources of information, will be encouraged to report themselves voluntarily to the Board and/or, at the Board's discretion, to a professional organization approved by the Board to seek assistance and monitored treatment;
23. Receive, review, and investigate complaints and adverse information about licensees, including *sua sponte* complaints;
24. Review and investigate reports received from entities having information pertinent to the professional performance of licensees;
25. Act to halt the unlicensed or illegal practice of medicine; review, investigate, and take appropriate action to enjoin reports received concerning the unlicensed practice of medicine; and seek penalties against those engaged in such practices;
26. Adjudicate those matters that come before it for judgement under the medical practice act and issue final decisions on such matters;
27. Share investigative information at the early stages of a complaint investigation with other Boards;
28. Issue cease and desist orders and to obtain court orders and injunctions to halt unlicensed practice, violation of this statute or the rules of the Board;
29. Institute actions in its own name and enjoin violators of the medical practice act;
30. Act on its own motion in disciplinary matters, administer oaths, issue notices, issue subpoenas in

the name of the state including for patient records, receive testimony, conduct hearings, institute court proceedings for contempt to compel testimony or obedience to its orders and subpoenas, take evidentiary depositions, and perform such other acts as are reasonably necessary under the medical practice act or other laws to carry out its duties;

31. Issue subpoenas in the course of an investigation, including for *duces tecum* to compel production of documents or testimony to any party or entity that may possess relevant information regarding the subject of the investigation;
32. Institute proceedings in courts of competent jurisdiction to enforce its orders and the provisions of the medical practice act;
33. Use preponderance of the evidence as the standard of proof and to issue final decisions;
34. Present to the proper authorities information it believes indicates an applicant or licensee may be subject to criminal prosecution;
35. Discipline licensees found in violation of the medical practice act;
36. Issue conditioned, restricted, or otherwise circumscribed licenses as it determines necessary;
37. Take the following actions, in accord with applicable state statutes, alone or in combination, against those found in violation of the medical practice act:
    a. Revoke, suspend, condition, restrict, and/or otherwise limit the license;
    b. Place the licensee on probation with conditions;
    c. Levy fines and/or assess the costs of proceedings against the licensee;
    d. Censure, reprimand and/or otherwise admonish the licensee;
    e. Require the licensee to provide monetary redress to another party, and/or provide a period of free public or community service;
    f. Require the licensee to satisfactorily complete an educational, training, and/or treatment program or programs; and
    g. Require the licensee to successfully complete an examination, examinations, or evaluations designated by the Board; and
38. Summarily suspend a license when there is imminent risk of the public health and safety prior to hearing and final adjudication;
39. Enforce final disciplinary action against a licensee as deemed necessary to protect public health and safety;
40. Report all final disciplinary actions, non-administrative license withdrawals as defined by the Board, license denials, and voluntary license limitations or surrenders related to physicians, with any accompanying license limitations or surrenders related to physicians, with any accompanying Board orders, findings of fact and conclusions of law, to the Federation Physician Data Center of the Federation of State Medical Boards of the United States and to any other data repository required by law, and report all such actions, denials and limitations or surrenders related to other licensees, with the same supporting documentation, to the National Practitioner Data Bank as required by law;
41. Develop policies for disciplining or rehabilitating physicians who demonstrate inappropriate sexual behavior with patients or other professional boundaries violations;
42. Acknowledge receipt of complaints or other adverse information to persons or entities reporting to the Board and to the physician, and inform them of the final disposition of the matters

reported;

43. Develop and implement methods to identify dyscompetent physicians and physicians who fail to meet acceptable standards of care;
44. Develop or identify and implement methods to assess and improve physician practice;
45. Develop or identify and implement methods to ensure the ongoing competence of licensees;
46. Determine and direct the Board's operating, administrative, personnel, and budget policies and procedures in accord with applicable state statutes;
47. Acquire real property or other capital for the administration and operation of the Board;
48. Set necessary fees and charges to ensure active and effective pursuit of all of its responsibilities, legal and otherwise;
49. Develop and adopt its budget;
50. Employ, direct, reimburse, evaluate, and dismiss when appropriate the Board's executive director, in accord with the Board's state's procedures; Supervision of staff is the purview of the executive director.
51. Develop, recommend, and adopt rules, standards, policies, and guidelines related to qualifications of physicians and medical practice;
52. Engage in a full exchange of information with the licensing and disciplinary boards of other states and jurisdictions of the United States and foreign countries;
53. Direct the preparation and circulation of educational material, policies, and guidelines the Board determines is helpful and proper for licensees;
54. Develop educational programs to facilitate licensee awareness of provisions contained in the medical practice act and to facilitate public awareness of the role and function of state medical boards;
55. Delegate to the executive director the Board's authority to discharge its duties as appropriate; and
56. Recommend to the Legislature those changes in, or amendments to, the medical practice act that the Board determines would benefit the health, safety, and welfare of the public.

Section IV. State Medical Board Membership

Whatever the professional regulatory structure established by the government of the jurisdiction, the state medical board bears the primary responsibility for licensing and regulating the medical profession for the protection of the public. Every Board should include both physician and public members. All Board members should act to further the interest of the state, and not their personal interests.

Composition and Size

The Board should consist of enough members to appropriately discharge the duties of the Board, at least 25% of whom should be public members. The Board should consider several factors when determining the appropriate size and composition of a Board, including the size of a state's physician population, the composition and functions of Board committees, adequate separation of prosecutorial and judicial powers, and the other work of the Board envisions throughout this document. The Board should be of sufficient size to allow for recusals due to conflicts of interest and other occasional member absences without concentrating final decisions in the hands of too few members or loss of quorum.

Qualifications

The membership of the Board should be drawn from as many different regions of the State, as many different specialties as possible, and should reflect the licensee population.

Members should be citizens of the United States who have attained the age of majority as defined in the statutes of the State.

Sex, race, national or ethnic origin, creed, religion, disability, or age above majority shall not be used as the sole reason for making an individual eligible or ineligible to serve on the Board.

All physician members of the Board should be in active practice[2] (HOD 2012), hold full and unrestricted medical licenses in the jurisdiction, be persons of recognized professional ability and integrity, and should have resided or practiced in the jurisdiction long enough to have become familiar with the laws, policies, and practice in the jurisdiction (e.g., five years).

Public members of the Board should reside in the Board's respective jurisdiction and be persons of recognized ability and integrity; are not licensed physicians, providers of health care, or retired physicians or health care providers; have no past or current substantial personal or financial interests in the practice of medicine or with any organization regulated by the Board (except as a patient or care giver of a patient); and have no immediate familial relationships with individuals involved in the practice of medicine or any organization regulated by the Board, unless otherwise required by law.

Members of the Board should not be registered as a lobbyist representing any health care interest or association nor be an officer, Board member, or employee of a statewide or national organization established for advocating the interests of individuals involved in the practice of medicine or any organization regulated by the Board.

Terms

Members of the Board, whether appointed or elected, should serve staggered terms to ensure continuity. All appointments and elections should be confirmed through the legislative branch of the jurisdiction. The length of terms on the Board should be set to permit development of effective skill and experience by members (e.g., three or four years). However, a limit should be set on consecutive terms of service (e.g., two or three consecutive terms).

The term of Board service shall be three to four years.

A person should not serve as a member of the Board for more than three consecutive full terms, but may be reappointed two years after completion of such service. A person who serves more than two

[2] FSMB Report of the Special Committee on Reentry to Practice (HOD 2012) defines the clinically active physician as one who, at the time of license renewal, is engaged in direct, consultative, or supervisory patient care, or as further defined by the states. Clinically inactive physician is defined as one who is not engaged in direct, consultative or supervisory patient care at the time of license renewal, but who, as a result of their professional activities, influences the care provided by clinically active practitioners.

years of an un-expired term should be considered to have served a full term.

Terms of service should be staggered, one fourth of the Board's membership being appointed each year.

In order to ensure there is continual representation of public members, for Boards with up to four public members, the term of no more than one public member should expire in any one year. For Boards with more than four public members, the terms of no more than two public members should expire in any one year.

Requirements

Before assuming the duties of office, the following should be required of each member of the Board:

1. Take a constitutional oath or affirmation of office;
2. Swear or affirm that he/she is qualified to serve under all applicable statutes;
3. Sign a statement agreeing that he/she will disclose any potential conflicts of interest that may arise for that member in the conduct of Board business;
4. Sign a confidentiality and ethics statement agreeing to maintain the confidentiality of confidential Board business and patient identification and uphold high ethical standards in discharging Board duties.

The Board should also conduct, and new members should attend, a training program designed to familiarize new members with their duties and ethics of public service. The Board should hold an annual training program for new members.

Appointment

The members of the Board should be appointed by the Governor, who should make each appointment at least 30 calendar days prior to the beginning of the Board term being filled. The Governor should fill an unexpired term within 30 calendar days of the vacancy's occurrence. The incumbent should serve until the Governor names a replacement. Should the Governor not act as such, the Board, by majority vote, should select a qualified person to serve in the interim until the Governor acts. Any individual, organization or group should be permitted to suggest potential Board appointees to the Governor.

Removal

A Board member should be automatically removed from the Board if the Board member:

1. Ceases to be qualified;
2. Submits written resignation to the Board Chair or to the Governor;
3. Is absent from the state for a period of more than six months;
4. Is found guilty of a felony or an unlawful act involving moral turpitude by a court of competent jurisdiction;
5. Is found guilty of malfeasance, misfeasance, or nonfeasance in relation to the Board member's Board duties by a court of competent jurisdiction;
6. Is found to be mentally incompetent by a court of competent jurisdiction;
7. Fails to attend three successive Board meetings without just cause as determined by the Board,

or, if a new member, fails to attend the new members' training program without just cause as determined by the Board;

8. Is found to be in violation of the medical practice act; or
9. Is found to be in violation of the conflict of interest/ethics law.

Compensation/Reimbursement

Members of the Board should receive appropriate compensation for services and reimbursement for expenses at the respective state's current approved rate.

- Compensation: Service on the Board should not present an undue economic hardship. Board members should therefore receive compensation in an amount sufficient to allow full participation and not preclude qualified individuals from serving.
- Expenses: Each Board member's travel and expenses necessarily and properly incurred for active Board service should be paid at the respective state's current approved rate.
- Education/Training: Travel, expenses, and daily compensation should also be paid for each Board member's attendance, in or out of the Board's jurisdiction, for education or training purposes approved by the Board and directly related to Board duties.

Section V. State Medical Board Structure

Officers

The Board should elect annually from its members a president/chair, a vice president/vice- chair, a secretary-treasurer, and those other officers it determines are necessary to conduct its business. The officers shall serve for a one-year term.

- President/Chair: The president/chair should approve Board meeting agendas, preside at Board meetings, appoint Board committees and their chairs, and perform those other duties assigned by the Board and this statute.
- Vice President/Vice-Chair: The vice president/vice-chair should assist the president/chair in all duties as requested by the president/chair and should perform the duties of the president/chair in that officer's absence.
- Secretary/Treasurer: The secretary-treasurer should ensure the maintenance of the minutes of all meetings of the Board and that the expenditure of funds complies with respective state law.

Committees

To effectively facilitate its work, fulfill its duties and exercise its powers, the Board should be authorized to appoint committees from its membership, establish standing committees, including, but not limited to, licensing, investigation, finance, administration, personnel, rules, legislative communications, and public information committees. The chair should also be empowered to name ad hoc committees as required. Changes in membership should not be deemed to affect or hinder the continuing business or activity of any committee.

Other committees created by the Board should have responsibilities, consistent with the medical

practice act, delegated to them by the Board.

Funding

The medical practice act should provide that Board fees be adequate to fund the Board's ability to effectively regulate the practice of medicine under the act, and that those fees paid by licensees be used only for purposes related to licensee licensure, discipline, education and Board administration. A designated officer of the Board or employee, at the direction of the Board, should oversee the collection and disbursement of funds, and the State Auditor's Office (or the equivalent State office) should routinely audit the financial records of the Board and report to the Board and the Legislature.

Revenues

The Board should be fully supported by the revenues generated from its activities, including fees, charges and reimbursed costs, which the Board should deposit in an appropriate account, and the Board should also receive all interest earned on the deposit of such revenues. Such funds should be appropriated continuously and used by the Board only for administration and enforcement of the medical practice act. All fines levied by the Board may be deposited in the State General Fund, unless otherwise allowed by law. All administrative, investigative and adjudicatory costs recoupment should be deposited in the Board's account.

In the event the legislature imposes additional responsibilities on the Board beyond the Board's statutory responsibilities for licensure and discipline, the legislature should appropriate additional funds to the Board sufficient to carry out such additional responsibilities.

Budget

The Board should develop and adopt its own budget reflecting revenues, including the interest thereon, and costs associated with each health care field regulated. Revenues and interest thereon, from each health care field regulated should fully support Board regulation of that field. The budget should include allocations for establishment and maintenance of a reasonable reserve fund.

Setting Fees and Charges

All Board fees and charges should be set by the Board pursuant to its proposed budget needs. The Board should provide reasonable notice to the regulated healthcare professional and the public of all increases or decreases in fees and charges.

Fiscal Year

The Board should operate on the same fiscal year as the State.

Section VI. Meetings of the Board and Committee of the Board

Location

The Board and its committees should meet in the Board's offices, or other appropriate facilities in the same city as those offices. At their discretion, however, they may meet from time to time in other areas of the State to facilitate their work or to enhance communication with the public and members of the regulated professions.

Telephone or other telecommunication conference is an acceptable form of Board meeting if the president/chair alone or another officer and two Board members believe the Board's business can be properly conducted by teleconference. The Board should be authorized to establish procedures by which its committees may meet by telephone or other telecommunication conference system.

Frequency, Duration

The Board should meet at least bimonthly for a period sufficient to complete the work before it at that time. One meeting per quarter may be sufficient for states with small physician populations. Committees should meet as directed by the Board.

Special Meetings, Conferences

Emergency meetings of the Board may be called at any time by the president/chair or at the request of an officer and two Board members if required to enforce the medical practice act. The Board may establish procedures by which its committees may call emergency meetings in accordance with the State's open meeting laws.

Informal conferences of an investigation committee may be called by the chair of the committee for the purpose of holding discussions with licensees, accused or otherwise, who seek or agree to such conferences. Any disciplinary action taken as a result of such a conference and agreed to in writing by the Board and licensee should be binding and a matter of public record. The holding of an informal conference should be at an investigation committee's discretion and should not preclude formal disciplinary investigation, proceedings, or action.

Notice

The Board should establish a system for giving all Board and committee members reasonable notice of all Board and committee meetings. The Board should comply with the State's open meeting laws.

Quorum

A majority of members constitutes a quorum for the transaction of business by the Board or any committee of the Board. The business of the Board and its committees should be conducted in accord with the medical practice act and with rules of parliamentary procedure adopted by the Board.

Conflict of Interest

No member of the Board, acting in that capacity or as a member of any Board committee, shall participate in the deliberation, making of any decision, or the taking of any action affecting the Board member's own personal, professional, or pecuniary interest, or that of a known relative or of a business or professional associate. With advice of legal counsel, the Board shall adopt and annually review a conflict of interest policy to enforce this section.

Minutes

Minutes of all Board and committee meetings and proceedings, and other Board and committee materials, shall be prepared and kept in accord with the Board's adopted rules of parliamentary procedure and other applicable State laws.

Open Meetings

All meetings of the Board and its committees should be open to the public in accordance with the State's Open Meeting laws, with the following exceptions:

1. Meetings or portions of meetings of the Board, acting in its capacity as a hearing or adjudicatory body, held to receive testimony or evidence the public disclosure of which the Board determines would constitute an unreasonable invasion of personal privacy, to consult with legal counsel, to deliberate issues, and to arrive at disciplinary judgments;
2. Meetings or portions of meetings regarding investigations;
3. Meetings or portions of meetings regarding license applications; and
4. Meetings or portions of meetings regarding personnel actions.

The Board should ratify all recommendations or decisions made in nonpublic meetings in public, which should be matters of public record.

Confidentiality

The minutes and all records of nonpublic meetings are privileged and confidential and should not be disclosed, except to the Board or its designees for the enforcement of the medical practice act, except that all licensing decisions made by the Board and all disciplinary orders, with the associated findings of fact and conclusions of law and order, issued by the Board should be matters of public record.

The following should be privileged and confidential:

1. Application and renewal forms and any evidence submitted in proof or support of an application to practice, except that the following items of information about each applicant or licensee included on such forms should be matters of public record:
    a. Full name;
    b. Date of birth;
    c. Name(s) and location(s) of professional schools attended;
    d. School awarding professional degree, date of award, and designation of degree;
    e. Site(s) and date(s) of graduate certification(s) held and date(s) granted;
    f. Specialty certifications;
    g. Year of initial licensure in the State;
    h. Other states in which licensed to practice; and
    i. Current office address and telephone number.
2. All investigations and records of investigations;
3. Any report from any source concerning the fitness of any person to receive or hold a license;
4. Any communication between or among the Board and/or its committees, staff, advisors, attorneys, employees, hearing officers, consultants, experts, investigators and panels occurring outside public meetings; and
5. A complaint and the identity of an individual or entity filing an initial complaint with the Board.

Notwithstanding the foregoing provisions, the Board may cooperate with and provide documentation to

other boards, agencies or law enforcement bodies of the State, other states, other jurisdictions, or the United States upon written official request by such entity(s). The Board should share investigative information at the early stages of a complaint investigation in order to reduce the likelihood that a licensee may become licensed in one state while under investigation in another state.

These provisions should not be construed as prohibiting a respondent or the respondent's legal counsel from exercising the respondent's right of due process under the law.

Section VII. Administration of the State Medical Board

Offices

The Board should maintain offices it determines are adequate in size, staff, and equipment to effectively carry out the provisions of the medical practice act. At its discretion, it may establish branch offices, staffed and equipped as it finds necessary, in as many areas of the State as it believes require such branch offices to facilitate the work of the Board.

Administration

The Board should set out the function, operation, and administration structure of its offices.

Staff, Special Personnel

To effectively perform its duties under the medical practice act, the Board should be empowered to determine its staff needs and to employ, fix compensation for, evaluate, discipline, and remove its own full-time, part-time and temporary staff in accord with the statutory requirements of the State. The Board should also be assigned adequate legal counsel by the office of the attorney general and/or be authorized to employ private counsel or its own full-time attorney. The Board should define the duties of and qualifications for the executive director. Staff benefits should be provided in accord with the statutes of the State.

The Board's staff may include, but need not be limited to, the following:

- An executive director, who, among administrative and other delegated responsibilities, may assist, at the Board's discretion, in the discharge of the duties of the secretary-treasurer and if one exists, the licensing committee, the investigation committee, and any other standing or ad hoc committee;
- One or more assistant executive directors;
- One or more medical consultants, who shall be licensed to practice medicine in the State without restriction;
- Office and clerical staff;
- One or more attorneys, who may be full-time employees of the Board, contractors of the Board, or assigned from the Office of the State Attorney General by agreement between the Board and that office, or in private practice; and/or
- One or more investigators, who shall be trained in and knowledgeable about the investigation of medical and related health care practice.

Special Support Personnel

The Board may enlist, at its discretion, the services of experts, advisors, consultants, and others who are not part of its staff to assist it in more effectively enforcing the medical practice act. Such persons may serve voluntarily, be reimbursed for expenses in accord with State law and policy, or be compensated at a level commensurate with services rendered in accord with state law and policy. When acting for or on behalf of the Board, such persons should benefit from the same immunity and indemnification protections afforded by this statute to the members and staff of the Board.

Section VIII. Immunity, Indemnity, Protected Communication

The medical practice act should provide legal protection for the members of the Board and its staff and for those providing information to the Board in good faith.

Immunity

There shall be no liability, monetary or otherwise, on the part of, and no cause of action for damages shall arise against any current or former member, officer, administrator, staff member, committee member, examiner, representative, agent, employee, consultant, witness, or any other person serving or having served the Board, either as a part of the Board's operation or as an individual, as a result of any act, omission, proceeding, conduct, or decision related to the duties undertaken or performed in good faith and within the scope of the function of the Board.

Qualified Immunity and Indemnity

The medical practice act should provide the following:

1. There shall be no liability on the part of, and no action for damages against, any member of the Board, its agents, its employees, or any member of an examining committee of physicians appointed or designated by the Board, for any action undertaken or performed by such person within the scope of the duties, powers, and functions of the Board or such examining committee when such person is acting in good faith and in the reasonable belief that the action taken by such person is warranted.
2. If a current or former member, officer, administrator, staff member, committee member, examiner, representative, agent employee, consultant, or any other person serving or having served the Board requests the State to defend them against any claim or action arising out of any act, omission, proceeding, conduct, or decision related to their duties undertaken or performed in good faith in furtherance of the purposes of the medical practice act and within the scope of the function of the Board, and if such a request is made in writing at a reasonable time before trial, and if the person requesting defense cooperates in good faith in the defense of the claim or action, the State shall provide and pay for such defense and shall pay any resulting judgment, compromise, or settlement.
3. No person, committee, association, organization, firm, or corporation providing information to the Board in good faith and in the reasonable belief that such information is accurate and, whether as a witness or otherwise, shall be held, by reason of having provided such information, to be liable in damages under the law of the state or any political subdivision thereof.

4. In any suit brought against the Board, its employees or agents, any member of an examining committee appointed by the Board or any person, firm, or other entity providing information to the Board, when any such defendant substantially prevails in such suit, the court shall, at the conclusion of the action, award to any such substantially prevailing party defendant against any such claimant the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the claim was frivolous, unreasonable, without foundation, or in bad faith. For the purposes of this Section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.
5. There shall be no liability on the part of and no action for damages against any corporation, foundation, or organization that enters into any agreement with the Board related to the operation of any committee or program to identify, investigate, counsel, monitor, or assist any licensed physician who suffers or may suffer from alcohol or substance abuse or a physical or mental condition which could compromise such physician's fitness and ability to practice medicine with reasonable skill and safety to patients, for any investigation, action, report, recommendation, decision, or opinion undertaken, performed, or made in connection with or on behalf of such committee or program, in good faith, and in the reasonable belief that such investigation, action, report, recommendation, decision, or opinion was warranted.
6. There shall be no liability on the part of and no action for damages against any person who serves as a director, trustee, officer, employee, consultant, or attorney for or who otherwise works for or is associated with any corporation, foundation, or organization that enters into any agreement with the Board related to the operation of any committee or program to identify, investigate, counsel, monitor, or assist any licensed physician who suffers or may suffer from alcohol or substance abuse or a physical or mental condition which could compromise such physician's fitness and ability to practice medicine with reasonable skill and safety to patients, for any investigation, action, report, recommendation, decision, or opinion undertaken, performed, or made in connection with or on behalf of such committee or program, in good faith and in the reasonable belief that such investigation, action, report, recommendation, decision, or opinion was warranted.
7. In any suit brought against any corporation, foundation, organization, or person described in Subsection 4 or 5 of this Section, when any such defendant substantially prevails in the suit, the court shall, at the conclusion of the action, award to any substantially prevailing party defendant against any claimant the cost of the suit attributable to such claim, including reasonable attorney fees, if the claim was frivolous or brought without a reasonable good faith basis. For purposes of this Subsection, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains a judgment for damages, permanent injunction, or declaratory relief.
8. The state should defend a current or former member, officer, administrator, staff member, committee member, examiner, representative, agent, employee, consultant, witness, contractor, or any other person serving or having served the Board against any claim or action arising out of the medical practice act, omission, proceeding, conduct, or decision related to the person's duties undertaken or performed in good faith and within the scope of the function of the Board. The State should provide and pay for such defense and should pay any resulting judgment, compromise, or settlement.

Protected Communication

Every communication made by or on behalf of any person, institution, agency, or organization to the Board or to any person designated by the Board, relating to an investigation or the initiation of an investigation, whether by way of report, complaint, or statement, should be privileged. No action or proceeding, civil or criminal, should be permitted against any such person, institution, agency, or organization by whom or on whose behalf such a communication was made in good faith.

The protections afforded in this provision should not be construed as prohibiting a respondent or the respondent's legal counsel from exercising the respondent's constitutional right of due process under the law.

Section IX. Reports of the Board

Annual Report

The Board should present to the Governor, the Legislature and the public, at the end of each fiscal year, a formal report summarizing its licensing and disciplinary activity for that year. The report should include, but not limited to, the following information about each of the Board's regulated professions:

1. The total number of persons fully licensed by the State and the number of those licensees currently practicing in the State;
2. The number of licensees holding each form of limited license authorized by this statute;
3. The number of persons granted a full license by the State for the first time in the past year, the number of those licensees currently practicing in the State, and the number of full licenses denied in the past year;
4. The number of licensees currently practicing in-state about whom a complaint, a charge or an adverse item of information required by law was received in the past year;
5. The number and the source, by category, of complaints, charges and adverse items of information required by law received about licensees practicing in-state in the past year and the number of these found not to warrant action under this statute and the rules of the Board;
6. The number of disciplinary investigations conducted by the Board or its representatives concerning licensees practicing in-state in the past year;
7. The number of disciplinary actions, by category, taken by the Board in the past year against all licensees;
8. A ranking, by frequency, of primary causes for disciplinary action against all licensees in the past year;
9. A review of disciplinary activity related to holders of limited forms of license in the past year;
10. A review of the operations of the Board's current mechanisms for dealing with a licensee dependent on or addicted to alcohol or other addictive substances which have the potential to impair;
11. A schedule of all current fees and charges;
12. A revenue and expenditure statement for the past year indicating the percentage of revenue from and expenditures for each regulated profession;
13. A summary of other Board activities and a schedule of days met by the Board and each of its

committees during the year;
14. A summary of administrative and legislative activity in the past year;
15. A summary of the goals and objectives established by the Board for the coming fiscal year; and
16. A copy of the Board's strategic plan.

Public Record, Action Reports

Each of the Board's non-administrative license application withdrawals, license denials and final disciplinary orders, including any associated findings of fact and conclusions of law, should be matters of public record. Voluntary surrenders of or limitations on licenses shall also be matters of public record. The Board should promptly report all denials, orders, surrenders, and limitations to the public, all health care institutions in the State, appropriate State and federal agencies, related professional societies or associations in the State, and any data repository. The Board should make the information readily accessible to the public via the physician's profile. The Board should update the profile at least annually and offer the licensee an opportunity to correct erroneous information. A licensee's profile shall contain, but not be limited to:

1. Demographic Information: name and license number, gender, business or practice address, and birth date.
2. Medical Education: medical school(s)' name, address, year of graduation and degree, post-graduate training program(s)' name, address, years attended, and year completed.
3. License and Board Certification Information: license status, license type, original license date, license renewal date, specialty and type of practice, and board certification by a certifying authority recognized by the Board.
4. Criminal Convictions: a description of any conviction of a felony or a misdemeanor involving moral turpitude within the last five years, including cases with a deferred adjudication or expungement.
5. Malpractice History:
    a. The number of awards or judgments within the past 10 years;
    b. When the number exceeds 3, the number of demands, claims, and/or settlements paid by the licensee or on behalf of the licensee in the past 5 years; and
    c. A statement that malpractice payments do not necessarily demonstrate the quality of care provided by a physician, and that the Board independently investigates all reports of payment in malpractice cases, which will appear in the licensee's disciplinary history if the Board completed the investigation and took disciplinary action.
6. Disciplinary History:
    a. All disciplinary actions taken by the Board;
    b. A brief description of the reason for a disciplinary action;
    c. All disciplinary actions taken by other state medical/osteopathic boards and a brief description of the reason for discipline if available;
    d. All disciplinary actions taken by hospitals;
    e. An explanation of the types of discipline the Board takes and its effects on the licensee's ability to practice; and

f. A statement that hospitals may take disciplinary actions for reasons that do not violate the governing statutes.

Section X. Examinations

The medical practice act should provide for the Board's authority to approve an examination(s) of medical knowledge satisfactory to inform the Board's decision to issue a full, unrestricted license to practice medicine and surgery in the jurisdiction.

In order to ensure a high quality, valid, and reliable examination of physician preparedness to practice medicine, the Board may delegate the responsibilities for examination development, administration, scoring, and security to a third party or nationally recognized testing entity. Such an examination should be consistent with recognized national standards for professional testing such as those reflected in Standards for Educational and Psychological Testing.

No person should receive a license to practice medicine in the jurisdiction unless he or she has successfully completed all components of an examination(s) identified as satisfactory to the Board:

- The currently administered United States Medical Licensing Examination (USMLE) Steps 1,2,3 or The Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Levels 1,2,3; or
- Previously administered examinations such as the Federation Licensing Examination (FLEX), National Board of Medical Examiners (NBME) Parts or National Board of Osteopathic Medical Examiners (NBOME) Parts; or
- A combination of these examinations identified as acceptable by the Board.

The examination(s) approved by the Board should be in the English language and designed to ascertain an individual's fitness for an unrestricted license to practice medicine and surgery.

The Board may stipulate the numeric score or performance level required for passing the examination(s) or accept the recommended minimum passing score as determined by the developers of the examination.

The 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.

In order to support periodic or mandated reviews of its approved examination(s), the Board should be provided with reasonable access by the third party or testing entity in order to review the examination design, format, and content, as well as performance data and relevant procedures for test administration, security, and scoring.

Section XI. Requirements for Full Licensure

The medical practice act should provide minimum requirements for full licensure for the independent practice of medicine that bear a reasonable relationship to the qualifications and fitness necessary for

such practice. These provisions of the act should implement or be consistent with the following:

1. The applicant should provide the Board, or its agent, and attest to, or provide the means to obtain and verify the following information and documentation in a manner required by the Board:
    a. The applicant's full name and all aliases or other names ever used, current address, Social Security number, and date and place of birth;
    b. A signed photograph not more than two (2) years old and, at the Board's discretion, other documentation of identity;
    c. Originals of all documents and credentials required by the Board, notarized photocopies, or other verification acceptable to the Board of such documents and credentials;
    d. A list of all jurisdictions, United States or foreign, in which the applicant is licensed or has ever applied for licensure to practice medicine or is authorized or has ever applied for authorization to practice medicine, including all jurisdictions in which any license application or authorization has been withdrawn;
    e. A list of all jurisdictions, United States or foreign, in which the applicant has been denied licensure or authorization to practice medicine or as any other health care professional or has voluntarily surrendered a license or an authorization to practice medicine or as any other health care professional;
    f. A list of all sanctions, judgments, awards, settlements, or convictions against the applicant in any jurisdiction, United States or foreign, that would constitute grounds for disciplinary action under the medical practice act or the Board's rules and regulations;
    g. A detailed educational history, including places, institutions, dates, and program descriptions of all the applicant's education including all college, pre-professional, professional, and professional postgraduate education;
    h. A detailed chronological life history, including places and dates of residence, employment, and military service (United States or foreign) including periods of absence from the active practice of medicine;
    i. All Web sites associated with the applicant's practice and professional activities;
    j. A list and current status of all specialty certifications and the name of certifying organization; and
    k. Any other information or documentation the Board determines necessary.
2. The applicant should possess the degree of Doctor of Medicine or Doctor of Osteopathic Medicine/Doctor of Osteopathy from a medical college or school located in the United States, its territories or possessions, or Canada that was approved by the Board or by a private nonprofit accrediting body approved by the Board at the time the degree was conferred. No person who graduated from a medical school that was not approved at the time of graduation should be examined for licensure or be licensed in the jurisdiction based on credentials or documentation from that school nor should such a person be licensed by endorsement.
3. Should the applicant graduate from a medical school in a foreign country, other than Canada, the applicant should meet all the requirements established by the Board to determine the

applicant's fitness to practice medicine.

4. The applicant should have satisfactorily completed at least thirty-six (36) months of progressive postgraduate medical training (also termed graduate medical education, or GME) accredited by the Board, the Accreditation Council for Graduate Medical Education (ACGME), or the American Osteopathic Association (AOA).
5. The applicant should have passed the USMLE Steps 1, 2, 3 or COMLEX Levels 1, 2, 3 or a predecessor examination (FLEX, NBME Parts, NBOME Parts) or a combination of these examinations identified as accredited by the Board.
6. The applicant should have demonstrated a familiarity with the statutes and regulations of the jurisdiction relating to the practice of medicine and the appropriate use of controlled or dangerous substances.
7. The applicant should be physically, mentally, and professionally capable of practicing medicine in a manner acceptable to the Board and should be required to submit to a physical, mental, professional competency, or chemical dependency examination(s) or evaluation(s) if deemed necessary by the Board.
8. The applicant should not have been found guilty by a competent authority, United States or foreign, of any conduct that would constitute grounds for disciplinary action under the regulations of the Board or the act. The Board may be authorized, at its discretion, to modify this restriction for cause, but it should be directed to use such discretionary authority in a consistent manner.
9. If the applicant's license is denied or in accordance with Board policy, the applicant should be allowed a personal appearance before the Board or a representative thereof for interview, examination or review of credentials. At the discretion of the Board, the applicant should be required to present the applicant's original medical education credentials for inspection at the time of personal appearance.
10. The applicant should be held responsible for verifying to the satisfaction of the Board the validity of all credentials required for the applicant's medical licensure. The Board or its agent should verify medical licensure credentials directly from primary sources, and utilize recognized national physician information services (e.g., the Federation of State Medical Boards' Physician Data Center (PDC), which includes its Board Action Data Bank, and Federation Credentials Verification Service (FCVS); the files of the American Medical Association and the American Osteopathic Association; and other national data banks and information resources.)
11. The applicant should have paid all fees and have completed and attested to the accuracy of all application and information forms required by the Board before the Board's verification process begins. The Board should require the applicant to authorize the Board to investigate and/or verify any information provided to it on the licensure application.
12. Applicants should have satisfactorily passed a criminal background check.
13. Pay appropriate fees.

Graduates of Foreign Medical Schools

The medical practice act should provide minimum requirements, in addition to those otherwise established, for full licensure of applicants who are graduates of schools located outside the United

States, its territories or possessions, or Canada. These provisions of the act should implement or be consistent with the following:

1. Such applicants should possess the degree of Doctor of Medicine, Bachelor of Medicine, or a Board-approved equivalent based on satisfactory completion of educational programs acceptable to the Board.
2. Such applicants should be eligible by virtue of their medical education, training, and examination for unrestricted licensure or authorization to practice medicine in the country in which they received that education and training.
3. Such applicants should have passed an examination acceptable to the Board that adequately assesses the applicants' medical knowledge.
4. Such applicants should be certified by the Educational Commission for Foreign Medical Graduates or its Board-approved successor(s), or by an equivalent Board-approved entity.
5. Such applicants should have a demonstrated command of the English language satisfactory to the Board.
6. Such applicants should have satisfactorily completed at least thirty-six (36) months of progressive post-graduate medical training accredited by the Board, the Accreditation Council for Graduate Medical Education (ACGME), or the American Osteopathic Association (AOA).
7. All credentials, diplomas, and other required documentation in a foreign language submitted to the Board by or on behalf of such applicants should be accompanied by certified English translations acceptable to the Board.
8. Such applicants should have satisfied all applicable requirements of the United States Immigration and Naturalization Service.

Section XII. Licensure by Endorsement, Expedited Licensure by Endorsement, and Temporary and Special Licensure

The medical practice act should provide for licensure by endorsement, expedited licensure by endorsement, and in certain clearly defined cases, for temporary and special licensure.

Endorsement for Licensed Applicants

The Board should be authorized, at its discretion, to issue a license by endorsement to an applicant who:

1. Has complied with all current medical licensing requirements save that for examination administered by the Board;
2. Has passed a medical licensing examination given in English by another state, the District of Columbia, or a territory or possession of the United States or Canada, provided the Board determines that examination was equivalent to its own current examination, or an independent testing agent designated by the Board; and
3. Has a valid current medical license in another state, the District of Columbia, or a territory or possession of the United States or Canada.

Expedited Licensure by Endorsement

The Board should be authorized, at its discretion, to issue an expedited license by endorsement to an applicant who provides documentation of:

1. Identity as required by the Board;
2. All jurisdictions in which the applicant holds a full and unrestricted license;
3. Graduation from an approved medical school:
    a. Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA) of the American Osteopathic Association (AOA) approved medical school;
    b. Fifth Pathway certificate; or
    c. Educational Commission for Foreign Medical Graduates (ECFMG) certificate.
4. Passing one or more of the following examinations acceptable for initial licensure within three attempts per step/level:
    a. United States Medical Licensing Examination (USMLE) Steps 1-3 or its predecessor examinations, the National Board of Medical Examiners (NBME) I-III or the Federation Licensing Examination (FLEX);
    b. Comprehensive Osteopathic Medical Licensure Examination (COMLEX-USA) Levels 1-3 or its predecessor examinations, the National Board of Osteopathic Medical Examiners Levels 1-3 or its predecessor examination(s); and/or
    c. Medical Council of Canada Qualifying Examinations (MCCQE) or its predecessor examination(s) offered by the Licentiate Medical Council of Canada.
5. Successful completion of the total examination sequence within seven (7) years, except when in combination with a Ph.D. program;
6. Successful completion of three (3) years of progressive postgraduate training in a program accredited by the Accreditation Council on Graduate Medical Education (ACGME) or the AOA; and/or
7. Certification or recertification by a medical specialty board recognized by the American Board of Medical Specialties (ABMS) or the AOA within the previous ten (10) years. Lifetime certificate holders who have not passed a written specialty recertification examination must demonstrate successful completion of the Special Purpose Examination (SPEX), Comprehensive Osteopathic Medical Variable Purpose Examination (COMVEX) or applicable specialty recertification examination.

Boards should obtain supplemental documentation including, but not limited to:

1. Criminal background check;
2. Absence of current/pending investigations in any jurisdiction where licensed;
3. Verification of specialty board certification; and
4. Professional experience.

Physicians desiring an expedited process for licensure may utilize the Federation Credentials Verification Service (FCVS), or credentials verification meeting equivalent standards for verification of core

credentials, or rely on the primary source verification of the state board of first licensure for:

1. Medical school diploma;
2. Medical school transcript;
3. Dean's certificate;
4. Examination history;
5. Disciplinary history;
6. Identity (photograph and certified birth certificate or original passport);
7. ECFMG certificate, if applicable; and
8. Fifth Pathway certificate, if applicable, and postgraduate training verification.

Temporary Licensure

The Board should be authorized to establish regulations for issuance of a temporary medical license for the intervals between Board meetings. Such a license should:

1. Be granted only to an applicant demonstrably qualified for a full and unrestricted medical license under the requirements set by the medical practice act and the regulations of the Board; and
2. Automatically terminate within a period specified by the Board.

Special Licensure

The Board should be authorized to issue conditional, restricted, probationary, limited or otherwise circumscribed licenses as it determines necessary. It is up to the discretion of the state medical board to set the criteria for issuing special purpose licenses. This provision should include, but not be limited to, the ability to issue a special license for the following purposes:

1. To provide medical services to a traveling sports team, coaches, and staff for the duration of the sports event;
2. To provide volunteer medical services to under-insured/uninsured patients;
3. To provide medical services to youth camp enrollees, counselors, and staff for the duration of the youth camp; and
4. To engage in the limited practice of medicine in an institutional setting by a physician who is licensed in another jurisdiction in the United States.

Section XIII. Limited Licensure for Physicians in Postgraduate Training

The medical practice act should provide that all physicians in all postgraduate training in the state or jurisdiction who are not otherwise fully licensed to practice medicine should be licensed on a limited basis for educational purposes. These provisions of the act should implement or be consistent with the following:

1. To be eligible for limited licensure, the applicant should have completed all the requirements for full and unrestricted medical licensure except postgraduate training or specific examination

requirements.

2. Issuance of a limited license specifically for postgraduate training should occur only after the applicant demonstrates that he/she is accepted in a residency program. The application for limited licensure should be made directly to the Board in the jurisdiction where the applicant's postgraduate training is to take place.
3. The Board should establish by regulation restrictions for the limited license to assure that the holder will practice only under appropriate supervision and within the confines of the program within which the resident is enrolled.
4. The limited license should be renewable annually and upon the written recommendation of the supervising institution, including a written evaluation of performance, until the Board regulations require the achievement of full and unrestricted medical licensure.
5. The disciplinary provisions of the medical practice act should apply to the holders of the limited and postgraduate training license as if they held full and unrestricted medical licensure.
6. The issuance of a limited license should not be construed to imply that a full and unrestricted medical license would be issued at any future date.

Postgraduate Training Program Reporting Requirements

Program directors responsible for postgraduate training should be required annually to provide the Board a written report on the status of program participants having a limited license.

The report should inform the Board about program participants who have successfully completed the program, have departed from the program, have had unusual absences from the program, or have had problematic occurrences during the course of the program.

The report should include an explanation of any disciplinary action taken against a limited licensee for performance or behavioral reasons which, in the judgment of the program director, could be a threat to public health, safety, and welfare; unapproved or unexplained absences from the program; resignations from the program or nonrenewal of the program contract; dismissals from the program for performance or behavioral reasons; and referrals to substance abuse pro-grams not approved by the Board.

Failure to submit the annual program director's report shall be considered a violation of the mandatory reporting provisions of the medical practice act and shall be grounds to initiate such disciplinary action as the Board deems appropriate, including fines levied against the supervising institution and suspension of the program director's medical license.

Section XIV: Periodic Renewal

The medical practice act should provide for the periodic renewal of medical licenses to permit the Board to review the qualifications of licensees on a regular basis. These provisions of the act should implement or be consistent with the following:

At the time of periodic renewal, the Board should require the licensee to demonstrate to its satisfaction the licensee's continuing qualification for medical licensure. The Board should design the application for licensure renewal to require the licensee to update and/or add to the information in the Board's file

relating to the licensee and the licensee's professional activity. It should also require the licensee to report to the Board the following information:

1. Any action taken for acts or conduct similar to acts or conduct described in the medical practice act as grounds for disciplinary action against a licensee by:
    a. Any jurisdiction or authority (United States or foreign) that licenses or authorizes the practice of medicine or participation in a payment or practice program;
    b. Any peer review body;
    c. Any specialty certification board;
    d. Any health care organization;
    e. Any professional medical society or association;
    f. Any law enforcement agency;
    g. Any health insurance company;
    h. Any malpractice insurance company;
    i. Any court; and
    j. Any governmental agency.
2. Any adverse judgment, settlement, or award against the licensee or payment by or on behalf of the licensee arising from a professional liability demand, claim, or case.
3. The licensee's voluntary surrender of or voluntary limitation on any license or authorization to practice medicine in any jurisdiction, including military, public health, and foreign.
4. Any denial to the licensee of a license or authorization to practice medicine by any jurisdiction, including military, public health, and foreign.
5. The licensee's voluntary resignation from the medical staff of any health care organization or voluntary limitation of the licensee's staff privileges at such an organization if that action occurred while the licensee was under formal or informal investigation by the organization or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct, or mental, physical, alcohol, or drug impairment.
6. The licensee's voluntary resignation or withdrawal from a national, state, or county medical society, association, or organization if that action occurred while the licensee was under formal or informal investigation or review by that body for any reason related to possible medical incompetence, unprofessional conduct, mental, physical, alcohol, or drug impairment.
7. Whether the licensee is currently suffering from any condition that adversely affects or impairs the licensee's practice of medicine.
8. The licensee's completion of continuing medical education or other forms of professional maintenance and/or evaluation, including specialty board certification or recertification, within the renewal period.

The Board should be authorized, at its discretion, to require continuing medical education for license renewal and to require documentation of that education. The Board should have the authority to audit, randomly or specifically, licensees for compliance.

The Board should require the licensee to apply for license renewal in a manner prescribed by the board and attest to the accuracy and truthfulness of the information submitted. The Board should be

authorized to collect a fee for renewal of a license.

The Board should be directed to establish an effective system for reviewing renewal forms. It should also be authorized to initiate investigations and/or disciplinary proceedings based on information submitted by licensees for license renewal.

Failure to report fully and correctly as outlined above should be grounds for disciplinary action by the Board.

Section XV. Disciplinary Process

The medical practice act should provide for disciplinary and/or remedial action against licensees and the grounds on which such action may be taken. These provisions of the act should implement or be consistent with the following:

Range of Actions

A range of progressive disciplinary and remedial actions should be made available to the Board. The Board should be authorized, at its discretion, to take disciplinary, non-disciplinary, public or non-public actions, singly or in combination, as the nature of the violation requires and to promote public protection. These include, but are not limited to, the following:

1. Revocation of the medical license;
2. Suspension of the medical license;
3. Probation;
4. Stipulations, limitations, restrictions, probation, and conditions relating to practice;
5. Censure (including specific redress, if appropriate);
6. Reprimand;
7. Letters of concern and advisory letters:
    a. The Board should be authorized to issue a confidential (if allowed by state law), non-reportable, non-disciplinary letter of concern, or advisory letter to a licensee when evidence does not warrant formal discipline, but the Board has noted indications of possible errant conduct by the licensee that could lead to serious consequences and formal action if the conduct were to continue. In its letter of concern or advisory letter, the Board should also be authorized, at its discretion, to request clarifying information from the licensee.
8. Monetary redress to another party;
9. A period of free public service, either medical or non-medical;
10. Satisfactory completion of an educational, training and/or treatment program(s), or professional developmental plan:
    a. The Board should be authorized, at its discretion, to require professional competency, physical, mental, or chemical dependency examination(s) or evaluation(s) of any applicant or licensee, including withdrawal and laboratory examination of bodily fluids, tissues, hair, or nails.
11. Levy fines; and

12. Payment of administrative and disciplinary costs.

Grounds for Action

The Board should be authorized to take disciplinary action for unprofessional or dishonorable conduct, which should be defined to mean, but not be limited to, the following:

1. Fraud or misrepresentation in applying for or procuring a medical license or in connection with applying for or procuring periodic renewal of a medical license;
2. Cheating on or attempting to subvert the medical licensing examination(s);
3. The commission or conviction or the entry of a guilty, nolo contendere plea, or deferred adjudication (without expungement) of:
    a. A misdemeanor related to the practice of medicine and any crime involving moral turpitude; or
    b. A felony related to the practice of medicine. The Board shall revoke a licensee's license following conviction of a felony, unless a 2/3 majority vote of the board members present and voting determined by clear and convincing evidence that such licensee will not pose a threat to the public in such person's capacity as a licensee and that such person has been sufficiently rehabilitated to warrant the public trust;
4. Conduct likely to deceive, defraud, or harm the public;
5. Disruptive behavior and/or interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient;
6. Making a false or misleading statement regarding the licensee's skill or the efficacy or value of the medicine, treatment, or remedy prescribed by the licensee or at the licensee's direction in the treatment of any disease or other condition of the body or mind;
7. Representing to a patient that an incurable condition, sickness, disease, or injury can be cured;
8. Willfully or negligently violating the confidentiality between physician and patient except as required by law;
9. Professional incompetency as one or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes negligence, as determined by the Board;
10. Being found mentally incompetent or of unsound mind by any court of competent jurisdiction;
11. Being physically or mentally unable to engage in the practice of medicine with reasonable skill and safety;
12. Practice or other behavior that demonstrates an incapacity or incompetence to practice medicine;
13. The use of any false, fraudulent, or deceptive statement in any document connected with the practice of medicine;
14. Giving false, fraudulent, or deceptive testimony while serving as an expert witness;
15. Practicing medicine under a false or assumed name;
16. Aiding or abetting the practice of medicine by an unlicensed, incompetent, or impaired person;
17. Allowing another person or organization to the licensee's license to practice medicine;

18. Commission of any act of sexual misconduct, including sexual contact with patient surrogates or key third parties, which exploits the physician-patient relationship in a sexual way;
19. Habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability;
20. Failing or refusing to submit to an examination or any other examination that may detect the presence of alcohol or drugs upon Board order or any other form of impairment;
21. Prescribing, selling, administering, distributing, diverting, ordering or giving any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug for other than medically accepted therapeutic purposes;
22. Knowingly prescribing, selling, administering, distributing, ordering, or giving to a habitual user or addict or any person previously drug dependent, any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug, except as otherwise permitted by law or in compliance with rules, regulations, or guidelines for use of controlled substances and the management of pain as promulgated by the Board;
23. Prescribing, selling, administering, distributing, ordering, or giving any drug legally classified as a controlled substance or recognized as an addictive drug to a family member or to the licensee themselves;
24. Violating any state or federal law or regulation relating to controlled substances;
25. Signing a blank, undated, or predated prescription form;
26. Obtaining any fee by fraud, deceit, or misrepresentation;
27. Employing abusive, illegal, deceptive, or fraudulent billing practices;
28. Directly or indirectly giving or receiving any fee, commission, rebate, or other compensation for professional services not actually and personally rendered, though this prohibition should not preclude the legal functioning of lawful professional partnerships, corporations, or associations;
29. Disciplinary action of another state or federal jurisdiction against a license or other authorization to practice medicine or participate in a federal program (payment or treatment) based upon acts or conduct by the licensee similar to acts or conduct that would constitute grounds for action as defined in this section, a certified copy of the record of the action taken by the other state or jurisdiction being conclusive evidence thereof;
30. Failure to report to the Board any adverse action taken against oneself by another licensing jurisdiction (United States or foreign), by any peer review body, by any health care institution, by any professional or medical society or association, by any governmental agency, by any law enforcement agency, or by any court for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
31. Failure to report or cause a report to be made to the Board of any physician upon whom a physician has evidence or information that appears to show that the physician is incompetent, guilty of negligence, guilty of a violation of this act, engaging in inappropriate relationships with patients, is mentally or physically unable to practice safely, or has an alcohol or drug abuse problem;
32. Failure of physician who is the chief executive officer, medical officer, or medical staff to report to the Board any adverse action taken by a health care institution or peer review body, in addition to the reporting requirement in 31. (Note: a report under 31 may need to wait until the peer review and due process procedures are completed, but the report under 30 must be

reported immediately without waiting for the final action of the health care institution and applies to all physicians not just staff physicians);

33. Failure to report to the Board surrender of a license limitation or other authorization to practice medicine in another state or jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society has surrendered the authority to utilize controlled substances issued by any state or federal agency, or has agreed to a limitation to or restriction of privileges at any medical care facility while under investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
34. Failure to report any adverse judgment, award, or settlement against the licensee resulting from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
35. Failure to report to the Board any adverse judgment, settlement, or award arising from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
36. Failure to provide pertinent and necessary medical records to another physician or patient in a timely fashion when legally requested to do so by the subject patient or by a legally designated representative of the subject patient regardless of whether the patient owes a fee for services;
37. Improper management of medical records, including failure to maintain timely, legible, accurate, and complete medical records and to comply with the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Part 160 and 164, of the Health Insurance Portability and Accountability Act of 1996;
38. Failure to furnish the Board, its investigators, or representatives information legally requested by the Board or failure to comply with a Board subpoena or order;
39. Failure to cooperate with a lawful investigation conducted by the Board;
40. Violation of any provision(s) of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board;
41. Engaging in conduct calculated to, or having the effect of, bringing the medical profession into disrepute or conduct unbecoming of the medical profession, including but not limited to, violation of any provision of a national code of ethics acknowledged by the Board and/or failing to uphold the standards of the profession;
42. Failure to follow generally accepted infection control procedures;
43. Failure to comply with any state statute or board regulation regarding a licensee's reporting responsibility for HIV, HVB (hepatitis B virus), seropositive status or any other reportable condition (including child abuse and vulnerable adult abuse) or disease;
44. Practicing medicine in another state or jurisdiction without appropriate licensure;
45. Conduct which violates patient trust, exploits the physician-patient relationship, or violates professional boundaries, regardless of the medium;
46. Failure to offer appropriate procedures/studies, failure to protest inappropriate managed care denials, failure to provide necessary service, or failure to refer to an appropriate provider within such actions are taken for the sole purpose of positively influencing the physician's or the plan's financial wellbeing;

47. Providing treatment or consultation recommendations, including issuing a prescription via electronic or other means, unless the physician has obtained a history and physical evaluation of the patient adequate to establish diagnosis and identify underlying conditions and/or contraindications to the treatment recommended/provided;
48. Violating a Board formal order, condition of probation, consent agreement, or stipulation;
49. Representing, claiming, or causing the appearance that the physician possesses a particular medical specialty certification by a Board recognized certifying organization (ABMS, AOA) if not true;
50. Failing to obtain adequate patient informed consent;
51. Using experimental treatments without appropriate patient consent and adhering to all necessary and required guidelines and constraints;
52. Any conduct that may be harmful to the patient or the public;
53. Failing to divulge to the Board upon legal demand the means, method, procedure, modality, or medicine used in the treatment of an ailment, condition, or disease;
54. Conduct likely to deceive, defraud, or harm the public;
55. The use of any false, fraudulent, or deceptive statement in any document connected with the practice of the healing arts including intentional falsifying or fraudulent altering of a patient or medical care facility record;
56. Failure to keep written medical records which accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination results, and test results;
57. Delegating professional responsibilities to a person when the licensee knows or has reason to know that such person is not qualified by training, experience, or license to perform them;
58. Using experimental forms of therapy without proper informed patient consent, without conforming to generally accepted criteria or standard protocols, without keeping detailed legible records, or without having periodic analysis of the study and results reviewed by a committee or peers; and
59. Failing to properly supervise, direct, or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation, or practice protocols.

Enforcement and Disciplinary Action Procedures

The medical practice act should provide for procedures that will permit the Board to take appropriate enforcement and disciplinary action when and as required, while assuring fairness and due process to licensees. These provisions of the act should implement or be consistent with the following:

Board Authority: The Board should be empowered to commence legal action to enforce the provisions of the medical practice act and to exercise full discretion and authority with respect to disciplinary actions. In the course of an investigation, the Board's authority should include the ability to issue subpoenas to licensees, health care organizations, complainants, patients, and witnesses to produce documents or appear before the Board or staff to answer questions or be deposed. The Board should have the power to enforce its subpoenas, including disciplining a non-compliant licensee, and it is incumbent upon the subpoenaed party to seek a motion to quash the subpoena.

Administrative Procedures: The existing administrative procedures act or similar statute, in whole or in part, should either be applicable to or serve as the basis of the procedural provisions of the medical practice act. The procedural provisions should provide for Board investigation of complaints; notice of formal or informal charges or allegations to the licensee; a fair and impartial hearing for the licensee before the Board, an examining committee or hearing officer; an opportunity for representation of the licensee by counsel; the presentation of testimony, evidence and arguments; subpoena power and attendance of witnesses; a record of the proceedings; and judicial review by the courts in accordance with the standards established by the jurisdiction for such review. The Board should have subpoena authority to conduct comprehensive reviews of a licensee's patient and office records and administrative authority to access otherwise protected peer review records. The Board should not need the patients' consent to obtain copies of medical records, nor shall health care institutions' peer-review privilege bar the Board from obtaining copies of peer review information. Once in the Board's possession, the patient records and peer review records should have the same legal protection from disclosure as they have when in the possession of the licensee, the patient or the peer-review organization.

Standard of Proof: The Board should be authorized to use preponderance of the evidence as the standard of proof in its role as trier of fact for all levels of discipline.

Informal Conference: Should there be an open meeting law, an exemption to it should be authorized to permit the Board, at its discretion, to meet in informal conference with a licensee who seeks or agrees to such a conference. Disciplinary action taken against a licensee because of such an informal conference and agreed to in writing by the Board and the licensee should be binding and a matter of public record. However, license revocation and suspension should be held in open formal hearing, unless executive session is permitted by the State's open meetings law. The holding of an informal conference should not preclude an open formal hearing if the Board determines such is necessary.

Summary Suspension: The Board should be authorized to summarily suspend or restrict a license prior to a formal hearing when it believes such action is required to protect the public from an imminent threat to public health and safety. The Board should be permitted to summarily suspend or restrict a license by means of a vote conducted by telephone conference call or other electronic means if appropriate Board officials believe such prompt action is required. Proceedings for a formal hearing should be instituted simultaneously with the summary suspension. The hearing should be set within a reasonable time of the date of the summary suspension. No court should be empowered to lift or otherwise interfere with such suspension while the Board proceeds in a timely fashion.

Cease and Desist Orders/Injunctions: The Board should be authorized to issue a cease-and-desist order and/or obtain an injunction to restrain any person or any corporation or association and its officers and directors from violating any provision of the medical practice act. Violation of an injunction should be punishable as contempt of court. No proof of actual damage to any person should be required for issuance of a cease-and-desist order and/or an injunction, nor should issuance of an injunction relieve those enjoined from criminal prosecution, civil action, or administrative process for violation of the medical practice act.

Board Action Reports: All the Board's final disciplinary actions, non-administrative license withdrawals, and license denials, including related findings of fact and conclusions of law, should be matters of public record. The Board should report such actions and denials to the National Practitioner Data Bank and Board Action Data Bank of the Federation of State Medical Boards of the United States within 30 days of the action being taken, to any other data repository required by law, and to the media. Voluntary surrender of and voluntary limitation(s) on the medical license of any person should also be matters of public record and should also be reported to the Federation of State Medical Boards of the United States and to any other data repository by law. The Board should have the authority to keep confidential practice limitations and restrictions due to physical impairment when the licensee has not violated any provision in the medical practice act.

Tolling Periods of License Suspension or Restriction: The Board should provide, in cases of license suspension or restriction, that any time during which the disciplined licensee practices in another jurisdiction without comparable restriction shall not be credited as part of the period of suspension or restriction.

Section XVI: Compulsory Reporting and Investigation

The medical practice act should provide that certain persons and entities report to the Board any possible violation of the act or of the Board's rules and regulations by a licensee. These provisions of the act should implement or be consistent with the following:

Any person should be permitted to report to the Board in a manner prescribed by the Board, any information he or she believes indicates a medical licensee is or may be dyscompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine.

The following should be required to report to the Board promptly and in writing any information that indicates a licensee is or may be dyscompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine; and any restriction, limitation, loss or denial of a licensees staff privileges or membership that involves patient care:

1. All licensees licensed under the act,
2. All licensed health care providers,
3. The state medical associations and its components,
4. All hospitals and other health care organizations in the state, to include hospitals, medical centers, long term care facilities, managed care organizations, ambulatory surgery centers, clinics, group practices, coroners, etc.,
5. All chiefs of staff, medical directors, department administrators, service directors, attending physicians, residency directors, etc.,
6. All liability insurance organizations,
7. All state agencies,
8. All law enforcement agencies in the state,
9. All courts in the state,
10. All federal agencies (e.g., Drug Enforcement Administration, Food and Drug Administration,

Centers for Medicare and Medicaid Services, Veterans Health Administration, and Department of Defense),

11. All peer review bodies in the state, and
12. All resident training program directors.

A licensee's voluntary resignation from the staff of a health care organization or voluntary limitation of a licensee's staff privileges at such an organization should be promptly reported to the Board by the organization if that action occurs while the licensee is under formal or informal investigation by the organization or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct, or mental, physical, alcohol or drug impairment.

Malpractice insurance carriers, the licensee's attorney, a hospital, a group practice, and the affected licensees should be required to file with the Board a report of each final judgment, settlement, arbitration award, or any form of payment by the licensee or on the licensee's behalf by any source upon any demand, claim, or case alleging medical malpractice, battery, dyscompetence, incompetence, or failure of informed consent. Licensees not covered by malpractice insurance carriers should be required to file the same information with the Board regarding themselves. All such reports should be made to the Board promptly (e.g., within 30 days).

The Board should be permitted to investigate any evidence that appears to show a licensee is or may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine.

Any person, institution, agency, or organization who reports in good faith and not made in bad faith, a licensee pursuant to paragraphs 2 and 3 of this section should not be subject to civil damages or criminal prosecution for so reporting. A bad faith report is grounds for disciplinary action under the medical practice act. There should be no monetary liability on the part of, and no cause of action for damages should arise against, any person, institution, agency, or organization for reporting in good faith.

To assure compliance with compulsory reporting requirements, specific civil penalties should be established for demonstrated failure to report (e.g., up to $10,000 per instance).

The Board should promptly acknowledge all reports received under this section. The Board should promptly notify persons or entities reporting under this section of the Board's final disposition of the matters reported.

Section XVII. Impaired Physicians

The medical practice act should provide for the limitation, restriction, conditioning, suspension or revocation of the medical license of any licensee whose mental or physical ability to practice medicine with reasonable skill and safety is impaired.

The Board should have available to it a confidential impaired physician program approved by the Board and charged with the evaluation and treatment of licensees who are in need of rehabilitation. The Board may directly provide such programs or through a formalized contractual relationship with an

independent entity whose program meets standards set by the Board. The Board shall have the ability to monitor or audit the program to ensure the program meets the requirements of the Board.

The Board should be authorized, at its discretion, to require a licensee or applicant to submit to a mental or physical examination, body fluid, nail, or hair follicle test, or a chemical addiction, abuse, or dependency evaluation conducted by an independent evaluator designated or approved in advance by the Board. The results of the examination or evaluation should be admissible in any hearing before the Board or hearing officer, despite any claim of privilege under a contrary rule or statute. Every person who receives a license to practice medicine or who files an application for a license to practice medicine should be deemed to have given consent to submit to mental or physical examination or a chemical addition, abuse, or dependency evaluation, and to have waived all objections to the admissibility of the results in any hearing before the Board. If a licensee or applicant fails to submit to an examination or evaluation when properly directed to do so by the Board, the Board should be permitted to enter a final order upon proper notice, hearing, and proof of refusal.

If the Board finds, after an evaluation, examination or hearing, that a licensee is mentally, physically, or chemically impaired, it should be authorized to take one or more of the following actions:

1. Direct the licensee to submit to therapy, medical care, counseling, or treatment acceptable to the Board and comply with monitoring to ensure compliance;
2. Suspend, limit, restrict, or place conditions on the licensee's medical license for the duration of the impairment and monitoring or treatment; and/or
3. Revoke the licensee's medical license.

Any licensee or applicant who is prohibited from practicing medicine under this provision should be afforded, at reasonable intervals, an opportunity to demonstrate to the satisfaction of the Board that he or she can resume or begin the practice of medicine with reasonable skill and safety. A license should not be reinstated, however, without the payment of all applicable fees and the fulfillment of all requirements as if the applicant had not been prohibited from practicing medicine.

While all impaired licensees should be reported to the Board in accord with the mandatory reporting requirements of the medical practice act, unidentified and unreported impaired licensees should be encouraged to seek treatment. To this end, the Board should be authorized, at its discretion, to establish rules and regulations for the review and approval of a medically directed Physician Health Program (PHP). Those conducting a Board-approved PHP should be exempt from the mandatory reporting requirements relating to an impaired licensee who is participating satisfactorily in the program, or the Board should hold its report in confidence and without action, unless or until the impaired licensee ceases to participate satisfactorily in the program. The Board should require a PHP to report any impaired licensee whose participation is unsatisfactory to the Board as soon as that determination is made. Participation in an approved PHP should not protect an impaired licensee from Board action resulting from a report of licensee impairment from another source or resulting from an investigation of other medical practice violations. The Board should be the final authority for approval of a PHP, should conduct a review of its approved program(s) on a regular basis and should be permitted to withdraw or

deny its approval at its discretion. The PHP should be required to report to the Board information regarding any violation of the medical practice act by a PHP participant, other than the impairment, even if the violation is unrelated to the licensee's impairment.

Section XVIII: Dyscompetent and Incompetent Licensees

The medical practice act should provide for the restriction, conditioning, suspension, revocation, or denial of the medical license of any licensee who the Board determines to be dyscompetent or incompetent. These provisions of the act should implement or be consistent with the following:

The Board should be authorized to develop and implement methods to identify dyscompetent or incompetent licensees and licensees who fail to provide the appropriate quality of care. The Board should also be authorized to develop and implement methods to assess and improve licensee practices.

The Board should have access to a Board-approved assessment program charged with assessing licensees' clinical competency.

The Board should be authorized, at its discretion, to require a licensee or an applicant for licensure to undergo a physician competency evaluation conducted by a Board-designated independent evaluator at licensee's own expense. The results of the assessment should be admissible in any hearing before the Board or hearing officer, despite any claim of privilege under a contrary rule or statute. Every person who receives a license to practice medicine or who files an application for a license to practice medicine should be deemed to have given consent to submit to a physician competency evaluation, and to have waived all objections to the admissibility of the results in any hearing before the Board or hearing officer. If a licensee or applicant fails to submit to a competency assessment when properly directed to do so by the Board, the Board should be permitted to enter a final order upon proper notice, hearing, and proof of refusal to submit to such an evaluation.

If the Board finds, after evaluation by the assessment program, that a licensee or applicant for licensure is unable to competently practice medicine, it should be authorized to take one or more of the following actions:

1. Suspend, revoke, or deny the licensee's medical license or application;
2. Restrict or limit the licensee's practice to those areas of demonstrated competence and comply with monitoring to ensure compliance;
3. Place conditions on the licensee's license; and/or
4. Direct the licensee to submit to a Board approved remediation program and comply with monitoring to ensure compliance to resolve any identified deficits in medical knowledge or clinical skills acceptable to the Board.

Any licensee or applicant for licensure who is prohibited from practicing medicine, or who has had restrictions or conditions placed upon their license, under the above section, should be afforded, at reasonable intervals, an opportunity to demonstrate to the satisfaction of the Board that he/she can resume or begin the practice of medicine, or can practice without the restrictions or conditions, with reasonable skill and safety. A license should not be reinstated, however, without the payment of all

applicable fees and the fulfillment of all requirements as if the applicant had not been previously prohibited.

The Board should be authorized to require the assessment program to provide to the Board a written report of the results of the assessment with recommendations for remediation of the identified deficiencies.

The Board should have access to Board approved remedial medical education programs for referral of licensees in need of remediation. Such programs shall incorporate and comply with standards set by the Board. During remediation, the program shall provide, at Board determined intervals, written reports to the Board on the licensee's progress. Upon completion of the remediation program, the program shall provide a written report to the Board addressing the remediation of the previously identified areas of deficiency. The Board should be authorized to mandate that the licensee undergo post-remediation assessment to identify areas of continued deficit. The licensee shall be responsible for all expenses incurred as part of the assessment and the remediation.

Section XIX: Physician Assistants

The medical practice act should provide for the Board to license and regulate physician assistants.

Administration

The Board should administer and enforce these provisions of the medical practice act with the advice and assistance of the Physician Assistant Council.

Licensing

No person should perform or attempt to practice as a physician assistant without first obtaining a license from the Board and having a supervising physician.

An applicant for licensure as a physician assistant should complete all Board application forms and pay a nonrefundable fee. The forms should request the applicant provide their name and address and such additional information as the Board deems necessary. The Board may issue a license to a physician assistant applicant who fulfills all board requirements for licensure. However, a licensed physician assistant is prohibited from practicing until they have an agreement with a supervising physician(s).

Each licensed physician assistant should renew their license and file updated documentation stating their name and current address and any additional information as required by the Board. A fee set by the Board should accompany each renewal and filing of updated documentation.

The Board may require written notification by the supervising physician and the physician assistant if the relationship is changed or severed for a reason that would have an adverse effect for patient care.

Persons not licensed by the Board who hold themselves out as physician assistants should be subject to penalties applicable to the unlicensed practice of medicine.

Rules and Regulations

The Board should be empowered to adopt and enforce rules and regulations for:

1. Setting qualifications of education, skill, and experience for the licensing of a person as a physician assistant and providing forms and procedures for licensure and for renewal; and
2. Evaluating applicants for licensure as physician assistants.

Disciplinary Actions

The Board should be empowered to deny, revoke, or suspend any license, to limit or restrict the location of practice, to issue reprimands, to remove the authorization of a supervising physician, and to limit or restrict the practice of a physician assistant upon grounds and according to procedures similar to those for such disciplinary actions against licensed physicians. Such actions should be reported to the National Practitioner Databank and the Federation of State Medical Boards.

Duties and Scope of Practice

A physician assistant should be permitted to provide those medical services delegated to them by the supervising physician that are within their training and experience.

Responsibility of Supervising Physician

Every physician supervising or employing a physician assistant should be legally responsible for the delegation of health care tasks, the performance and the acts and omissions of the physician assistant. Nothing in these provisions, however, should be construed to relieve the physician assistant of any responsibility for any of their own acts and omissions. No physician should have under their supervision more staff, physician assistant, or otherwise than the physician can adequately supervise. In the event the supervising physician is absent, he or she must provide for appropriate supervision of the physician assistant by another licensed physician. Each and every relationship should adhere to all statutory requirements for licensure.

Renewal

The Board should be authorized, at its discretion, to require evidence of satisfactory completion of continuing medical education for license renewal.

FSMB Advisory Council of Board Executives

2017-2018 Members:

Kimberly Kirchmeyer, Medical Board of California

Kathleen Selzler Lippert, JD, CMBE Kansas State Board of Healing Arts

Maegan Carr Martin, JD, Tennessee State Board of Medical Examiners

Micah Matthews, MPA, Washington Medical Quality Assurance Commission

Frank Meyers, JD, District of Columbia Board of Medicine

Ex Officio Members:

Kevin Bohnenblust, JD, President, Administrators in Medicine

Mark Bowden, MPA, CMBE, Vice President, Administrators in Medicine

Kathleen Haley, JD, CMBE, FSMB BOD, Oregon Medical Board

Ian Marquand, FSMB BOD, Montana Board of Medical Examiners

FSMB Staff Support:

Shiri A. Hickman, JD

BRD RPT 18-5

REPORT OF THE BOARD OF DIRECTORS

Subject: **Report on Resolution 17-2: Advocacy for Professional Licensure of Emergency Medical Service Providers**

Referred to: **Reference Committee A**

In April 2017, the Federation of State Medical Boards House of Delegates referred Resolution 17-2, Advocacy for Professional Licensure of Emergency Medical Service (EMS) Providers, to the Board of Directors for study. The Resolution, submitted by the Montana Board of Medical Examiners, states:

> *Resolved*, that the Federation of State Medical Boards (FSMB) adopt a position supporting professional licensure of paramedics and other advanced life support EMS providers under the authority of state medical boards; and be it further
>
> *Resolved*, that the FSMB coordinate and collaborate with individual state medical boards and other stakeholders to develop model statutory language for states to utilize in adopting a professional licensing process and standards for EMS providers.

The Board of Directors considered the Resolution and tasked the Advisory Council of Board Executives to evaluate the regulatory oversight of paramedics and make a recommendation as to the position of the FSMB. The Board noted that the Advisory Council of Board Executives would be reviewing and recommending revisions to the *Essentials of a State Medical and Osteopathic Medical Practice Act* and the *Elements of a State Medical and Osteopathic Board* and would therefore be well positioned to study this issue and draft model statutory language, if the resolution was to be recommended for adoption.

Background

Each state, territory and the District of Columbia has a lead EMS agency, according to the National Association of State Emergency Medical Services Officials (NASEMSO).[i] These agencies are usually a part of the state health department, but in some states they are part of a multidisciplinary state public safety department, or are an independent state agency. State EMS agencies are responsible for the overall planning, coordination, and regulation of the EMS system within the state as well as licensing local EMS agencies and personnel.

[i] https://www.nasemso.org/About/StateEMSAgencies/StateEMSAgencyListing.asp

There is longstanding history of state regulation of EMS providers, with promulgation and execution of state laws and rules regarding EMS provider requirements for practice dating as far back as 1972. This includes accreditation of educational programs, use of a valid, reliable and legally defensible examination, criminal history checks, and ongoing competency maintenance requirements such as minimum continuing education credits and skill proficiency demonstration.

Additionally, recent developments in critical care transport and community paramedicine has served as a catalyst to the adoption of state laws and rules requiring physician oversight of EMS providers. These rules typically entail physician oversight and review of patient care, physician review of written patient care protocols, and when necessary, physician contact during patient care via radio or telephone.

State Medical Boards

Today only four state medical boards have oversight of EMS professionals: Alaska State Medical Board; Hawaii Medical Board; Commonwealth of the Northern Mariana Islands; and the Montana Board of Medical Examiners. According NASEMSO, the licensing and regulation of EMS personnel began in the 1970's and has steadily migrated away from state boards of medicine to separate State EMS regulatory boards. These EMS boards are not only responsible for the licensing of EMS personnel, but also the nation's 21,000 EMS agencies that respond to 911 emergencies and provide transport, including specialty care air medical transport, and ground transport.[ii] This regulatory scheme is similar to the boards of pharmacy that license not only the individual pharmacists but also pharmacies, distributors, manufactures, and wholesalers.

The number of non-physician health care providers that are under the purview of state medical boards varies significantly throughout the country, from athletic trainers to polysomnography techs. The FSMB has not heretofore taken a position on what professions should be regulated by the medical board, with the exception of physician assistants for whom the medical and osteopathic boards license the majority, and therefore a specific recommendation and practice act for EMS personnel would not be in keeping with current policy or practice. Additionally, state medical boards would require extra human and financial resources to take on the licensure and regulation of another health occupation, and boards have not indicated their desire to do so. However, it should be noted that state medical boards have an indirect role in the oversight of EMS personnel through the licensure and regulation of the EMS associated physician medical directors.

Advisory Council of Board Executives

The FSMB Advisory Council of Board Executives (Council) is made up of nine executive directors, including the two associate members of the FSMB Board of Directors and the

[ii] https://www.nhtsa.gov/staticfiles/nti/ems/pdf/811723.pdf

president and vice president of Administrators in Medicine. The Council provides guidance to the Board and FSMB staff on FSMB projects and services, state and federal legislative agenda, and is responsible for the three year review and revision of the *Essentials of a State Medical and Osteopathic Practice Act* and *Elements of a State Medical and Osteopathic Board*. The Board of Directors tasked the Council to evaluate Resolution 17-2 and make its recommendation to the Board. The Council met on August 17, 2017 at the FSMB office in Washington, D.C.

The Council noted the limited resources of state medical boards and the capacity of boards to take on additional regulated professions. The Council recognized the authority and discretion of the state to delegate oversight of the health occupation to best protect the public within their individual state structures. The Advisory Council recommended the Board of Directors not pursue policy in favor of Resolution 17-2, primarily due to the additional responsibilities and resources that would be required for the licensing of EMS providers, investigation and adjudication of complaints, and standard enforcement. Additionally, the Council noted current political pressures and criticisms of state occupational licensure generally and were concerned policy proposals for additional layers of oversight would be ill advised.

As an alternative approach to Resolution 17-2, the recommendations contained in FSMB's policy, *Regulatory Strategies for Achieving Greater Cooperation and Collaboration Among Health Professional Boards* (HOD 2017) may address the concerns expressed in Resolution 17-2. The policy recommends that state medical boards establish procedures for exchanging information with other boards, agencies, and departments responsible for regulating health-related occupations, facilities, and programs, and for coordinating investigations involving matters within the jurisdiction of more than one regulatory body. These procedures would apply to exchanging information between the state medical board and the state EMS agency to 1) conduct joint investigations; 2) share investigatory data; and create or develop processes to facilitate communication and collaboration between the board/agency.

Resolution 17-2 also speaks to the need for standardization of licensing and practice standards among the states. While there are variances in state licensure requirements for EMS personnel based on the needs and available resources in individual states, the majority require passage of a national examination and certification from the National Registry of Emergency Medical Technicians. Additionally, the NASEMSO, with support from the U.S. Department of Homeland Security, has initiated an interstate licensure compact that should further standardize licensing requirements among states. To participate in the compact, EMS personnel must have passed the National Registry of Emergency Medical Technicians (NREMT) examination for initial licensure and have an unrestricted license in his/her home state.

Conclusion

In conclusion, the Board of Directors concurs with the Advisory Council of Board Executives and does not recommend a policy change at this time regarding the licensure and regulation of EMS personnel. The Board further finds that the policy, *Regulatory Strategies for Achieving Greater Cooperation and Collaboration Among Health Professional Boards* (HOD 2017), applies and is a more feasible approach to Resolution 17-2.

ITEM FOR ACTION:

For information.

Resolution 18-4

Federation of State Medical Boards
House of Delegates Meeting
April 28, 2018

Subject: Interprofessional Continuing Education (IPCE)

Introduced by: FSMB Board of Directors

Approved: February 2018

Whereas, a commitment to lifelong learning and continuing professional development is critical to a physician's ability to keep up with advances in medicine and with changes in the delivery of care; and

Whereas, state medical and osteopathic boards require continuing medical education for license renewal as a means of assuring the public that licensed physicians are maintaining their competence; and

Whereas, insufficient communication and coordination of care between physicians and other health care professionals in team-based care settings is a patient safety issue; and

Whereas, interprofessional education and team-based care among physicians, nurses and pharmacists is a critical component of health care delivery and improvement; and

Whereas, the Federation of State Medical Boards (FSMB) works with the National Council of State Boards of Nursing (NCSBN) and the National Association of Boards of Pharmacy (NABP) to support collaborative educational opportunities, including regularly hosting Tri-Regulator Meetings for state and territorial licensing boards for medicine, nursing and pharmacy; and

Whereas, Interprofessional Continuing Education (IPCE) is defined as a process by which individuals from two or more professions learn with, from, and about each other to enable effective collaboration and improve health outcomes; and

Whereas, a Joint Accreditation system for Interprofessional Continuing Education was launched in 2009 that is a collaboration of the Accreditation Council for Continuing Medical Education (ACCME®), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC); and

Whereas, the Joint Accreditors have adopted a shared credit (IPCE credit) that designates an educational activity as having been planned by and for an interprofessional team;

Therefore, be it hereby

Resolved, that the Federation of State Medical Boards supports and recognizes Interprofessional Continuing Education for physicians that is identified by IPCE credit and is accredited by the Joint Accreditation system launched by the Accreditation Council for Continuing Medical Education, the Accreditation

Council for Pharmacy Education and the American Nurses Credentialing Center, as an additional means of satisfying continuing medical education requirements for medical license renewal.

TAB I: Report of Reference Committee B

MANAGEMENT NOTE:

The following reports and resolutions will be submitted to Reference Committee B. Following testimony at the Reference Committee hearing, a report containing the Reference Committee's recommendations will be presented to the House of Delegates:

1. BRD RPT 18-1: Report of the Workgroup to Study Regenerative and Stem Cell Therapy Practices

2. BRD RPT 18-2: Report of the Workgroup on Prescription Drug Monitoring Programs

3. Resolution 18-1: Acute Opioid Prescribing Workgroup and Guidelines (OH)

4. Resolution 18-2: Testing Under Time Constraints of the Necessary and Explicit Component of the USMLE (MN)

5. BRD RPT 18-3: Report of the FSMB Workgroup on Physician Wellness and Burnout

6. Resolution 18-5: Workgroup on Artificial Intelligence and its Potential Impact on Patient Safety and Quality of Care in Medical Practice (PA-M)

BRD RPT 18-1

REPORT OF THE BOARD OF DIRECTORS

Subject: **Report of the FSMB Workgroup to Study Regenerative and Stem Cell Therapy Practices**

Referred to: **Reference Committee B**

The Federation of State Medical Boards (FSMB) Workgroup to Study Regenerative and Stem Cell Therapy Practices was convened in May of 2017 by FSMB Chair Gregory B. Snyder, M.D., DABR, in response to a letter from U.S. Senator Lamar Alexander (R-TN), Chairman of the U.S. Senate Health, Education, Labor, and Pensions (HELP) Committee, urging the FSMB to develop best practices for state medical and osteopathic boards (hereinafter referred to as "state medical boards") in regulating the promotion, communication, and practices of treatments received at stem cell clinics in the United States.

Members of the Workgroup are: Scott A. Steingard, DO, Chair (FSMB Director-at-Large, Past President, Arizona Board of Osteopathic Examiners in Medicine and Surgery); Debbie J. Boe (Former Public Member, Minnesota Board of Medical Practice); Sandra L. Coletta (Public Member, Rhode Island Board of Medical Licensure and Discipline); Sarah L. Evenson, JD, MBA (Former Public Member, Minnesota Board of Medical Practice); H. Joseph Falgout, MD (Chair, Alabama Board of Medical Examiners); Joseph E. Fojtik, MD, FACP (Deputy Medical Coordinator, Illinois Department of Financial & Professional Regulation); Gary R. Hill, DO (Member, Alabama Medical Licensure Commission); Howard R. Krauss, MD (Member, Medical Board of California). Subject matter experts included: Ronald E. Domen, MD, FACP, FCAP (Penn State College of Medicine); Zubin Master, PhD (Mayo Clinic); Douglas Oliver, MSW; and Bruce D. White, DO, JD (Alden March Bioethics Institute). Participating ex officio were Gregory B. Snyder, MD, DABR, FSMB Chair; Patricia A. King, MD, PhD, FACP, FSMB Chair-elect; and Humayun J. Chaudhry, DO, MS, MACP, MACOI, FSMB President and CEO.

The Workgroup was charged with: 1) evaluating the prevalence, promotional practices, and incidences of patient harm related to regenerative medicine and adult stem cell therapies in the U.S.; 2) evaluating current regulatory approaches that will protect the public, recognizing the potential for improved patient outcomes through health innovation and technology; 3) identifying best practices for state medical and osteopathic boards in investigating complaints of patient harm, fraud, and compliance with licensure requirements; and 4) issuing a report on the Workgroup's findings from prevailing research and recommending best regulatory practices and guidelines related to physicians' use of regenerative medicine and adult stem cell therapies in a manner consistent with safe and responsible medicine.

The Workgroup met in person in Washington, D.C. on September 7, 2017 and by teleconference on December 11, 2017.

In completing its charge, the Workgroup drafted its report in the form of a guidance document, with recommendations that address the regulation of the provision of stem cell and regenerative therapies, as well as their promotion and communication to patients, and documentation of treatments provided. The recommendations do not address which uses are appropriate or for specific conditions or symptoms, as this area of medicine continues to be dynamic and subject to change. Rather, the recommendations focus on sensible and necessary principles of patient safety, autonomy, and non-exploitation.

A draft of the report was distributed to FSMB member boards and other key stakeholder organizations in December 2017 with comments due January 26, 2018. The draft report was distributed to the American Medical Association (AMA), American Osteopathic Association (AOA), Council of Medical Specialty Societies (CMSS), U.S. Food and Drug Administration (FDA), Office of U.S. Senator Lamar Alexander (R-TN), Association of Clinical Research Organizations (ACRO), and others for comment. Minimal comments were received, and all were generally positive.

The FSMB Board of Directors considered the draft *Report of the FSMB Workgroup to Study Regenerative and Stem Cell Therapy Practices* at its meeting on February 8, 2018 in Washington D.C. and discussed clarifications to the document.

ITEM FOR ACTION:

The Board of Directors recommends that:

The House of Delegates ADOPT the *Report of the FSMB Workgroup to Study Regenerative and Stem Cell Therapy Practices*, and the remainder of the Report be filed.

Attachment 1

REPORT OF THE FSMB WORKGROUP TO STUDY REGENERATIVE AND STEM CELL THERAPY PRACTICES

Section One. Introduction and Charge:

The Federation of State Medical Boards (FSMB) Workgroup to Study Regenerative and Stem Cell Therapy Practices was convened in May of 2017 by FSMB Chair Gregory B. Snyder, M.D., DABR, in response to a letter (Attachment 1) from U.S. Senator Lamar Alexander (R-TN), Chairman of the U.S. Senate Health, Education, Labor, and Pensions (HELP) Committee, urging the FSMB to develop best practices for state medical and osteopathic boards (hereinafter referred to as "state medical boards") in regulating the promotion, communication, and practices of treatments received at stem cell clinics in the United States.

In order to address Senator Alexander's request, Dr. Snyder charged the Workgroup with:

1) Evaluating the prevalence, promotional practices, and incidences of patient harm related to regenerative medicine and adult stem cell therapies in the U.S.;

2) Evaluating current regulatory approaches that will protect the public, recognizing the potential for improved patient outcomes through health innovation and technology;

3) Identifying best practices for state medical and osteopathic boards in investigating complaints of patient harm, fraud, and compliance with licensure requirements; and

4) Issuing a report on the Workgroup's findings from prevailing research and recommending best regulatory practices and guidelines related to physicians' use of regenerative medicine and adult stem cell therapies in a manner consistent with safe and responsible medicine.

Stem cell and regenerative therapies offer opportunities for advancement in the practice of medicine and the possibility of an array of new treatment options for patients experiencing a variety of symptoms and conditions. Despite significant momentum in research and development, and the potential for such medical advancements, there is reasonable concern about a growing number of providers and clinics in the United States that are undermining the field. Such providers and clinics have been known to apply, prescribe or recommend therapies inappropriately, over-promise without sufficient data to support claims, and exploit patients who are often in desperate circumstances and willing to try any proposed therapy as a last resort, even if there is excessive cost or scant evidence of efficacy.

The following report aims to raise awareness about regenerative and stem cell therapy practices generally, outline their potential benefits and risks, and provide basic guidance for state medical boards and licensed physicians and physician assistants. Central to all of the

recommendations provided herein is a range of imperatives, including the importance of protecting the public, respecting patient autonomy, preventing patient exploitation, obtaining informed consent, and appropriately documenting care that is recommended and provided.

The Workgroup's deliberations were aided by participants and subject matter experts who brought varying perspectives. For example, Dr. Ronald Domen has expertise in stem cell therapies, bioethics and humanities, and has served on numerous ethics committees at institutional, state, and national levels. Dr. Zubin Master of the Mayo Clinic has extensive training and education in cellular and molecular biology, bioethics and genetics, as well as research and publications on stem cell therapies. Mr. Douglas Oliver became known to the Workgroup through a recommendation by Senator Lamar Alexander of Tennessee, was a recipient of stem cell therapies himself, and has a foundation that advocates for stem cell therapies based on his own experiences and those of others like him. Dr. Bruce White has educational backgrounds in medicine, law, pharmacy and ethics and currently serves as Director of the Alden March Bioethics Institute at Albany Medical College and is Chair of Medical Ethics at the College. The Workgroup also received written comments from several external organizations. The sum of these perspectives aided the Workgroup in producing a balanced report on this emerging issue of national importance.

Section Two. Definitions:

Homologous (Allogeneic) Use: the repair, reconstruction, replacement, or supplementation of a recipient's cells or tissues with a HCT/P (human cells, tissues, and cellular and tissue-based product) that performs the same basic function or functions in the recipient as in the donor, including when such cells or tissues are for autologous use.[1]

> According to the Food and Drug Administration's (FDA) *Regulatory Considerations for Human Cell, Tissues, and Cellular and Tissue-Based Products: Minimal Manipulation and Homologous Use / Guidance for Industry and Food and Drug Administration Staff (November 2017)*, the FDA "generally considers an HCT/P to be for homologous use when it is used to repair, reconstruct, replace, or supplement:
>
> • Recipient cells or tissues that are identical (e.g., skin for skin) to the donor cells or tissues, and perform one or more of the same basic functions in the recipient as the cells or tissues performed in the donor; or
>
> • Recipient cells or tissues that may not be identical to the donor's cells or tissues, but that perform one or more of the same basic functions in the recipient as the cells or tissues performed in the donor."[2]

[1] 21 CFR 1271.3(c)

[2] U.S. Food and Drug Administration (November 2017). Regulatory Considerations for Human Cells, Tissues, and Cellular and Tissue-Based Products: Minimal Manipulation and Homologous Use Guidance for Industry and Food and Drug Administration Staff.

Autologous Use: the implantation, transplantation, infusion, or transfer of human cells or tissue back into the individual from whom the cells or tissue were recovered.[3]

Informed and Shared Decision Making: The process by which a physician discusses, in the context of the use of regenerative and stem cell therapies, the risks and benefits of such treatment with the patient.[4] The patient is given an opportunity to express preferences and values before collaboratively evaluating and arriving at treatment decisions.[5]

Informed Consent:[6] Evidence documenting appropriate patient informed consent typically includes the following elements:

- Identification of the patient, the physician, and the physician's credentials;
- Types of transmissions permitted using regenerative and stem cell therapies (e.g. prescription refills, appointment scheduling, patient education, etc.);
- Agreement from the patient with the physician's determination about whether or not the condition being diagnosed and/or treated is appropriate for regenerative and stem cell therapy;[7] and
- Express patient consent to forward patient-identifiable information to a third party
- An accurate description of the benefits and risks of treatment or intervention, based on scientific evidence, as well as an explanation of alternatives to treatment or an intervention, and the right to withdraw from treatment or an intervention without denial of standard of care to patients.

Minimal Manipulation: (minor processing including purification, centrifugation, washing, preservation, storage) – the Food and Drug Administration (FDA) argues that it has the authority to regulate anything beyond minimal manipulation and homologous use:
"(1) For structural tissue, processing that does not alter the original relevant characteristics of the tissue relating to the tissue's utility for reconstruction, repair, or replacement; and
(2) For cells or nonstructural tissues, processing that does not alter the relevant biological characteristics of cells or tissues."[8]

[3] 21 CFR 1271.3(a)
[4] Federation of State Medical Boards (2016). Model Guidelines for the Recommendation of Marijuana in Patient Care.
[5] Barry, MJ, Edgman-Levitan, S. (2012). Shared Decision Making – The Pinnacle of Patient-Centered Care. *N Engl J Med*, 366:780-781.
[6] With respect to informed consent for the purposes of research studies involving human subjects, researchers should be aware of the basic elements of informed consent outlined in 21 CFR Part 50.25 "Protection of Human Subjects."
[7] Federation of State Medical Boards (2014). Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine.
[8] 21 CFR 1271.3(f)

Unproven Stem Cell Intervention: Stem cell therapy that lacks compelling evidence, based upon scientific studies, to validate its treatment efficacy.[9]

Section Three. Background, Prevalence and Marketing of Regenerative and Stem Cell Therapies:

Historically, many of the clinics providing unproven stem cell interventions fell under the definition of "stem cell tourism" because most patients seeking such interventions had to travel outside of North American jurisdictions to receive them. The landscape in the United States has evolved considerably over the last few years with hundreds of new clinics opening across the country and many more physicians willing to provide stem cell and regenerative therapies. A study identified 351 U.S. businesses with over 570 clinics engaged in direct-to-consumer (DTC) marketing of stem cell interventions.[10] It has also been suggested that growth in this area of medicine, especially in terms of adult, amniotic, fat-derived and bone marrow stem cell therapies to treat a host of conditions and injuries, is accelerating, both in the U.S. and internationally, and, perhaps counterintuitively, such growth is noted to be most significant in jurisdictions with more stringent regulatory frameworks.[11]

Stem cell clinics typically reach their patients through online DTC marketing, primarily through information provided on company websites. Data purportedly supporting unproven stem cell interventions commonly undermine information about risks and overemphasize information about benefits. Treatment options are described on such websites and are often accompanied by supporting information in the form of journal articles, patient testimonials, and accolades related either to the clinic itself or its affiliated physicians and researchers. Supporting information that accompanies marketing materials can appear to be legitimate, but can also overemphasize, exaggerate, inflate, or misrepresent information derived from legitimate (or even questionable) sources. A physician engaging in such practices of deceptive or false advertising can be in violation of a state's *Medical Practice Act*. Information provided on clinic websites should be represented accurately and come from reputable peer-reviewed publications or respected external organizations.

Some clinics, however, that are engaged in the provision of treatment modalities that lack evidence – or an appropriate rationale for application of that modality to particular medical conditions – often use what have been described as "tokens of scientific legitimacy" to lend credence to treatments offered or the quality of a clinic and its associated professionals. Examples of such tokens of legitimacy include patient or celebrity testimonials and

[9] Sipp D, et al. (2017). Marketing of Unproven Stem Cell-Based Interventions: A Call to Action. *Science Translational Medicine*, 9:397.

[10] Turner L, Knoepfler P. (2016). Selling Stem Cells in the USA: Assessing the Direct-to-Consumer Industry *Cell Stem Cell* 19, August 4, 154-7.

[11] Berger, et al. (2016) Global Distribution of Businesses Marketing Stem Cell-Based Interventions. *Cell Stem Cell* 19, August 4, 158-62.

endorsements, clinician affiliations or memberships in academic or professional societies, registrations in clinical trials, claims of various types of certifications or awards, and others.[12] Further detail and explanations are provided in **Table 1**.

Physicians are ordinarily permitted to advertise themselves, their practice and services offered, provided that such advertisements do not contain claims that may be deceptive or are intentionally false or misleading. Further, physicians should be mindful of ways in which patient testimonials, quality ratings, or other evaluative data is presented to prospective patients through advertisements. In advertising stem cell treatments to potential patients, physicians are responsible for ensuring that all information, especially in terms of risks, benefits and efficacy, is presented in an objective manner. Physicians must not deliberately misrepresent the expected outcomes or results of treatments offered. Physicians should be prepared to support any claims made about benefits of treatment(s) with documented evidence, for example with studies published in peer-reviewed publications.[13]

Physicians must be accurate and not intentionally misleading in providing descriptions of their training, skills, or treatments they are able to competently offer to patients. This includes descriptions of one's specialization and any specialty board certifications.[14]

A recent study on the prevalence and marketing practices of businesses offering stem cell treatments internationally noted the presence of the following elements in their marketing practices:

- Mention of affiliations with a professional society or network
- Claims of partnerships with academic institutions
- Statements of receipt of FDA approval, or explicit mention of exemption from FDA oversight
- Mention of official endorsement from a local or other authority, or professional accreditation
- Listing of patents granted
- Statement that clinical trials of investigational stem cell-based interventions are being conducted[15]

The marketing practices and information found on a business' website can be important sources of data for state medical boards as they investigate complaints made against physicians

[12] Sipp D, et al. (2017). Marketing of Unproven Stem Cell-based Interventions: A Call to Action. *Sci. Transl. Med*. 9, eaag0426.

[13] Federation of State Medical Boards (2016). *Position Statement on Sale of Goods by Physicians and Physician Advertising*.

[14] *Ibid*.

[15] Berger, et al. (2016) Global Distribution of Businesses Marketing Stem Cell-Based Interventions. *Cell Stem Cell* 19, August 4, 158-62.

affiliated with businesses providing regenerative and stem cell treatments. Even where an appropriate informed consent process seems to be in place, deceptive or fraudulent information on clinic websites and other marketing materials could mislead patients into consenting to treatment, thereby invalidating the informed consent process.

Physicians must make accurate claims about the enrollment process of subjects, treatments, and products in clinical trials and are responsible for ensuring that any research conducted and described in marketing materials is carried out according to accepted research protocols and recognized standards. Physicians should consider consulting with Institutional Review Boards (IRBs) to clarify processes and must seek IRB approval, where necessary. The National Institutes of Health (NIH) provides helpful guidance on clinical trials and research methods.[16] Physicians are also encouraged to consult the guidance contained in the *International Conference on Harmonisation's Harmonised Tripartite Guideline for Good Clinical Practice* to support acceptability of clinical data by patients, state medical boards, and other regulatory authorities.[17]

Table 1: Co-opted Tokens of Scientific Legitimacy[18]

Accreditations and awards	Asserting certification of products or practices by international standards organizations or claiming training certification
Boards and advisers	Convening scientific or medical advisory boards featuring prominent business leaders and academic faculty members
Clinical study registration	Registering trials whose apparent purpose is solely to attract patients willing to pay to participate in them
Ethics review	Using the imprimatur of "ethics review" to convey a sense of legitimacy to their products or procedures
Location	Renting of laboratory or business space within a legitimate scientific or government institution
Membership	Joining established academic or professional societies to suggest legitimacy by association
Outcome registries	Publication of open-ended voluntary monitoring data sets rather than undertaking controlled clinical trials
Patenting	Suggesting that patent applications or grants indicate clinical utility rather than initiation of an application process or recognition of novelty and inventiveness

[16] National Institutes of Health, Office of Science Policy: https://osp.od.nih.gov/clinical-research/clinical-trials/

[17] International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use. (2016). ICH Harmonised Tripartite Guideline for Good Clinical Practice E6(R2).

[18] Sipp D, et al. (2017). Marketing of Unproven Stem Cell-based Interventions: A Call to Action. *Sci. Transl. Med*. 9, eaag0426.

Publication	Publishing research and commentary in journals with limited anonymous peer review
Rationales	Citing preclinical and other research findings to justify clinical application without sufficient efficacy testing in humans
Self-regulation	Forming organizations to self-regulate in ways that support premature commercialization
Technical Language	Using scientific-sounding words that imply academic rigor
Testimonials and Endorsements	Providing expert opinions or celebrity comments on unsupported clinical uses or standing of the provider

Section Four. Patient Perceptions:

In seeking treatment for any condition, patients desire safety and efficacy, but may overlook risks to their own safety or a lack of evidence of efficacy in favor of access to treatment, particularly in circumstances where traditional treatment options seem limited or have been exhausted. The power of hope also is known to play a significant role in how patients attempt to gain control over their illness and its potential treatments, thereby putting them in a position of increased vulnerability.[19] This is especially the case when patients and their families have overcome various obstacles on the path to a treatment, including raising large sums of money to pay for it. This can lead to a psychological predisposition to anticipate and assume a positive outcome, regardless of the treatment in question or the availability of compelling evidence.

Given the vulnerable state of some patients who seek regenerative and stem cell therapies, perhaps without the requisite knowledge for making informed decisions, there is increased potential for patient exploitation. Physicians must therefore be mindful of the ways in which at-risk or susceptible patients may process information and arrive at decisions about their treatment options, expectations, and ultimately, the potential for success. A promising way of navigating such difficult circumstances, where treatment options are uncertain or complex, is through the use of shared decision making. This process, whereby the physician describes the risks and benefits of potential treatment options and the patient is given an opportunity to express preferences and values before collaboratively arriving at and evaluating treatment decisions,[20] may help mitigate the risk of patient exploitation and ensure that consent to any treatment option has been provided in an informed manner.

The process of obtaining informed consent and engaging in shared decision making with patients involves conveying information about the reasonable effectiveness of a proposed treatment, as well as its risks and benefits. This can be particularly difficult with respect to regenerative and stem cell therapies, as this is an area of medicine that currently lacks

[19] Petersen, et al. (2014). Therapeutic Journeys: The hopeful travails of stem cell tourists, *Sociology of Health & Illness*, 36(5):670-85, pp. 1–16.
[20] Barry, MJ, Edgman-Levitan, S. (2012). Shared Decision Making – The Pinnacle of Patient-Centered Care. *N Engl J Med*, 366:780-781.

substantive data on efficacy. Generation of relevant data and evidence has not occurred to a sufficient enough degree and this is often blamed on the difficulty involved in organizing large-scale, randomized controlled trials as part of the approval process for novel therapies. However, the FDA has recently argued that a statistically significant 100% improvement in an outcome measure ($\alpha = 0.05$, $\beta = 0.1$) may be detected with a randomized trial involving as few as 42 participants.[21]

The lack of a formal mechanism for reporting outcomes of unproven stem cell interventions, both positive and negative, adds to the difficulty involved in generating data on the effectiveness of such interventions, as does the fact that there is neither a requirement, nor a mechanism, for reporting adverse events related to interventions administered outside of clinical trials and investigations. In the current environment, this increases the importance of appropriate documentation of treatment(s) and ongoing care in patients' medical records. A centralized cell therapy registry for reporting treatment and outcomes may improve the current information available about the effectiveness of such therapies and interventions. It may also dissuade unscrupulous practitioners from engaging in the provision of unproven interventions without an adequate or appropriate basis in theory or peer-acknowledged practice, a pre-requisite for the provision of any intervention, whether proven or not.[22]

Section Five. Regulatory Landscape:

The current state of affairs for regulatory oversight on regenerative and stem cell therapies (including human cells and tissues), at both the federal and state level, is evolving and will continue to change in the coming years. In November 2017, the FDA released two guidance documents to explain the Agency's current thinking on stem cell policy. However, this thinking, as well as the agency's jurisdiction and authority, may evolve in the future.

Until recently, the regulatory landscape for stem cell and regenerative therapies has been at times restrictive, allowing patients to access stem cell interventions only under the *Expanded Access to Investigational Drugs for Treatment Use* program. Treatments are eligible under this program if they are undergoing testing in a clinical trial and are subject to approval by the FDA. Three-quarters of the states in the nation have passed "Right to Try" legislation, however, which allows terminally ill patients to receive experimental therapies that have passed phase 1 trials without seeking FDA approval.[23] The U.S. Congress is also considering similarly proposed

[21] Marks PW, et al. (2017). Clarifying Stem-Cell Therapy's Benefits and Risks, *NEJM* 376;11, 1007-9.

[22] White, BD, Gelinas, LC, (2016). "Balancing the Surgeon's Responsibility to Individuals and Society," published in S.C. Stain et al. (eds.), *The SAGES Manual Ethics of Surgical Innovation*, Switzerland: Springer International Publishing, 191-211.

[23] *Lancet* Commission: Stem Cells and Regenerative Medicine. Published Online October 4, 2017 http://dx.doi.org/10.1016/S0140-6736(17)31366-1

legislation and in August of 2017, the U.S. Senate passed *S. 204, Trickett Wendler, Frank Mongiello, Jordan McLinn, and Matthew Bellina Right to Try Act of 2017*.

The *21st Century Cures Act* (Public Law 114–255), signed into law in December of 2016, represents legislative efforts at the federal level to expand and accelerate patient access to treatment, in addition to promoting innovation in medical products and treatments. With respect to regenerative medicine, the Act amends Section 506 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 356) by requiring expedited review for regenerative medicine therapies, including human cells and tissues, intended to treat, modify, reverse, or cure a serious or life-threatening disease or condition, where there is preliminary clinical evidence indicating that the drug has the potential to address unmet medical needs. There are also ongoing efforts at the federal level to ensure even greater access to treatments that are not subject to FDA approval prior to administration to patients.

Regulation in the regenerative and stem cell therapy arena is continuing to evolve. Human cells, tissues, and cellular or tissue-based products (HCT/Ps) are currently regulated under Sections 351 and 361 of the Public Health Service Act.[24] However, a HCT/P can be regulated solely under Section 361 of the PHS Act if it is:

1. Minimally manipulated,
2. Intended for homologous use only,
3. Not combined with another article, and
4. Either:
    a. Does not have a systemic effect and is not dependent upon the metabolic activity of living cells for its primary function; or
    b. Has a systemic effect or is dependent upon the metabolic activity of living cells for its primary function, and is for autologous use, use in a first or second-degree blood relative, or reproductive use.[25]

The difference between an HCT/P that is regulated under both sections of the Public Health Service Act, as opposed to solely under Section 361, is significant for providers of stem cell treatments since the requirements for pre-market authorization of a product are much more stringent under Section 351 and require conducting clinical investigations under an investigational new drug (IND) application and obtaining a biologics license through the FDA, whereas requirements under Section 361 focus only on the prevention of communicable diseases.[26] This represents a lower regulatory threshold for HCT/Ps; their use and transplantation can be considered to fall under the practice of medicine and would, therefore, be regulated by state medical boards.

[24] The Public Health Service Act of 1944 outlines a policy framework for federal and state cooperation in health services and provides for the licensing of biological products.
[25] 21 CFR 1271.10(a)
[26] United States Food and Drug Administration: Regulatory Considerations for Human Cell, Tissues, and Cellular and Tissue-Based Products: Minimal Manipulation and Homologous Use

In regulating this evolving area of medical practice, state medical boards will need to strive to achieve an appropriate balance between respecting the autonomy of patients as they seek viable and reasonable treatment options, and adequately safeguarding them against the risks presented by novel, but often unproven and potentially dangerous, interventions. Results from a 2017 survey of its member boards conducted by the FSMB indicate that a third (n = 17) of the 51 responding boards have investigated complaints against physicians related to regenerative medicine or stem cell therapy, and that eight of those boards have taken disciplinary action against physicians for issues relating to regenerative medicine or stem cell therapy.

In ensuring that physicians offer regenerative and stem cell therapies in a manner that is consistent with safe and responsible practices, state medical boards should ensure that any treatment offered to patients is informed by an appropriate history and physical examination; such informed consent is obtained after an explanation has been provided describing risks, benefits, alternative treatment options, expected convalescence, and expected treatment outcomes; that relevant information about the clinical encounter and ongoing care plans has been documented in the patient's medical record; that the physician is appropriately trained in, and knowledgeable about the proposed treatment; and that the patient has not been coerced in any way into receiving treatment(s) or exploited through the charging of excessive fees.

In order to implement best practices for regenerative and stem cell therapies, physicians must understand the relevant clinical issues and should obtain sufficient targeted continuing education and training.[27]

The recommendations in the final section of this report provide further detail on various requirements that apply to the provision of regenerative and stem cell therapies that state medical boards may wish to consider.

Section Six. Recommendations:

The recommendations that follow address the regulation of the provision of stem cell and regenerative therapies, as well as their promotion and communication to patients, and documentation of treatments provided. The recommendations do not address which uses are appropriate or not for specific conditions or symptoms, as this area of medicine continues to be dynamic and subject to change. Rather, they focus on sensible and necessary principles of patient safety, autonomy, and non-exploitation.

[27] Federation of State Medical Boards (2017). *Guidelines for the Chronic Use of Opioid Analgesics*.

The FSMB recommends that:

1. Where evidence is unavailable for a particular treatment in the form of clinical trials or case studies, physicians must only proceed with an appropriate rationale for the proposed treatment, and justification of its use, in relation to the patient's symptoms or condition. Novel, experimental, and unproven interventions should only be proposed when traditional or accepted proven treatment modalities have been exhausted. In such instances, there must still be a basis in theory or peer-acknowledged practice.[28]

2. State medical boards raise awareness among licensees of applicable federal and state legislation and guidelines regarding regenerative and stem cell therapies, including "right to try" legislation existing or pending at the state and federal levels. State medical boards should also keep their licensees and the public apprised of new developments and regulations in the field of regenerative and stem cell therapies. This may include educational resources, guidance documents, and appropriate industry and stakeholder information on a state medical board's website. State medical boards should further provide information as to reporting procedures of adverse actions related to stem cell interventions.

3. State medical boards should examine their policies and rules addressing informed consent and consider expanding these to include a shared decision making framework that includes the following general elements at a minimum:

- An explanation, discussion, and comparison of treatment options with the patient
- An assessment of the patient's values and preferences
- Arrival at a decision in partnership with the patient
- An evaluation of the patient's decision in partnership with the patient

4. State medical boards should review professional marketing materials and claims, including any office/clinic and/or doctor websites, and information publicly available about an office/clinic or licensee on online blogs or social media, as information sources in the investigation of complaints made against physicians.

5. State medical boards should pro-actively monitor warning letters sent to licensees that are made publicly available on the FDA website in order to ascertain information, and consider opening an investigation, about licensees who may be engaged in other unscrupulous or unprofessional practices related to the provision of regenerative and stem cell therapy. State medical boards should investigate such practices, when appropriate, in conjunction with applicable state laws, policies, and procedures.[29]

[28] White, BD, Gelinas, LC, (2016). "Balancing the Surgeon's Responsibility to Individuals and Society," published in S.C. Stain et al. (eds.), *The SAGES Manual Ethics of Surgical Innovation*, Switzerland: Springer International Publishing, 191-211.

[29] The FDA's warning letters are available at the following address: https://www.fda.gov/ICECI/EnforcementActions/WarningLetters/default.htm

6. Physicians must only offer treatments to patients for which they have a bona fide physician-patient relationship. Physicians must have received adequate and appropriate training, and be able to perform any proposed intervention safely and competently.[30]

7. Physicians should employ a "shared decision making" process when discussing treatment options with patients. Physicians must avoid any claims that may be deceptive or are intentionally or knowingly false or misleading, especially in terms of making promises about uncertain or unrealistic outcomes.

8. Physicians should not use gag orders (rulings that a case must not be discussed publicly) or disclaimers as a way to circumvent liability.

9. Physicians should be prepared to support any claims made about benefits of treatments or devices with documented evidence, for example with studies published in peer-reviewed publications.

10. Physicians should refrain from charging excessive fees for treatments provided. Further, physicians should not recommend, provide, or charge for unnecessary medical services, nor should they make intentional misrepresentations to increase the level of payment they receive.[31]

11. Physicians should consult and educate patients about stem cell interventions and alert them to important resources available to the community. A list of selected resources is provided in **Appendix A**.

[30] Federation of State Medical Boards (2014). *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine*.

[31] American Medical Association, *Code of Medical Ethics*, Opinion 11.3.1.

APPENDIX A: SAMPLE LIST OF EDUCATIONAL RESOURCES ON REGENERATIVE AND STEM CELL THERAPY PRACTICES

The Australian Stem Cell Handbook 2015

Stem Cell Basics (National Institutes of Health)

Stem Cell Patient booklet (Albany Medical College)

A closer look at Stem Cells (International Society for Stem Cell Research)

Patient Handbook on Stem Cell Therapies (International Society for Stem Cell Research)

Stem Cell Tourism (California Institute for Regenerative Medicine)

The Power of Stem Cells (California Institute for Regenerative Medicine)

SCOPE: Learn About Stem Cells in Your Native Language (The Niche)

WORKGROUP TO STUDY REGENERATIVE AND STEM CELL THERAPY PRACTICES

Scott A. Steingard, DO, Chair
FSMB Director-at-Large
Past President, Arizona Board of Osteopathic Examiners in Medicine and Surgery

Debbie J. Boe
Former Public Member, Minnesota Board of Medical Practice

Sandra L. Coletta
Public Member, Rhode Island Board of Medical Licensure and Discipline

Sarah L. Evenson, JD, MBA
Former Public Member, Minnesota Board of Medical Practice

H. Joseph Falgout, MD
Chair, Alabama Board of Medical Examiners

Joseph E. Fojtik, MD, FACP
Deputy Medical Coordinator, Illinois Department of Financial & Professional Regulation

Gary R. Hill, DO
Member, Alabama Medical Licensure Commission

Howard R. Krauss, MD
Member, Medical Board of California

SUBJECT MATTER EXPERTS
Ronald E. Domen, MD, FACP, FCAP
Penn State College of Medicine

Zubin Master, PhD
Mayo Clinic

Douglas Oliver, MSW
Patient Appointee
Founder and Executive Director, Regenerative Outcomes Foundation

Bruce D. White, DO, JD
Alden March Bioethics Institute

EX OFFICIOS
Gregory B. Snyder, MD, DABR
Chair, FSMB

Patricia A. King, MD, PhD, FACP
Chair-elect, FSMB

Humayun J. Chaudhry, DO, MS, MACP, MACOI
President and CEO, FSMB

STAFF SUPPORT
Jonathan Jagoda, MPP
Director, Federal Government Relations, FSMB

Mark Staz, MA
Director, Continuing Professional Development

BRD RPT 18-2

REPORT OF THE BOARDS OF DIRECTORS

Subject: ***Prescription Drug Monitoring Programs (PDMPs)*****, Report and Recommendations of the Workgroup on PDMPs**

Referred to: **Reference Committee B**

In April 2017, the FSMB House of Delegates adopted Resolution 17-1, Mandatory Use of Prescription Drug Monitoring Programs which directed FSMB to –

- Establish a task force to study PDMP use in the U.S. and its territories;
- Evaluate whether mandatory PDMP use positively impacts patient outcomes and prescribing practices;
- Evaluate the feasibility of incorporating the PDMP into an electronic medical record system; and
- Develop recommendations regarding mandatory use of PDMP data by licensed prescribers and dispensers.

Accordingly, FSMB Chair Gregory B. Snyder, MD, DABR, appointed the Workgroup on Prescription Drug Monitoring Programs (PDMP) which was comprised of a diverse group of medical and policy stakeholders. Members of the Workgroup are: Anna Z. Hayden, DO, Chairman; J. Mark Bailey, DO, PhD (University of Alabama at Birmingham); Daniel Blaney-Koen, JD (American Medical Association); Mark E. Bowden, MPA, CMBE (IA); Shawn Brooks (U.S. Food and Drug Administration); Danna E. Droz, JD, RPh (National Association of Boards of Pharmacy); Robert P. Giacalone, JD, RPh (OH); Patrice A. Harris, MD, MA (American Medical Association); Robin N. Hunter Buskey, DHSc, PA-C (NC); William K. Hoser, MS, PA-C (VT-Medical); Christina A. Mikosz, MD, MPH (Centers for Disease Control); Rebecca Poston, MHL (Electronic-Florida Online Reporting of Controlled Substance Evaluation (E-FORCSE) Program); Louis J. Prues, DMin, MDiv, MBA (MI-Medical); Jean L. Rexford (CT); Thomas H. Ryan, JD, MPA (WI); Judy Staffa, PhD, RPh (U.S. Food and Drug Administration); and Joseph R. Willett, DO (MN). Participating ex officio were Gregory B. Snyder, MD, DABR; Patricia A. King, MD, PhD, FACP; and Humayun J. Chaudhry, DO, MACP, FSMB President/CEO.

The Workgroup was charged with evaluating the impact of mandatory PDMP query on patient outcomes and the prescribing of controlled substances; evaluating challenges to increasing PDMP utilization, including, but not limited to: a) authority to access; b) currency of data; c) Electronic Medical Record (EMR) integration; and d) interoperability; and developing recommendations to state medical and osteopathic boards (hereafter referred to as "state medical boards") regarding physician utilization of PDMPs, including a recommendation regarding mandatory query.

To accomplish its charge, the Workgroup conducted a review of PDMP statutes, rules, and state medical board policies currently enacted across the United States, research reports and peer-reviewed articles in the medical literature and policy statements regarding the use of PDMP. The

report is provided as a guidance document for state medical boards and other state agencies to maximize the effective use of PDMPs.

The Workgroup met in person and via web conference to develop its report, *Prescription Drug Monitoring Programs* **(Attachment 1)**. A draft of the report was distributed to FSMB member boards and other key stakeholder organizations for comment in December 2017 with comments due January 26, 2018. Comments were generally supportive and have been incorporated to the extent that they did not substantively conflict with the Workgroup's recommendations. The FSMB Board of Directors considered the draft report at its meeting on February 8, 2018 in Washington D.C. and discussed clarifications to the document.

ITEM FOR ACTION:

The Board of Directors recommends that:

The House of Delegates ADOPT the recommendations in the report, *Prescription Drug Monitoring Programs,* and the remainder of the report be filed.

Attachment 1

PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs)

Report and Recommendations of the Workgroup on PDMPs

INTRODUCTION

In April 2017, the Federation of State Medical Boards (FSMB) Chair, Gregory B. Snyder, MD, DABR, appointed a Workgroup on Prescription Drug Monitoring Programs (PDMP) in accordance with FSMB Resolution 17-1: Mandatory Use of Prescription Drug Monitoring Programs, which was adopted by the FSMB's House of Delegates and which directed the FSMB to establish a task force to study PDMP use in the United States and its territories. The Workgroup was charged with evaluating the impact of mandatory PDMP query on patient outcomes and the prescribing of controlled substances; evaluating challenges to increasing PDMP utilization, including, but not limited to: a) authority to access; b) currency of data; c) Electronic Medical Record (EMR) integration; and d) interoperability; and developing recommendations to state medical and osteopathic boards (hereafter referred to as "state medical boards") regarding physician utilization of PDMPs, including a recommendation regarding mandatory query.

This document provides recommendations for state medical boards and other state agencies to maximize the effective use of PDMPs.

In developing the recommendations that follow, the Workgroup conducted a review of PDMP statutes, rules, and state medical board policies currently enacted across the United States, research reports and peer-reviewed articles in the medical literature and policy statements regarding the use of PDMP.

Section 1. Background

Overdose deaths from prescription opioids in the United States quintupled between 1999-2016, totaling more than 200,000 deaths during that time. In 2016, more than 46 people died every day from overdoses involving prescription opioids.[1][2] This escalating public health epidemic has led to a wave of implementations and upgrades to states' prescription drug monitoring programs over the past decade in an effort to curb substance use disorder.

State regulatory, administrative, and law enforcement agencies have long seen the need to establish systems to track and monitor the prescribing and dispensing of certain controlled substances, a recognition that dates to 1918.[3] California has the oldest continuous program, created in 1939. Early PDMPs were paper-based and collected data on Schedule II prescribing and dispensing only. Collected data was typically reported into such systems within 30 days of the time from dispensing.

In 1990, a new era of electronic PDMPs broke ground when Oklahoma became the first state to require electronic transmission of such data, which helped reduce operational costs and increase accuracy and timely submissions. By 1992, 10 states had operational PDMPs and many other states were considering establishing their own. In 1995, Nevada became the first state to expand the type of drugs reported to the PDMP, expanding from Schedule II only to Schedules II-IV. At the same time, Nevada also became the first state to provide unsolicited reports back to prescribers. By 2000, 15 states had established PDMPs. Between 2000-2012, 34 additional states established such a program, bringing the total number to states with PDMPs to 49. In 2014, the District of Columbia established a PDMP, bringing the total of operational PDMPs to 49 states, plus D.C. and Guam. Puerto Rico has also enacted legislation creating a PDMP but it is not yet operational.

As of September 2017, Missouri remains the only state without a statewide, operational PDMP. To work around this obstacle, St. Louis County established its own PDMP in March 2016 and, since then, this PDMP has gone live (as of April 2017) and more than 50 counties in the state and several individual cities have joined as participants, representing more than 70 percent of Missouri's population and 91 percent of its prescribers.[4] Separately, in July 2017, the Missouri governor issued an executive order to create a statewide PDMP that allows the Missouri Department of Health and Senior Services to analyze and identify inappropriate prescribing, dispensing, and obtaining of controlled substances, and to address these actions by making

[1] Centers for Disease Control, Opioid Data Analysis. https://www.cdc.gov/drugoverdose/data/analysis.html
[2] Centers for Disease Control, Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. http://wonder.cdc.gov
[3] Blumenschein, Karen, et. al. "Review of Prescription Drug Monitoring Programs in the United States." Institute for Pharmaceutical Outcomes and Policy, University of Kentucky, June 2010. http://chfs.ky.gov/NR/rdonlyres/85989824-1030-4AA6-91E1-7F9E3EF68827/0/KASPEREvaluationPDMPStatusFinalReport6242010.pdf.
[4] St. Louis County Prescription Drug Monitoring Program, "PDMP Program Update." http://www.stlouisco.com/Portals/8/docs/document%20library/PDMP/UPDATE-%20St.%20Louis%20County%20PDMP.pdf

referrals to appropriate government officials, including law enforcement and professional licensing boards.[5]

While the common goal of PDMPs is to provide prescribers and other health care professionals with accurate information about the prescriptions that patients have obtained, a state's decision to apply comprehensive mandates varies widely. The differences between states relate to the types of drugs monitored and the types of prescribers who are mandated to query, as well as to the circumstances which necessitate querying the PDMP, among other differences. [6][7] For instance, some PDMPs monitor Schedules II-IV controlled substances, while others monitor Schedules II-V or certain non-controlled substances.[8] Thirty-six states and the District of Columbia mandate PDMP query under certain circumstances. Of those, 27 states require querying the PDMP during the initial prescribing of a designated substance, while nine states require querying the PDMP before each prescription of a designated substance. Twelve states mandate querying the PDMP when prescribing for the treatment of pain and 14 states require it when prescribing for drug addiction. Among those states requiring a prescriber to query the PDMP prior to the initial prescription of a designated substance, some only require it if it is a Schedule II or III opioid, while others require it only if the initial opioid prescription surpasses a seven-day supply.[9]

This report aims to provide guidance to state medical boards about effective PDMP use, one of many strategies being recommended to address the growing prescription opioid epidemic.

Section 2. Definitions

Mandatory Registration – A state's requirement that prescribers of controlled substances must register with the state's PDMP.

Prescription Drug Monitoring Program – A patient safety tool designed to facilitate the collection, analysis, and reporting of information about the prescribing and dispensing of controlled substances.[10]

[5] Missouri Executive Order. No. 17-18, 2018. https://www.sos.mo.gov/library/reference/orders/2017/eo18

[6] Blumenschein, Karen, et. al. "Review of Prescription Drug Monitoring Programs in the United States." Institute for Pharmaceutical Outcomes and Policy, University of Kentucky, June 2010. http://chfs.ky.gov/NR/rdonlyres/85989824-1030-4AA6-91E1-7F9E3EF68827/0/KASPEREvaluationPDMPStatusFinalReport6242010.pdf.

[7] Wen, Hefei, et al. "States with Prescription Drug Monitoring Mandates Saw A Reduction in Opioids Prescribed to Medicaid Enrollees." Health Affairs, vol. 36, no. 4, Apr. 2017, pp. 733–741., www.ncbi.nlm.nih.gov/pubmed/28373340.

[8] "Substances Monitored by PMP." National Alliance for Model State Drug Laws, May 2016, www.namsdl.org/library/8D7261F8-E47D-B6A5-DD0CAFA98FEA4846.

[9] "Mandated Use of State Prescription Drug Monitoring Programs: Highlights of Key State Requirements." National Alliance for Model State Drug Laws, June 2017. http://www.namsdl.org/library/6735895A-CA6C-1D6B-B8064211764D65D0/

[10] Federation of State Medical Boards (FSMB). Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain. Washington, DC: The Federation, 2013.

Universal Use – A state's requirement that prescribers must query the patient's PDMP history before initially prescribing opioid pain relievers and benzodiazepines, and at certain intervals thereafter.[11]

Unsolicited Reports – Proactive communications from the PDMP to prescribers, dispensers, law enforcement, and/or regulators to provide information about patient prescriptions and/or the prescribing activity of a health care professional based upon PDMP data.[12]

3. Mandatory Registration

Studies show that between 2010-2012, states with operational PDMPs saw an average registration rate of 35 percent among licensed prescribers who prescribed at least one controlled substance during that period. [13] In 2014, a national survey found that 53 percent of primary care physicians used their state's PDMP at least once, but many were not using the PDMP on a routine basis.[14] Although there have been extensive educational campaigns to recruit prescribers to participate in their state's PDMP, results have not always been successful.[15] At the same time, however, PDMP registration has increased significantly, increasing from approximately 471,000 to more than 1.3 million from 2014 to 2016. During the same time period, queries by physicians and other health care professionals increased from approximately 61 million to more than 136 million.[16]

States are seeing success in increasing prescriber PDMP registration rates through other methods, such as mandatory registration. Massachusetts took a staggered, low resource-intensive approach by linking PDMP enrollment to the renewal of state controlled substance registration, where renewals are required every three years for practitioners. The process established by Massachusetts allowed for a continuous workflow for PDMP staff, rather than a surge in applications immediately after the enactment of mandatory PDMP registration legislation. As a result, the state first saw a gradual increase in registration, followed by a more dramatic increase, between 2011-2016. In 2011 and 2012, only 1 percent and 2 percent of prescribers were registered with the PDMP, respectively. By the end of 2014, however, nearly 66 percent of prescribers were enrolled. By September 2015, that percentage increased to 83 percent, and by January 2016, more than 90 percent had enrolled.[17]

4. Universal Use

[11] CDC Prevention Status Report, https://wwwn.cdc.gov/psr/NationalSummary/NSPDO.aspx
[12] The PEW Charitable Trusts, *Prescription Drug Monitoring Programs: Evidence-Based Practices to Optimize Prescriber Use*, December 2016. www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs.
[13] Wen, Hefei, et al. "States with Prescription Drug Monitoring Mandates Saw A Reduction in Opioids Prescribed to Medicaid Enrollees." Health Affairs, vol. 36, no. 4, Apr. 2017, pp. 733–741., www.ncbi.nlm.nih.gov/pubmed/28373340.
[14] Ibid.
[15] Ibid.
[16] Survey of state PDMP administrators. American Medical Association.
[17] The PEW Charitable Trusts, *Prescription Drug Monitoring Programs: Evidence-Based Practices to Optimize Prescriber Use*, December 2016. www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs.

Research shows that between 2011-2014, 85 percent of states that implemented some form of a PDMP universal use mandate were based upon legislation that was of limited scope and strength. Due to the weakness of the mandates in these cases, it is unlikely that they will prove effective in improving opioid prescribing practices.[18] Efforts to strengthen universal use mandates are supported by President Donald Trump's Commission on Combating Drug Addiction and the Opioid Crisis, which recommends that federal agencies mandate PDMP querying.[19]

States that have established an effective PDMP, in part or in whole, employ certain evidence-based practices. These practices include delegated authority, unsolicited reports, data timeliness, streamlined enrollment, educational initiatives, integration and data sharing, enhanced user interfaces, and proper funding, with delegated authority, data timeliness, and integration and data sharing being critical elements.[20]

Delegated Authority

Prescription Drug Monitoring Programs can serve as valuable tools to help inform prescribers' decision making and identify potential substance use disorder, but a significant barrier to increasing prescriber use of them is the time typically needed to query the system.[21] To decrease the time spent by prescribers reviewing patient records, many states authorize registered users to delegate non-prescriber employees the ability to access the system using sub-accounts. States vary, however, in whether a delegate has to be a licensed individual or not, as well as in the number of prescriber delegates permissible. Currently, 47 states and the District of Columbia authorize prescribers to delegate such authority, with 36 states actively doing so.[22] Some states only permit two delegates per prescriber, while others impose no limits.[23]

In Kentucky, the state's PDMP, known as the Kentucky All Schedule Prescription Electronic Reporting Program (KASPER), does not restrict the number of subaccounts to licensed staff. Prescribers also have no limit on the number of designated delegates, who are also permitted to serve as a delegate for multiple prescribers. For prescribers sharing multiple delegates, delegates are able to select the prescriber from a dropdown list to accurately record for which prescriber a

[18] Wen, Hefei, et al. "States with Prescription Drug Monitoring Mandates Saw A Reduction in Opioids Prescribed to Medicaid Enrollees." Health Affairs, vol. 36, no. 4, Apr. 2017, pp. 733–741., www.ncbi.nlm.nih.gov/pubmed/28373340.

[19] The President's Commission on Combating Drug Addiction and the Opioid Crisis, "Final Report," 15 November 2017. https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf

[20] The PEW Charitable Trusts, *Prescription Drug Monitoring Programs: Evidence-Based Practices to Optimize Prescriber Use*, December 2016. www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs.

[21] Rutkow, L. et al. "Many primary care physicians are aware of prescription drug monitoring programs, but many find the data difficult to access." Health Affairs, vol. 34, no. 3, March 2015, pp. 484-492., http://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.1085

[22] Brandeis University PDMP Training and Technical Assistance Center. "PDMPs Authorized and Engaged in Sending Solicited and Unsolicited Reports to Health Care Providers and Patients." http://www.pdmpassist.org/pdf/Health_Care_Entity_Table_20170824.pdf

[23] The PEW Charitable Trusts, *Prescription Drug Monitoring Programs: Evidence-Based Practices to Optimize Prescriber Use*, December 2016. www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs.

report is being queried. The prescriber is responsible for deactivating accounts of delegates who leave the practice or otherwise warrant discontinuance of PDMP access. Delegates are permitted to conduct queries and provide reports for prescriber review, but are prohibited from conducting the clinical review of data that the state's mandate requires. As a result of allowing such delegated authority, during the fourth quarter of 2015 delegates requested nearly 64 percent of in-state prescriber reports, despite accounting for 42 percent of combined delegate and prescriber master accounts by the end of that year. [24]

Unsolicited Reports

PDMPs provide prescription history reports to authorized users upon request (these are also known as "solicited" reports), but when these reports are not requested useful information can go unseen or unused by prescribers. In an effort to increase utilization, many PDMPs proactively send "unsolicited" (and, therefore, unrequested) reports to specific prescribers, dispensers, state licensing boards, and law enforcement agencies that contain data suggestive, or indicative, of multiple provider episodes or inappropriate prescribing and dispensing.[25]

In 2005, Maine began sending prescribers quarterly threshold notification reports via U.S. mail, but in 2013 moved to monthly emailed alerts. Originally, these alerts were sent to registered PDMP users only when one of three criteria was met by a patient: 1) exceeds a certain number of prescribers and pharmacies in a three-month period; 2) exceeds a specified average daily dose of acetaminophen coming from prescriptions of opioid-acetaminophen combination drugs; or 3) is prescribed buprenorphine and another opioid in a 30-day period. In 2015, however, the state's legislature added two new criteria to initiate alerts: 1) multiple overlapping prescriptions for medications containing opioids; and 2) prescriptions for more than 300 morphine milligram equivalents daily for more than 45 consecutive days within a 90 day period. Alert recipients must log into their PDMP account to review the patient's prescription history, which includes the other providers who prescribed to the patient, the pharmacies that dispensed to the patient, drugs and quantities and other details of prescriptions dispensed for the past three months. Additionally, the state recently enabled prescribers to request reports based on their own set thresholds. It is believed that unsolicited reports may have affected prescriber behavior from 2010 to 2014 when the state saw a steady decline in the rate of multiple provider episodes.[26]

Additionally, in Indiana, a prescriber who believes a patient's PDMP data suggests questionable activity has the option to send email alerts to other prescribers and dispensers of the patient. These "user-led unsolicited report" email alerts do not contain a patient's name or any conclusions, but rather contains a hyperlink to a patient's prescription history report that registered users can review after logging into the PDMP, thus ensuring Health Insurance Portability and Accountability Act (HIPAA) compliance. These alerts serve to notify prescribers and dispensers that a patient may be using unnecessary prescription drugs, may be receiving controlled substances from multiple providers, or may be involved in controlled substance

[24] Ibid.

[25] Brandeis University PDMP Training and Technical Assistance Center, "Guidance on PDMP Best Practices: Options for Unsolicited Reporting," May 2016. http://www.pdmpassist.org/pdf/COE_documents/Add_to_TTAC/Update%20to%20Brandeis%20COE%20Guidance%20on%20Unsolicited%20Reporting%20final.pdf

[26] Ibid.

diversion. Indiana first launched its user-led unsolicited reports in March 2012. After the first three months of the program, 140 practitioners had sent 2,284 alerts on 214 unique patients, at virtually no cost to the program.[27]

Data timeliness

A prescriber's ability to effectively use PDMP data to asses a patient's prescription history can only be as complete as the data that is transmitted into the system by a dispenser. If a PDMP report does not contain information about the most recently dispensed controlled substances, a prescriber may lack valuable data to determine the best course of treatment. Because of this, it is imperative to minimize the pharmacy reporting interval. States are increasingly moving away from weekly reporting towards daily PDMP data reporting. In 2015, 24 states required daily data submissions. As of July 2017, 40 states and the District of Columbia required data to be reported within 24 hours or one business day. Oklahoma is the only state currently requiring real-time reporting,[28] but the transition from daily reporting to real-time required two years and involved intensive effort and overtime for the PDMP, as well as redesign for pharmacy data systems and workflow procedures.[29]

Streamlined Enrollment

In order to access PDMP data, prescribers must typically establish online accounts with a state's PDMP system. This process requires the prescriber to submit, and the PDMP to verify, identifying information, such as name, date of birth, state controlled substance prescribing or medical practice license number, DEA registration number, driver's license number, place of employment, medical specialty, and contact information. Once the prescriber's state controlled substance prescribing or medical practice license number and a DEA registration number is verified, the prescriber may create an account and begin to query patients' controlled substance prescription history. Unfortunately for many prescribers, the process can be time consuming to complete registration applications as some states require paper applications and notarization.[30] To expedite PDMP registration, and to transition away from paper applications, some states began migrating to an online registration system, in addition to automatic prescriber enrollment, during initial medical licensure and licensure renewal.

In 2012, the Tennessee Legislature enacted legislation mandating that prescribers use the state's PDMP and dispensers register. The comprehensive mandate required DEA-registered prescribers and dispensers to register with the PDMP within the first eight months after the law's enactment. New licensees are required to register with the PDMP within 30 days. The universal use mandate went into effect four months after prescribers and dispensers were required to register. In an

[27] Indiana Scheduled Prescription Electronic Collection & Tracking (INSPECT). "Presentation on User-Led Unsolicited Reporting (ULUR)." 2012. http://www.pdmpassist.org/pdf/PPTs/National2012/2_Allain_StatePanelInnovationsIndiana.pdf

[28] National Alliance for Model State Drug Laws, "Frequency of Prescription Drug Monitoring Program Data," 30 June 2017. http://www.namsdl.org/library/03B95893-0EE2-3766-EABAD212B5C8E8D3/

[29] The PEW Charitable Trusts, *Prescription Drug Monitoring Programs: Evidence-Based Practices to Optimize Prescriber Use*, December 2016. www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs.

[30] The Network for Excellence in Health Innovation, "Issue Brief – Physicians and PDMPs: Improving the Use of Prescription Drug Monitoring Programs," November 2015. https://www.nehi.net/writable/publication_files/file/pdmp_issue_brief_11.18.pdf

effort to handle the influx of registrations, Tennessee adopted an online registration system. This system automatically attempts to validate a prescriber's information using electronic databases for the state's professional health care licenses, driver's licenses, and DEA prescriber registration. For prescribers who do not have health care licenses or DEA numbers, such as medical residents in hospitals in some states, PDMP registration is still processed manually. As a result of the streamlined online registration system for licensed prescribers and dispensers, the number of registered prescribers has increased 127 percent between 2011 (a year before the mandate went into effect) and 2014. Additionally, average queries per month have increased 203 percent during that same time period.[31]

Educational Initiatives

Many state medical boards require physicians to complete continuing medical education (CME) in specific content areas, such as pain management and controlled substance prescribing practices. Thirty-two of the 50 states, and the District of Columbia, mandate at least one content-specific CME course. Of those 32 states, 29 states require CME focused on either pain management or controlled substance prescribing practices, or in some circumstances both. In 26 out of those 29 states, the CME requirements are for both allopathic and osteopathic physicians. In two states, Oklahoma and Nevada, only osteopathic physicians are required to complete CME on pain management/controlled substance prescribing practices, while in Vermont only allopathic physicians are required to complete such CME. Additionally, 12 of the 29 states require CME on pain management/controlled substance prescribing practices for all physicians, while the other 17 states only require a subset of physicians to complete such requirements, such as controlled substance providers or certain providers who work in pain clinics.[32]

In order to assist prescribers in completing CME requirements, as well as educate prescribers who are not required to complete content-specific CME, the federal government promotes certain educational initiatives. The U.S. Department of Health and Human Service's (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) jointly developed the "Substance Use Trainings" webpage as an online educational resource that provides one-time and ongoing training activities dedicated to pain management and controlled substance prescribing practices. HHS's Office of Disease Prevention and Health Promotion also developed an online education resource, *Pathways to Safer Opioid Use*, while the U.S. Food and Drug Administration's (FDA) Risk Evaluation and Mitigation Strategy (REMS) for extended release/long-acting opioids requires CME to be offered by opioid manufacturers.[33] As part of REMS, the FDA released the *FDA Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics*, which contains core educational messages for the development of continuing

[31] The PEW Charitable Trusts, *Prescription Drug Monitoring Programs: Evidence-Based Practices to Optimize Prescriber Use*, December 2016. www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs.

[32] Xu, Jing, PhD, MA; Gribble, Anna, MSW, MPH, et al. "State Continuing Education Requirements for Physicians and Dentists, Including Requirements Related to Pain Management and Controlled Substance Prescribing," Journal of Medical Regulation, Vol. 103, Number 3, 2017.

[33] Ibid.

education activities focused on safe prescribing.[34] The Centers for Disease Control (CDC) also provides educational materials, such as *Applying CDC's Guideline for Prescribing Opioids: An Online Training Series for Providers* and *What Healthcare Providers Need to Know About PDMPs.*[35][36]

While a majority of states require physicians to complete certain content-specific CME, FSMB policy states that, "the FSMB believes mandatory continuing medical education is a matter reserved for the individual state jurisdictions."[37]

Integration and Data Sharing

The value of PDMP data is based in part on whether such data is readily available and accessible. Although PDMPs collect controlled substance prescription information in a central repository, the adoption and utilization of a PDMP by prescribers is slowed when such data is not integrated into health information technology (HIT) systems, specifically electronic health records (EHR).

There have been several efforts and initiatives to spur the pace at which PDMP data is integrated, such as SAMHSA's PDMP Electronic Health Records Integration and Interoperability Expansion (PEHRIIE) program, which funded projects in nine states from 2012-2016. The goal of this program was to increase prescriber utilization by integrating PDMP data into HITs. The program also sought to increase the comprehensiveness of PDMP data by increasing interstate PDMP data sharing.[38]

Programs such as PEHRIIE demonstrate the effectiveness of integrating PDMP data into HITs. During the fourth quarter of 2014, the state of Washington became interoperable with OneHealthPort, a statewide HIE, enabling integration with the Emergency Department Information Exchange (EDIE), a hub connecting hospital emergency departments. In 2015, the first full calendar year after integration, the PDMP provided 2,222,446 solicited reports to prescribers, compared to 2014, when 26,546 solicited reports were provided to prescribers.[39] Significant increases in solicited reports were also experienced in Kansas after PDMP data was integrated with the Via Christi Health Network, the largest healthcare provider in Kansas, in late 2013. After integration, solicited reports provided to Via Christi prescribers increased from 31,156 reports in 2013 to 223,000 reports in 2015. Compared to other prescribers in Kansas, the number of solicited reports increased significantly less, from 23,171 in 2013 to 65,242 in 2015.

[34] United States Food and Drug Administration, *Introduction for the FDA Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics,* May 2017. https://www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/UCM515636.pdf

[35] Centers for Disease Control, *Applying CDC's Guideline for Prescribing Opioids: An Online Training Series for Provider.* https://www.cdc.gov/drugoverdose/training/overview/index.html

[36] Centers for Disease Control, *What Healthcare Providers Need to Know About PDMPs.* https://www.cdc.gov/drugoverdose/pdmp/providers.html

[37] Federation of State Medical Boards (FSMB), *FSMB Policy 100.2, Mandating Continuing Medical Education*, Washington, DC: The Federation, 1980.

[38] Centers for Disease Control (CDC). "Integrating & Expanding Prescription Drug Monitoring Program Data: Lessons from Nine States," February 2017. https://www.cdc.gov/drugoverdose/pdf/pehriie_report-a.pdf

[39] Ibid.

Several states also announced efforts to integrate prescription drug information into EHRs and other HITs. In August 2017, Indiana announced that it would integrate PDMP data into EHRs at hospitals and physician practices across the state at no cost to the facility or individual practitioner. The phased-in integration is scheduled to be completed by 2020.[40] Michigan also announced in June 2017 that state and federal funds will be invested over a two year period to integrate the state's PDMP, Michigan Automated Prescription System, into EHRs and pharmacy dispensation systems.[41] Additionally, Arizona, Kansas, Massachusetts, Ohio, Pennsylvania, and Virginia are supporting integration into EHRs, HITs, and pharmacy dispensing systems at no cost.

These recent state trends to integrate PDMP data are in line with recommendations being conveyed at the federal level, including the President's Commission on Combating Drug Addiction and the Opioid Crisis, which recommended in November 2017 that "PDMP data integration with electronic health records, overdose episodes, and substance use disorder-related decision support tools for providers is necessary to increase effectiveness."[42]

The ability for prescribers to view prescription drug history information across state lines can assist in identifying a potential substance use disorder. To facilitate interstate PDMP data sharing and integration, states have opted to connect to a data sharing hub. Forty-five states and the District of Columbia are currently engaged in some form of interstate data sharing, while three other states are in the process of implementing data sharing.[43] Not all states, however, allow universal data sharing among states. Some states allow prescribers in any state to access PDMP data, while other states allow prescribers from specific states within a region. These are usually in-state policy decisions that often change to expand toward a goal of universal access.

The President's Commission on Combating Drug Addiction and the Opioid Crisis also recommended supporting federal legislation mandating states that receive grant funds to comply with PDMP requirements, including data sharing, and establishing and maintaining a data-sharing hub.[44]

In an effort to reduce barriers to data sharing across state lines, there have been various data sharing hubs launched to facilitate data sharing in compliance with each state's data access regulations. At the request of several PDMPs, the National Association of Boards of Pharmacy (NABP) created Prescription Monitoring Program (PMP) InterConnect in 2011. PMP InterConnect provides for encrypted data to be transmitted across state lines. To date, 45 states have executed a memorandum of understanding (MOU) with NABP to participate and 42 of

[40] Sweeney, Evan, "Indiana announces plans to integrate PDMP data into EHRs across the state," FierceHealthcare, 25 August 2017. https://www.fiercehealthcare.com/ehr/indiana-announces-plans-to-integrate-pdmp-data-into-ehrs-across-state

[41] Office of Governor Rick Snyder, "Patient Protections Strengthened as State Fully Integrates MAPS into Health Systems," 19 June 2017. http://www.michigan.gov/snyder/0,4668,7-277-73341_73343-424218--,00.html

[42] The President's Commission on Combating Drug Addiction and the Opioid Crisis, *Final Report*, 15 November 2017. https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf

[43] Brandeis University PDMP Training and Technical Assistance Center, "Interstate Data Sharing," 20 September 2017. http://www.pdmpassist.org/pdf/Interstate_Data_Sharing_20170920.pdf

[44] The President's Commission on Combating Drug Addiction and the Opioid Crisis, "Final Report," 15 November 2017. https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf

those states are now live. Each month, PMP InterConnect processes more than 15 million requests.[45]

Separately, RxCheck is another data sharing hub that was created with support from the U.S. Bureau of Justice Assistance (BJA) and using the Prescription Monitoring Information Exchange (PMIX) National Architecture specifications. As of July 2017, there are four states that are engaged in interstate data sharing with RxCheck, while two states are currently implementing interstate data sharing and eight states have plans to connect to RxCheck.

Enhanced User Interfaces

While having access to PDMP data is integral for prescribers, it is equally important that prescribers are able to quickly analyze and use that data. As the amount of controlled substance prescription information available to prescribers has increased in recent years, prescribers have sought ways to quickly analyze the most important information for clinical decision making. To address this, states began exploring ways to better interpret the data. Some of these methods included adding an enhanced user interface to the PDMP system that includes, but is not limited to, a total morphine milligram equivalent (MME) calculation for each opioid prescription, a daily MME dose level, and flags or alerts if a patient's MME surpasses a certain threshold.[46]

In 2016, the California PDMP, Controlled Substance Utilization Review and Evaluation System (CURES) underwent a redesign to help prescribers improve their clinical decision-making when evaluating whether to prescribe a controlled substance. The new updated program contains a dashboard that provides users patient alerts, including a list of patients who are prescribed more than 100 MME per day; have obtained prescriptions from six or more prescribers or pharmacies during the past 12 months; are prescribed more than 40 milligrams of methadone daily; have been prescribed opioids for more than 90 consecutive days; or are concurrently prescribed benzodiazepines and opioids.[47]

Enhanced user interfaces are a recent development and, as such, there is a paucity of evidence on its effectiveness in identifying a potential substance use disorder or coordinating care in the case of a multiple provider event.

Data Security/Patient Protections

As the use of PDMP increases nationwide and controlled substances prescription history is increasingly used by prescribers, patients are increasingly concerned about the security of their data and the possibility of law-enforcement scrutiny. Prescribers are also increasingly concerned

[45] National Association of Boards of Pharmacy, "Connecting State Prescription Monitoring Programs Nationwide," November 2017. https://nabp.pharmacy/wp-content/uploads/2017/11/NABP-InterConnect-Flyer-November-2017.pdf

[46] The PEW Charitable Trusts, *Prescription Drug Monitoring Programs: Evidence-Based Practices to Optimize Prescriber Use*, December 2016. www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs.

[47] California Department of Justice, "CURES 2.0: Prescription Drug Monitoring Program" (presentation September 2015). https://www.sfhp.org/files/providers/Best_Practices/CURES_2.0_PPT.pdf

that medical consultations are no longer a private affair and that staff access pose the potential for unscrupulous use and data leaking. [48]

Substance use disorder is a multifaceted problem and often requires collaboration among various agencies and stakeholders. PDMPs are primarily used as a public health tool, but law enforcement agencies see PDMPs as a potential law enforcement tool. An increase in law enforcement scrutiny of PDMP data may significantly affect a prescriber's clinical decision making and cause a prescriber to under prescribe.[49]

A balanced approach between patient safety and data protection has been encouraged by various stakeholders. Both the American Medical Association (AMA) and the American Society of Addiction Medicine (ASAM) believe that PDMP data should be considered protected health information, and should not be released outside of the health care system unless there is authorization for release from the individual patient. The AMA also supports access to PDMP data via a warrant, as well as when the public safety demands in certain situations. [5051]

The United States District Court for the District of Oregon, Portland Division affirmed the limits of law enforcement access in February 2014 in *Oregon Prescription Drug Monitoring Program v. United States Drug Enforcement Administration*. The Court found that federal drug investigators cannot access patients' prescription information without proving probable cause and obtaining a warrant. The Court also found that administrative subpoenas are insufficient to demand information relevant to investigations into potential drug violations, such as a doctor who improperly prescribes drugs.[52] In June 2017, the United States Court of Appeals for the Ninth Circuit reversed the ruling as it found that requiring a court order to enforce the subpoena on the DEA interfered with Congress' intent to strengthen law enforcement tools against the traffic of illicit drugs. It recognized, however, that medical records require strong legal safeguards.[53]

In Georgia, in addition to authorizing prescribers and dispensers, and their designated delegates, the Georgia Drugs and Narcotics Agency is authorized to provide requested prescription information collected to a patient, or the patient's attorney; local or state law enforcement or

[48] Islam, M Mofizul and McRae, Ian S, "An inevitable wave or prescription drug monitoring programs in the context of prescription opioids: pros, cons and tensions," BMC Pharmacology & Toxicology, 6 August 2014. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4138942/

[49] Ibid.

[50] American Society of Addiction Medicine, "Public Policy Statement on Measures to Counteract Prescription Drug Diversion, Misuse and Addiction," 25 January 2012. https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2012/01/26/measures-to-counteract-prescription-drug-diversion-misuse-and-addiction

[51] American Medical Association, "Prescription Drug Monitoring Program Confidentiality H-95.946, 2015. https://policysearch.ama-assn.org/policyfinder/detail/prescription%20drug%20monitoring%20program?uri=%2FAMADoc%2FHOD.xml-0-5325.xml

[52] *Oregon Prescription Drug Monitoring Program v. US Drug Enforcement Administration*, 998 F.Supp.2d 957 (2014) https://www.leagle.com/decision/infdco20140212990.

[53] *Oregon Prescription Drug Monitoring Program v. US Drug Enforcement Administration*, 860 F.3d 1228 (2017) https://www.leagle.com/decision/infco20170626117

prosecutorial officials pursuant to the issuance of a search warrant from an appropriate court or official in the county in which the office of such law enforcement or prosecutorial officials are located or to federal law enforcement or prosecutorial officials pursuant to the issuance of a search warrant or a grand jury subpoena; to the Georgia Drugs and Narcotics Agency, the Georgia Composite Medical Board or any other state regulatory board governing prescribers or dispensers in this state, or the Department of Community Health for purposes of the state Medicaid program upon the issuance of a subpoena by such agency, board, or department pursuant to their existing subpoena power or to the federal Centers for Medicare and Medicaid Services upon the issuance of a subpoena by the federal government pursuant to its existing subpoena powers.[54]

Proper Funding

To continually maintain and update a state's PDMP system often comes with a certain level of financial need. It is often difficult, however, for states to properly fund such operations and projects. In order to meet these demands, states use a wide variety of funding mechanisms, whether in whole or in part, including state appropriations, registration and licensing fees, and federal grants.

One source of funding for states has been legislative appropriations and state government funding. In October 2015, Ohio Governor John Kasich announced that the state would invest up to $1.5 million a year to integrate the Ohio Automated Rx Reporting System (OARRS) directly into electronic medical records and pharmacy dispensing systems across the state, allowing instant access for prescribers and pharmacists.[55]

In addition to licenses to practice medicine, several states require a controlled substance prescribing license that is separate from DEA registration. The registration fees from these state prescribing licenses frequently go to support the PDMP, whether in full or in part. This funding mechanism assesses a fee on a subset of providers while the more current thinking is that all licensed providers should have access to their patients' PDMP data.[56]

Instead of allocating funds from a specific controlled substance prescribing license, some states allocate a certain percentage from all professional licensing fees to go towards the state's PDMP. Although this avenue provides consistent funding, it is limited in dollar amount and increasing the allocated percentage may affect other operations of the Board.[5758]

States often leverage federal grants to fund and maintain PDMP projects, as well. Since 2003, the U.S. Department of Justice's Bureau of Justice Assistance has administered the Harold Rogers PDMP Grant Program to reduce opioid misuse and the number of overdose fatalities by

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[54] Ga. Code § 16-13-30

[55] Ohio Automated Rx Reporting System, https://wholesale.ohiopmp.gov/Portal/Integration.aspx

[56] PDMP TTAC, "Funding Options for Prescription Drug Monitoring Programs," 3 July 2013. http://www.pdmpassist.org/pdf/PDMP_Funding_Options_TAG.pdf

[57] Brandeis University PDMP Training and Technical Assistance Center, "Funding Options for Prescription Drug Monitoring Programs," 3 July 2013. http://www.pdmpassist.org/pdf/PDMP_Funding_Options_TAG.pdf

[58] National Alliance for Model State Drug Laws, "Funding Provisions of PDMPs," May 2016. http://www.namsdl.org/library/57555C8D-B77F-0F68-987334839CA29924/

supporting the implementation, enhancement, and proactive use of state PDMPs. For Fiscal Year 2017, two-year grants were awarded to 10 states and Puerto Rico totaling $3,966,932.[59] The CDC also provides funding opportunities to support states' efforts to enhance and maximize PDMPs, including the Data Driven Prevention Initiative (DDPI) and Prevention for States (PfS) Funding Opportunity Announcements.[6061] Additionally, SAMHSA also provides a variety of funding opportunities for states to enhance their PDMPs.[62]

5. Recommendations

1. Mandatory Registration –
States should require PDMP registration for prescribers of controlled substances. This registration should take place at the time of the prescriber's initial medical licensure application or next renewal. In an effort to expedite the process, state PDMPs should facilitate online registration to meet the expected increase in applications.

2. Universal Use of PDMPs–
States should require universal use of PDMPs if the state's PDMP contains certain characteristics. Ideally, all the characteristics listed below would be present within a state's PDMP system but some are more critical than others to the functionality of the PDMP.

a. Group 1: Critical Characteristics Needed for an Effective PDMP
   i. Delegation –
   Each prescriber should be permitted to delegate authority to access the PDMP to any member of their health care team by creating subaccounts without limitations. Delegates should be able to be shared by multiple providers, such as a physician group or emergency department or similar setting. The prescriber must have the authority to deactivate a delegate's subaccount for any reason, including, but not limited to, leaving the practice or no longer serving in that capacity.

   In order to ensure delegate accountability, prescribers must be allowed to audit their delegates' activity and use of the PDMP.

[59] U.S. Department of Justice, Bureau of Justice Assistance, Harold Rogers PDMP Grant Program, https://www.bja.gov/funding/Category-5-awards.pdf
[60] Centers for Disease Control, *Data Driven Prevention Initiative*. https://www.cdc.gov/drugoverdose/foa/ddpi.html
[61] Centers for Disease Control, *Prevention for States*. https://www.cdc.gov/drugoverdose/states/state_prevention.html
[62] Substance Abuse and Mental Health Services Administration. Grants Related to Prescription Drug Misuse and Abuse. https://www.samhsa.gov/prescription-drug-misuse-abuse/grants

ii. Data timeliness/accuracy –
State PDMPs should require daily reporting of controlled substance prescription. Although it may be ideal to have real-time reporting, there is a paucity of data at this time to support it.[63]

In order to ensure data accuracy, prescribers should be able to review their prescribing history and provide corrections to it, if necessary.

iii. Integration and Data Sharing –
In order to minimize any workflow disruption, states should integrate their PDMP system with electronic health records and pharmacy systems. Ideally, this integration will provide near-instant and seamless access to critical prescription history information to both prescribers and pharmacists.

States should engage in interstate PDMP data sharing.

b. Group 2: Other Characteristics Needed for an Effective PDMP
i. Unsolicited reports –
In an effort to notify prescribers of a patient's prescribing information, as well as the prescriber's own prescribing history, PDMP systems should provide unsolicited reports. Examples of information in such reports may include multiple provider episodes, combinations of commonly misused drugs, or exceeding a designated threshold for an average daily dose of an opioid in morphine milligram equivalents.

To protect patients, prescribers should generate user-led unsolicited reports to send to other prescribers treating the same patient. These user-led unsolicited reports are sent at the discretion of the prescriber and serve as a judgment that the patient may be receiving a potentially harmful controlled substance or has experienced a situation, such as an overdose, that may increase the patient's future risk of overdose or abuse.

When possible, these reports should be sent electronically and should not contain identifying patient information, but rather alert and direct the prescriber to query the PDMP to view the information.

ii. Educational initiatives –
A state medical board may choose to encourage or require prescribers to complete content-specific continuing medical education related to prescribing practices including, but not limited to, PDMP utilization.

iii. Enhanced user interface –

[63] The PEW Charitable Trusts, *Prescription Drug Monitoring Programs: Evidence-Based Practices to Optimize Prescriber Use*, December 2016. www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs.

PDMP system tools to increase usability for prescribers should be considered. These components, as part of a PDMP's interface, may include, but are not limited to, a summary of morphine milligram equivalent (MME) for each opioid prescription and a daily MME dose level, as well as any other "red" flags or alerts for a specific patient.

iv. Data Security/Patient Privacy –
States should grant PDMP data access to local, state, and federal law enforcement only when there is an issuance of warrant/judicial finding of probable cause.

States should grant PDMP data access to state medical boards when a licensee is under investigation by the board for inappropriate prescribing.

In order to protect the privacy of patient information and to ensure proper patient treatment, Medicare, Medicaid, state health insurance programs and/or health care payment benefit providers and insurers should not have access to a patient's PDMP record unless a subpoena has been issued in accordance with existing subpoena powers.

v. Proper funding –
To meet the demands of updating and maintaining a PDMP, states should implement a sustainable funding mechanism, whether through state funding or federal grant programs.

WORKGROUP MEMBERS
Anna Z. Hayden, DO, Chairman
FSMB Director-at-Large
Member, Florida Board of Osteopathic Medicine

Mark E. Bowden, MPA, CMBE
Executive Director, Iowa Board of Medicine

Robert P. Giacalone, JD, RPh
Vice President, Ohio Medical Board

Robin N. Hunter Buskey, DHSc, PA-C
Past Member, North Carolina Medical Board

William K. Hoser, MS, PA-C
Chairman, Vermont Board of Medical Practice

Louis J. Prues, DMin, MDiv, MBA
Public Member, Michigan Board of Medicine

Jean L. Rexford
FSMB Director-at-Large
Public Member,
Connecticut Medical Examining Board

Thomas H. Ryan, JD, MPA
Executive Director,
Wisconsin Medical Examining Board

Joseph R. Willett, DO
Member, Minnesota Board of Medical Practice

SUBJECT MATTER EXPERTS
J. Mark Bailey, DO, PhD
Professor, University of Alabama at Birmingham

Daniel Blaney-Koen, JD
Senior Legislative Attorney,
American Medical Association

Shawn Brooks
Health Communication Specialist, Center for Drug Evaluation and Research,
U.S. Food and Drug Administration

Danna E. Droz, JD, RPh
Prescription Monitoring Program (PMP) Liaison,
National Association of Boards of Pharmacy

Patrice A. Harris, MD, MA
President, American Medical Association

Christina A. Mikosz, MD, MPH
Medical Officer, National Center for Injury Prevention and Control,
Centers for Disease Control

Rebecca Poston, MHL
Program Manager, Electronic-Florida Online Reporting of Controlled Substance Evaluation (E-FORCSE) Program

Judy Staffa, PhD, RPh
Associate Director for Public Health Initiatives,
Office of Surveillance and Epidemiology,
U.S. Food and Drug Administration

EX-OFFICIOS
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Chair-elect, FSMB

Humayun J. Chaudhry, DO, MACP,
President and CEO, FSMB

STAFF SUPPORT
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Chief Advocacy Officer, FSMB

John P. Bremer
Manager, State Legislation and Policy, FSMB

Resolution 18-1

Federation of State Medical Boards
House of Delegates Meeting
April 28, 2018

Subject: Acute Opioid Prescribing Workgroup and Guidelines

Introduced by: State Medical Board of Ohio

Approved: January 2018

Whereas, long-term use of opioids frequently begins with the treatment of acute pain; and

Whereas, millions of Americans undergo surgical procedures and sustain painful injuries every year; and

Whereas, many, if not most, people have their first exposure to opioids in the acute medical and postoperative settings; and

Whereas, acute medical and postoperative prescribing varies widely by prescriber; and

Whereas, the duration, dosage, and formulation of opioids can have a dramatic impact on the likelihood of risk of acute medical and postoperative persistent opioid use; and

Whereas, prescriber awareness of risk factors for persistent opioid use could deter overprescribing of opioids, which could lead to a decreased incidence of long-term opioid use. This would lead to a decreased incidence of addiction, comorbidity, and diversion; and

Whereas, a number of states may be considering – or have already implemented – rules or laws limiting the permissible number of days, morphine equivalency and type of opioid to prescribe for acute conditions; and

Whereas, prescribers frequently practice in multiple states in which acute opioid prescribing laws and rules may vary significantly;

Therefore, be it hereby

Resolved, that the Federation of State Medical Boards (FSMB) perform a comprehensive review of acute opioid prescribing patterns, practices, federal laws and guidance (including Centers for Disease Control and Prevention guidelines), and state rules and laws across the United States; and

Resolved, that the FSMB perform a comprehensive review of data related to patient outcomes, comparing states with and without limitations on opioid prescribing for acute conditions; and

Resolved, that the FSMB establish a workgroup tasked to formulate acute opioid prescribing guidelines and best practices, and to present these guidelines and best practices to the House of Delegates at the FSMB annual meeting in 2019.

Resolution 18-2

Federation of State Medical Boards
House of Delegates Meeting
April 28, 2018

Subject: Testing Under Time Constraints of the Necessary and Explicit Component of the United States Medical Licensure Examination (USMLE)

Introduced by: Minnesota Board of Medical Practice

Approved: November 2017

Whereas, the USMLE is an exam used for licensure by states; and

Whereas, the USMLE is used to determine the safety of physicians in the independent practice of medicine; and

Whereas, the practice of medicine is constrained by time; and

Whereas, the USMLE has been publicized as a test of knowledge; and

Whereas, testing under time constraint is not considered a component of the USMLE;

Therefore, be it hereby

Resolved, that the Federation of State Medical Boards study and consider the addition of testing time constraint as an explicit component of the USMLE examination.

BRD RPT 18-3

REPORT OF THE BOARD OF DIRECTORS

Subject: **Report of the FSMB Workgroup on Physician Wellness and Burnout**

Referred to: **Reference Committee B**

The Federation of State Medical Boards (FSMB) Workgroup on Physician Wellness and Burnout, chaired by Dr. Arthur S. Hengerer, M.D., has been tasked with examining the issues of physician wellness and burnout from a regulatory perspective, identifying key patient safety issues, and determining ways in which member boards can be supported.

The Workgroup's charge includes identifying resources and strategies to address physician burnout. In accomplishing its charge, the Workgroup focused on: 1) educating state medical boards and physicians through the creation of a compendium of research and resources on identifying, managing and preventing physician burnout; 2) raising awareness about the prevalence of burnout among physicians and other health care professionals and thereby reducing stigma associated with seeking help for burnout symptoms; 3) evaluating current research on the impact of physician burnout on patient care; and 4) convening stakeholder organizations and experts to discuss physician wellness and recommend best practices for identifying, managing and preventing physician burnout throughout the career continuum.

Over the course of two years, the Workgroup examined the issue of physician burnout from a broad perspective, reviewing existing research, resources, and strategies for addressing it. The Workgroup has drafted a report that includes recommendations, most of which pertain to the licensing and license renewal processes of state medical boards, as well as suggestions for external organizations that aim to address physician burnout. Workgroup members include Mohammed A. Arsiwala, MD; Amy Feitelson, MD; Doris C. Gundersen, MD; Kathleen Haley, JD; Brian J. Miller, MD; Roger M. Oskvig, MD; Michael R. Privitera Jr., MD; Jean L. Rexford; Dana C. Shaffer, DO; Scott A. Steingard, DO; and Barbara E. Walker, DO.

A draft of the report was distributed to FSMB member boards in December 2017, as well as to several external organizations and individuals with a nexus to physician wellness and burnout. Comments received were generally positive and the Workgroup has revised its Report to address them, where appropriate. The FSMB Board of Directors considered the draft *Report of the FSMB Workgroup on Physician Wellness and Burnout* at its meeting on February 7, 2018 in Washington D.C. and discussed clarifications to the document.

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 Wellness and Burnout*, and the remainder of the Report be filed.

Attachment 1

FSMB Workgroup on Physician Wellness and Burnout

Draft Report and Recommendations

Executive Summary:

The Federation of State Medical Boards (FSMB) Workgroup on Physician Wellness and Burnout was convened in April of 2016 by FSMB Chair Arthur S. Hengerer, M.D. to identify resources and strategies to address physician burnout.

While the Workgroup examined the issue of physician burnout from a broad perspective, reviewing as many facets of this complex issue as possible, including existing research, resources, and strategies for addressing it, the recommendations for state medical and osteopathic boards (hereinafter referred to collectively as "state medical boards") found in this report focus first and foremost on the licensing process. The Workgroup also saw fit to include commentary and recommendations on several other aspects of physician wellness and burnout, though some of these areas may not be under the direct purview of the FSMB or its member boards. The FSMB recognizes the importance of collaboration for effectively supporting physicians and protecting patients in the face of circumstances that lead to burnout, which is ultimately a patient safety issue. A shared accountability model that includes responsibilities to be carried out by providers from all the health professions, including physicians and physician assistants, and with organizations from across the health care community is therefore recommended as the most promising course of action to address this important issue.

Recommendations for state medical boards related to the licensing process include considering whether it is necessary to include probing questions about a physician applicant's mental health, addiction, or substance use on applications for medical licensure or their renewal, and whether the information these questions are designed to elicit, ostensibly in the interests of patient safety, may be better obtained through means less likely to discourage treatment-seeking among physician applicants.

Where member boards strongly feel that questions addressing the mental health of physician applicants must be included on medical licensing applications, several recommendations are included in this report for the appropriate phrasing of such questions, including focusing only on current impairment, which may be more meaningful in the context of a physician's ability to provide safe care to patients in the immediate future.

State medical boards are also encouraged to approach physician wellness and burnout from a non-punitive perspective, avoiding public disclosure of any information about a physician's diagnosis during licensing processes and offering "safe haven" non-reporting options (mentioned later in this report) to physicians

who are under treatment and in good standing with a recognized physician health program (PHP) or other appropriate care provider.

It is also recommended that boards take advantage of all opportunities available to them to discuss physician wellness, communicate regularly with licensees about relevant board policies and available resources, and make meaningful contributions to the ongoing national dialogue about burnout in order to advance a positive cultural change that reduces the stigma among and about physicians seeking treatment for mental, behavioral, physical or other medical needs of their own.

The Workgroup's recommendations to external organizations and stakeholders focus on increasing the awareness and availability of information and resources for addressing physician burnout and improving wellness. The value of noting and listing the availability of accessible, private, confidential counselling resources is a particular point of emphasis in this report, as is dedicating efforts to ensuring that any new regulation, technology, or initiative is implemented with due consideration to any potential for negative impact on physician wellness.

This report, which follows two years of careful study, evaluation and discussion by Workgroup members, FSMB staff, and various stakeholders, is intended to support initial steps by the medical regulatory community to begin to address the issues associated with promotion of physician wellness and mitigation of burnout, to the extent that is possible. The information and recommendations contained herein are based on principles of fairness and transparency, and grounded in the primacy of patient safety. They emphasize a responsibility among state medical boards to work to ensure physician wellness as a component of their statutory right and duty to protect patients.

Background and Charge:

In 2014, the Ethics and Professionalism Committee of the Federation of State Medical Boards (FSMB) engaged in several discussions about the risks to patient safety that may result from disruptive physician behavior. As these discussions proceeded, it became apparent from a review of the literature and discussions with state medical boards that a link exists between many instances of disruptive behavior and symptoms of professional burnout experienced by so-called "disruptive physicians." The Committee, chaired by Dr. Janelle A. Rhyne, M.D., MACP, determined that further research into physician health, self-care, and burnout should be conducted to identify resources that may be of value for state medical boards and physicians alike, and to outline possible roles for the FSMB and its partners to better promote patient safety and quality health care.

Given the complexity of the issue and the many factors contributing to physician burnout, in 2016, Dr. Arthur S. Hengerer, MD, (while serving as Chair of the FSMB), established the FSMB Workgroup on Physician Wellness and Burnout to study the

issue further. The Workgroup was specifically charged with identifying resources and strategies to address physician burnout. To accomplish its charge, the Workgroup reported that it would engage in a multi-part work program that would likely involve: 1) educating state medical boards and physicians through the creation of a compendium of research and resources on identifying, managing and preventing physician burnout; 2) raising awareness about the prevalence of burnout among physicians and other health care professionals, helping reduce the stigma sometimes associated with physicians seeking help for burnout symptoms; 3) evaluating current research on the impact of physician burnout on patient care; and 4) convening stakeholder organizations and experts to discuss physician wellness and to recommend best practices for promoting physician wellness and helping physicians identify, manage and prevent burnout throughout their career continuum (i.e. from medical school through residency training and throughout their years of licensed, unsupervised practice.)

The purpose of this report is to summarize the steps taken by the Workgroup in fulfilment of their charge, to share information gathered as part of this process, and to provide a series of recommendations for state medical boards and others to consider for addressing burnout and its symptoms. It should be noted that the Workgroup's charge does not include tasks related to defining the phenomenon of burnout or performing further analysis into the concept itself, as it was felt there is a significant amount of valuable research that has already been done in these areas and is ongoing. Much of this research, including some that is inchoate, was reviewed by the Workgroup in fulfilment of the third component of its charge. This body of research is referenced herein and informs many of the recommendations contained in this report. While burnout is a phenomenon that may impact physicians at all stages of their career, it should be noted that the recommendations specific to state medical boards in this report focus primarily on the licensing process. The Workgroup feels it is also important, however, to share information in this report related to issues beyond the licensing process. Such additional information and guidance is provided for the benefit of relevant partner organizations and stakeholders responsible for undergraduate, graduate and continuing medical education; medical school, residency training and health facility accreditation; governance, information technology, health insurance, and other activities and functions that support the provision of health care to the nation's citizens.

In developing the content and recommendations of this report, the Workgroup understands and endorses the importance of the "quadruple aim," which added a call for improvements in the quality of work lives of physicians and other health care providers[1] to the existing three aims of improving the health of populations, enhancing the patient experience of care, and reducing the per capita cost of health

[1] Bodenheimer T, Sinsky C (2014), From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *Ann Fam Med*, 12 (6): 573-576.

care.[2] As argued by proponents of the fourth aim, improved population health cannot be achieved without ensuring the health and well-being of health care providers.

Several definitions have been applied to the phenomenon of physician burnout and, for the purposes of this report, it is considered a psychological response that may be experienced by doctors exposed to chronic situational stressors in the health care practice environment. This is characterized by overwhelming exhaustion, feelings of cynicism and detachment from work, and a sense of ineffectiveness and lack of accomplishment.[3] While burnout's manifestations and consequences vary widely, they could result in significant harm to patients.

It has been widely reported for more than a decade that nearly 100,000 preventable medical errors occur in the United States each year.[4] More recent findings suggest that between 210,000 and 400,000 deaths each year are associated with preventable harm.[5] Many of these errors may be attributed to physician burnout and its drivers, such as excessive caseloads, negative workplace culture, poor work-life balance, or perceived lack of autonomy in one's work.[6] Burnout affects a significant proportion of the U.S. physician workforce. A 2012 study conducted by Shanafelt and colleagues showed that 45.5% of surveyed physicians demonstrated at least one symptom of burnout.[7] When this study was repeated three years later with a different sample, the authors demonstrated that burnout and work-life dissatisfaction had increased by 9% over the three year period.[8] In addition to obvious risks to patient safety, an alarming and extreme result of physician burnout has been the disproportionate (relative to the general population) levels of suicide

[2] Berwick DM, Nolan TW, Whittington J. (2008). The Triple Aim: care, health, and cost. *Health Aff* (Millwood), 27(3):759–69.

[3] Maslach, C., Jackson, S.E. (1981). The Measurement of Experienced Burnout. *Journal of Occupational Behavior*, 2(2):99-113. See also, Maslach C, Jackson SE, Leiter MP. *(*1996). *Maslach Burnout Inventory Manual. 3rded*. and Maslach C, et al. (2001). Job Burnout. *Annu Rev Psychol*, 52:397–422.

[4] Kohn LT, Corrigan J, Donaldson MS. (2000). To Err Is Human: Building a Safer Health System. Washington, DC: National Academies Press (US).

[5] James JT. (2013). A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care. *Journal of Patient Safety***,** 9(3):122-128.

[6] Shanafelt TD, Noseworthy JH. (2016). Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc*, 92:129-146.

[7] Shanafelt TD, et al. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine*, 172(18):1377-1385.

[8] Shanafelt TD, Hasan O, Dyrbye L, et al. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc,* 90:1600-1613.

in recent years by physicians, medical residents and even medical students.[9,10] One is hard-pressed to find a phenomenon that negatively affects a broader array of stakeholders in health care than burnout. It impacts providers from all health professions. State medical boards' duty to protect the public, in this regard, also includes a responsibility to ensure the wellness of its licensees.

Features and Consequences of Burnout:

Physicians experiencing burnout, according to the medical literature, exhibit a wide array of signs, symptoms and related conditions, including fatigue, loss of empathy, detachment, depression, and suicidal ideation. The three principal components of burnout are widely described in the medical literature as emotional exhaustion, depersonalization, and diminished feelings of personal accomplishment.[11] Many of these symptoms are also said to be linked to low levels of career satisfaction.

Career satisfaction may be diminished by even a single influencing factor. Unreasonable increases in workload, for example, may quickly lead to dissatisfaction with one's career. Loss of job satisfaction has been noted as both a primary contributor to burnout as well as a contributor to its further progression.[12] Burnout has specifically been found to be the single greatest predictor of surgeons' satisfaction with career and choice of specialty.[13] It may also be a significant contributor to increased rates of suicidal ideation among both physicians[14] and medical students.[15]

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[9] Rubin R. (2014). Recent Suicides Highlight Need to Address Depression in Medical Students and Residents. *JAMA,* 312(17):1725-1727.
[10] Gold KJ, Sen A, Schwenk TL. (2013). Details on suicide among US physicians: data from the National Violent Death Reporting System. *Gen Hosp Psych,* 35:45-49.
[11] Maslach C, Schaufeli WB, Leiter MP. (2001). Job burnout. *Annual Review of Psychology,* 52:397-422.
[12] Mirvis DM, Graney MJ, Kilpatrick AO. (1999). Burnout among leaders of the Department of Veterans Affairs medical centers: contributing factors as determined by a longitudinal study. *J Health Hum Serv Adm,* 21:390-412, and Mirvis DM, Graney MJ, Kilpatrick AO. (1999). Trends in burnout and related measures of organizational stress among leaders of Department of Veterans Affairs medical centers. *J Healthc Manag*, 44(5):353-365. (Via Chopra SS. (2004). JAMA, 291(5):633).

[13] Shanafelt TD, et al. (2009). Burnout and Career Satisfaction among American Surgeons. *Annals of Surgery*, 250(3):463-471.
[14] Shanafelt TD, Balch CM, Dyrbye LN, et al. (2011). Suicidal ideation among American surgeons. *Arch Surg*, 146:54-62.
[15] Schwenk TL, Davis L, Wimsatt LA. (2010). Depression, stigma, and suicidal ideation in medical students. *JAMA*, 304(11): 1181-1190.

Physicians experiencing manifestations of burnout are also reported to be more prone to engage in unprofessional behavior,[16] commit surgical or diagnostic medical errors,[17,18,19] and lose the trust[20] of their patients, while also decreasing their satisfaction.[21] At a time when there is compelling evidence of a shortage of qualified practicing physicians in many parts of the United States, losing additional physicians to early or unnecessary retirement would have a detrimental impact on patient access to care across the country. As the American Medical Association's Policy on Physician Health and Wellness states, "When health or wellness is compromised, so may be the safety and effectiveness of the medical care provided."[22]

Factors Contributing to Burnout:

While a large proportion of physicians are said to experience burnout and its correlates, they do not always experience it in the same way or for the same reasons. Physicians may be predisposed to burnout because of personality traits that led them to pursue a medical career in the first place, such as perfectionism, self-denial, and compulsiveness. These are traits that are said to be common among practicing physicians. Predisposition to burnout may be stronger in instances where personal factors such as denial of personal vulnerability, tendencies to delay gratification, or excess feelings of guilt are layered onto these aforementioned personality traits. While burnout is a distinct phenomenon from mental illness and substance use disorders, the latter two issues can play a compounding role in a

[16] Dyrbye LN, Massie FS, Jr., Eacker A, et al. (2010). Relationship between burnout and professional conduct and attitudes among US medical students. *JAMA,* 304: 1173-1180.

[17] Privitera MR, et al. (2015). Physician Burnout and Occupational Stress: An inconvenient truth with unintended consequences. *Journal of Hospital Administration*, 4(1).

[18] Shanafelt TD, Balch CM, Bechamps G, et al. (2010). Burnout and medical errors among American surgeons. *Ann Surg,* 251:995-1000.

[19] West CP, Huschka MM, Novotny PJ, et al. (2006). Association of perceived medical errors with resident distress and empathy: a prospective longitudinal study. *JAMA*, 296(9):1071-1078.

[20] Haas JS, Cook EF, Puopolo AL, Burstin HR, Cleary PD, Brennan TA. (2000). Is the professional satisfaction of general internists associated with patient satisfaction? *J Gen Intern Med*, 15(2):122-128.

[21] Anagnostopolous F, Liolios E, Persefonis G, Slater J, Kefetsios K, Niakas D. (2012). Physician burnout and patient satisfaction with consultation in primary health care settings: evidence of relationships from a one-with-many design. *J Clin Psychol Med Settings*. 19(4):401-410.

[22] *Code of Medical Ethics*, (2016). American Medical Association, Opinion 9.3.1.

physician's struggle with burnout, making the identification and effective treatment of its symptoms or causes even more difficult.[23]

It is a common misconception that physicians are more susceptible to suffering from burnout at later stages in their career, presumably from fatigue and aging. In fact, research has demonstrated that physicians in the middle of their careers are at the highest risk for burnout.[24] Education and training also appear to be critical peak times for physicians, physicians-in-training or medical students to suffer from burnout.[25,26]

The environment in which physicians work, including their choice of specialty, also plays a significant role in contributing to burnout. Shanafelt and colleagues have shown substantial differences in burnout rates by specialty, although changes in the highest and lowest rates were noted between 2011[27] and 2014.[28] The control, or lack thereof, that physicians have over their work environment plays a significant role in predisposition to burnout. This may explain why emergency medicine is frequently found at or near the top of the list of medical and surgical specialties with the highest proportion of physicians experiencing burnout. Emergency physicians often work in environments that are high-demand and low-control.[29] While finding meaning in one's work has long been claimed to be the antidote to burnout,[30] it may be difficult to find such meaning absent an adequate degree of control over one's work environment.

The movement towards maximal standardization of processes, often labeled a phenomenon of "deprofessionalization," is also claimed to be a contributor to burnout among physicians. There is worry among some professionals, in medicine and other health care fields, that an expectation for rigid adherence to guidelines

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[23] Oreskovich M, Kaups K, Balch C, et al. (2011). The prevalence of alcohol use disorders among American surgeons. *Arch Surg*, 147:168-174.

[24] Dyrbye LN, et al. (2013). Physician satisfaction and burnout at different career stages. *Mayo Clinic Proceedings*, 88(12):1358-1367.

[25] Dyrbye LN, Shanafelt TD. (2016). A narrative review on burnout experienced by medical students and residents. Med Educ, 50:132-149.

[26] Dyrbye LN, et al. (2014). Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Academic Medicine*, 89(3):443-451.

[27] Shanafelt TD, et al. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine,* 172(18):1377-1385.

[28] Shanafelt TD, Hasan O, Dyrbye L, et al. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc,* 90:1600-1613.

[29] https://www.medpagetoday.com/emergencymedicine/emergencymedicine/54916

[30] Sotile W. (2002). *The Resilient Physician*.

will replace what were formerly considered the more elegant, artistic and satisfying aspects of medical practice.[31] These movements need not be perceived as threats to physician autonomy or to the exercise of professional judgment. Rather, embracing evidence-based medicine, focusing on the value of care that is provided, and celebrating increasingly positive outcomes can contribute to great improvements in patient and population health. Professional judgment will continue to play an important role in realizing these improvements.

Frustrations have also been voiced in relation to the move in health care delivery away from paper-based records to electronic health records (EHRs). Many physicians have expressed dissatisfaction with the intrusiveness and complexity of EHR use and the limits this sometimes places on the ways in which they are able and capable of effectively documenting treatment decisions and provision of care.[32] These frustrations exist in addition to those related to the often complex, redundant, or non-intuitive methods of data entry and other elements of medical record keeping associated with EHRs,[33,34,35] as well as the fact that most systems are not yet fully interoperable. However, complaints made about particular aspects of an evolving or disruptive technology should not be interpreted as calls to abandon the important gains in patient safety, professional communication, and even efficiency that have been brought about by the introduction and implementation of EHR systems. Rather, they should be interpreted as important user feedback that may contribute to ongoing improvement of such technology.

The constantly changing and evolving nature of medicine, as well as the challenges faced by the American health care system itself, also appear to be affecting the way many physicians feel within their professional roles. A recent study reported that 65% of physicians who were surveyed predicted an ongoing deterioration in the quality of health care that they deliver, which in turn has been attributed, in part, to the erosion of physician autonomy.[36] When evolving requirements are layered onto

[31] Aasland OG. (2015). Healthy Doctors – Sick Medicine. *Professions and Professionalism*, 5(1).
[32] Friedberg MW, et al. (2013). Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. RAND Corporation, https://www.rand.org/pubs/research_reports/RR439.html.
[33] Arndt BG, et al. (2017). Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations. *Ann Fam Med*, 15(5):419-426.
[34] Levinson J, Price BH, Saini V. (2017). Death By A Thousand Clicks: Leading Boston Doctors Decry Electronic Medical Records. Common Health, http://www.wbur.org/commonhealth/2017/05/12/boston-electronic-medical-records.
[35] Sinsky C, et al. (2016) Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. *Ann Intern Med*. 165:753-760.
[36] Emanuel EJ, Pearson SD. (2012). Physician autonomy and health care reform. *Journal of the American Medical Association*, *307*(4), 367-368.

new expectations with regard to technology, quality reporting, increased clinical volume, and numerous other initiatives required by payers, employers, and even state medical boards, it may not be surprising that physicians are experiencing burnout at alarming rates. While many of the initiatives that place additional burdens on physicians are grounded in strong rationales related to patient safety and quality care, the burnout resulting from their combined effect may actually inhibit the success of the initiatives themselves.[37] This should certainly bring pause to those charged with implementing initiatives and requirements to carefully evaluate their effectiveness, unintended consequences, and potential burden, but also to communicate their goals and perceived value. The reaction of the profession to the ongoing changes that are occurring may also indicate particular attitudes within the culture of medicine that would benefit from further discussion, as would support to integrate positive change into practice.

Burnout is not always related to stressors arising in a physician's work environment or to a physician's character traits. Family issues, personal and professional relationships, financial pressures, insufficient work-life balance, or other external stressors may also contribute to burnout. Efforts aimed at the identification, treatment, or prevention of burnout must, therefore, approach the issue from a broad enough perspective to take all of these factors into account.

Challenges and Barriers to Addressing Burnout:

While there has been a promising rise in the number of peer-reviewed research publications addressing the topic of physician burnout, in the academic medical literature, popular media and so-called gray literature (e.g., white papers, position statements, organizational reports), there seems to be a perceived lack of resources available to identify and address the issue. This perception may be misguided, however, since several academic institutions, health systems, medical specialty societies, independent physicians, physician health programs, and state medical boards make many useful, high-quality resources available (See Appendix A.). While more resources would be beneficial to physicians, and ultimately their patients, their development should be complemented with efforts aimed at highlighting best practices. Research is also needed to identify how sources of burnout might differ for male and female physicians in order that resources may be appropriately tailored. A more coordinated effort to raise awareness not only about the issue of physician burnout but also about resources for ameliorating related circumstances may also serve to reduce stigma and facilitate identification and treatment. It may also help improve systems issues that impact burnout by improving communication, team building, and collaboration within and among health care professions. Broader

[37] Dyrbye LN, Shanafelt TD. (2011). Physician Burnout: A Potential Threat to Successful Health Care Reform. *JAMA 305(19):2009-2010*.

awareness may also better equip physicians in their capacity as leaders to improve circumstances for those with whom they work.[38]

Many physicians are reluctant to seek help for burnout or any of its many underlying causes for fear that they will be perceived as weak or unfit to practice medicine by their colleagues or employers, or because they assume that seeking such care may have a detrimental effect on their ability to renew or retain their state medical license, arguably the most important credential a physician receives during their professional career.[39,40,41,42,43] This stigma may be felt as early as medical school,[44] a particularly dangerous cultural feature in a population where symptoms of anxiety and depression have been found to be more prevalent than in the general population.[45] In a study by Dyrbye and colleagues, it was found that only a third of the medical students experiencing features of burnout sought help and that stigma was seen as a barrier for those who chose not to seek help.[46] The same reluctance is seen with respect to help-seeking for other types of stigmatized suffering such as depression, substance use disorders, or suicidal ideation.[47] Without adequate modeling of appropriate self-care behaviors among faculty mentors, progress at stigma reduction will likely be slow. Further, while there are laudable examples of programs at academic medical centers across the country which responsibly offer

[38] Shanafelt TD, et al. (2015). Impact of Organizational Leadership on Physician Burnout and Satisfaction, *Mayo Clinic Proceedings*, 90(4):432-440.
[39] Chew-Graham CA, et al. (2003). 'I wouldn't want it on my CV or their records': medical students' experiences of help-seeking for mental health problems. *Medical Education*, 37(10):873–880.
[40] Federation of State Medical Boards. (2011). Policy on Physician Impairment.
[41] Guille C, et al. (2010). Utilization and Barriers to Mental Health Services Among Depressed Medical Interns: A Prospective Multisite Study, *Journal of Graduate Medical Education*, 2(2):210-214.
[42] Gold K, et al. (2016). "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *General Hospital Psychiatry,* 43:51–57.
[43] Dyrbye LN, et al. (2017). Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*, 92(10):1486-1493.
[44] Schwenk TL, et al. (2010). Depression, Stigma, and Suicidal Ideation in Medical Students. *JAMA,* 304(11):1181-1190.
[45] Rotenstein LS, Ramos MA, Torre M, et al. (2016). Prevalence of depression, depressive symptoms, and suicidal ideation among medical students, a systematic review and meta-analysis. *JAMA,* 316(21):2214-2236.
[46] Dyrbye LN, et al. (2015). The Impact of Stigma and Personal Experiences on the Help-Seeking Behaviors of Medical Students with Burnout. *Academic Medicine*, 90(7):961-969.
[47] Dyrbye LN, et al. (2017). Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*, 92(10):1486-1493.

accessible, complementary, private, and confidential counselling to medical students,[48] these programs are by no means widely available.

Privacy and confidentiality of a physician's health and treatment history is important to allow those in need of help to come forward without fear of punishment, disciplinary action, embarrassment or professional isolation. The use of confidential services whenever possible in lieu of regulatory awareness is preferred in order to mitigate fear of negative impacts on licensure, employment, or collegial relationships. When confidential services are not utilized, it is less likely licensees will receive early intervention and appropriate treatment, thereby foregoing opportunities for early detection of potentially impairing illness or recovery.

Funding for important programs and initiatives such as those identified above is often difficult to obtain. However, there is a growing body of research that identifies the cost savings for hospitals and employers associated with providing them, particularly when costs associated with medical errors and lower quality of care attributed to burnout are mitigated, as are high turnover rates, absenteeism, and loss of productivity.[49]

Another challenge to identifying and addressing burnout is the fact that the associated stigma may reduce the degree to which the phenomenon itself is discussed. This impacts not only a physician's own willingness to discuss or seek help for burnout, but also the willingness of fellow physicians to address or report instances of impairment among their colleagues, especially that which unduly risks the safety of patients. While the duty to report impairment or incompetence and the duty to encourage help-seeking may seem to conflict, in that a fear of being reported could cause a physician to conceal problems and avoid help, the duty to report is actually based on principles of patient safety and ethics. The duty to report also aims to assist physicians in seeking the help they need in order to continue practicing safely.

In addition to the cultural stigma associated with admitting experiences of burnout, recent research has shed light on the potential impact of licensure and license renewal processes of state medical boards that may discourage treatment-seeking

[48] Examples include the HEAR Program at UC San Diego (available to everyone at the UCSD Health System, not only medical students), the Henderson Student Counseling Center at Nova Southeastern University, the Wellness Resources offered at Oregon Health and Science University, and the Medical Student Counseling and Wellness Center at the Herbert Wertheim College of Medicine, Florida International University.

[49] Shanafelt T, Goh G, Sinsky C. (2017). The Business Case for Investing in Physician Well-Being. *JAMA Intern Med*. 177(12):1826-1832.

among physicians.[50,51] State medical boards may inadvertently discriminate unfairly against physicians suffering from mental illness or substance use disorders, or against those who choose to take a leave of absence from practice to prevent or recover from burnout. The very presence of application questions for medical licensure or licensure renewal may stigmatize those suffering from mental and behavioral illnesses for which physicians might otherwise seek care. In fact, questions about substance abuse and mental illness on state medical licensure renewal applications have nearly doubled between 1996 and 2006.[52] While information about a physician's health status (both mental and physical) may be essential to a state medical board's solemn duty to protect the public, the FSMB has previously noted that a history of mental illness or substance use does not reliably predict future risk to the public.[53] It is also very important to recognize that court interpretations of the Americans with Disabilities Act (ADA) have suggested that state medical boards should focus on current functional impairment rather than a history of diagnoses or treatment of such illness.[54]

In carrying out their duty to protect the public and ensure that only individuals who are fully qualified to practice medicine are granted licenses, state medical boards usually, and for good reasons, insist that they must have sufficient information with which to make medical licensure decisions. During the licensure granting process, state boards also work diligently to ensure that candidates for licensure (or renewal) provide a thorough assessment of their fitness to practice, balanced by protecting their rights as contained in ADA legislation. Fear among prospective and current licensees about potential limitations placed on their ability to practice medicine independently, however, or of their previous diagnoses or treatments somehow being made public despite HIPAA and other federal privacy and confidentiality laws, may cause some physicians to misrepresent personal information that is requested or not respond accurately at all to licensing application questions.[55] In such instances, paradoxically, the efforts of state medical boards to get comprehensive information may not yield the accurate information

[50] Gold K, et al. (2016). "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *General Hospital Psychiatry,* 43:51–57.
[51] Dyrbye LN, et al. (2017). Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*, 92(10):1486-1493.
[52] Polfliet SJ. (2008). A National Analysis of Medical Licensure Applications. *J Am Acad Psychiatry Law*, 36(3): 372.
[53] Federation of State Medical Boards. (2006). Federation of State Medical Boards: Americans With Disabilities Act of 1990. License Application Questions: A Handbook for Medical Boards.
[54] Polfliet SJ. (2008). A National Analysis of Medical Licensure Applications. *J Am Acad Psychiatry Law*, 36(3):373.
[55] Gold K, et al. (2016). "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *General Hospital Psychiatry,* 43:51–57.

they seek about a physician's practice risks to patients. They may also discourage treatment-seeking among physicians, thereby increasing the degree of risk to patients presented by physicians experiencing conditions that remain undiagnosed or untreated.

Recommendations:

The majority of the recommendations that follow are designed for state medical boards to consider and pertain mainly to the inclusion and phrasing of questions on state medical licensing applications. Appropriately addressing the issue of physician burnout provides a unique opportunity for state medical boards to declare, directly or indirectly, that it is not only normal but anticipated and acceptable for a physician to feel overwhelmed from time to time and to seek help when appropriate. This is also an important opportunity for state medical boards to highlight and promote the benefits of physician health, both mental and physical, to help reduce stigma, to clarify related regulatory and reporting issues, promote patient safety and assure the delivery of quality health care. Physicians should feel safe about reporting burnout and be able to take appropriate measures to address it without fear of having their licensure status placed in jeopardy.

Safeguarding physician wellness and mitigating damage caused by burnout cannot be accomplished through isolated actions and initiatives by individual organizations alone. Coordinated efforts and ongoing collaboration will be essential not only for addressing the many systemic issues that contribute to burnout but also for ensuring that appropriate tools, resources, and programs are continuously in place and readily available to help physicians avoid and address burnout. As such, the FSMB also offers suggestions and recommendations to its partner organizations, many of which have been instrumental in furthering the FSMB's current understanding of burnout, its related features, and the role of the regulatory community in addressing and safeguarding physician health.

Ultimately, the Workgroup and the FSMB believe that a shared accountability model that includes several related responsibilities among regulatory, educational, systemic, organizational, and administrative stakeholders provides a promising way forward. The specific recommendations outlined below begin to address what such responsibilities should entail.

The FSMB recognizes its responsibility to help address physician burnout, not only through following its own recommendations and promoting the resources provided in this report, but also by continuing its collaborative efforts with partner organizations from across the wider health care community.

For State Medical Boards:

1. The FSMB recommends that state medical boards review their medical licensure (and renewal) applications and **evaluate whether it is necessary to include probing questions about a physician applicant's mental health, addiction, or substance use**, and whether the information these questions are designed to elicit in the interests of patient safety may be obtained through means that are less likely to discourage treatment-seeking among physician applicants. For example, some boards subscribe to notification services such as the National Practitioner Data Bank's "Continuous Query" service or other data services that provide information about arrests or convictions, including for driving under the influence, within their states which can serve as a proxy finding for physician impairment. The FSMB also recommends in its *Essentials of a State Medical and Osteopathic Practice Act* that boards require applicants to satisfactorily pass a criminal background check as a condition of licensure.[56]

2. Where state medical boards strongly feel that questions addressing the mental health of physician applicants must be included on medical licensing applications, they should **carefully review their applications to ensure that appropriate differentiation is made between the illness with which a physician has been diagnosed and the impairments that may result**. Application questions must focus only on current impairment and not on illness, diagnosis, or previous treatment in order to be compliant with the Americans with Disabilities Act (ADA).

3. The ADA requires licensure application questions to focus on the presence or absence of current impairments that are meaningful in the context of the physician's practice, competence, and ability to provide safe medical treatment to patients. **Applications must not seek information about impairment that may have occurred in the distant past and state medical boards should limit the time window for such historical questions to two years or less, though a focus on the presence or absence of current impairment is preferred.**

   Questions that address the mental health of the applicant should be posed in the same manner as questions about physical health, as there is no distinction between impairment that might result from physical and mental illness that would be meaningful in the context of the provision of safe treatment to patients.

   Where boards wish to retain questions about the health of applicants on licensing applications, **the FSMB recommends that they use the language**

[56] Federation of State Medical Boards. (2015). *Essentials of a State Medical and Osteopathic Practice Act.*

recommended by the American Psychiatric Association:
"*Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?* (Yes/No)"[57,58]

4. **The FSMB recommends that state medical boards consider offering the option of "safe haven non-reporting" to applicants for licensure who are receiving appropriate treatment for mental health or addiction**. While it is up to boards to determine what constitutes appropriate treatment, the FSMB recommends that physicians who are monitored by, and in good standing with, the recommendations of a state or territorial Physician Health Program (PHP) be permitted to apply for medical licensure or license renewal without having to disclose their diagnosis or treatment to the board. The option of safe haven non-reporting should only be offered when treatment received is commensurate with the illness being treated and has a reasonable chance of avoiding any resultant impairment.

5. **State medical boards should work with their state legislatures to ensure that the personal health information of licensees related to an illness or diagnosis is not publicly disclosed as part of a board's processes**. Information disclosed must relate only to impairment of professional abilities, medical malpractice, and professional misconduct.[59]

6. **State medical boards should emphasize the importance of physician health, self-care, and treatment-seeking for all health conditions by including a statement to this effect on medical licensing applications, state board websites, and other official board communications**. Where appropriate, options for treatment and other resources should be made available, such as information about a state Physician Health Program (PHP), services offered through a county, state, or national medical society, and any other relevant programs. These means of communicating the importance of physician health and self-care are aimed at helping physicians with relevant information and resources but could also help raise awareness among patients of the importance of physician wellness and the threat of burnout to their doctors and their own care.

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[57] American Psychiatric Association. (2015). Position statement on inquiries about diagnosis and treatment of mental disorders in connection with professional credentialing and licensing.

[58] The American Psychiatric Association (APA) passed an Action Paper in November 2017, resolving to query state medical boards and notify them about their compliance with APA policy and the ADA.

[59] Center C, Davis M, Detre T, et al. (2003). Confronting depression and suicide in physicians: a consensus statement. *JAMA*, 289(23):3161–3166.

7. **State medical boards should clarify through communications, in print and online, that an investigation is not the same as a disciplinary undertaking**. Achieving an understanding of this distinction among licensees may help begin to dispel the stigma associated with reporting burnout and remove a barrier to physicians seeking help in times of need.

8. **State medical boards are encouraged to maintain or establish relationships with a PHP in their state and to support the use of data from these programs in a board's decision-making**.

9. **State medical boards should examine the policies and procedures currently in place for working with physicians who have been identified as impaired in a context that is meaningful for the provision of safe care to patients to ensure that these are fair, reasonable, and fit for the purpose of protecting patients. All such processes should be clearly explained and publicly available.**

10. **State medical boards should be aware of potential burdens placed on licensees by new or redundant regulatory requirements**. They should seek ways of facilitating compliance with existing requirements to support licensees and ensure that they are able to spend time with patients and in those areas of medicine which they find most meaningful. "Reducing the cumulative burden of rules and regulations may improve professional satisfaction and enhance physicians' ability to focus on patient care."[60]

Upon implementing some or all of the above changes to state medical board policy or processes that are meant to reduce the stigma associated with mental health issues and encourage treatment-seeking, the board should communicate these, and their rationale, to current and prospective licensees, as well as patients and the public. State medical boards should also raise the issue of physician burnout more often, emphasizing the importance of physician wellness, help-seeking, and the availability of accessible, confidential, and private counselling programs for physicians and all health professionals.

For External Stakeholders and Partner Organizations:

Professional Medical Organizations and Societies:

11. Professional medical societies at local, state, and national levels have a key role to play in encouraging physicians to seek treatment, both preventive

[60] Friedberg MW, et al. (2013). Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. RAND Corporation, https://www.rand.org/pubs/research_reports/RR439.html.

and curative, for the physical and mental health issues they face, as well as for features of burnout. The FSMB recognizes the many exemplary programs and initiatives of professional medical societies and encourages their continued advocacy for physician wellness and the availability of support and treatment services.

12. The FSMB recommends a sustained focus in the medical profession on the importance of self-care with an aim to reduce the stigma attached with seeking treatment for health issues, particularly ones related to mental health.

13. The FSMB recommends that attempts be made to expand the availability of accessible, private, and confidential counseling for physicians through medical societies, such as those provided by organizations like the Lane County Medical Society (Oregon), which has a program with several features identified as best practices for physician wellness by the Workgroup. Counseling via telehealth could also enhance access and provide greater assurance of privacy to those seeking care.

14. Given the prevalence of burnout, all physicians need to be educated about the resources currently available regarding burnout, including those referenced in Appendix A, for self-awareness, and for identification and referral of peer professionals who may have burnout. Medical societies are encouraged to partner with other organizations identified in this report to improve awareness of resources and their dissemination.

15. The FSMB recommends that professional medical societies and organizations representing physicians, such as the American Medical Association, the American Osteopathic Association, and the Council of Medical Specialty Societies work with state medical boards to raise awareness among the public of the importance of physician wellness not only because of its inherent value to physicians themselves but also as a significant contributor to patient safety.

Centers for Medicaid and Medicare Services:

16. The FSMB recommends careful analysis of any new requirements placed on physicians to determine their potential impact on physician wellness. Any new requirements that could serve as a driver of burnout in physicians must be supported by evidence and accompanied by a strong rationale that is based in improving patient care to justify any new burdens imposed on physicians.

State Government, Health Departments, and Legislatures:

17. As state government, health departments, and legislatures make decisions that can impact physicians, the FSMB recommends that they weigh the potential value of proposed new regulations against potential risks to the health of physicians and other clinicians.

Vendors of Electronic Health Records (EHR) systems and standard setting organizations:

18. As a promising advancement in the provision and documentation of care, but also a key driver of frustration with medical practice, EHRs need to be improved in a way that takes the user experience into greater consideration than it does currently. This experience may be improved through facilitating greater ease of data entry into the system, as well as ease of access to data from the system. Vendors are encouraged to include end-user physicians on their builder teams to optimize input about operability and interoperability.

19. Efforts to reduce redundant or duplicative entry should be required by standard setting organizations, such as the Office of the National Coordinator for Health IT (ONC), and reflected in the EHR systems ultimately designed by vendors.

20. EHR vendors are encouraged to focus future improvements on facilitating and improving the provision of patient care. The primary purposes of an EHR relate to documentation of care received by a patient, retrieval of patient care related information and data, and patient communication.

Medical Schools and Residency Programs:

21. The FSMB encourages the Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, the American Medical Association, the American Osteopathic Association and the institutions they represent, to continue their laudable efforts at improving the culture of medicine and facilitating open conversations about illness and wellness in order to promote positive change.

22. The FSMB recommends continued efforts to encourage medical students and residents to value self-care and understand the positive impacts that physician wellness can have on patient care.

23. The FSMB recommends that medical schools, residency programs, and their accrediting bodies consider ways of amplifying the medical student and

resident voice on systemically induced pressures and support trainees by providing means for raising issues related to medical student and resident health and well-being anonymously.

Hospitals/Employers:

24. The FSMB recommends that hospitals revise, where necessary and appropriate, their questions asked as part of their credentialing process according to the recommendations made above for the medical licensing community to ensure that these are not discouraging physicians or other health professionals from seeking needed treatment.

25. The FSMB recommends that hospitals and health systems assess physician health at regular intervals using a validated instrument and act upon the results. Employers should keep results of these assessments internal to the organization or health system in order to promote workplace change, while avoiding threatening or punitive cultures.

26. Hospitals, as well as the American Hospital Association and related organizations, are encouraged to officially adopt the "Quadruple Aim" to demonstrate the importance they place in the health and wellness of the physicians and all other health professionals they employ and recognize the impact of provider health on safe patient care.

27. Hospitals should ensure that their policies and procedures are adopted with consideration given to the impact they have on the health of the hospital workforce. Decisions impacting hospital the health of hospital and health system employees should be made with adequate input from individuals representing the impacted sectors of that workforce.

28. While acknowledging the need for hospitals to acknowledge all staff in their programmatic development, employers are encouraged to make resources and programs available to physicians, including time and physical space for making connections with colleagues and pursuing personal goals that add meaning to physicians' work lives. Resources and programs should not always be developed and implemented in a "one size fits all" manner, but should incorporate consideration of the different stressors placed on male and female physicians, within and outside of the workplace, and be tailored appropriately. Resources related to EHR implementation and use should also be made available by employers, including training to optimize use and support for order-entry such as scribes or other technological solutions aimed at restoring time available to physicians.

29. Hospitals should ensure that mandatory reports related to physician competence and discipline are made available to state medical boards and other relevant authorities.

Insurers:

30. The FSMB recommends that insurance carriers revise, where necessary and appropriate, their questions on applications for professional liability insurance according to the recommendations made above for the medical licensing community to ensure that these are not discouraging physicians or other health professionals from seeking needed treatment.

31. In evaluating the quality of care provided by physicians, insurers should look beyond cost-saving measures and use metrics related to physician health and incentivize practice patterns that contribute to physician wellness.

Accrediting Organizations:

32. In its ongoing development of standards for the accreditation of undergraduate medical education programs, graduate medical education training programs, hospitals and healthcare facilities, the FSMB encourages those organizations charged with the accreditation of institutions and educational programs to include standards related to required resources and policies aimed at protecting medical student, medical resident and attending physician health.

Physicians:

33. Physician wellness is a complex issue, made up of system-wide and individual components. However, physicians have a responsibility to attend to their own health, well-being, and abilities in order to provide care of the highest standard.[61] This involves a responsibility to continually self-assess for indicators of burnout, discuss and support the identification of health issues with peers, and seek help or treatment when necessary. Physicians are encouraged to make use of services of state Physician Health Programs, which, where available, can be accessed confidentially in instances where patient harm has not occurred.

[61] General Assembly of World Medical Association at Geneva Switzerland. (1948). *Declaration of Geneva,* as amended by the WMA General Assembly, October 2017.

34. Physicians are encouraged to inform themselves about their ethical duty, oftentimes codified in state statutes, to report issues related to incompetence and unsafe care delivered by their peers. They are also encouraged to engage in open dialogue with peers about the importance of self-care, treatment-seeking, and the threats to themselves and their patients presented by burnout.

35. Physicians are also encouraged to seek an appropriate balance between time spent on practice and related work and activities external to work, particularly ones with restorative potential.

Conclusion

The duty of state medical boards to protect the public includes a responsibility to ensure physician wellness and to work to minimize the impact of policies and procedures that impact negatively on the wellness of licensees, both prospective and current. The rationale for this duty is based on the link between physician burnout and its intendant risks to patient safety, the fact that some regulatory processes employed by state medical boards can have negative impacts on the health and wellness of physicians themselves, and the potential for regulatory change to support physician wellness and help prevent further instances of burnout.

The information and recommendations in this Report of the FSMB's Workgroup on Physician Wellness and Burnout are meant to support initial steps in the medical regulatory community and to contribute to ongoing conversation about patient safety and physician health.

FSMB WORKGROUP ON PHYSICIAN WELLNESS AND BURNOUT

Arthur S. Hengerer, MD, FACS, Chair
Immediate Past-Chair, Federation of State Medical Boards

Mohammed A. Arsiwala, MD
Vice Chair, Michigan Board of Medicine

Amy Feitelson, MD
Former Member, New Hampshire Board of Medicine

Doris C. Gundersen, MD
Federation of State Physician Health Programs

Kathleen Haley, JD
FSMB Director-at-Large
Executive Director, Oregon Medical Board

Brian J. Miller
Individual Member

Roger M. Oskvig, MD
Former Chair, New York State Board for Medicine

Michael R. Privitera Jr., MD
University of Rochester Medical Center

Jean L. Rexford
FSMB, Director-at-Large
Board Member, Connecticut Medical Examining Board

Dana C. Shaffer, DO
Secretary Treasurer, National Board of Osteopathic Medical Examiners

Scott A. Steingard, DO
FSMB Director-at-Large
Past President, Arizona Board of Osteopathic Examiners in Medicine and Surgery

Barbara E. Walker, DO
President-elect, North Carolina Medical Board

EX OFFICIOS:

Gregory B. Snyder, MD, DABR
Chair, FSMB

Patricia A. King, MD, PhD, FACP
Chair-elect, FSMB

Humayun J. Chaudhry, DO, MS, MACP, MACOI
President and CEO, FSMB

STAFF SUPPORT:

Mark L. Staz, MA
Director, Continuing Professional Development, FSMB

APPENDIX A: SAMPLE RESOURCE LIST

The following list is offered as a sample of resources available to support and facilitate the understanding, diagnosis, treatment, and prevention of symptoms of burnout or to maintain and improve physician wellness. The FSMB has not conducted an in-depth evaluation of individual resources, and inclusion herein does not indicate, nor is it to be interpreted as, an endorsement or guarantee of quality. Further, while some resources listed below are available free of charge, others are only accessible through purchase.

Federation of State Medical Boards, Policy on Physician Impairment, 2011.

Federation of State Medical Boards: Americans With Disabilities Act of 1990. License Application Questions: A Handbook for Medical Boards. Dallas, TX: Federation of State Medical Boards of the United States, Inc., 2006.

The standard tool used to evaluate rates of burnout is the Maslach Burnout Inventory, developed in the 1980s by Christina Maslach, PhD, a psychologist at the University of California Berkeley.

The HappyMD.com – in particular, the burnout prevention matrix, 117 ways to prevent burnout

Accreditation Council for Graduate Medical Education – Physician Wellbeing Resources

American Academy of Family Physicians - Physician Burnout Resources Page:

American College of Emergency Physicians (ACEP) – ACEP Wellness Resource page

American College of Physicians – Resources on Physician Well-Being and Professional Satisfaction

American Medical Association Steps Forward website:

American Osteopathic Association – AOA Physician Wellness Strategy

Association of American Medical Colleges – Wellbeing in Academic Medicine

Federation of State Physician Health Programs

Mayo Physician Well-being Program:

National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience

Remembering the Heart of Medicine

Stress Management and Resiliency Training (SMART) program

SuperSmartHealth

The Studer Group

The Well-Being Index (Mayo Clinic)

Resolution 18-5

Federation of State Medical Boards
House of Delegates Meeting
April 28, 2018

Subject: Workgroup on Artificial Intelligence and its Potential Impact on Patient Safety and Quality of Care in Medical Practice

Introduced by: Pennsylvania State Board of Medicine

Approved: February 2018

Whereas, The Internet can gather large amounts of data from diverse sources that include but are not limited to electronic health records, digital images, and mobile apps; and

Whereas, Technology enables the compilation, storage, and processing of vast amounts of data to help identify clinically significant patterns and provide predictions; and

Whereas, Recent developments propel interest in healthcare AI, whether defined as "artificial intelligence," the ability of a computer to complete tasks in a manner typically associated with a rational human being, or "augmented intelligence," design that enhances human intelligence rather than replaces it; and

Whereas, Healthcare AI has been developed and applied to clinical decision support, treatment protocols, diagnostic recommendations, clinical prognostication, drug development, personalized medicine, patient monitoring, chronic care, and patient flow analytics; and

Whereas, Healthcare AI operates with variable levels of transparency, vetting, and oversight by experts and regulators; and

Whereas, Technology industry leaders and academic institutions have developed and implemented healthcare AI for radiology, pathology, oncology, ophthalmology, cardiology, and dermatology, and further applications are anticipated; [1-13] and

Whereas, Modern machine learning technology in healthcare AI can readily re-identify data sources posing a challenge to confidentiality of protected health information; [14] and

Whereas, Investment in healthcare AI is robust and a recent report from Markets and Markets pins the healthcare AI sector at nearly $8 billion in 2022, accelerating at a compound annual growth rate of 52.68 percent over the forecast period; [15, 16] and

Whereas, State medical boards should have an understanding of AI and its impact on medical practice;

Therefore, be it hereby

Resolved, That the Federation of State Medical Boards will convene a workgroup comprised of relevant stakeholders and subject matter experts including the American Medical Association to provide state medical boards with an understanding of AI and its potential impact on patient safety and quality of care in medical practice.

[1] IBM: *IBM Watson Health Closes Acquisition of Truven Health Analytics*. https://www- 03.ibm.com/press/us/en/pressrelease/49474.wss.

[2] ARS Technica. *IBM's Watson Proves Useful at Fighting Cancer-Except in Texas.* https://arstechnica.com/science/2017/02/ibms-watson-proves-useful-at-fighting-cancer-except-in-texas/.

[3] Xconomy: *Microsoft's Strategy for Finding What's Next in Healthcare AI.* https://www xconomy.com/seattle/2017/11/08/microsofts-strategy-for-finding-whats-next-in-healthcare-a-i/.

[4] Google Inc.: *Detecting Cancer Metastases on Gigapixel Pathology Images.* https://arxiv.org/abs/1703.02442.

[5] Dai W, et al. *Prediction of hospitalizations due to heart diseases by supervised learning methods.* https://www ncbi nlm nih.gov/pmc/articles/PMC4314395/pdf/nihms643126.pdf.

[6] Esteva A, et al. *Dermatologist-level classification of skin cancer with deep neural networks.* Nature (42) 115, 2017.

[7] JASON: *Artificial Intelligence for Health and Health Care*. MITRE Corporation, December 2017.

[8] GulshanV, et al. *Development and Validation of a Deep Learning Algorithm for Detection of Diabetic Retinopathy in Retinal Fundus Photographs.* https://jamanetwork.com/journals/jama/fullarticle/2588763.

[9] HealthIT News. *Google powers up AI, machine learning accelerator for healthcare.* http://www.healthcareitnews.com/news/google-powers-ai-machine-learning-accelerator-healthcare.

[10] Yu KH, et al. *Predicting non-small cell lung cancer prognosis by fully automated microscopic pathology image features*. https://www nature.com/articles/ncomms12474.

[11] Gibbons C, et al. *Supervised Machine Learning Algorithms Can Classify Open-Text Feedback of Doctor Performance With Human-Level Accuracy.* http://www.jmir.org/2017/3/e65/.

[12] Rajwa B, et al. *Automated Assessment of Disease Progression in Acute Myeloid Leukemia by Probabilistic Analysis of Flow Cytometry Data. h*ttp://ieeexplore.ieee.org/document/7511726/?part=1.

[13] Dai W, et al. *Prediction of hospitalizations due to heart diseases by supervised learning methods.*https://www.ncbi nlm nih.gov/pmc/articles/PMC4314395/pdf/nihms643126.pdf.

[14] Osoba O, et al. *An Intelligence in Our Image: The Risks of Bias and Errors in Artificial Intelligence*: RAND Corporation, 2017.

[15] CB Insights. *The Race for AI: Google, Baidu, Intel, Apple in a Rush to Grab Artificial Intelligence Startups.* https://www.cbinsights.com/research/top-acquirers-ai-startups-ma-timeline/.

[16] MarketsandMarkets. *Artificial Intelligence in Healthcare Market by Offering (Hardware, Software and Services), Technology (Deep Learning, Querying Method, NLP, and Context Aware Processing), Application, End-User Industry, and Geography – Global Forecast to 2022.* https://www marketsandmarkets.com/Market-Reports/artificial-intelligence-healthcare-market-54679303.html

Federation of State Medical Boards
Report of the Nominating Committee
January 19, 2018

The Nominating Committee met on Friday, January 19, 2018 in Irving, Texas at 9:00 am CST. FSMB Immediate Past Chair Dr. Arthur Hengerer serves as Chair of the Committee. Other members of the Committee include Dr. Howard (Joey) Falgout, Dr. Jone Geimer-Flanders, Dr. Marilyn Heine, Dr. Stuart Mackler, Dr. Michelle Terry and Carmela Torrelli. Providing staff support were FSMB President and CEO Dr. Humayun Chaudhry, Director of Leadership Services Pat McCarty, and Governance Support Associate Pam Huffman.

Dr. Hengerer expressed his sincere appreciation for the Committee's dedication and emphasized the importance 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.

Scott A. Steingard, DO – Arizona Osteopathic

With only one candidate for chair-elect, Dr. Steingard will be elected by acclamation; his current term on the FSMB Board of Directors does not expire until 2019, therefore his election as chair-elect will result in a partial term of one year to be filled.

Treasurer – 1 fellow, to be elected for a three-year term

The Treasurer shall perform the duties customary to that office and shall perform such other duties as the Bylaws and custom and parliamentary usage may require or as the Board of Directors shall deem appropriate; serves as chair of the Finance Committee and as an ex officio member of the Audit Committee.

Updated 02-20-18

Jerry G. Landau, JD – Arizona Osteopathic

With only one candidate for treasurer, Mr. Landau will be elected by acclamation; his current term as a director-at-large on the FSMB Board of Directors expires in May 2018 and is one of the full terms that will need to be filled.

Board of Directors – 4 fellows; three to be elected for a three-year term each; one to be elected for a one-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.

Mohammed A. Arsiwala, MD – Michigan Medical
Anna Z. Hayden, DO – Florida Osteopathic
Shawn P. Parker, JD, MPA* – North Carolina
Anita M. Steinbergh, DO – Ohio
Sarvam P. TerKonda, MD – Florida Medical
Joseph R. Willett, DO - Minnesota

*In accordance with the FSMB bylaws, "*At least two members of the Board, who are not Associate Members, shall be non-physicians, at least one of whom shall be a public/consumer member."* With Mr. Landau's pending election as treasurer and the continued service of another public member on the Board, this bylaws requirement will be fulfilled. Therefore, there will be no need to address the public member candidacy separately. The public member and physician candidates will be included on the same slate.

One candidate will need to be elected to fill Mr. Landau's expired term (a 3-year term). Dr. Hayden's current term as director-at-large on the Board expires in May 2018 resulting in a 2nd full term to be filled. The term of another board member who is not eligible for re-election also expires in 2018 resulting in a 3rd full term to be filled. A fourth candidate will need to be elected to serve a partial term of 1 year due to Dr. Steingard's pending election as chair-elect.

Nominating Committee – 3 fellows**,** each to be elected for a two-year term

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.

Nathaniel B. Berg, MD – Guam [Dr. Berg has withdrawn his nomination)*
Ahmed D. Faheem, MD – West Virginia Medical
Robert P. Giacalone, RPh, JD – Ohio
Kenneth J. Walker, MD – Virginia

Updated 02-20-18

*In accordance with the FSMB bylaws, *"At least one elected member of the Nominating Committee shall be a public member."* The term of the one public member currently on the Nominating Committee will expire in May 2018; therefore the 2018 House of Delegates will be required to elect at least one public member. With only three candidates for the Nominating Committee, including the requisite public member, the three candidates will be elected by acclamation.

No two Nominating Committee members are to be from the same member board. Continuing members of the Committee are from Alabama, Pennsylvania Medical and Washington Medical.

Respectfully submitted,

Arthur S. Hengerer, MD, FACS
Chair, Nominating Committee

Updated 02-20-18

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 5)

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, refers 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 in good standing. 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 (a member of the Board 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 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 two 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 Associate Members 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/Special Committees and Workgroups

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 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 special committees. Three continuing and two new workgroups undertook projects in FY 2018:

Workgroup on Board Education Service and Training (BEST) *(FY 2017)*
Workgroup on Education about Medical Regulation *(FY 2016)*
Workgroup on Physician Wellness and Burnout *(FY 2017)*
Workgroup on Prescription Drug Monitoring Programs *(FY 2018)*
Workgroup to Study Regenerative and Stem Cell Therapy Practices *(FY 2018)*

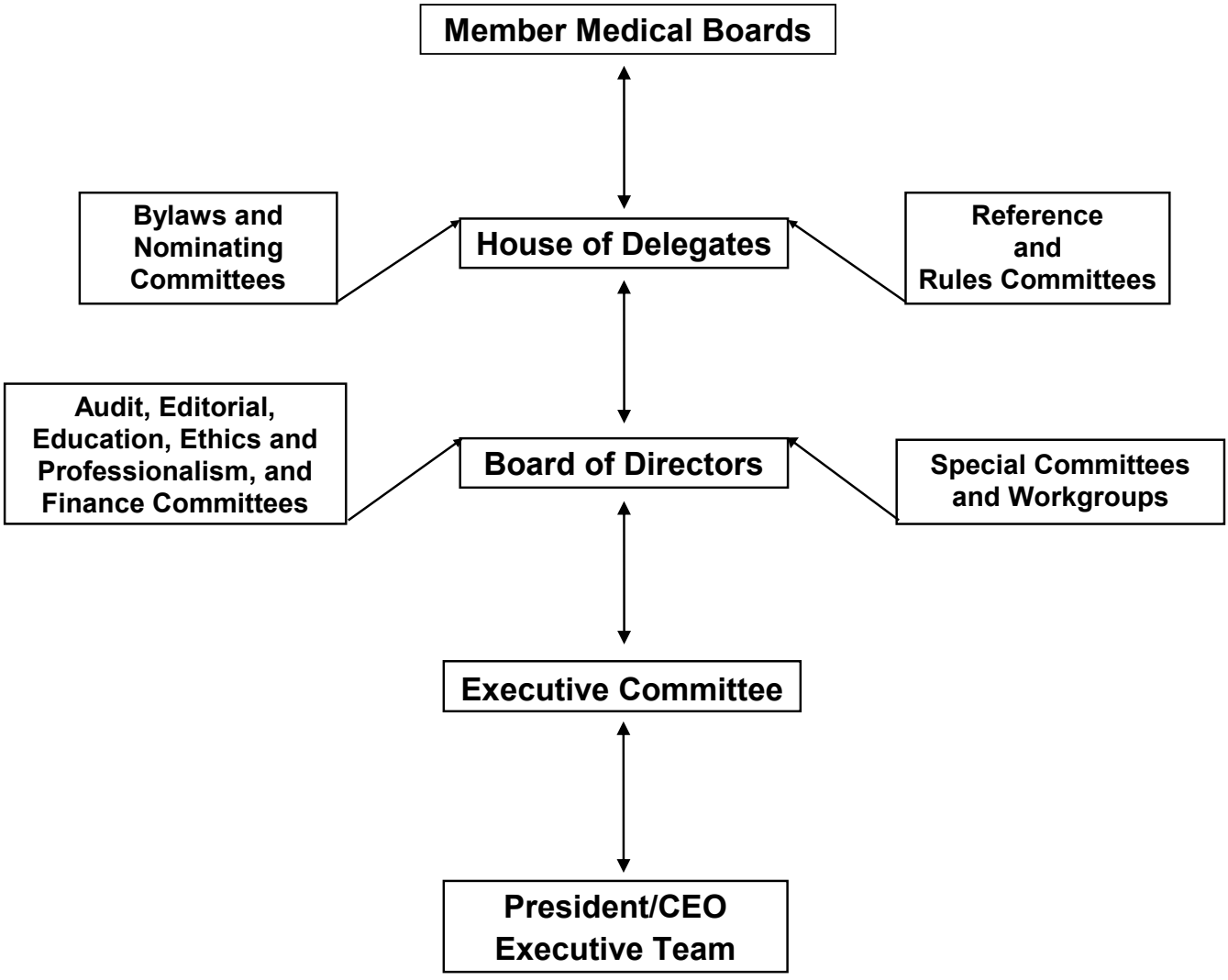
In addition to the existence of standing and special committees and workgroups, a Rules Committee and Reference Committee(s) meet at each Annual Meeting to help facilitate the progress of business at the House of Delegates meeting.

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 apprises 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 Financial Officer, Chief Information Officer/Sr. Vice President for Operations, Sr. Vice President for Assessment Services, and Sr. Vice President for Legal Services.

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 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

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 distributed with the Annual Meeting materials and sent electronically to the Voting Delegates and executive scholarship recipients attending the Annual Meeting.

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 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 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.

At 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 Fellows of the FSMB at the time of the election may run for elective office**. An individual member who as a result of appointment or confirmation is designated to be a member of a Member Medical Board shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of 36 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 Associate Members

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 Associate Members who are elected by the Board of Directors. At least two members of the Board, who are not Associate Members, shall be non-physicians, at least one of whom shall be a public/consumer member. Directors-at-Large each serve for a term of three (3) years and are eligible to be re-elected for one additional term. For this purpose, 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. Associate Members of the Board shall serve one two-year term. One Associate Member is elected each year.

c. Nominating and Other Standing Committee Members:

At least three 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 required on appropriate actions to be taken by the House of Delegates), and reference information. **In 2018, for the first time, the House of Delegates business meeting materials are to be distributed electronically to all Annual Meeting attendees, approximately one month prior to the meeting. A minimum number of hard copies of Reference Committee materials will still be placed in the back of the Reference Committee meeting rooms.**

VII. Rules Committee

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 2017 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 shall be permitted to attend. 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. 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 should be Fellows, Honorary Fellows or Associate Members of the Federation, but should 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 will be conducted by written ballot.

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 Fellows at the time of election.

VII. Elections:

Voting shall be by electronic ballot. In the event electronic balloting is not possible because of technical or other reasons, voting shall be conducted by written ballot. If there is only one candidate for office, then that individual shall be declared elected by acclamation.

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.

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 written ballot shall be one marked with the legible name of a qualified candidate(s) in that election.

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 the *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 (Scholarship Recipients)

I. Designation of Voting Delegates and Senior Staff Representatives (Scholarship Recipients)

During the month of December prior to the Annual Meeting, the presidents/chairs and executive directors of each Member Board are sent an email communication requesting they begin the process of identifying the individuals who will be attending the FSMB House of Delegates meeting as their board's Voting Delegate (usually the president/chair) and senior staff representative (usually the executive director). The FSMB provides scholarships for the voting delegate and one senior staff person from each board to attend the Annual Meeting.

In the event the board president/chair cannot attend the meeting as the Voting Delegate, an alternate may be identified by the board president/chair to attend in his/her place. Only board members or a board's Associate Member of the FSMB may be designated as an alternate delegate. In the event the executive director cannot attend the meeting as the senior staff representative, another executive staff person may be identified by the board president/chair to attend in the executive director's place.

A response form is to be completed and signed by the president/chair and returned to the FSMB indicating the names of the individuals who have been selected as Annual Meeting scholarship recipients.

II. Registration and Program Information

Upon receiving the scholarship recipient form, the FSMB will forward a confirmation letter, registration form, reimbursement policy and travel information to the selected individuals. The Annual Meeting registration fee is waived for scholarship recipients.

III. Voting Delegate Information

Upon identification of each board's Voting Delegate, FSMB will provide specific information to the delegate that will assist him/her in carrying out his/her Voting Delegate responsibilities in a truly representative capacity on behalf of the delegate's Member Medical Board.

IV. Travel Reimbursement Guidelines for Voting Delegates

The FSMB will reimburse Voting Delegates **up to $1,800** for travel, lodging and meal expenses incurred to attend the FSMB's Annual Meeting and House of Delegates Meeting according to the Travel Reimbursement Guidelines. In the event the president/chair cannot attend the meeting, an alternate member of the medical board may be selected by the board president/chair to attend as the designated Voting Delegate.

Only board members or Associate Members who participate as the **Voting Delegate at the House of Delegates meeting** will be eligible for reimbursement of expenses under this policy.

The FSMB does not reimburse on a per diem basis. Receipts for all individual expenses over $25 are required. The Annual Meeting registration fee will be waived.

AIR TRAVEL

The FSMB will reimburse the cost of one coach class, round trip airline ticket for the voting delegate attending the annual meeting. **Tickets must be booked 14 days prior to travel through the FSMB's authorized travel agency and billed directly to the corporate account. Tickets booked less than 14 days prior to travel or booked elsewhere will not be reimbursed.**

However, if the Voting Delegate has access to a lower fare (such as a government rate) through another source, the FSMB will reimburse that airfare provided he/she obtains a written quote from the FSMB's travel agency for comparison. **The FSMB's Director of Meetings & Travel must be notified prior to making these alternate reservations**. The traveler will not be reimbursed for flights "purchased" with airline miles, credit card points, or similar.

Should the Voting Delegate choose a flight itinerary at a higher fare than a comparable fare offered by the FSMB's travel agency, he/she will be responsible for the additional expense regardless of whether the $1,800 expense cap is reached.

Airline Class of Service

All air travel must be in coach class. Travelers are expected to use the lowest logical airfare available (see below for definition) regardless of personal participation in a frequent flyer program. **Tickets will be nonrefundable and nontransferable.**

Upgrades for Air Travel
Upgrades may be used only if they do not disqualify the traveler from a cheaper fare and are only allowed at the traveler's personal expense.

Personal Stopovers
Travelers must pay for any personal stopovers which increase airfare.

Changes to Tickets
Changes to tickets must be pre-approved by FSMB's Director of Meetings & Travel. Any additional fare or fee resulting from the change (including for standby travel on an earlier flight) will be at the traveler's expense unless the FSMB is requesting the traveler to make the change.

Lowest Airfare Definition
Travelers are expected to book the lowest logical airfare as determined by the travel agency based on the following parameters.

> Negotiated Airfares - This could include designated airlines for certain routes, with which the Federation has a negotiated rate.
>
> Routing - Routing requires no more than one stop with one change of plane for each way of a round trip. Routing does not increase the one-way total elapsed trip time (origin to destination) by more than 2 hours.
>
> Time Window - Departure/arrival must be no more than 1 ½ hours before or after requested time for flights of 4 or more hours and 1 hour for flights less than 4 hours.

Baggage Fees
The FSMB will reimburse airline charges for up to two checked bags. Overweight baggage fees will not be reimbursed.

Preferred Seating
If traveler's seating preference is not available within the "base airfare", the FSMB will reimburse up to $75 roundtrip to purchase such seating.

GROUND TRANSPORTATION
If using rail or personal automobile, the total expense for such travel may not exceed the cost of prevailing coach airfare.

Reimbursement for use of personal autos will be at the prevailing IRS standard mileage rate plus fees for parking and tolls. Other auto expenses (violation tickets, maintenance) are not reimbursable.

Reasonable cab fares and transfers to and from the airport will be reimbursed. **Rental car expenses are not reimbursable.**

LODGING

In order to take advantage of the FSMB's scholarship, the Voting Delegate must stay at the host hotel. Hotel costs will be reimbursed at the host hotel's single convention rate for up to **four nights from Wednesday through Saturday nights**.

MEALS & INCIDENTALS

Meals **(when not provided)** and incidentals (e.g., tips, phone calls) will be reimbursed up to $100 per day from Wednesday through Sunday. Consumption of alcohol is at the traveler's personal risk and the FSMB expects the traveler to act responsibly and avoid intoxication.

The FSMB does not reimburse on a per diem basis. Receipts for all meals are required. Itemized restaurant receipts should be submitted. Credit card signature receipts alone may not meet the requirements of this policy.

Excessive phone calls, in terms of number or length, will not be reimbursed.

UNAUTHORIZED EXPENSES

Miscellaneous personal and business expenses are not reimbursable. These include: expense charges for family members or guests; expenses incurred for business related to other organizations; movies, gift shop purchases, business center, dry cleaning/laundry, and Continuing Medical Education fees.

SPECIAL TRAVEL ACCOMMODATIONS

Individuals with documented disabilities as defined under the Americans with Disabilities Act Amendments Act of 2008 (ADAAA) may request special travel accommodations. Individuals requesting special accommodations must provide appropriate documentation to support the request. Requests will be evaluated on an individual basis.

The ADAAA and accompanying regulations define a person with a disability as someone that (1) has a physical or mental impairment that substantially limits one or more major life activities; or (2) has a record of such an impairment; or (3) is regarded as having such an impairment. The purpose of documentation is to validate that the

individual is covered under the ADAAA as a disabled individual. The purpose of accommodations is to provide equal access for individuals traveling on behalf of FSMB.

REIMBURSEMENT FORMS

The FSMB Request for Reimbursement of Travel Expenses should be completed and submitted to the FSMB's Director of Meetings and Travel within **30 days** following completion of travel. Requests for extensions must be in writing. Reimbursement will not be granted for requests received after **30 days** unless a request for an extension has been submitted.

The FSMB does not reimburse on a per diem basis. Receipts for all individual expenses exceeding $25 must be attached to the reimbursement request.

V. Travel Reimbursement Guidelines for Board Executive Directors

The Federation of State Medical Boards of the United States, Inc. (FSMB) will reimburse board executive directors **up to $1,800** for travel, lodging and meal expenses incurred to attend the FSMB's Annual Meeting according to the Travel Reimbursement Guidelines. In the event the board executive director cannot attend the meeting, another senior staff person may be selected by the board president/chair to attend in the executive director's place

The FSMB does not reimburse on a per diem basis. Receipts for all individual expenses over $25 are required. The Annual Meeting registration fee will be waived.

AIR TRAVEL

The FSMB will reimburse the cost of one coach class, round trip airline ticket for the board executive director attending the Annual Meeting. **Tickets must be booked 14 days prior to travel through the Federation's authorized travel agency and billed directly to the corporate account. Tickets booked less than 14 days prior to travel or booked elsewhere will not be reimbursed.**

However, if the executive director has access to a lower fare (such as a government rate) through another source, the FSMB will reimburse that airfare provided he/she obtains a written quote from the FSMB's travel agency for comparison. **The FSMB's Director of Meetings & Travel must be notified prior to making these alternate reservations.** The traveler will not be reimbursed for flights "purchased" with airline miles, credit card points, or similar.

Should the board executive director choose a flight itinerary at a higher fare than a comparable fare offered by the FSMB's travel agency, he/she will be responsible for the additional expense regardless of whether the $1,800 expense cap is reached.

Airline Class of Service
All air travel must be in coach class. Travelers are expected to use the lowest logical airfare available (see below for definition) regardless of personal participation in a frequent flyer program. **Tickets will be nonrefundable and nontransferable.**

Upgrades for Air Travel
Upgrades may be used only if they do not disqualify the traveler from a cheaper fare and are only allowed at the traveler's personal expense.

Personal Stopovers
Travelers must pay for any personal stopovers which increase airfare.

Changes to Tickets
Changes to tickets must be pre-approved by FSMB's Director of Meetings and Travel. Any additional fare or fee resulting from the change (including for standby travel on an earlier flight) will be at the traveler's expense unless the FSMB is requesting the traveler to make the change.

Lowest Airfare Definition
Travelers are expected to book the lowest logical airfare as determined by the travel agency based on the following parameters.

> Negotiated Airfares – This could include designated airlines for certain routes, with which the Federation has a negotiated rate.
>
> Routing - Routing requires no more than one stop with one change of plane for each way of a round trip. Routing does not increase the one-way total elapsed trip time (origin to destination) by more than 2 hours.
>
> Time Window - Departure/arrival must be no more than 1 ½ hours before or after requested time for flights of 4 or more hours and 1 hour for flights less than 4 hours.

Baggage Fees
The FSMB will reimburse airline charges for up to two checked bags. Overweight baggage fees will not be reimbursed.

Preferred Seating
If traveler's seating preference is not available within the "base airfare", the FSMB will reimburse up to $75 roundtrip to purchase such seating.

GROUND TRANSPORTATION
If using rail or personal automobile, the total expense for such travel may not exceed the cost of prevailing coach airfare.

Reimbursement for use of personal autos will be at the prevailing IRS standard mileage rate plus fees for parking and tolls. Other auto expenses (violation tickets, maintenance) are not reimbursable.

Reasonable cab fares and transfers to and from the airport will be reimbursed. **Rental car expenses are not reimbursable.**

LODGING
In order to take advantage of the FSMB's scholarship, the board executive director must stay at the host hotel. Hotel costs will be reimbursed at the host hotel's single convention rate for up to **four nights from Wednesday through Saturday nights.**

MEALS & INCIDENTALS
Meals **(when not provided)** and incidentals (e.g., tips, phone calls) will be reimbursed up to $100 per day from Wednesday through Sunday. Consumption of alcohol is at the traveler's personal risk and the FSMB expects the traveler to act responsibly and avoid intoxication.

The FSMB does not reimburse on a per diem basis. Receipts for all meals are required. Itemized restaurant receipts should be submitted. Credit card signature receipts alone may not meet the requirements of this policy.

Excessive phone calls, in terms of number or length, will not be reimbursed.

UNAUTHORIZED EXPENSES
Miscellaneous personal and business expenses are not reimbursable. These include: expense charges for family members or guests; expenses incurred for business related to other organizations; movies, gift shop purchases, business center, dry cleaning/laundry, and Continuing Medical Education fees.

SPECIAL TRAVEL ACCOMMODATIONS
Individuals with documented disabilities as defined under the Americans with Disabilities Act Amendments Act of 2008 (ADAAA) may request special travel accommodations. Individuals requesting special accommodations must provide

appropriate documentation to support the request. Requests will be evaluated on an individual basis.

The ADAAA and accompanying regulations define a person with a disability as someone that (1) has a physical or mental impairment that substantially limits one or more major life activities; or (2) has a record of such an impairment; or (3) is regarded as having such an impairment. The purpose of documentation is to validate that the individual is covered under the ADAAA as a disabled individual. The purpose of accommodations is to provide equal access for individuals traveling on behalf of FSMB.

REIMBURSEMENT FORMS

The FSMB Request for Reimbursement of Travel Expenses should be completed and submitted to the Federation's Director of Meetings and Travel within **30 days** following completion of travel. Requests for extensions must be in writing. Reimbursement will not be granted for requests received after **30 days** unless a request for an extension has been submitted.

The FSMB does not reimburse on a per diem basis. Receipts for all individual expenses exceeding $25 must be attached to the reimbursement request.

2017 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

An individual member who as a result of appointment or confirmation is designated to be a member of a Member Medical Board shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of 36 months thereafter.

SECTION C. HONORARY FELLOWS

Thirty-six months after completion of service on a Member Medical Board, a Fellow shall become an Honorary Fellow of the FSMB and 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 to be an Associate Member of the FSMB. No Associate Member shall continue in that capacity 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, Treasurer and Secretary.
2. Only an individual who is a Fellow 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 Treasurer shall be elected every third year at the Annual Meeting of the House of Delegates.
4. Officers shall be elected by a majority of the members of the House of Delegates present and voting.
5. 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.

6. 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 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.
4. 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 Treasurer shall serve for a single term of three years or until the Treasurer's successor assumes the office.
3. Officers shall assume office upon final adjournment of the Annual Meeting of the House of Delegates at which they were elected.
4. 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 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, the Immediate Past Chair, nine Directors-at-Large and two Associate Members. At least two members of the Board, who are not Associate Members, shall be non-physicians, at least one of whom shall be a public/consumer member.
2. NOMINATION OF ASSOCIATE MEMBERS: Nominations for Associate Member positions shall be accepted from Member Boards, the Board of Directors and Administrators in Medicine (AIM). Associate Members shall be elected 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. A partial term totaling one-and-a-half years or more shall count as a full term. Associate Members shall each serve for a term of two years. Associate Members shall not be eligible to serve consecutive terms.

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 60 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 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 power and 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 member shall be by certified mail, return receipt requested, to the last address known to the Board and is effective upon mailing.
    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 is filed with the Secretary of the Board. Delivery to the Board shall be by certified mail, return receipt requested, directed to the Secretary of the Board at the FSMB corporate office. Delivery is effective upon mailing.
    c. At the next Board meeting, 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 did not file a written response the Board shall proceed with a determination. Delivery is effective upon mailing.
    d. If the Board votes to proceed with removal of the officer or Board member, at a Board meeting held no less than thirty days after delivery of the notice, 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.
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.

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 an individual shall be nominated and, if elected, shall serve for 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. ASSOCIATE MEMBERS: In the event of a vacancy of an Associate Member, the Board of Directors may appoint a substitute to complete the Associate Member'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 two 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 Associate Members of 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 Associate Members of the Board, by majority vote, shall choose another Director-at-Large to serve the remainder of the one-year term. 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 21 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 14 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 90 days prior to the date of the meeting.

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 30 days prior to the date of the meeting.

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-member 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 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. 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 60 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 60 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 2017