House of Delegates

May 2, 2020

CHANGES TO VOTING DELEGATES

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

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

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 Board of Medical Examiners

Medical Licensure Commission of Alabama**

Alaska State Medical Board

Arizona Board of Osteopathic Examiners in Medicine and Surgery

Arizona Medical Board

Arkansas State Medical Board*

Medical Board of California

Osteopathic Medical Board of California

Colorado Medical Board

Connecticut Medical Examining Board

Delaware Board of Medical Licensure and Discipline

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 Board of Medicine

Illinois Department of Financial and Professional Regulation: Division of 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 Board of Medicine

Commonwealth of the Northern Mariana Islands Health Care Professions Licensing Board

State Medical Board of Ohio*

Oklahoma Board of Medical Licensure and Supervision*

Oklahoma State 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 Board of Medical and Osteopathic Examiners

Tennessee Board of Medical Examiners

Tennessee Board of Osteopathic Examination

Texas Medical Board

Utah Physicians and Surgeons 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 Commission

Washington Board of Osteopathic Medicine and Surgery

West Virginia Board of Medicine

West Virginia Board of Osteopathic Medicine

Wisconsin Medical Examining Board*

Wyoming Board of Medicine

*Original 1912 charter member board of the FSMB

**New Member Medical Board, February 2020

2019-20 Board of Directors

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

Welcome New Fellows, Affiliate Member and Courtesy Members

Fellows

Alabama Board of Medical Examiners
William Jay Suggs, MD
Jane Ann Weida, MD
Amanda Jean Williams, MD

Arizona Board of Osteopathic Examiners in Medicine and Surgery
Ken S. Ota, DO
Dawn Walker, DO

Medical Board of California
Asif Mahmood, MD
Eserick Watkins

Osteopathic Medical Board of California
Hemesh Mahesh Patel, DO

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

Connecticut Medical Examining Board
Shawn London, MD
David A. Schwindt, MD

Delaware Board of Medical Licensure & Discipline
Ashish P. Shah, MD

District of Columbia Board of Medicine
Christopher Raczynski, MD
Joelle Simpson, MD, MPH, FAAP, FACEP
William Strudwick, MD

Florida Board of Medicine
Scot Ackerman, MD
Kevin Cairns, MD
David Diamond, MD
Shailesh Gupta, MD
Luz Marina Pages, MD

Georgia Composite Medical Board
Despina D. Dalton, MD
Matthew W. Norman, MD

Guam Board of Medical Examiners
Arania Adolphson, MD
Annie Bordallo, MD

Idaho Board of Medicine
Catherine Cunagin, MD
Keith Davis, MD
Paula Phelps, PA

Illinois Division of Professional Regulation - Medical Disciplinary Board
Amy J. Derick, MD
Shami Goyal, MD
Peter M. C. Hofmann, MD
Umang Patel, MD
Sreenivas Reddy, MD

Kansas Board of Healing Arts
Molly Black, MD
Sherri Wattenbarger, JD

Kentucky Board of Medical Licensure
Mary Nan Mallory, MD
Mark A. Schroer, MD
Bill A. Webb, DO

Louisiana State Board of Medical Examiners
Patrick T. O'Neill, MD
Leonard Weather, MD

Maine Board of Licensure In Medicine
Emory E. Liscord, MD

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

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

Mississippi State Board of Medical Licensure
Daniel Paul Edney, MD
Thomas Edward Joiner, MD

Missouri Board of Registration For the Healing Arts
Naveed Razzaque, MD
Marc K. Taormina, MD

Montana Board of Medical Examiners
Molly Biehl, DO
Ashleigh Magill, MD
Gina Painter, DPM
Douglas Womack, L.Ac

Nebraska Board of Medicine & Surgery
Brian J. Keegan, MD, FACP

Nevada State Board of Medical Examiners
Maggie Arias-Petrel
Bret W. Frey, MD

New Hampshire Board of Medicine
Linda M. Tatarczuch, MSW

New Mexico Medical Board
Eric W. Anderson, MD
Buffie Saavedra
Mark Edward Unverzagt, MD

New York State Office of Professional Medical Conduct
Myra M. Nathan, PhD

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

North Dakota Board of Medicine
Lacey L. Armstrong, MD
Darin Leetun
Jay Metzger, PA-C
Michael Quast, MD

State Medical Board of Ohio
Jonathan Fiebel, MD
Harish Kakarala, MD

Oklahoma Board of Medical Licensure & Supervision
Clayton Bullard
Jeremy Hall
Trevor Nutt
Don L. Wilber, MD

Pennsylvania State Board of Medicine
Ronald E. Domen, MD

Pennsylvania State Board of Osteopathic Medicine
Arlene Seid, MD

Rhode Island Board of Medical Licensure & Discipline
Crista Durand
Sajeev Handa, MD
Nancy Kirsch

South Carolina Board of Medical Examiners
Dion L. Franga, MD
Theresa Mills-Floyd, MD

South Dakota Board of Medical & Osteopathic Examiners
Christopher T. Dietrich, MD
Aaron B. Shives, MD
Suzanne Veenis

Tennessee Board of Medical Examiners
Stephen D. Loyd, MD
Samantha E. McLerran, MD

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

Utah Osteopathic Physicians & Surgeons Licensing Board
Michael Derr, DO
Tricia Ferrin, DO

Utah Physicians & Surgeons Licensing Board
K. Kumar Shah

Vermont Board of Medical Practice
Margaret Tandoh, MD

Vermont Board of Osteopathic Physicians & Surgeons
Jesper Brickley, DO
Matthew Gilbert, DO

Virgin Islands Board of Medical Examiners
Brian C. Bacot, MD

Virginia Board of Medicine
Joel Silverman, MD

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

Washington State Board of Osteopathic Medicine & Surgery
Trice Konschuh

Wisconsin Medical Examining Board
Milton Bond, Jr.
Clarence Chou, MD
Sumeet Goel, DO

Staff Fellows

Alabama Board of Medical Examiners
William M. Perkins

Alaska State Medical Board
Alysia D. Jones

Arizona Medical Board
Patricia E. McSorley, JD

Arizona Board of Osteopathic Examiners in Medicine and Surgery
Justin Bohall

Arkansas State Medical Board
Amy Embry

Medical Board of California
Christine Lally

Osteopathic Medical Board of California
Mark M. Ito

Colorado Medical Board
Paula E. Martinez, MBA

Commonwealth of the Northern Mariana Islands Health Care Professions Licensing Board
Esther S. Fleming

Connecticut Medical Examining Board
Jeffrey A. Kardys

Delaware Board of Medical Licensure and Discipline
Devashree M. Singh, MBA

District of Columbia Board of Medicine
Frank B. Meyers, JD

Florida Board of Medicine
Claudia Kemp, JD

Florida Board of Osteopathic Medicine
Kama Monroe, JD

Georgia Composite Medical Board
LaSharn Hughes, MBA

Guam Board of Medical Examiners
Zennia Cruz Pecina, MSN, RN, CCHP

Hawaii Medical Board
Ahlani K. Quiogue

Idaho Board of Medicine
Anne K. Lawler, JD, RN

Illinois Division of Professional Regulation - Medical Disciplinary Board/ Medical Licensing Board
Brian Zachariah, MD

Medical Licensing Board of Indiana
Laura Turner, JD

Iowa Board of Medicine
Kent M. Nebel, JD

Kansas State Board of Healing Arts
Tucker Poling, JD

Kentucky Board of Medical Licensure
Michael S. Rodman

Louisiana State Board of Medical Examiners
Vincent A. Culotta, Jr., MD

Maine Board of Licensure in Medicine
Dennis E. Smith, JD

Maine Board of Osteopathic Licensure
Susan E. Strout

Maryland Board of Physicians
Christine A. Farrelly

Massachusetts Board of Registration in Medicine
George Zachos, JD

Michigan Board of Medicine
TBD

Michigan Board of Osteopathic Medicine and Surgery
TBD

Minnesota Board of Medical Practice
Ruth M. Martinez, MA

Mississippi State Board of Medical Licensure
Kenneth E. Cleveland, MD

Missouri Board of Registration for the Healing Arts
Connie Clarkston

Montana Board of Medical Examiners
Samuel Hunthausen

Nebraska Board of Medicine and Surgery
Jesse Cushman

Nevada State Board of Medical Examiners
Edward O. Cousineau, JD

Nevada State Board of Osteopathic Medicine
Sandra L. Reed, MPA

New Hampshire Board of Medicine
Penny Taylor

New Jersey State Board of Medical Examiners
William V. Roeder, JD

New Mexico Medical Board
Sondra Frank, JD

New Mexico Board of Osteopathic Medical Examiners
Roberta Perea

New York State Board for Medicine
Stephen J. Boese

New York State Office of Professional Medical Conduct
Paula M. Breen

North Carolina Medical Board
R. David Henderson, JD, CMBE

North Dakota Board of Medicine
Bonnie Storbakken, JD

North Dakota Board of Medicine
Bonnie Storbakken, JD

State Medical Board of Ohio
Stephanie M. Loucka, JD

Oklahoma State Medical Board of Licensure and Supervision
Lyle R. Kelsey, MBA, CAE, CMBE

Oklahoma State Board of Osteopathic Examiners
TBD

Oregon Medical Board
Nicole A. Krishnaswami, JD

Pennsylvania State Board of Medicine
Suzanne M. Zerbe

Pennsylvania State Board of Osteopathic Medicine
Aaron Hollinger

Puerto Rico Board of Medical Licensure and Discipline
Norma Torres Delgado, MHSA

Rhode Island Board of Medical Licensure and Discipline
James V. McDonald, MD, MPH

South Carolina Board of Medical Examiners
Sheridon H. Spoon, Esq

South Dakota Board of Medical and Osteopathic Examiners
Margaret B. Hansen, PA-C, MPAS, CMBE

Tennessee Board of Medical Examiners/Tennessee Board of Osteopathic Examination
Angela Lawrence, MSM

Texas Medical Board
Stephen Brint Carlton, JD

Utah Physicians and Surgeons Licensing Board/Utah Osteopathic Physicians and Surgeons Licensing Board
Larry Marx

Vermont Board of Medical Practice
David K. Herlihy, Esq

Vermont Board of Osteopathic Physicians and Surgeons
Corey Young

Virgin Islands Board of Medical Examiners
Deborah K. Richardson-Peter, MPA

Virginia Board of Medicine
William L. Harp, MD

Washington Medical Commission
Melanie De Leon, JD, MPA

Washington Board of Osteopathic Medicine and Surgery
Renee Fullerton

West Virginia Board of Medicine
Mark A. Spangler, MA, LPC

West Virginia Board of Osteopathic Medicine
Jonathan T. Osborne, Esq

Wisconsin Medical Examining Board
Thomas H. Ryan, MPA, JD

Wyoming Board of Medicine
Kevin D. Bohnenblust, JD, CMBE

Affiliate Member

Texas Physician Assistant Board

Courtesy Members

Christos Christolias, MD
Carlos Echevarria, MD
Alan Ericksen, MD

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

HOUSE OF DELEGATES ANNUAL BUSINESS MEETING
MAY 2, 2020

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

12. Treasurer's Report G
Jerry G. Landau, JD, Treasurer
►***For Action***

13. Report of the Reference Committee H
Denise Pines, MBA
►***For Action***

14. Report of the Nominating Committee I
Patricia A. King, MD, PhD, FACP, Immediate Past Chair

15. Elections
Scott A. Steingard, DO, Chair
►***For Action***

16. Installation of New Chair and Board Members
Scott A. Steingard, DO, Chair

17. Remarks by Newly Elected Chair
Cheryl L. Walker-McGill, MD, MBA, FY 2021 Chair

18. Announcement of 2021 Annual Meeting Site
Humayun J. Chaudhry, DO, MACP, President/CEO

19. Adjournment, *4:30 p.m. PDT*

Appendix I – House of Delegates Meeting Guidebook J
Appendix II – FSMB Bylaws K

FEDERATION OF STATE MEDICAL BOARDS
2020 ANNUAL HOUSE OF DELEGATES MEETING

Report of the Rules Committee

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

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

Linda Gage-White, M.D., Parliamentarian

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

Sandra McAllister, Executive Administrative Associate, recorder

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

Your Committee on Rules recommends the following:

I. House Security:

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

II. Credentials:

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. In appointing a teller, the presiding officer may appoint any individual who can confirm accuracy of any electronic balloting as a teller. Tellers shall not be designated voting delegates at 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 representatives participating using the remote electronic platform shall communicate their vote through an electronic communication to a teller.

VI. Nominations:

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

VII. Elections:

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

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

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

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

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

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

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

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

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

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

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

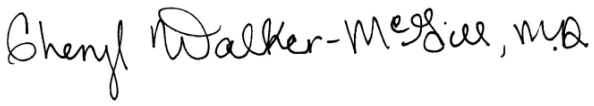
A ballot containing more than one vote for the same person is invalid.

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

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

I want to thank the committee participants.

Respectfully submitted,



Cheryl Walker-McGill, M.D., MBA
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 National Board of Medical Examiners (NBME)
5. Report on the National Commission on Certification of Physician Assistants (NCCPA)

ITEM FOR ACTION:

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

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

MANAGEMENT NOTE:

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

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

ITEM FOR ACTION:

No action required; report is for information only.

American Board of Medical Specialties
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 2020

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

Navigating the Impact of COVID-19

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

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

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

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

Physician Board Certification on the Rise

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

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

ABMS, NBME Co-host Professionalism Symposium

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

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

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

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

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

Task Forces Continue Work Toward New Standards for Continuing Certification

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

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

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

CertLink Longitudinal Assessment Programs Increase Learning and Retention

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

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

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

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

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

A study published in *JAMA Surgery* analyzed severe DAs by licensing boards for 44,290 physicians who

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

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

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

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

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

ABMS Names Senior Vice President, Certification Standards and Programs

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

ABMS Invites Applications for 2020–2021 Visiting Scholars Program

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

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

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

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

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American Board of Medical Specialties (ABMS)
(3-year term)

Jeffrey D. Carter, MD — Missouri, 1st term, Exp. 4/21

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

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

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

ABMS also maintains a website (www.certificationmatters.org) 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 serving her final term and will reach maximum tenure in December 2020. Dr. Zanolli, who was elected Chair of the ACCME in December 2019, is serving his final term on the Board and will reach maximum tenure in December 2021.

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

ITEM FOR ACTION:

No action required; report is for information only.

FSMB HOUSE OF DELEGATES

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

APRIL 2020

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

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

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

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

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

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

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

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

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

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

Respectfully submitted,

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

Accreditation Council for Continuing Medical Education (ACCME)

(may serve two 3-year terms)

Linda Gage-White, MD, PhD, MBA	Louisiana, 2nd term, Exp. 12/20
Michael D. Zanolli, MD (ACCME Chair)	Tennessee-Medical, 2nd term, Exp.12/21

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)	2nd term, Exp. 12/21
Crystal Gyiraszin	3rd term, Exp. 12/21
Paul J. Lambiase (New York OPM)	3rd term, Exp. 12/20

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- 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 30, 2020

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

MANAGEMENT NOTE:

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

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

ITEM FOR BOARD ACTION:

No action required; report is for information only.

FSMB HOUSE OF DELEGATES

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

MAY 2020

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The meeting was the adjourned.

Respectfully submitted,

Kenneth B. Simons, MD

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

Kenneth B. Simons, MD — Wisconsin, 1st term, Exp. 4/21

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

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

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

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

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

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

The ACGME is located at: 401 North Michigan Avenue, Suite 2000, Chicago, IL, 60611
Phone: (312) 755-5000
Fax: (312) 755-7498
Chief Executive Officer: Thomas J. Nasca, MD, MACP
Email: c/o Melissa Dyan Lynn (Executive Asst. to the CEO) – mdl@acgme.org
Web site: www.acgme.org

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

MANAGEMENT NOTE:

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

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

ITEM FOR BOARD ACTION:

No action required; report is for information only.

FSMB HOUSE OF DELEGATES

REPORT OF THE REPRESENTATIVES TO NBME

APRIL 2020

INTRODUCTION

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

REFLECTION AND VISION

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

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

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

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

USMLE

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

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

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

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

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

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

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

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

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

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

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

POST-LICENSURE ASSESSMENT SYSTEM (PLAS)

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

- In 2019, **the new SPEX examination was released**; it's shorter in length by 2 ½ hours, and the content focuses on tasks that physicians perform in practice (i.e., competencies for practice) and less on disease mechanisms.
- The PLAS program continues to provide **a toolbox of assessment services to third-party collaborators** at eight different locations.

NBME 2019 ANNUAL REPORT SUMMARY:

IMPROVING ASSESSMENT THROUGH RESEARCH & DEVELOPMENT

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

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

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

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

CONTRIBUTING TO MEDICAL SCHOOLS, STUDENTS, & FACULTY

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

- **NICE** fosters skill development in assessment and provides a networking venue for medical school faculty. The second of these conferences was held in Indianapolis, Indiana, on May 15-16, 2019; 240 medical faculty participated.

- The **SEEF Medical Education Research Fellowship** was introduced in 2019 and is a project-based faculty development program. The fellowship provides an opportunity for medical school faculty to develop skills in medical education and assessment research for those who have committed to working with a team of interested colleagues. Eight individuals have been selected to form the inaugural cohort.

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

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

SERVICES TO THE MEDICAL EDUCATION COMMUNITY

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

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

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

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

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

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

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

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

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

SERVICES TO THE HEALTH PROFESSIONS ORGANIZATIONS

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

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

COLLABORATION FOR VETINARY ASSESSMENTS

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

SERVICES TO THE INTERNATIONAL COMMUNITY

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

Recent work includes 31 international medical schools using IFOM and 21 using CAS in 2019. In addition, the FSMB and NBME collaborated on an essential assessment with the Health Professions Council of South Africa (HPCSA) that debuted to 221 candidates in August 2019.

CONCLUSION

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

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

Respectfully submitted,

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

National Board of Medical Examiners (NBME)

Arthur S. Hengerer, MD	New York PMC, 2nd term, Exp. 3/21
Patricia A. King, MD, PhD, FACP	Vermont Medical, 1st term, Exp. 3/23
Ralph C. Loomis, MD	North Carolina, 1st term, Exp. 3/21
Gregory B. Snyder, MD	Minnesota, 1st term, Exp. 3/21
Cheryl L. Walker-McGill, MD	North Carolina, 1st term, Exp. 3/21

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

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

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

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

The NBME is located at: 3750 Market Street, Philadelphia, PA, 19104-3102.
Phone: (215) 590-9500
Fax: (215) 590-9755
Web site: www.nbme.org
President/CEO: Peter Katsufrakis, MD

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

MANAGEMENT NOTE:

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

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

ITEM FOR BOARD ACTION:

No action required; report is for information only.

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

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

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

Alternative to PANRE Pilot Launch

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

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

2019 Annual Report from the NCCPA Review Committee

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

Other Highlights

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

- 2020 launches NCCPA's three-year global initiatives strategic plan. Its mission is to facilitate development of adaptable certification processes to enhance the provision of quality healthcare globally and continue to participate in global activities that are consistent with NCCPA's Purpose and Passion.

- The nccPA Health Foundation (www.nccpahealthfoundation.net) continues to pursue its mental and oral health initiatives. The Foundation has awarded dozens of grants in 2019 which have supported PA-led efforts to promote skin cancer prevention, childhood nutrition, exercise, oral health, human trafficking awareness, and care for the rural, undeserved. In 2020, the Health Foundation will increase available funding.

- NCCPA continues to house and support the PA History Society (www.pahx.org). In 2018 the PA History Society facilitated a successful inaugural 2-day *PA Historian Boot Camp*. Since then, additional 1-day and 2-day Boot Camps took place in 2019 at AAPA and PAEA conferences and at NCCPA headquarters, with additional Boot Camps being planned for 2020. The objective of the Boot Camps is to teach PAs how to save, study and share the story of their institutional history and the legacy of the PA profession, in addition to establishing a cohort of faculty to be future historians. Category 1 CME has been awarded to this initiative for a third year. In November 2019, the NCCPA Board of Directors purchased the remaining 16 available brick pavers for the PA Veterans Garden, located at the Stead Center in Durham, North Carolina.

It is an honor to serve in the FSMB seat on the NCCPA Board of Directors. Please feel free to contact me (peggy.robinson@duke.edu) 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 2020

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

Peggy Riley Robinson, MS, MHS, PA-C North Carolina, 2nd term, Exp. 12/21

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

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

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

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

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

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

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

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

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 27, 2019
Fort Worth, Texas

Call to Order

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

Roll Call

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

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

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

Agenda

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

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

Announcement of Parliamentarian and Tellers

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

Welcome New Fellows, Affiliate Members and Official Observers

Dr. Chaudhry welcomed new FSMB Fellows, 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 Wednesday, April 17, 2019 and was chaired by Scott A. Steingard, DO. 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 accepted as presented.

ACTION: **ACCEPTED the Consent Agenda.**

Minutes

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

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

Report of the FSMB Chair

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

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

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

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

Report of the Reference Committee A

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

1. Report of the Bylaws Committee

The Bylaws Committee, chaired by Katie L. Templeton, JD, met on November 5, 2018, to consider the current Bylaws, three proposed changes to the Bylaws, and make recommendations for any other 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: Michael G. Chrissos, MD; W. Reeves Johnson, Jr., MD; Frank B. Meyers, JD; and Mark D. Olszyk, MD, MBA. Ex officio members included FSMB Chair Patricia A. King, MD, PhD, FACP; FSMB Chair-elect Scott A. Steingard, DO; and FSMB President-CEO Humayun J. Chaudhry, DO, MACP.

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

PROPOSED BYLAWS AMENDMENT #1 is as follows:

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

Section A. Membership and Terms

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

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

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

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

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

The Reference Committee heard no further testimony.

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

Article IV. Board of Directors:

Section A. Membership and Terms

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

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

3. TERMS: Directors-at-Large shall each serve for a term of three years and shall be eligible to be reelected to one additional term. Staff Fellows shall serve for a term of two years and

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.

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

PROPOSED BYLAWS AMENDMENT #2 is as follows:

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

Section C. Election of Directors-at-Large

1. At least three of the Directors-at-Large shall be elected each year at the Annual Meeting of the House of Delegates by a majority of the votes cast.

2. If no candidate receives a majority of the votes on the first ballot, and one seat is to be filled, a runoff election shall be held between the two candidates who received the most votes on the first ballot.

3. If more than one seat is to be filled from a single list of candidates, and if one or more seats are not filled by majority vote on the first ballot, a runoff election shall be held, with the ballot listing candidates equal in number to twice the number of seats remaining to be filled. These candidates shall be those remaining who received the most votes on the first ballot. The same procedure shall be used for any required subsequent runoff elections. In the event of a tie vote in a runoff election up to two additional runoff elections shall be held.

4. Prior to the election, the presiding officer shall cast a sealed vote, ranking each candidate in a list. The presiding officer's vote is counted for the candidate in the runoff election who is highest on the list. The presiding officer's vote is counted only to resolve a tie that cannot be decided by the process set forth in this section.

5. Directors shall assume office upon final adjournment of the Annual Meeting of the House of Delegates at which they were elected.

6. Only an individual who is a **Board Member** Fellow at the time of the individual's election shall be eligible for election as a Director of the FSMB.

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

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

The Reference Committee heard no further testimony.

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

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

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

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

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

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

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

> *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), state rules and laws across the United States, available data, and present a report to the House of Delegates at the Annual Meeting in 2019.*

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

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

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

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

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

Reference Committee A heard no further testimony.

ACTION: No action required; report was for Information Only

3. <u>Resolution 19-1: Correlation Between Licensee USMLE or COMLEX Passage Attempt Rate and Reports of State Medical Board Discipline</u>

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

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

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

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

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

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

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

(1) Identify current licensing requirements specific to USMLE and COMLEX, including time and/or attempt limits on these examinations;
(2) Identify existing, or facilitate additional, research evaluating whether time and/or attempt limitations on USMLE and COMLEX correlate with external measures such as a decrease in future medical board disciplinary action and/or medical malpractice;

(3) Begin work toward a long-term goal of research exploring the correlation between performance on these licensing examinations and other measures of clinical aptitude or outcomes; and

(4) Share initial findings through a written report to the FSMB House of Delegates in spring 2020 and with subsequent periodic reports as research becomes available.

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

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

The Reference Committee heard no further testimony.

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

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

Report of the Reference Committee B

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

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

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

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

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

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

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

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

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

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

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

2. <u>BRD RPT 19-3: Report on Resolution 18-3: Permitting Out-of-State Practitioners to Provide Continuity of Care in Limited Situations</u>

In April 2018, the FSMB House of Delegates referred Resolution 18-3: Permitting Out-of-State Practitioners to Provide Continuity of Care in Limited Situations to the FSMB Board of Directors of Study. The resolution called for the FSMB to 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 through 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. The Board of Directors called upon the Advisory Council of Board Executives to evaluate the resolution and make recommendations to the Board of Directors to inform a report to the House of Delegates in April 2019.

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

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

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

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

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

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

3. <u>Resolution 19-4: Emergency Licensure Following a Natural Disaster (NC)</u>

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

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

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

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

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

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

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

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

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

4. <u>Resolution 19-5: Informed Consent Policy (NC)</u>

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

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

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

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

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

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

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

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

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

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

5. <u>Resolution 19-6: Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office Policy (2013) (NC)</u>

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

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

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

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

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

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

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

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

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

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

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

6. <u>Resolution 19-7: Policy on Physician Impairment (NC)</u>

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

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

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

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

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

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

<u>Report of the Nominating Committee</u>

Gregory B. Snyder, MD, DABR, presented the report of the Nominating Committee and read the slate 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:	**Cheryl Walker-McGill, MD (2019-2020)**
(by acclamation)	
Directors-at-Large:	**Jone Geimer-Flanders, DO (2019-2022)**
	Shawn P. Parker, JD, MPA (2019-2022)
	Joseph R. Willett, DO (2019-2022)
Nominating Committee:	**Nathaniel B. Berg, MD, DABR (2019-2021)**
(by acclamation)	**Maroulla S. Gleaton, MD (2019-2021)**
	Joy M. Neyhart, DO (2019-2021)

Announcement of Future FSMB Annual Meeting Locations

Dr. King announced that the 2020 Annual Meeting will be held in San Diego, CA at the Manchester Grand Hyatt hotel April 30-May 2, 2020. The 2021 FSMB Annual Meeting will take place April 29-May 1, 2021 at the Hilton Minneapolis hotel in Minneapolis, MN.

Concluding Remarks

Dr. King announced board meeting details for those newly elected to the board along with details on the Nominating Committee breakfast for those elected to the Nominating Committee. Dr. King also thanked everyone in attendance.

Adjournment

There being no further business, the annual business meeting of the House of Delegates was adjourned at 3:35 pm.

Sandy McAllister
Pat McCarty
Recorders

CHAIR’S REPORT

COMING SOON

REPORT OF THE PRESIDENT-CEO

COMING SOON

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

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

Goal I: State Medical Board Support

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Goal II: Advocacy and Policy Leadership

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

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

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

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

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

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

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

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

Goal III: Collaboration

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

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

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

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

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

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

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

Goal IV: Education

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

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

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

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

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

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

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

Goal V: Data and Research Services

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

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

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

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

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

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

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

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

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

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

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

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

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

Goal VI: Organizational Strength and Excellence

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

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

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

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

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

TREASURER’S REPORT

COMING SOON

TAB H: Report of the Reference Committee

MANAGEMENT NOTE:

The following reports have been submitted to the Reference Committee for consideration:

1. Report of the Bylaws Committee
   (For Action)

2. BRD RPT 20-1: Report of the Special Committee on Strategic Planning
   (For Action)

3. BRD RPT 20-2: Report of the Workgroup on Physician Sexual Misconduct
   (For Action)

4. BRD RPT 20-3: Report on Resolution 19-1: Licensing Exam Research
   (For Information)

5. BRD RPT 20-4: Report on Resolution 19-4: Emergency Licensure Following a Natural Disaster
   (For Information)

During the Reference Committee's deliberations on April 30th, it will consider any written testimony submitted by Member Medical Boards. The deadline for submitting testimony is **April 23.** The testimony should be in the form of a letter addressed to:

Denise Pines, MBA
Reference Committee Chair
Send to: pmccarty@fsmb.org

Following the deliberations of the Reference Committee, a report containing the Reference Committee's recommendations will be posted on the Members Portal on **May 1** and presented to the House of Delegates on **May 2**.

REPORT OF THE BYLAWS COMMITTEE

SUBJECT: **PROPOSED AMENDMENTS TO THE BYLAWS OF THE FEDERATION OF STATE MEDICAL BOARDS**

REFERRED TO: **REFERENCE COMMITTEE**

The Bylaws Committee, chaired by W. Reeves Johnson, Jr. MD, met on October 28, 2019 to consider the current Bylaws, review two proposed amendments and additional commentary submitted for consideration, and make recommendations for any necessary changes. In keeping with its charge, the Committee also discussed the FSMB Articles of Incorporation as they relate to the Bylaws. Members of the Committee include: Lawrence J. Epstein, MD; Genevieve M. Goven; MD, Sandra Schwemmer; DO, Timothy E. Terranova; and Stuart T. Williams, JD. Ex officio members include FSMB Chair Scott A. Steingard, DO, FSMB Chair-Elect Cheryl L. Walker-McGill, MD, MBA and FSMB President-CEO Humayun J. Chaudhry, DO.

In accordance with Article XIV, Section A of the FSMB Bylaws, notice of the meeting of the Bylaws Committee was provided on August 26, 2019.

The Bylaws Committee received two formal proposals for amendments and two other submissions of comments that did not communicate specific amendments but raised organizational issues worthy of general review and discussion. These issues included a review of the state of incorporation, modification of the existing Candidates Forum, nomination process for staff fellows, and roles of chair-elect and past chair, as well as the interdependence of the Bylaws allowing for the role of FSMB President and his or her appointment as the corporate secretary. The Bylaws Committee noted its appreciation of such questions, but ultimately decided that addressing these issues would not be proper through Bylaws amendments and shared the ideas with FSMB staff for future consideration.

After thorough review of the Bylaws and consideration of all questions, comments and proposed amendments, the Bylaws Committee presents the following two proposed amendments for consideration. The Bylaws may be amended at any annual meeting of the House of Delegates by *two-thirds* of those present and voting.

PROPOSED AMENDMENT #1

The North Carolina Medical Board urged the Bylaws Committee to review the composition of the Ethics and Professionalism Committee and consider whether allowing for additional members would increase opportunities for Fellows to serve on this increasingly important committee.

The Committee engaged in a discussion of the current process and methodology of committee appointments. Membership in standing committees, including Ethics and Professionalism, is determined by the Chair, with the approval of the Board of Directors (Bylaws, Article VIII, Section A). Each year, the FSMB surveys current Fellows for interest in serving on committees and consults with executive staff. Each Chair selects individuals for committee assignments in accordance with the

FSMB Bylaws and the FSMB Board of Directors Policy Compendium. In general, the Policy Compendium urges that the number of individuals appointed to committees and/or external organizations be maximized in order to expand participation. The Policy Compendium includes appointment guidelines that stress the experience and qualifications of individuals recommended for appointments should reflect the duties and responsibilities commensurate with the appointments. The Policy Compendium also stresses the importance of diversity of membership and directs the Chair to make decisions that ensure a broad representation of the Federation's membership.

The committee recognized that interest in serving on committees continues to grow. For example, over 20 individuals indicated interest in serving on the Ethics and Professionalism Committee for Fiscal Year 2019-2020. Recognizing the importance and scope of the areas studied by the Ethics and Professionalism Committee, it was discussed how the current membership structure could make appointment decisions difficult for the Chair and limit the ability for qualified Fellows to contribute.

The Bylaws Committee aligned behind the rationale of the proposal and agreed that increasing Committee membership provides additional perspectives on challenging topics and allows the Committee's membership greater ability to collaborate with the FSMB's other generative committees, such as the Education and Editorial Committees. The Bylaws Committee entertained discussion regarding the impact an increase in the size of the Ethics and Professionalism Committee would have on its scope and nature. The Committee also discussed other methods of increasing participation on committees. Committee members shared practices from other organizations, including the use of adjunct members to committees. These members would participate in the study and discussion of issues but would not have a vote on matters before the committee. According to Committee members, several other healthcare organizations have used this model to greatly benefit the diversity of opinions as well as foster future leadership.

The Bylaws Committee questioned the budgetary impact of additional members. Because most committees, including the Ethics and Professionalism Committee, meet through teleconference or other electronic platforms, the Committee determined any cost to be de minimis.

Proposed Amendment #1

ARTICLE VIII
SECTION F. ETHICS AND PROFESSIONALISM COMMITTEE
The Ethics and Professionalism Committee shall be composed of up to ~~**five**~~ **eight** Fellows and up to two subject matter experts. The Ethics and Professionalism Committee shall address ethical and professional issues pertinent to medical regulation.

PROPOSED AMENDMENT #2

Both the FSMB Board of Directors and the North Carolina Medical Board asked the Bylaws Committee to review the effective date of Bylaws approved by the FSMB House of Delegates and assess whether amendment would be proper. The North Carolina Medical Board suggested the

adoption of language so that amendments become effective ". . . upon adjournment of the Annual Meeting of the House of Delegates at which they were adopted . . ..", citing that such a change would prevent Bylaws amendments from unduly impacting subsequent matters coming before the House of Delegates during that meeting. The FSMB Board of Directors' Governance Committee met in Summer 2019 and expressed similar concerns about the immediate applicability of approved changes, but determined that the Bylaws review process, rather than modification to governance policies, would provide a more proper forum for discussion. In July 2019, the Board of Directors approved a motion referring to the Bylaws Committee the issue of the House of Delegates election balloting and a possible change to the effective date of approved Bylaws amendments.

The Bylaws Committee understood that as Article XIV, Section B, is currently written and interpreted, any changes to the Bylaws go into effect immediately after passage by the House of Delegates. Over the past 6 years, several Bylaws changes impacted the process of voting at the House of Delegates and the structure of the Board of Directors, requiring immediate actions to ensure legal compliance with the Bylaws. The Bylaws Committee recognized that the shared intent of the recommendations of both the North Carolina Medical Board and the FSMB Board of Directors would provide clarity of interpretation and allow for issues that impact organizational structure or process, such as additional Board of Directors membership or changes to the voting procedures at the House of Delegates, to be implemented with heightened fairness and proper notice.

However, the Bylaws Committee debated the proper manner in which to apply the intent of both of these proposals. The Bylaws Committee discussed whether it may be necessary for some amendments to go into immediate effect and the possible need to preserve immediacy in the Bylaws. Members of the Bylaws Committee also shared experiences and scenarios gleaned from experience with medical boards, legislation and other organizations that assisted in identification of best practices. Specifically, it was noted that when proposed to reference committees as well as the House of Delegates, resolutions before the FSMB House of Delegates do not contain an effective date. Inclusion of an effective date was identified as a more proper vehicle to address concerns about immediate applicability of amendments that would impact organizational structure or election process. A Bylaws change that alludes to the inclusion of an effective date on future amendments to the Bylaws would also allow reference committees to review the impact of the amendment and delay implementation of a desired change, if deemed necessary to maintain integrity of process.

Proposed Amendment #2

ARTICLE XIV
SECTION B. EFFECTIVE DATE
These Bylaws and any other subsequent amendments thereto, shall become effective upon their adoption, except as otherwise provided ~~**herein**~~ **in the amendment**.

BRD RPT 20-1

REPORT OF THE BOARD OF DIRECTORS

Subject: **Report of the Special Committee on Strategic Planning: *FSMB Strategic Plan***

Referred to: **Reference Committee**

The Special Committee on Strategic Planning was convened in August and November 2019 by FSMB Chair-elect/Committee Chair Cheryl Walker-McGill, MD, MBA to evaluate the continued relevance of the FSMB's 2015-2020 Strategic Plan, which includes the organization's Vision, Mission Statement and Strategic Goals. The Committee was asked to develop recommendations for enhancing or changing the current Strategic Plan and presenting its recommendations to the House of Delegates in 2020 for approval.

Members of the Committee include George Abraham, MD (MA); Ronald Domen, MD (PA-M), FSMB Past Chair Daniel Gifford, MD (AL); William Hoser, MS, PA-C (VT-M); Lyle Kelsey, MBA (OK-M); FSMB Immediate Past Chair Patricia King, MD, PhD (VT-M); Frank Meyers, JD (DC); Kevin O'Connor, MD (VA); FSMB Past Chair Janelle Rhyne, MD (NC); Katie Templeton, JD (OK-O); Christy Valentine, MD (LA) and Sherif Zaafran, MD (TX). FSMB Chair Scott Steingard, DO participated as ex officio. Facilitating the Committee's work was FSMB consultant Paul Larson, MS of Paul Larson Communications.

In completing its charge, the Special Committee met in person on August 14-15 and by videoconference on November 22, 2019. During its deliberations, the Committee considered key facts about the FSMB and its Member Medical Boards including their structure and function; environmental factors impacting medical regulation; challenges and opportunities affecting key stakeholders; and information on the changing national healthcare policy landscape.

The result of the Special Committee's work are recommendations for a revised Strategic Plan that are intended to respond to:

- The need for the FSMB to provide strong **leadership in an era of accelerating change** in the health care sector, and the importance of adaptability and the ability to manage change in this new era.
- The continuing rise of **data-use and technology** – including telemedicine and artificial intelligence – as significant factors in health care.
- The particular need to maintain vigilance, safety and oversight in the midst of **new team-based care models** and **a blurring scope-of-practice environment**.
- The continuing need for **service and support from the FSMB for its member boards** – which will rely increasingly on the FSMB to serve as a hub and facilitator

at a time when the sharing of data, resources and best practices requires a strongly interconnected medical regulatory community.

- **Increasing public empowerment** – bringing with it the need for state medical boards to be responsive to the clear preferences of consumers/patients, who put a priority on efficiency, speed and transparency when dealing with institutions.
- Trends toward **corporatization, commoditization and consolidation** in health care, which may have potentially profound impacts on medical regulation.
- The rise of **legislative/political incursions into medicine** and **de-regulatory forces** in the United States, including developments since the Supreme Court's *North Carolina Board of Dental Examiners v. Federal Trade Commission* decision.
- Changing trends in the nation's **workforce of physicians, physician assistants and other health care professionals**, and in the ways **medical education** is delivered.

The draft report of the Special Committee on Strategic Planning **(Attachment 1)** was distributed to FSMB member boards in December 2019 and January 2020 for comment. All comments received were in support of the new Strategic Plan. Accordingly, the Board of Directors approved the Special Committee's report but removed the original timeframe of the new Strategic Plan (2020-2025) since this is a living document and will be adjusted as needed. The new Strategic Plan also has been updated to reflect the addition of a new Member Medical Board – the Medical Licensure Commission of Alabama – increasing the total number of Member Medical Boards from 70 to 71. The Board of Directors recommends that the proposed *FSMB Strategic Plan* contained in the report be adopted by the House of Delegates and the remainder of the report be filed.

ITEM FOR ACTION:

The Board of Directors recommends that,

the House of Delegates ADOPT the *FSMB Strategic Plan* contained in the Report of the Special Committee on Strategic Planning and the remainder of the report be filed.

BRD RPT 20-1 Attachment 1

FEDERATION OF STATE MEDICAL BOARDS
SPECIAL COMMITTEE ON STRATEGIC PLANNING

Report on FSMB Strategic Plan Recommendations

FSMB Strategic Planning Committee Summary and Proposed Plan

The FSMB Special Committee on Strategic Planning met August 14-15, 2019 in Euless, Texas, and again by videoconference on November 22, to review the FSMB's current strategic plan and make recommendations for a new plan, to be implemented in May 2020.

In preparation for its discussions, the Committee reviewed a variety of documents and information resources, including the:

- 2015 FSMB Board Report on Strategic Planning
- 2019 FSMB Strategic Planning Surveys, gauging opinions of state medical boards leaders and other stakeholders
- Summaries of strategic-visioning exercises conducted by the FSMB Board of Directors and FSMB staff in 2018 and 2019
- 2019 Report of the FSMB House of Delegates on the FSMB 2015-2020 Strategic Plan

At its August meeting, the Committee engaged in large-group and small-group discussions, identifying environmental factors, challenges and opportunities in health care and medical regulation that could impact the next Strategic Plan.

After a comprehensive review of the current Strategic Plan, the Committee concluded that the plan remains fundamentally sound in that it continues to focus on core values and relevant strategic imperatives. The Committee recommended slight adjustments, however, to align elements of the plan more closely with emerging trends and new issues of importance to state medical boards.

The recommended changes are intended to respond to:

- The need for the FSMB to provide strong **leadership in an era of accelerating change** in the health care sector, and the importance of adaptability and the ability to manage change in this new era.
- The continuing rise of **data-use and technology** – including telemedicine and artificial intelligence – as significant factors in health care.
- The particular need to maintain vigilance, safety and oversight in the midst of **new team-based care models** and **a blurring scope-of-practice environment**.
- The continuing need for **service and support from the FSMB for its member boards** – which will rely increasingly on the FSMB to serve as a hub and facilitator at a time when the sharing of data, resources and best practices requires a strongly interconnected medical regulatory community.
- **Increasing public empowerment** – bringing with it the need for state medical boards to be responsive to the clear preferences of consumers/patients, who put a priority on efficiency, speed and transparency when dealing with institutions.

- Trends toward **corporatization, commoditization and consolidation** in health care, which may have potentially profound impacts on medical regulation.
- The rise of **legislative/political incursions into medicine** and **de-regulatory forces** in the United States, including developments since the Supreme Court's *North Carolina Board of Dental Examiners v. Federal Trade Commission* decision.
- Changing trends in the nation's **workforce of physicians, physician assistants and other health care professionals**, and in the ways **medical education** is delivered.

The Committee's discussions and conclusions underscore the need for strong leadership and wise policies from the medical regulatory community to help guide the next generation of medicine in the United States through a period of historic change.

SUMMARY OF DISCUSSIONS

Environmental Factors

The Committee discussed a variety of environmental factors impacting medical regulation that should be taken into account in developing a new strategic plan. These included:

The rapid advance of technology in health care. Technological innovations – particularly the use of telemedicine and the growth of artificial intelligence – are changing the way health care is delivered. While technology is clearly impacting medicine, it is also impacting the process of medical regulation: As an example, the digitization of records and use of block-chain technology will impact standard oversight processes, such as credentialing and credentials verification.

The role and importance of data. "Big Data" is a powerful factor across all sectors, as technology improves our ability to gather, analyze and share large amounts of information. The volume of health-care-related data – and new technology platforms that widen its potential use – continue to expand. This ability brings both opportunities and challenges, as issues of privacy, data ownership and systems-compatibility must be managed in a complex, dynamic environment.

Consolidation and corporatization in health care delivery. The rate of merger among hospitals and physician group-practices continues to increase, with a variety of impacts. More and more physicians are now working as employees of large health systems – which maintain their own internal physician oversight processes and practice standards, independent of the regulatory system. Additionally, large retailers – such as CVS and Walmart – are increasing their reach into the health care sector, with expanded health care delivery services offered through retail clinics. Google, Apple and other huge technology-based corporations are also expanding their role in health care – and changing consumer behavior and expectations in the process. The influence of these large corporate entities on the health system overall will continue to rise.

"Commoditization" in medical practice. The confluence of technological innovation and corporate growth and influence has led to an environment in which health care outcomes, quality, price and access are increasingly driven by the competitive marketplace. As a result, medicine becomes more vulnerable to de-professionalization, and the patient-physician relationship

becomes more vulnerable to de-personalization. As concerns about the impacts of commoditization grow, there is a perception that the overall influence of the medical community – an important bulwark for patient safety and quality in health care – is being undercut as a result of these trends.

The continued rise of consumer empowerment. Thanks largely to the growth of the Internet over several decades, consumers continue to wield greater influence in health care – ranging from increased awareness of medical options to self-diagnosis and heightened expectations for outcomes, cost and care delivery. The development of household and wearable medical devices and greater access to data have led patients to be given a larger role as partners in the health care team. Telemedicine, the growth of retail clinics and other fast, relatively inexpensive models of health care delivery are increasing the expectations of consumers – who don't want impediments and are less concerned about traditional titles, roles and scope of practice of those who provide their care.

Blurring of lines and traditional roles in health care. In the new team-based health care delivery environment, traditional scope-of-practice boundaries are beginning to shift – particularly in terms of the role of mid-level providers. Physician assistants and other health professionals continue to play a more prominent role in this environment, and the use of artificial intelligence and other technologies is accelerating new scope-of-practice trends.

Physician workforce changes. Demographic shifts indicate that physician shortages in key medical specialties – including primary care – will grow, creating access-to-care issues, particularly in rural areas of the United States. Additionally, the physician workforce is aging and some physicians are working at older ages than previous generations.

Issues in medical education. As technology continues to reshape medical practice, there is a growing need to re-think longstanding approaches in medical education. At the same time, the enormous cost of medical education – including debt-burdens of medical students – is raising concerns and impacting the distribution of new physicians across medical specialties, further contributing to workforce and access-to-care issues.

Physician wellbeing. Concerns about stress-related health issues in the medical workforce have risen in recent years. There is growing evidence that the wellbeing of physicians has significant impact on the quality of health care delivery and issues in medical regulation.

Challenges

Anti-occupational-licensing efforts and a culture of deregulation. In the wake of the Supreme Court's *North Carolina State Board of Dental Examiners v. Federal Trade Commission* decision, organized efforts are increasing nationally to scale back on occupational-licensing requirements. In addition, a culture of deregulation at both state and federal levels has noticeably grown in recent years – with what some perceive as legislative incursions or overreach into the practice of medicine. These trends put new pressures on boards' ability to conduct regulatory oversight.

Inefficiency of systems in a team-based, consumer-driven health care environment. With blurring lines in the scope of medical practice, professional regulators must be well-coordinated across sectors – but the current lack of systems integration and aligned policies make that a challenge. The issue is exacerbated by the demands of increasingly empowered consumers – and health care professionals – who have little tolerance for inefficiencies in systems. Of particular concern to boards is how to transition from legacy systems in an environment that requires nimbleness and speed.

Questions of accountability and responsibility in regulation. Rapid changes in health care delivery – including the rise of telemedicine, the use of artificial intelligence and an increase in team-based care models – have created new "grey areas" and challenges in determining accountability and responsibility in medical decision-making and care outcomes.

Quality control and maintenance of privacy in a data-rich environment. The ubiquity of data, the proliferation of entry-points for its collection, and the ease with which it can be shared raise new questions for boards regarding its management – including security, privacy and quality.

Opportunities

Leadership. In an era of great change and a high level of uncertainty about the future, the FSMB has an opportunity to play a strong leadership role. The health care system is experiencing "pendulum swings" – and institutions can earn support and trust in this environment by helping to provide stability to their stakeholders. By helping state boards navigate change – and helping build the public's trust in boards at the same time – the FSMB can establish its value.

Technology and data. The growing availability and importance of technology and data provides a unique opportunity for the FSMB, which in recent years has expanded its data capabilities – including infrastructure investments and a transition to digital platforms. The FSMB is positioned to serve as an information-hub, convener and facilitator as the regulatory community enters a new era of technology and data processing. The growing reality within medicine is that telemedicine, artificial intelligence and other modalities are here and have enormous potential but must be shaped by wise policy.

Education for boards and licensees. In the current health care environment, there is a strong need for ongoing educational opportunities for state medical boards – as well as their licensees. This is particularly important, given the relatively high turnover-rate in the state medical board community: Surveys show that 40% of stakeholders within the Federation have worked in medical regulation for less than five years. By focusing on educating its member boards about emerging trends and best practices and helping them provide targeted continuing professional education for their licensees, the FSMB can help ensure stability amid change.

Communications and advocacy. With the pace of change faced by the health care community, the need for close communication between institutions and their stakeholder audiences – and strong advocacy on key issues – has never been greater. In this environment, the FSMB has the opportunity to deliver value by keeping boards informed, helping raise public awareness of the

work they do, and coordinating advocacy on their behalf. This is particularly important in an era when many boards face tight budgets and lean staffing.

BRD RPT 20-1 Attachment 1

CURRENT FSMB STRATEGIC PLAN, 2015-2020

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.

Strategic Goals

- ***State Medical Board Support*:** Serve state medical boards by promoting best practices and providing policies, advocacy, and other resources that add to their effectiveness.

- ***Advocacy and Policy Leadership*:** Strengthen the viability of state-based medical regulation in a changing, globally-connected health care environment.

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

- ***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.

- ***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.

- ***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.

PROPOSED FSMB STRATEGIC PLAN (RECOMMENDATIONS)

Changes to each of the sections of the current Strategic Plan that have been suggested are noted below.

1. "ABOUT THE FSMB" Statement

Current Statement

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.

Recommendation for change:

- Update "70 state medical and osteopathic regulatory boards" to "71 state medical and osteopathic regulatory boards"

Proposed Revised Statement

The Federation of State Medical Boards represents the 71 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.

2. VISION

Current 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.

Recommendations for change:

- Replace "helping state medical boards" with "supports state medical boards"
- Update the language slightly to better articulate the FSMB's role of working as an innovative partner as it meets the needs of state medical boards

Proposed Revised Vision

The FSMB supports state medical boards as they protect the public and promote quality health care, partnering and innovating with them to shape the future of medical regulation.

3. MISSION

Current 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.

Recommendations for change:

- Delete "the voice" and replace with "a national voice"
- Add "data"

Proposed Revised Mission

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

4. STRATEGIC GOALS

Current Goal 1 – no recommended changes

***State Medical Board Support*:** Serve state medical boards by promoting best practices and providing policies, advocacy, and other resources that add to their effectiveness.

Current Goal 2

***Advocacy and Policy Leadership*:** Strengthen the viability of state-based medical regulation in a changing, globally-connected health care environment.

Recommendations for change:

- Replace "viability" with "impact"
- Change "state-based medical regulation" to "state medical regulation"
- Delete "globally" and replace "changing" with "dynamic, interconnected"

Proposed Revised Goal 2

***Advocacy and Policy Leadership*:** Strengthen the impact of state medical regulation in a dynamic, interconnected health care environment.

Current Goal 3

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

Recommendations for change:

- Add "government entities" to help clarify that collaboration is sought with both private-sector and public-sector partners
- Include "state" in addition to "national" and "international"
- Replace "strengthen" with "build" to reduce the repetition of the word "strengthen" in the strategic plan goals

Proposed Revised Goal 3

***Collaboration*:** Build participation and engagement among state medical boards and expand collaborative relationships with state, national and international organizations and government entities.

Current Goal 4

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

Recommendations for change:

- Add "Communications" to the goal's title
- Move the phrase "Raise public awareness" to the beginning of the goal's description
- Add the word "effectiveness"

Proposed Revised Goal 4

***Communications and Education*:** Raise public awareness of the vital role of state medical boards while providing educational tools and resources that enhance the quality and effectiveness of medical regulation.

Current Goal 5

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

Recommendations for change:

- Add "Technology" to the goal's title; collapse "Research Services" under the heading "Data"
- Begin the stated goal as follows: "Provide leadership in the use of emerging health care technology that impacts medical regulation, and…"
- Change "data-sharing and research capabilities" to "data integration and research capabilities"
- Change "while providing" to "to share"
- Streamline verbiage to keep goal consistent in length with the other goals by changing "to state medical boards, the public and other stakeholders" to "with stakeholders"

Proposed Revised Goal 5

***Technology and Data*:** Provide leadership in the use of emerging health care technology that impacts medical regulation, and expand the FSMB's data integration and research capabilities to share valuable information with stakeholders.

Current Goal 6

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

Recommendations for change:

- Remove "financial"
- Replace "vitality and adaptability" with "efficiency, effectiveness and adaptability"

Proposed Revised Goal 6

***Organizational Strength and Excellence*:** Enhance the FSMB's organizational efficiency, effectiveness and adaptability in an environment of change and strengthen its resources in support of its mission.

BRD RPT 20-1 Attachment 1

FSMB STRATEGIC PLAN (FOR APPROVAL)

About the FSMB

The Federation of State Medical Boards represents the 71 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 supports state medical boards as they protect the public and promote quality health care, partnering and innovating with them to shape the future of medical regulation.

Mission Statement

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

Strategic Goals

- ***State Medical Board Support*:** Serve state medical boards by promoting best practices and providing policies, advocacy, and other resources that add to their effectiveness.

- ***Advocacy and Policy Leadership*:** Strengthen the impact of state medical regulation in a dynamic, interconnected health care environment.

- ***Collaboration*:** Build participation and engagement among state medical boards and expand collaborative relationships with state, national and international organizations and government entities.

- ***Communications and Education:*** Raise public awareness of the vital role of state medical boards while providing educational tools and resources that enhance the quality and effectiveness of medical regulation.

- ***Technology and Data*:** Provide leadership in the use of emerging health care technology that impacts medical regulation, and expand the FSMB's data integration and research capabilities to share valuable information with stakeholders.

- ***Organizational Strength and Excellence*:** Enhance the FSMB's organizational efficiency, effectiveness and adaptability in an environment of change and strengthen its resources in support of its mission.

BRD RPT 20-2

REPORT OF THE BOARD OF DIRECTORS

Subject: Report of the FSMB Workgroup on Physician Sexual Misconduct

Referred to: Reference Committee

The Federation of State Medical Boards (FSMB) Workgroup on Physician Sexual Misconduct, chaired by Dr. Patricia A. King, M.D., Ph.D., has been charged with 1) collecting and reviewing available disciplinary data, including incidence and spectrum of severity of behaviors and sanctions, related to sexual misconduct; 2) identifying and evaluating barriers to reporting sexual misconduct to state medical boards, including, but not limited to, the impact of state confidentiality laws, state administrative codes and procedures, investigative procedures, and cooperation with law enforcement on the reporting and prosecution/adjudication of sexual misconduct; 3) evaluating the impact of state medical board public outreach on reporting; 4) reviewing the FSMB's 2006 policy statement, *Addressing Sexual Boundaries: Guidelines for State Medical Boards,* and revising, amending or replacing it, as appropriate; and 5) assessing the prevalence of sexual misconduct training in undergraduate and graduate medical education and developing recommendations and/or resources to address gaps.

Over the course of two years, the workgroup carried out its charge by reviewing existing research, policy, resources, and strategies for addressing physician sexual misconduct. The workgroup also held two in-person meetings in 2018, received additional information during the FSMB's 2019 Annual Meeting through a Plenary Panel Discussion that included several viewpoints, as well as a Board Forum that hosted more than 200 attendees for an in-depth discussion of key issues, and held a Symposium on Sexual Boundary Violations in Washington, D.C. on June 6, 2019, that also included participants from several state medical boards not represented on the workgroup. A teleconference was held on October 16, 2019 to discuss an initial draft Report with feedback and proposed changes conveyed to the FSMB Board of Directors during an oral report at its October 2019 meeting, followed by a discussion of the board.

A revised draft incorporating feedback received from the Board of Directors was distributed to state medical boards during a comment period held from November 26, 2019 to January 10, 2020. Comments were received from several organizations and members of the public, as well as seven state medical boards. Feedback received was categorized according to the following themes:

- Requirements for notification to law enforcement
- Feasibility of and best practices for remediation
- The duty to report, including peer and institutional reporting, as well as whistleblower protection
- Transparency of data, regulatory processes, complaints, and bases for discipline
- Notification to existing patients of stipulation and to new patients of previous disciplinary action
- Education of clinicians, state medical boards and the public
- Chaperones and practice monitors
- Additional requests of the FSMB:

- Model legislation (e.g., Duty to Report)
- Collection of background data on state laws, made publicly available
- Education across the continuum for appropriate treatment of patients (in collaboration with partners, e.g., AACOM, AAMC, ACGME, AOA)
- Facilitation of development and exchange of best practices among boards
- Facilitation and provision of training on implicit bias and trauma-informed investigations
- Funding for data development, coding, and analysis pilots by boards and others

The workgroup met again via teleconference on January 29, 2020 to discuss feedback received and provide input for its incorporation into a new draft. This revised draft was distributed to the Board of Directors electronically and discussed during a videoconference held on March 2, 2020. During this videoconference, the Board voted to approve the Report **(Attachment 1)** and recommended its adoption by the House of Delegates.

ITEM FOR ACTION:

The Board of Directors recommends that:

The House of Delegates ADOPT the recommendations contained in the *Report of the FSMB Workgroup on Physician Sexual Misconduct* and the remainder of the Report be filed.

BRD RPT 20-2 Attachment 1

Report of the FSMB Workgroup on Physician Sexual Misconduct

DRAFT

Section 1: Introduction and Workgroup Charge

The relationship between a physician and patient is inherently imbalanced. The knowledge, skills and training statutorily required of all physicians puts them in a position of power in relation to the patient. The patient, in turn, often enters the therapeutic relationship from a position of vulnerability due to illness, suffering, and a need to divulge deeply personal information and subject themselves to intimate physical examination. This vulnerability is further heightened in light of the patient's trust in their physician, who has been granted the power to deliver care, prescribe needed treatment and refer for appropriate specialty consultation.

It is critical that physicians act in a manner that promotes mutual trust with patients to enable the delivery of quality health care. When there is a violation of that relationship through sexual misconduct, such behavior and actions can have a profound, enduring and traumatic impact on the individual being exploited, their family, the public at large, and the medical profession as a whole. Properly and effectively addressing sexual misconduct by physicians through sensible standards and expectations of professionalism, including preventive education, as well as through meaningful disciplinary action and law enforcement when required, is therefore a paradigmatic expression of self-regulation and its more modern iteration, shared regulation.

In May of 2017, Patricia King, M.D., PhD., Chair at the time of the Federation of State Medical Boards (FSMB), created and led a Workgroup on Physician Sexual Misconduct (hereafter referred to as "the Workgroup"), and charged its members with 1) collecting and reviewing available disciplinary data, including incidence and spectrum of severity of behaviors and sanctions, related to sexual misconduct; 2) identifying and evaluating barriers to reporting sexual misconduct to state medical boards, including, but not limited to, the impact of state confidentiality laws, state administrative codes and procedures, investigative procedures, and cooperation with law enforcement on the reporting and prosecution/adjudication of sexual misconduct; 3) evaluating the impact of state medical board public outreach on reporting; 4) reviewing the FSMB's 2006 policy statement, *Addressing Sexual Boundaries: Guidelines for State Medical Boards,* and revising, amending or replacing it, as appropriate; and 5) assessing the prevalence of sexual boundary/harassment training in undergraduate and graduate medical education and developing recommendations and/or resources to address gaps.

In carrying out its charge, the Workgroup adopted a broad lens with which to scrutinize not only the current practices of state medical boards and other professional regulatory authorities in the United States and abroad, but also elements of professional culture within American medicine, including notions of professionalism, expectations related to reporting instances of misconduct or impropriety, evolving public expectations of the medical profession, and the impact of trauma on survivors of sexual misconduct. In analyzing these issues, the Workgroup benefited tremendously from discussions with several of the FSMB's partner organizations and stakeholders that also have a role in addressing the issue of physician sexual misconduct. The Workgroup extends its thanks, in particular, to the American Association of Colleges of

Osteopathic Medicine (AACOM), Association of American Medical Colleges (AAMC), Student Osteopathic Medical Association (SOMA), Australian Health Practitioner Regulation Agency (AHPRA), American Medical Association (AMA), American Medical Women's Association (AMWA), American Osteopathic Association (AOA), Council of Medical Specialty Societies (CMSS), Federation of Medical Regulatory Authorities of Canada (FMRAC), Federation of State Physician Health Programs (FSPHP), several provincial medical regulatory colleges from Canada, subject matter experts from Justice3D, PBI Education, and additional physician experts, and especially the victim and survivor advocates who bravely shared their experiences with Workgroup members. This report has been enriched by these partners' valuable contributions.

A call for cultural change

The Workgroup acknowledged the importance of the environment and culture, from medical school to practice, for the development of and commitment to positive professional values and behaviors in medicine. In this regard, the Workgroup also acknowledged the existence of several highly problematic aspects of sexual misconduct in medical education and practice, many of which permeate the prevailing culture of medicine and self-regulation. The National Academies of Sciences report that organizational culture plays a primary role in enabling harassment and that sexually harassing behaviors are not typically isolated incidents.[1] Medical students and trainees who are subjected to environments in which harassment is accepted suffer not only as victims, but may also be undermined in their educational and professional attainment, resulting in loss of talent for the profession. To the extent that a culture that is permissive of sexual harassment results in perceived license to engage in such conduct oneself, patients are ultimately put at risk of dire consequences. Permissive environments could also reduce the likelihood that bystanders will feel responsibility to report misconduct.

Beyond the many instances, both reported and unreported, of sexual assault and boundary violations, concerns about sexual misconduct in medicine include various aspects of the investigative and adjudicatory processes designed to address them; the professional responsibility of health care practitioners to report suspected instances of sexual misconduct and patient harm; variation in state medical board policies and processes, as well as in state laws; transparency of state medical board processes and actions; a widespread need for education and training among medical regulators, board investigators, attorneys, and law enforcement personnel about trauma and how it might impact complainant accounts and the investigative process; and challenges posed for decisions about re-entry to practice and remediation.

This report summarizes these problematic elements so that they may be more widely appreciated, while offering potential solutions and strategies for state medical boards to consider for their jurisdictions. It aspires to provide best practice recommendations and highlight existing strategies and available tools to allow boards, including board members, executive directors, staff, and attorneys, to best protect the public while working within their established frameworks and resources. The report also advocates for an educational focus to change and improve

[1] National Academies of Sciences, Engineering, and Medicine. 2018. *Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine*. Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/24994.

culture, awareness, and behaviors across the continuum of medical education and practice, so as to improve care for and protection of patients.

Section 2: Principles

The analysis in this report is informed by the following principles:

- **Trust**: The physician-patient relationship is built upon trust, understood as a confident belief on the part of the patient in the moral character and competence of their physician.[2] In order to safeguard this trust, the physician must act and make treatment decisions that are in the best interests of the patient at all times.
- **Professionalism**: The avoidance of sexual relationships with patients has been a principle of professionalism since at least the time of Hippocrates. Professional expectations still dictate today that sexual contact or harassment of any sort between a physician and patient is unacceptable.
- **Fairness**: The principle of fairness applies to victims (also sometimes described as survivors) of sexual misconduct, who must be granted fair treatment throughout the regulatory process and be afforded opportunities to seek justice for wrongful conduct committed against them. Fairness also applies to physicians who are subjects of complaints in that they must be granted due process in investigative and adjudicatory processes; proportionality should be considered in disciplinary actions.
- **Transparency**: The actions and processes of state medical boards are designed in the public interest to regulate the medical profession and protect patients from harm. As such, the public has a right to information about these processes and the bases of regulatory decisions.

Section 3: Terminology:

Sexual Misconduct:

For the purposes of this report, physician sexual misconduct is understood as behavior that exploits the physician-patient relationship in a sexual way. Sexual behavior between a physician and a patient is never diagnostic or therapeutic. This behavior may be verbal or physical, can occur in person or virtually,[3] and may include expressions of thoughts and feelings or gestures that are of a sexual nature or that a patient or surrogate[4] may reasonably construe as sexual. Hereinafter, the term "patient" includes the patient and/or patient surrogate.

Physician sexual misconduct often takes place along a continuum of escalating severity. This continuum comprises a variety of behaviors, sometimes beginning with "grooming" behaviors which may not necessarily constitute misconduct on their own, but are precursors to other, more

[2] Beauchamp T and Childress J., (2001) *Principles of Biomedical Ethics*, 5th ed., 34.
[3] Federation of State Medical Boards, *Social Media and Electronic Communication*, 2019.
[4] Surrogates are those individuals closely involved in patients' medical decision-making and care and include spouses or partners, parents, guardians, and/or other individuals involved in the care of and/or decision-making for the patient.

severe violations. Grooming behaviors may include gift-giving, special treatment, sharing of personal information or other acts or expressions that are meant to gain a patient's trust and acquiescence to subsequent abuse.[5] When the patient is a child, adolescent or teenager, the patient's parents may also be groomed to gauge whether an opportunity for sexual abuse exists.

More severe forms of misconduct include sexually inappropriate or improper gestures or language that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient. These may not necessarily involve physical contact, but can have the effect of embarrassing, shaming, humiliating or demeaning the patient. Instances of such sexual impropriety can take place in person, online, by mail, by phone, and through texting.

Additional examples of sexual misconduct involve physical contact, such as performing an intimate examination on a patient with or without gloves and without clinical justification or explanation of its necessity, and without obtaining informed consent.

The severity of sexual misconduct increases when physical contact takes place between a physician and patient and is explicitly sexual or may be reasonably interpreted as sexual, even if initiated by the patient. So-called "romantic" behavior between a physician and a patient is never appropriate, regardless of the appearance of consent on the part of the patient. Such behavior would at least constitute grooming, depending on the nature of the behavior, if not actual sexual misconduct, and should be labeled as such.

The term "sexual assault" refers to any type of sexual activity or contact without consent (such as through physical force, threats of force, coercion, manipulation, imposition of power, etc., or circumstances where a person lacks the capacity to provide consent due to age or other circumstances) and may be used in investigations where there is a need to emphasize the severity of the misconduct and related trauma. Sexual assault is a criminal or civil violation and should typically be handled in concert with law enforcement. Sexual assault should be reported to law enforcement immediately, except in cases where reporting would contravene the wishes of an adult complainant and non-reporting in such an instance is permitted by applicable state law.

While the legal term "sexual boundary violation" is a way of denoting the breach of an imaginary line that exists between the doctor and patient or surrogate, and is commonly used in medical regulatory discussions, the members of the Workgroup felt that it was an overly broad term that may encompass everything from isolated instances of inappropriate communication to sexual misconduct and outright sexual assault. Thus, this report avoids the term in favor of more specific terms.

Trauma:

For the purposes of this report, the definition of trauma provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) is used:

[5] American Academy of Pediatrics "Protecting Children from Sexual Abuse by Health Care Providers," Committee on Child Abuse and Neglect, 2010-2011, Published in *Pediatrics*, August 2011, Vol. 128, Issue 2.

"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[6]

According to SAMHSA, "a program, organization, or system that is *trauma-informed* realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization."[7]

Patient:

A patient is understood as an individual with whom a physician is involved in a care and treatment capacity within a legally defined and professional physician-patient relationship.

Physician:

While this report primarily addresses physician licensees, the content and recommendations should be viewed as applying to all health professionals licensed by member boards of the FSMB, as well as other members of the health care team, including medical students.

Section 4: Patient Rights and Expectations for Professional Conduct in the Physician-Patient Encounter

Communication and Patient Education

Communication between a physician and patient should occur throughout any examination or procedure (provided the patient is not under general anesthetic during the procedure), including conveying the medical necessity, what the examination or procedure will involve, any discomfort the patient might experience, the benefits and risks, and any findings. This is especially important during the performance of an intimate examination. This not only lays out the parameters of the interaction for both parties; it may also help minimize the possibility that the patient will misinterpret the physician's actions.

The use of educational resources to educate patients about what is normal and expected during medical examinations and procedures is encouraged and should be provided by both physicians and state medical boards.

[6] Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
[7] *Id*. Emphasis added.

Informed Consent and Shared Decision-Making

The informed consent process can be a useful way of helping a patient understand the intimate nature of a proposed examination, as well as its medical necessity. The informed consent process should include, at a minimum, an explanation, discussion, and comparison of treatment options with the patient, including a discussion of any risks involved with proposed procedures; an assessment of the patient's values and preferences; arrival at a decision in partnership with the patient; and an evaluation of the patient's decision in partnership with the patient. This process must be documented in the patient's medical record.

Where possible, the consent process should take place well in advance of any procedure so that the patient has an opportunity to consider the proposed procedure in the absence of competing considerations about cancellation or rescheduling. Requiring decisions at the point of care puts patients at a disadvantage because they may not have time to consider what is being proposed and what it means for themselves and their values. However, it is recognized that obtaining consent well in advance is not always possible for urgent, emergency, or same-day procedures. The consent process should also include information about the effects of anaesthesia, including the possibility of amnesia, because these can be particularly problematic with respect to sexual misconduct. Use of understandable (lay, or common) language during the consent process is essential.

In instances where a patient is unable to provide consent to a pelvic or otherwise intimate examination due to the presence of anesthesia or for any other reason, an intimate examination should only be performed when it is medically necessary. Intimate examinations must never be performed for purely educational purposes when consent cannot be obtained.

Section 5: Complaints and the Duty to Report

In order for state medical boards to effectively address instances of sexual misconduct, they must have access to relevant information about licensees that have harmed or pose a significant risk of harming patients. The complaints process and physicians' professional duty to report instances of sexual misconduct are therefore central to a regulatory board's ability to protect patients.[8]

Complaints and Barriers to Complaints

It is essential for patients or their surrogates to be able to file complaints about their physicians to state medical boards in order that licensees who pose a threat to patients may be investigated and appropriate action taken. However, studies have estimated that sexual misconduct by physicians is significantly under reported, and several challenges which may dissuade patients from filing complaints must be overcome.[9] These include distrust in the ability or willingness of institutions

[8] Additional reporting to entities other than state medical boards may also be warranted for purposes of patient protection, including law enforcement, hospital or medical staff administration, and medical school or residency program directors and supervisors.

[9] Dubois J, et al. Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases. *Sexual Abuse* 2019, Vol. 31(5) 503–523

such as state medical boards, hospitals and other health care organizations to take action in instances of sexual misconduct; fear of abandonment or retaliation by the physician; societal or personal factors related to stigma, shame, embarrassment and not wanting to relive a traumatic event; a lack of awareness about the role of state medical boards and how to file complaints; or uncertainty that what has transpired is, indeed, unprofessional and unethical.

State medical boards can play an important role in providing clarity about the complaints process by providing information to the public about the process itself and how, why, and when to file a complaint. Recommended methods for optimizing the complaints process include:

- Providing the option to file complaints via multiple channels, including in writing, by telephone, email, or through online forms
- Making the process accessible to patients with information about filing complaints that is clearly posted on state medical board websites
- Ensuring that information about the complaints process is made available via translation for complainants who do not speak English

State medical boards, the FSMB and its partner organizations representing medical specialties whose members perform intimate examinations and procedures may also wish to provide education for patients on topics such as:

- The types of behavior that should be expected of physicians
- Types of behavior that might warrant a complaint
- What to do in the event that a physician's actions make a patient uncomfortable
- Circumstances that would warrant a report directly to law enforcement

State medical boards can also restore public trust and confidence in the complaints process by demonstrating swift and appropriate action on verified complaints.

The ability to file a complaint anonymously may be especially important in instances of sexual misconduct. The trauma and fear associated with sexual misconduct can pose barriers to legitimate complaints, especially when anonymity is not granted. While the ability of complainants to remain anonymous to the general public is recommended, complainant anonymity to the state medical board may not be possible.

State medical boards should address complaints related to sexual misconduct as quickly as possible for the benefit and protection of the complainant and other patients. Initial stages of investigations should be expedited to determine whether there is a high likelihood of imminent risk to the public, meriting steps to modify or cease practice while the investigation is completed.

State medical board staff and board investigators of administrative complaints are encouraged to communicate frequently with complainants throughout the complaint and investigative processes and to ask complainants about their preferred mode and frequency of communication, as well as their expectations from the process. Where possible, boards should consider having a patient liaison or navigator on staff who would be specially trained to provide one-on-one support to complainants and their families.

Duty to Report

In a complaint-based medical regulatory system, it is imperative that state medical boards have access to the information they require to effectively protect patients.[10] In addition to a robust complaints process, it is therefore essential that patients, physicians and everyone involved in healthcare speak up whenever something unusual, unsafe or inappropriate occurs. All members of the healthcare team, as well as institutions, including state medical boards, hospitals and private medical clinics also have a legal as well as an ethical duty to report instances of sexual misconduct and other serious patient safety issues and events. This duty extends beyond physician-patient encounters to reporting inappropriate behavior in interactions with other members of the healthcare team, and in the learning environment.

Early reporting of sexual misconduct is critical. This includes reporting of those forms of misconduct at the less egregious end of the spectrum that fall under potential grooming behaviors. Evidence indicates that less egregious violations that go unreported frequently lead to more egregious ones. Less egregious acts and grooming behaviors are almost always committed in private or after hours where they cannot be witnessed by parties external to the physician-patient encounter and therefore go unreported. Early reporting is therefore one of the only ways in which sexual misconduct with patients can be prevented from impacting more patients.

The ethical duty to report has proven insufficient in recent years, however, to provide the information state medical boards must have to stop or prevent licensees from engaging in sexual misconduct. There are likely several factors that inhibit reporting, including the corporatization of medical practice, which has led many institutions to deal with instances of misconduct internally. While corporatization increases accountability for many physicians and internal processes may be effective in addressing some types of sexual misconduct, it can also cause some institutions to neglect required reporting and the need for transparency. Physicians may also avoid reporting because of the moral distress and discomfort some physicians feel when asked to report their colleagues, and the impracticality of reporting where power dynamics exist and where stakes are high for reporters.

Thus, rather than relying on professional or ethical duties alone, alternative strategies and approaches should be considered. State medical boards should have the ability to levy fines against institutions for failing to report instances of egregious conduct. While many boards already have statutory ability to do so, they are reluctant to engage in legal proceedings with hospitals or other institutions with far greater resources at their disposal. An ability to publicize reasons for levying fines may also be helpful as the reputational risk to an institution could provide added incentives to report.

Results of hospital and health system peer review processes should also be shared with state medical boards when sexual misconduct is involved. This type of conduct is fundamentally different from other types of peer review data related to performance and aimed at quality improvement and, while still relevant to medical practice, should be subject to different rules regarding reporting. Hospitals should also be required to report to state medical boards instances

[10] Federation of State Medical Boards, *Position Statement on Duty to Report*, 2016.

where employed physicians have been dismissed or are forced to resign due to concerns related to sexual misconduct.

Boards should have the authority to impose disciplinary action on licensees for failure to report. Where such authority does not currently exist, legislative change may be sought.[11] Language used in state laws describing when reporting is mandatory varies and can include "actual knowledge" of an event, "reasonable cause" to believe that an event occurred, "reasonable belief," "first-hand knowledge," and "reasonable probability" (as distinguished from "mere probability").[12] Despite the variance in language, the theme of reasonability runs throughout. If it is reasonable to believe that misconduct occurred, this should be reported to the state medical board and, in most instances, to law enforcement.

Reporting to Law Enforcement

There is variability in state laws that address when state medical boards are required to report instances of sexual misconduct to law enforcement. Despite this variability, best practices dictate that boards have a duty to report to law enforcement anytime they become aware of sexual misconduct or instances of criminal behavior. When reporting requirements are unclear, consultation with a board attorney is recommended, but boards are encouraged to err on the side of reporting. Protocols and consensus can also be established in collaboration with law enforcement to help clarify reporting requirements. This can also help to clarify circumstances where law enforcement should report instances of physician sexual misconduct to state medical boards.

In limited circumstances, boards may choose not to report to law enforcement. These may involve less egregious forms of sexual misconduct such as inappropriate speech or include circumstances where a complainant requests that law enforcement not be notified, as long as there is no law establishing a mandatory reporting requirement. Wishes of complainants should be respected in such circumstances, as victims may be at different stages of coming to terms with the trauma they've experienced. However, reporting to law enforcement must occur for any instance of child abuse, abuse of a minor, and abuse of a dependent adult, regardless of whether the complainant wants reporting to occur. In any instance where reporting sexual misconduct to law enforcement is considered, especially in instances where a decision is made *not* to report, a clear rationale for the board's decision should be documented. Boards can also facilitate the reporting process for patients by offering assistance or educational resources about the reporting process and relevant contact information.

Cultivating Professionalism

Empowering physicians and physicians in training to report violations of professional standards is essential given the barriers posed by the hierarchical structure of most health care institutions. Those in a position to observe and report sexual misconduct should be protected from retaliation and adverse consequences for medical school matriculation, training positions, careers or

[11] See, e.g., N.C. Gen. Stat. § 90-5.4

[12] Starr, Kristopher T Reporting a Physician Colleague for Unsafe Practice: What's the Law? *Nursing2019*: February 2016 - Volume 46 - Issue 2 - p 14

promotions. Cultivating positive behavior through role modelling and establishing clear guidance based on the values of the profession is the responsibility of multiple parties, not the state medical board alone. A broader notion of professionalism should be adopted that goes beyond expectations for acceptable conduct to include a duty to identify instances of risk or harm to patients, thereby making non-reporting professionally unacceptable. Physicians who fail to report known instances of sexual misconduct should be liable for sanction by their state medical board for the breach of their professional duty to report.

Unscrupulous, frivolous or vexatious reporting motivated by competition or personal animus is counterproductive to fulfilling this notion of professionalism and protecting the public, so should be met with disciplinary action. Processes for reporting and complaints should be normalized by making them a core component of medical professionalism, rather than a burdensome responsibility that befalls particular unfortunate individuals. This may help physicians feel less like investigators and more like responsible stewards of professional values. Those physicians and other individuals who do report in good faith should be protected from retaliation through whistleblower legislation and given the option to remain anonymous.

Section 6: Investigations

State Medical Board Authority

It is imperative that state medical boards have sufficient statutory authority to investigate complaints and any reported allegations of sexual misconduct. State medical boards should place a high priority on the investigation of complaints of sexual misconduct due to patient vulnerability unique to such cases. The purpose of the investigation is to determine whether the report can be substantiated in order to collect sufficient facts and information for the board to make an informed decision as to how to proceed. If the state medical board's investigation indicates a reasonable probability that the physician has engaged in sexual misconduct, the state medical board should exercise its authority to intervene and take appropriate action to ensure the protection of the patient and the public at large.

Each complaint should be investigated and judged on its own merits. Where permitted by state law, the investigation should include a review of previous complaints to identify any such patterns of behavior, including malpractice claims and settlements. In the event that such patterns are identified early in the investigation, or the physician has been the subject of sufficient previous complaints to suggest a high likelihood that the physician presents a risk to future patients, or in the event of evidence supporting a single egregious misconduct event, the state medical board should have the authority to impose terms or limitations, including suspension, on the physician's license prior to the completion of the investigation.

The investigation of all complaints involving sexual misconduct should include interviews with the physician, complainant(s) and/or patient and/or patient surrogate. The investigation may include an interview with a current or subsequent treating practitioner of the patient and/or patient surrogate; colleagues, staff and other persons at the physician's office or worksite; and

persons that the patient may have told of the misconduct. Physical evidence and police reports can also be valuable in providing a more complete understanding of events.

In many states, a complaint may not be filed against a physician for an activity that occurred beyond a certain time threshold in the past. There is a growing trend among state legislatures in recent years to extend or remove the statute of limitations in cases of rape, sexual assault and other forms of sexual misconduct. Given the impact that trauma can have on a victim of sexual misconduct, the length of time that it may take to understand that a violation has occurred, to come to terms with it, or be willing to relive the circumstances as part of the complaints process, the members of the Workgroup feel that no limit should be placed on the amount of time that can elapse between when an act of misconduct occurred and when a complaint can be filed.

Trauma-Informed Investigations

Because of the delicate nature of complaints of sexual misconduct and the potential trauma associated with it, state medical boards should have special procedures in place for interviewing and interacting with such complainants and adjudicating their cases. In cases involving trauma, emotions may not appear to match the circumstances of the complaint, seemingly salient details may be unreported or unknown to the complainant, and the description of events may not be recounted in linear fashion. Symptoms of trauma may therefore be falsely interpreted as signs of deception by board investigators or those adjudicating cases.

Professionals who are appropriately trained and certified in the area of sexual misconduct and victim trauma should conduct the state medical board's investigation and subsequent intervention whenever possible. Best practices in this area suggest that board members and staff should undergo specialized training in victim trauma. It is further recommended that all board staff who work with complainants in cases involving sexual misconduct undergo this training to develop an understanding of how complainants' accounts in cases involving trauma can differ from other types of cases. This can inform reasonable expectations on behalf of those investigating and adjudicating these cases and help eliminate biases. The FSMB and state medical boards should work to identify and ensure the availability of high-quality training in trauma and a trauma-informed approach to investigations. While a greater understanding of victim trauma is a priority, additional training in implicit bias related to gender, gender identity, race, and ethnicity would also help ensure fair and comfortable processes for victims.

Where state medical boards have access to investigators of different genders, boards should seek the complainant's preference regarding the gender of investigators and assign them accordingly. State medical boards should also allow inclusion of patient advocates in the interview process and treat potential victims (survivors) with empathy, humanity, and in a manner that encourages healing. Questioning of both complainants and physicians should take the form of an information-gathering activity, not an aggressive cross-examination.

Section 7: Comprehensive Evaluation

State medical boards regularly use diagnostic evaluations for health professionals who may have a physical or mental impairment. Similarly, the use of diagnostic evaluations when handling a complaint regarding sexual misconduct provides significant information that may not otherwise be revealed during the initial phase of the investigation. A comprehensive evaluation may be valuable to the board's ability to assess future risk to patient safety.

A comprehensive evaluation is not meant to determine findings of fact. Rather, its purpose is to:

- assess and define the nature and scope of the physician's behavior,
- identify any contributing illness, impairment, or underlying conditions that may have predisposed the physician to engage in sexual misconduct or that might put future patients at risk,
- assist in determining whether a longstanding maladaptive pattern of inappropriate behavior exists, and
- make treatment recommendations if rehabilitative potential is established.

If its investigation reveals a high probability that sexual misconduct has occurred, the state medical board should have the authority to order an evaluation of the physician and the physician must be required to consent to the release to the board all information gathered as a result of the evaluation. The evaluation of the physician follows the investigation/intervention process but precedes a formal hearing.

The evaluation of a physician for sexual misconduct is complex and may require a multidisciplinary approach. Where appropriate, it should also include conclusions about fitness to practice.

Section 8: Hearings

Following investigation and evaluation (if appropriate), the state medical board should determine whether sufficient evidence exists to proceed with formal charges against the physician. In most jurisdictions, initiation of formal charges is public and will result in an administrative hearing unless the matter is settled.

Initiation of Charges

In assessing whether sufficient evidence exists to support a finding that sexual misconduct has occurred, corroboration of a patient's testimony should not be required. Although establishing a pattern of sexual misconduct may be significant, a single case is sufficient to proceed with a formal hearing. State medical boards should have the authority to amend formal charges to include additional complainants identified prior to the conclusion of the hearing process.

Open vs Closed Hearings

If state medical boards are required, by statute, to conduct all hearings in public, including cases of sexual misconduct, many patients may be hesitant to come forward in a public forum and relate the factual details of what occurred. State medical boards should have the statutory authority to close the hearing during testimony which may reveal the identity of the patient. Where closing a hearing is not possible, great care should be taken to deidentify any personally identifying or sensitive information in transcripts and medical records. The decision to close the hearing, in part or in full, should be at the discretion of the board. Neither the physician nor the witness should control this decision. Boards should allow the patient the option of having support persons available during both open and closed hearings.

Patient Confidentiality

Complaints regarding sexual misconduct are highly sensitive. Therefore, enhanced attention must be given to protecting a patient's identity, including during board discussion, so that patients are not discouraged from coming forward with legitimate complaints against physicians. State medical boards should have statutory authority to ensure nondisclosure of the patient's identity to the public. This authority should include the ability to delete from final public orders any patient identifiable information.

Testimony

Sexual misconduct cases involve complex issues; therefore, state medical boards may consider the use of one or more expert witnesses to fully develop the issues in question and to define professional standards of care for the record. Additionally, the evaluating/treating physician or mental health care practitioners providing assessment and/or treatment to the respondent physician may be called as witnesses. The evaluating clinician may provide details of treatment, diagnosis and prognosis, especially the level of insight and change by the practitioner. Also, a current or subsequent treating practitioner of the patient, especially a mental health provider, may be called as a witness. All these witnesses may provide insight into factors that led to the alleged sexual misconduct, an opinion regarding the level of harm incurred by the patient, and describe the physician's rehabilitative potential and risk for recidivism.

Implicit Bias

In any case that comes before a state medical board, it is important for those responsible for adjudicating the case to be mindful of any personal bias that may impact their review and adjudication. Bias can be particularly strong where board members themselves have been victims of sexual assault or have been subject to previous accusations regarding sexual misconduct. Bias may even influence the decisions of state medical board members by virtue of their being physicians themselves. Training about implicit bias is recommended for board members and staff in order to help identify implicit bias and mitigate the impact it may have on their work.[13]

[13] Project Implicit, accessed November 13, 2019 at https://implicit.harvard.edu/implicit/

Diverse representation on state medical boards in terms of gender, age, and ethnicity is important for ensuring balanced discussion and decisions. The inclusion of public members on state medical boards can also contribute to the reduction of bias in adjudication, while also amplifying the patient perspective through commitment to the priorities and interests of the public.[14] In order to ensure effective and meaningful participation from public members, appropriate orientation and education about their role should occur.

Section 9: Discipline

State medical boards have a broad range of disciplinary responses available to them that are designed to protect the public. Upon a finding of sexual misconduct, the board should take appropriate action and impose one or more sanctions reflecting the severity of the conduct and potential risk to patients. Essential elements of any board action include a list of mitigating and aggravating factors, an explanation of the violation in plain language, clear and understandable terms of the sanction, and an explanation of the consequences associated with non-compliance.

Findings of even a single case of sexual misconduct are often sufficiently egregious as to warrant revocation of a physician's medical license. Certain serious forms of unprofessional conduct should presumptively provide the basis for revocation of a license in order to protect the public. Misconduct in this class would include sexual assault, conduct amounting to crimes related to sex, regardless of whether charged or convicted, or egregious acts of a sexual nature. State medical boards should also consider revocation in instances where a physician has repeatedly committed lesser acts, especially following remedial efforts.

In a limited set of instances, state medical boards may find that mitigating circumstances do exist and, therefore, stay the revocation and institute terms and conditions of probation or other practice limitations. If a physician is permitted to remain in practice and gender- or age-based restrictions are used by state medical boards, consideration may also be given to coupling these restrictions with additional regulatory interventions such as education, monitoring or other forms of probation.

In determining an appropriate disciplinary response, the board should consider the factors listed in **Table 1**.

[14] Johnson DA, Arnhart KL, Chaudhry HJ, Johnson DH, McMahon GT, The Role and Value of Public Members in Health Care Regulatory Governance *Acad Med*, Vol. 94, No. 2 / February 2019

Table 1: Considerations in determining appropriate disciplinary response	
• Patient Harm[15] • Severity of impropriety or inappropriate behavior • Context within which impropriety occurred • Culpability of licensee • Psychotherapeutic relationship • Existence of a physician-patient relationship • Scope and depth of the physician-patient relationship • Inappropriate termination of physician-patient relationship	• Age and competence of patient • Vulnerability of patient • Number of times behavior occurred • Number of patients involved • Period of time relationship existed • Evaluation/assessment results • Prior professional misconduct/disciplinary history/malpractice • Recommendations of assessing/treating professional(s) and/or state physician health program • Risk of reoffending

Boards should not routinely consider romantic involvement, patient initiation or patient consent to be a legal defense. Sexual misconduct may still occur following the termination of a physician-patient relationship, especially in long-standing relationships or ones that involve a high degree of emotional dependence. Time elapsed between termination of the relationship is insufficient in many contexts to determine that sexual contact is permissible. Other factors that should be considered in assessing the permissibility of consensual sexual contact between consenting adults following the termination of a physician-patient relationship can include documentation of formal termination; transfer of the patient's care to another health care provider; the length of time of the professional relationship; the extent to which the patient has confided personal or private information to the physician; the nature of the patient's health problem; and the degree of emotional dependence and vulnerability.[16] Termination of a physician-patient relationship for the purposes of allowing sexual contact to occur is unacceptable and would still constitute sexual misconduct because of the trust, inherent power imbalance between a physician and patient, and patient vulnerability that exist leading up to, during and following the decision to terminate the relationship. Any consent to sexual or

[15] Broadly understood as inclusive of physical and emotional harm, resulting distrust in the medical system and avoidance of future medical treatment, and other related effects of trauma.
[16] Washington Medical Commission, *Guideline on Sexual Misconduct and Abuse*, 2017.

romantic activity provided by a patient within the context of a physician-patient relationship or immediately after its termination should be considered invalid.

Society's values and beliefs evolve, and some individuals may be slower to abandon long-held beliefs, even where these may be sexist or prejudiced in other ways. However, adherence to an outdated set of generational values that has since been found to be unacceptable is not a reason to overlook or excuse sexual misconduct.

The potential existence of a physician workforce shortage or maldistribution, or arguments related to particular restrictions being tantamount to taking a physician "out of work" should also not be used as reasons for leniency or for allowing patients to remain in harm's way. In cases involving sexual misconduct, it is simply not true that unsafe or high-risk care is better than no care at all. A single instance, let alone many instances, can cause an extremely high degree of damage to individuals and the communities in which they reside. However, staying true to the principle of proportionality also means considering the fact that some forms of discipline, including public notifications, generate significant shame upon the disciplined physician. This can compound the degree of severity of a disciplinary action and may be taken into consideration by state medical boards where less egregious forms of sexual impropriety are involved.

Temporary or Interim Measures:

In the event that a state medical board decides to remove a licensee from practice or limit the practice of a licensee as a temporary measure in order to reduce the risk of patient harm while an investigation takes place, there are several different interim measures that can be used. Common measures include an interim or summary suspension/cessation of practice, restrictions from seeing patients of a certain age or gender, restrictions from seeing patients altogether, or the mandatory use of a practice monitor (to be understood as distinct from a chaperone, as explained below) for all patient encounters.

The appropriateness of age and gender-based interim restrictions should be considered carefully before being imposed by state medical boards. Sexual misconduct often occurs for reasons related to power, rather than because of a sexual attraction to a particular gender or age group, thereby making these restrictions ineffective to protect patients in many cases.

Remediation

As discussed above, many forms of sexual misconduct and harmful actions that run against the core values of medicine should appropriately result in revocation of licensure. However, there may be some less egregious forms of sexual impropriety with mitigating circumstances for which a physician may be provided the option of participating in a program of remediation to be able to re-enter practice or have license limitations lifted following a review and elapse of an appropriate period of time.

The decision to allow a physician who has committed an act of sexual misconduct the opportunity to undergo a program of remediation with an end goal of potential license reinstatement is difficult for boards to make. Boards are therefore encouraged to draw from the

professional resources that already exist in making determinations about remediation potential and license reinstatement.

State medical boards should be mindful that not all physicians who have committed sexual misconduct are capable of remediation. Reinstatement and monitoring in such a context would therefore be inappropriate. For those who are considered for remediation, if at any point it becomes clear that the physician presents a risk of reoffending or otherwise harming patients, the remediation process should be abandoned, and reinstatement should not occur.

In determining whether remediation is feasible for a particular physician, state medical boards may wish to make use of a risk stratification methodology that considers the severity of actions committed, the mitigating and aggravating factors listed in section 9 above (Discipline), the character of the physician, including insight and remorse demonstrated, as well as an understanding of how their actions violated standards of professional ethics and state medical practice acts, and the perceived likelihood that they may reoffend. The consequences to patients and the general public of allowing a physician to engage in remediation and re-enter practice after a finding of sexual misconduct should be considered, including any erosion of the public trust in the medical profession and the role of state medical boards.

The goals of the remediation process should be clearly outlined, including expectations for acceptable performance on the part of the physician. The process of remediation should take place in-person (online or other forms of distance learning would not be sufficient), require full disclosure of and relate to the physician's offense(s) and be targeted to identified gaps in understanding of their particular vulnerabilities and other risks for committing sexual misconduct. As a condition of successful completion of a program of remediation, participants should be required to articulate not only *why* their actions were wrong, but also *how* they arrived at the point at which they were willing to commit them, and *how* they will guard against arriving at such a point again. For this to occur, assessment and remediation partners must be provided access to investigative information in order to properly tailor remedial education to the particular context in which the misconduct occurred. Finally, state medical boards should be mindful that remediation cannot typically be said to have "occurred" following successful completion of an educational course. Rather, a longitudinal mechanism must be established for maintaining the physician's engagement in a process of coming to terms with their misconduct and avoiding the circumstances that led to it. The longitudinal mechanism both demonstrates the physician's commitment to accountability and the effectiveness of a board's monitoring reach.

The members of the Workgroup acknowledge that shortcomings exist in the current evidence base regarding the effectiveness of remediation in instances of sexual misconduct. As noted elsewhere in this report, recidivism is exceedingly difficult to study well. Recommendations about the use of consistent terminology and improving the tracking of disciplined physicians will contribute to understanding what kinds of remedial interventions are most appropriate and effective in the context of sexual misconduct. Moreover, the Workgroup feels that further research is needed in several other areas, such as group learning experiences, instruction in victim empathy, remedial instruction with or without additional interventions, and identification of subgroups of offenders who may be at higher risk of reoffending.

License Reinstatement/Removal of License Restriction(s)

In the event of license revocation, suspension, or license restriction, any petition for reinstatement or removal of restriction should include the stipulation that a current assessment, and if recommended, successful completion of treatment, be required prior to the medical board's consideration to assure the physician is competent to practice safely. Such assessment may be obtained from the physician's treating professionals, state physician health program (PHP),[17] or from an approved evaluation team as necessary to provide the board with adequate information upon which to make a sound decision.

Transparency of board actions:

As state medical boards regulate the profession in the interest of the public, it is essential that evolving public values and needs are factored into decisions about what information is made publicly available. It has been made clear in academic publications and popular media, as well as through the #MeToo and TimesUp movements that the public increasingly values transparency regarding disciplinary actions imposed on physicians. It is likely that any action short of a complete revocation of licensure will draw scrutiny from the public and popular media. Such scrutiny can also be expected regarding decisions to reinstate a license or remove restrictions. The public availability of sufficient facts to justify a regulatory decision and link it to a licensee's behavior and the context in which it occurred can help state medical boards to explain and justify their decision.

The ability to disclose particular details of investigative findings and disciplinary actions is limited by state statute in many jurisdictions. State medical boards are encouraged to convey this fact to the public in order to protect the trust that patients have in boards, but also make efforts to achieve legislative change, allowing them to publicize information that is in the public interest. Where disclosure is possible, boards should select means for conveying information that will optimally reach patients. This should include making information available on state medical board websites and reporting to the FSMB Physician Data Center, thereby allowing for disciplinary alerts to be sent to other jurisdictions in which the physician holds a license and making information about disciplinary actions publicly available through FSMB's docinfo.org website, and the National Practitioner Data Bank. The use of private agreements or letters of warning in cases involving sexual misconduct is inappropriate because of the importance of disclosure for public protection and data sharing with other state medical boards or medical regulatory authorities from other jurisdictions.

Boards should also consider additional means of communicating, such as through mobile phone applications,[18] notices in newspapers and other publications. California[19] and Washington[20] both

[17] "A Physician Health Program (PHP) is a confidential resource for physicians, other licensed healthcare professionals, or those in training suffering from addictive, psychiatric, medical, behavioral or other potentially impairing conditions. PHPs coordinate effective detection, evaluation, treatment, and continuing care monitoring of physicians with these conditions." Source: Federation of State Physician Health Programs.

[18] The Medical Board of California has launched a new mobile application allowing patients to receive updates about their physician, including licensure status and practice location.

[19] CA Bus and Prof Code §1007 (2018)

[20] RCW 18.130.063

require that patients be notified of sexual misconduct license stipulations/restrictions at the time of making an appointment and that the patient verify this notification. Other boards have required licensees to obtain signatures from all patients in their care acknowledging their awareness of an adjudication for professional sexual misconduct. Boards may wish to consider whether these could be viable options in their states.

State medical boards are also encouraged to implement clear coding processes for board actions that provide accurate descriptions of cases, and clearly link licensee behaviors to disciplinary actions. Where sexual misconduct has occurred, the case should be labeled as such. A label of "disruptive physician behavior" or even "boundary violation" is less helpful than the more specific label of "sexual misconduct." State medical boards and the FSMB should work together to develop consistent terminology that allows a violation and the underlying causes of discipline to be stated explicitly, thereby promoting greater understanding for the public and the state medical boards, while also enabling the tracking of trends, frequencies, recidivism and the impact of remedial measures.

Where particular actions on the part of the physician may not meet a threshold for disciplinary action, but might nonetheless constitute grooming or other concerning behaviors, state medical boards should consider ways in which to allow previously dismissed cases to be revisited during subsequent cases, such as through non-disciplinary letters of education or concern which remain on a licensee's record. The ability to revisit previous cases involving seemingly minor events can help identify patterns of behavior in a licensee and provide additional insight into whether a licensee poses a risk to future patients.

Section 10: Monitoring

Following a finding of sexual misconduct, if a license is not revoked or suspended, it is essential that a state medical board establish appropriate monitoring of the physician and their continued practice. Monitoring in the context of sexual misconduct occurs differently from monitoring substance use disorders and the resources available to boards differ from state to state. Many PHPs do not offer monitoring services for physicians who have faced disciplinary action because of sexual misconduct and even where such monitoring by a PHP is possible, it is typically only part of a way forward, rather than a solution on its own.[21]

For the purposes of this report, the members of the Workgroup understand the use of a *chaperone* as an informal arrangement of impartial observation, typically initiated by physicians themselves. A chaperone in this context is meant to protect the doctor in the event of a complaint, although their presence may also offer comfort to the patient.[22] The patient may request that the chaperone not be present for any portion of the clinical encounter. The American College of Obstetricians and Gynecologists (ACOG) has recently recommended that a chaperone be present for all breast, genital, and rectal examinations because of the profoundly negative

[21] Federation of State Physician Health Program Statement on Sexual Misconduct in the Medical Profession, May 2019.

[22] Paterson, R. Independent review of the use of chaperones to protect patients in Australia, Commissioned by the Medical Board of Australia and the Australian Health Practitioner Regulation Agency, February 2017.

effect of sexual misconduct on patients and the medical profession and the association between misconduct and the absence of a chaperone.[23]

The Workgroup supports ACOG's recommendation because of the potential added layer of protection that an impartial third party brings, while acknowledging that the use of board-mandated chaperones has been discontinued in some international jurisdictions and by particular state medical boards, because of a belief that they merely provide the illusion of safety and may therefore allow harmful behaviors to go unnoticed. There is risk of this occurring in instances where a chaperone is untrained or uninformed about their role, is an employee or colleague of the physician being monitored or does not adequately attend to their responsibilities. In order to distinguish a chaperone in a less formal arrangement with a physician from one mandated by a state medical board with established reporting requirements and formal training, the Workgroup recommends referring to the latter individual as a "practice monitor."

A *practice monitor* differs from a chaperone. We define a practice monitor as part of a formal monitoring arrangement mandated by a state medical board, required at all patient encounters, or all encounters with patients of a particular gender or age. The practice monitor's primary responsibility is to the state medical board and their presence in the clinical encounter is meant to provide protection to the patient through observation and reporting. Costs associated with employing a practice monitor are typically borne by the monitored physician, but practices may vary across states. The patient must be informed that the practice monitor's presence is required as part of a practice restriction. As the practice monitor is mandated for all clinical encounters, the patient may not request that the practice monitor not be present for any portion of the encounter. If a patient is uncomfortable with the presence of a practice monitor, they will need to seek care from a different physician. Patient supports (parents, family members, friends) may be present during examinations but do not replace, nor can they be used in lieu of a board mandated practice monitor.

While even this formal arrangement with a clearly defined role, training and direct reporting may have limitations, the practice monitor may be a useful option for boards in certain specific circumstances. In particular, in instances where there is insufficient evidence to remove a physician from practice altogether, but significant risk is believed to be present, the opportunity to mandate practice monitoring provides boards with an additional option, short of allowing a potentially risky physician to return to independent practice. As such, when practice monitors are implemented judiciously, the Workgroup believes that their use can enhance patient safety and should therefore be considered by state medical boards.

Practice monitors should only be used if the following conditions have been met:

- The practice monitor has undergone formal training about their role, including their primary responsibility and direct reporting relationship to the state medical board (as opposed to the physician being monitored).

[23] Sexual misconduct. ACOG Committee Opinion No. 796. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2020;135:e43–50.

- It is highly recommended that all practice monitors have clinical backgrounds. If they do not, their training must include sufficient content about clinical encounters so they can be knowledgeable about what is and is not appropriate as part of the monitored physician's clinical encounters with patients.
- The practice monitor should be approved by the state medical board and cannot be an employee or colleague of the monitored physician that may introduce bias or otherwise influence their abilities to serve as a practice monitor and report to the board or intervene when necessary. Pre-existing contacts of any sort are discouraged, but where a previously unknown contact is not available, the existing relationship should be disclosed. In some states, practice monitors are required to be active licensees of another health profession as it is felt that this reinforces their professional duty to report. When health professionals serve as practice monitors, they should not have any past disciplinary history.
- The practice monitor has been trained in safe and appropriate ways of intervening during a clinical encounter at any point where there is confidence of inappropriate behavior on the part of the physician, the terms of the monitoring agreement are not being followed, or a patient has been put at risk of harm.
- The practice monitor submits regular reports to the state medical board regarding the monitored physician's compliance with monitoring requirements and any additional stipulations made in a board order.
- Where possible, state medical boards should consider establishing a panel of different practice monitors that will rotate periodically among monitored physicians to ensure monitor availability and that a collegial relationship does not develop between a practice monitor and a monitored physician, unduly influencing the nature of the monitoring relationship.

Monitoring should be individualized and based on the findings of the multidisciplinary evaluation, and, as appropriate, subsequent treatment recommendations. If a diagnosis of contributory mental/emotional illness, addiction, or sexual disorder has been established, the monitoring of that physician should be the same as for any other mental impairment and state medical boards are encouraged to work closely with their state physician health program as a resource and support in monitoring. Conditions, which may also be used for other violations of the medical practice act, may be imposed upon the physician. Examples are listed in **Table 2**.

Table 2: Possible Conditions of Practice Following a Finding of Sexual Misconduct
• Supervision of the physician in the workplace by a supervisory physician • Requirement that practice monitors are always in attendance and sign the medical record attesting to their attendance during examination or other patient interactions as appropriate.[24] • Periodic on-site review by board investigator or physician health program staff if indicated. • Practice limitations as may be recommended by evaluator(s) and/or the state physicians health program. • Regular interviews with the board and/or state physician health program as required to assess status of probation. • Regular reports from a qualified and approved licensed practitioner, approved in advance by the board, conducting any recommended counseling or treatment. • Completion of a program in maintaining appropriate professional boundaries, which shall be approved in advance of registration by the board.

Section 11: Education

Education and training about professional boundaries in general and physician sexual misconduct in particular should be provided during medical school and residency, as well as throughout practice as part of a physician's efforts to remain current in their knowledge of professional expectations. This should include education about the prevalence of victimization and abuse in the general population and the fact that more than half of patients who are exploited sexually by physicians have been exploited before.

State Medical Board Members and Staff

State medical boards and the FSMB should take a proactive stance to educate physicians, board members and board staff about sexual misconduct and the effects of trauma. Members of state medical boards and those responsible for adjudicating cases involving sexual misconduct can also experience trauma. Education for dealing appropriately with traumatic elements of cases and finding appropriate help and resources would also be valuable for board members.

[24] Where a practice monitor does not have authority to make entries in a medical record, alternatives such as handwriting and scanning the attestation should be considered.

Medical Education and Training

Education and training should include information about professionalism and the core values of medicine; the nature of the physician-patient relationship, including the inherent power imbalance and the foundational role of trust; acceptable behavior in clinical encounters; and methods of reporting instances of sexual misconduct. For both medical schools and residency programs, this education and training should also include tracking assessment across the curriculum, identification of deficiencies in groups and individuals, remediation, and reassessment for correction, appropriate self-care, and the potential for developing psychiatric illness or addictive behaviors. Early identification of risk for sexual misconduct and unprofessionalism is central to public protection and maintaining public trust.

Physicians

For practicing physicians, because of lack of education or awareness, physicians may encounter situations in which they have unknowingly violated the medical practice act through boundary transgressions and violations. A reduction in the frequency of physician sexual misconduct may be achieved through education of physicians and the health care team. Engagement in accredited continuing medical education that addresses professionalism, appropriate and acceptable behavior, and methods for reporting sexual misconduct should be encouraged among physician licensees and other members of the healthcare team.

Resources should also be made available to physicians to help them develop better insight into their own behavior and its impact on others. These could include multi-source feedback and 360-degree assessments, and self-inventories with follow-up education based on the results. As with apology legislation, the use of these resources and the results from self-assessment or other forms of assistance should not be used against physicians. Such resources would likely be used more broadly if they came from specialty and professional societies, rather than from state medical boards alone.

Cooperation and Collaboration

State medical boards should develop cooperative relationships with state physician health programs, state medical associations, hospital medical staffs, other organized physician groups, and medical schools and training programs to provide physicians and medical students with educational information that promotes awareness of physician sexual misconduct. This information should include a definition of physician sexual misconduct, what constitutes appropriate physician-patient boundaries, how to identify and avoid common “grooming” behaviors such as adjusting appointment timing to facilitate time alone with a particular patient, contacting patients outside of clinical hours, or divulging personal information to a patient, and the potential consequences to both the patient and the physician when professional boundaries are not maintained. Physicians should be educated regarding the degree of harm patients experience as a result of sexual misconduct.

Patients

Education for patients is also essential so that they may be better informed about what to expect during a clinical encounter, what would constitute inappropriate behavior, and how to file a complaint with their state medical board. Information about boundary issues, including physician sexual misconduct, should be published in medical board newsletters and pamphlets. Media contacts should be developed to provide information to the public. Efforts should also be made by state medical boards and the FSMB to better educate the public about the existence and role of state medical boards.

Section 12: Summary of Recommendations

The goal of this report is to provide state medical boards with best practice recommendations for effectively addressing and preventing sexual misconduct with patients, surrogates and others by physicians, while highlighting key issues and existing approaches.

The recommendations in this section include specific requests of individual entities, as well as general ones that apply to multiple parties, including state medical boards, the FSMB and other relevant stakeholders. The Workgroup felt strongly that effectively addressing physician sexual misconduct requires widespread cultural and systemic changes that can only be accomplished through shared efforts across the medical education and practice continuum.

Culture:

1. Across the continuum from medical education to practice, continue to eliminate harassment and build culture that is supportive of professional behavior and does not tolerate harassment of any type.

Transparency:

2. State medical boards should ensure that sufficient information is publicly available (without breaching the privacy of complaints) to justify regulatory decisions and provide sufficient rationale to support them.

3. State medical boards should implement clear coding processes for board actions that provide accurate descriptions of behaviors underlying board disciplinary actions and clearly link licensee behaviors to disciplinary actions.

4. State medical boards and the FSMB should work together to develop consistent terminology for use in board actions that allows greater understanding for the public and the state medical boards, while also enabling the tracking of trends, frequencies, recidivism and the impact of remedial measures. These should support research and the early identification of risk to patients.

5. The means of conveying information to the public about medical regulatory processes, including professional expectations, reporting and complaints processes, and available resources should be carefully examined to ensure maximal reach and impact. Multiple communication modalities should be considered.

Complaints:

6. State medical boards are encouraged to provide easily accessible information, education and clear guidance about how to file a complaint to the state medical board, and why complaints are necessary for supporting effective regulation and safe patient care. The FSMB and its partner organizations representing medical specialties whose members perform intimate examinations and procedures should provide education to patients about the types of behavior that can be expected of physicians, what types of behavior might warrant a complaint, what to do in the event that actions on the part of a physician make a patient uncomfortable, and circumstances that would warrant a report to law enforcement.

7. State medical boards and board investigators of administrative complaints are encouraged to communicate frequently with complainants throughout the complaint and investigative process, according to the preferred mode and frequency of communication of the complainant.

8. Complaints related to sexual misconduct should be addressed as quickly as possible given their traumatic nature and to protect potential future victims.

9. State medical boards should have a specially trained patient liaison or navigator on staff who is capable of providing one-on-one support to complainants and their families.

Reporting:

10. State medical boards should have the ability to levy fines against institutions for failing to report instances of egregious conduct.

11. Results of hospital and health system peer review processes should be shared with state medical boards when sexual misconduct is involved.

12. Hospitals should be required to report to state medical boards instances where employed physicians have been dismissed or are forced to resign due to concerns related to sexual misconduct.

13. Physicians who fail to report known instances of sexual misconduct should be liable for sanction by their state medical board for the breach of their professional duty to report.

14. Unscrupulous, frivolous or vexatious reporting motivated by competition should be met with disciplinary action.

15. Physicians and other individuals who report in good faith should be protected from retaliation and given the option to remain anonymous.

Investigations:

16. If the state medical board's investigation indicates a reasonable probability that the physician has engaged in sexual misconduct, the state medical board should exercise its authority to intervene and take appropriate action to ensure the protection of the patient and the public at large.

17. Where permitted by state law, investigations should include a review of previous complaints to identify any patterns of behavior, including malpractice claims and settlements.

18. State medical boards should have the authority to impose interim terms or limitations, including suspension, on a physician's license prior to the completion of an investigation.

19. Limits should not be placed on the length of time that can elapse between when an act of alleged physician sexual misconduct occurred and when a complaint can be filed.

20. Investigators should use trauma-informed procedures when interviewing and interacting with complainants alleging instances of sexual misconduct and adjudicating these cases.

21. State medical board members involved in sexual misconduct cases (either in investigation or adjudication) and all board staff who work with complainants in cases involving sexual misconduct should undergo training in the area of sexual misconduct, victim trauma, and implicit bias.

22. Where possible, boards should seek the complainant's preference regarding the gender of investigators and assign them accordingly.

23. State medical boards should also allow inclusion of patient advocates in the interview process.

24. The FSMB and state medical boards should work to identify and ensure the availability of high-quality training in sexual trauma and a trauma-informed approach to investigations.

Comprehensive Evaluation:

25. State medical boards should have the authority to order a comprehensive evaluation of physicians where investigation reveals a high probability that sexual misconduct has occurred.

Hearings:

26. State medical boards should have statutory authority to ensure nondisclosure of the patient's identity to the public, including by closing hearings in part or in full, and deleting any identifiable patient information from final public orders. Patient identity must also be protected during board discussion.

Discipline:

27. Certain serious forms of unprofessional conduct should presumptively provide the basis for revocation of a license in order to protect the public. Misconduct in this class would include sexual assault, conduct amounting to crimes related to sex, regardless of whether charged or convicted, or egregious acts of a sexual nature. State medical boards should also consider revocation in instances where a physician has repeatedly committed lesser acts, especially following remedial efforts.

28. Gender and age-based restrictions should only be used by boards where there is a high degree of confidence that the physician is not at risk of reoffending.

29. Practice monitors should only be used as a means of protecting patients if the conditions outlined in this report have been met, including appropriate training, reporting relationship to the state medical board and lack of pre-existing relationship with the monitored physician.

30. When considering remedial action after sexual misconduct, state medical boards should employ a risk stratification model that also factors in risk of erosion of public trust in the medical profession and medical regulation.

31. As part of remedial efforts, any partners in the assessment and remediation of physicians should be provided access to investigative information in order to properly tailor remedial education to the context in which the sexual misconduct occurred.

32. Following remedial activities, state medical boards should monitor physicians to ensure that they avoid being in circumstances similar to those in which they engaged in sexual misconduct.

33. State medical boards should consider ways in which to allow pertinent information from previously dismissed cases to be revisited during subsequent cases, such as through non-disciplinary letters of concern or education which remain on a licensee's record.

Education:

34. Education and training about professional boundaries and physician sexual misconduct should be provided during medical school and residency, as well as throughout practice as part of a physician's efforts to remain current in their knowledge of professional expectations. This should include education about how to proceed with basic as well as sensitive/intimate exams and the communication with the patients that is required as a component of these exams. This education should be informed by members of the public, as best possible.

35. State medical boards and the FSMB should provide education to physicians, board members and board staff about sexual misconduct and the effects of trauma. This should include resources to help physicians develop better insight into their own behavior and its impacts on others. Resources and materials should be developed in collaboration with state physician health programs, state medical associations, hospital medical staffs, other organized physician groups, and medical schools and training programs.

36. As stated in Recommendation #6 regarding complaints, state medical boards are encouraged to provide easily accessible information, education and clear guidance about how to file a complaint to the state medical board, and why complaints are necessary for supporting effective regulation and safe patient care. The FSMB and its partner organizations representing medical specialties whose members perform intimate examinations and procedures should provide education to patients about the types of behavior that can be expected of physicians, what types of behavior might warrant a complaint, what to do in the event that actions on the part of a physician make a patient uncomfortable, and circumstances that would warrant a report to law enforcement.

37. The FSMB, state medical boards, medical schools, residency programs, and medical specialty and professional societies should provide renewed education on professionalism and the promotion of professional culture. A coordinated approach facilitated by ongoing communication is recommended to ensure consistency of educational messaging and content.

38. The FSMB should facilitate the adoption and operationalization of the recommendations in this report by providing state medical boards with an abridged version of the report which highlights key points and associates them with resources, model legislation, and educational offerings.

Appendix A: Sample Resources

The following is a sample list of resources available to support greater understanding of sexual misconduct, sexual boundaries, the impacts of trauma, and implicit bias. 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.

1. Sexual misconduct, sexual/personal/professional boundaries:
    - AMA: Code of Medical Ethics: Sexual Boundaries
        - Romantic or Sexual Relationships with Patients
        - Romantic or Sexual Relationships with Key Third Parties
        - Sexual Harassment in the Practice of Medicine
    - AMA: CME course: Boundaries for physicians
    - AAOS: Sexual Misconduct in the Physician-Patient Relationship
    - FSMB Directory of Physician Assessment and Remedial Education Programs
    - North Carolina Medical Board: Guidelines for Avoiding Misunderstandings During Patient Encounters and Physical Examinations
    - Vanderbilt University Medical Center: Online CME Course: Hazardous Affairs – Maintaining Professional Boundaries
    - Vanderbilt University Medical Center: Boundary Violations Index

2. Trauma-related resources:
    - SAMHSA: Concept of Trauma and Guidance for a Trauma-Informed Approach
    - National Institute for the Clinical Application of Behavioral Medicine: How Trauma Impacts Four Different Types of Memory
    - Frontiers in Psychiatry: Memory distortion for traumatic events: the role of mental imagery
    - Canadian Department of Justice: The Impact of Trauma on Adult Sexual Assault Victims
    - NIH: Trauma-Informed Medical Care: A CME Communication Training for Primary Care Providers
    - Western Massachusetts Training Consortium: Trauma Survivors in Medical and Dental Settings
    - American Academy of Pediatrics: Adverse Childhood Experiences and the Lifelong Consequences of Trauma
    - American Academy of Pediatrics: Protecting Physician Wellness: Working With Children Affected by Traumatic Events
    - Public Health Agency of Canada: Handbook on Sensitive Practice for Health Care Practitioners
    - Psychiatric Times: CME: Treating Complex Trauma Survivors
    - NHS Lanarkshire (Scotland): Trauma and the Brain (Video)
    - London Trauma Specialists: Brain Model of PTSD - Psychoeducation Video

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3. Implicit bias:
    - AAMC: Online Seminar: The Science of Unconscious Bias and What To Do About it in the Search and Recruitment Process
    - AAMC: Proceedings of the Diversity and Inclusion Innovation Forum: Unconscious Bias in Academic Medicine
    - AAMC: Exploring Unconscious Bias in Academic Medicine (Video)
    - ASME Medical Education: Non-conscious bias in medical decision making: what can be done to reduce it?
    - APHA: Patient Race/Ethnicity and Quality of Patient–Physician Communication During Medical Visits
    - Institute for Healthcare Improvement: Achieving Health Equity: A Guide for Health Care Organizations
    - BMC Medical Education: Training to reduce LGBTQ-related bias among medical, nursing, and dental students and providers: a systematic review
    - American Psychological Association: CE - How does implicit bias by physicians affect patients' health care?
    - Joint Commission: Implicit bias in health care
    - Oregon Medical Board: Cultural Competency – A Practical Guide for Medical Professionals
    - StratisHealth: Implicit Bias in Health Care (Quiz)

BRD RPT 20-3

REPORT OF THE BOARD OF DIRECTORS

Subject: **Report on Resolution 19-1: Licensing Exam Research (Minnesota Board of Medical Practice)**

Referred to: **Reference Committee**

At the April 2019 Federation of State Medical Boards (FSMB) House of Delegates (HOD) meeting, the Minnesota Board of Medical Practice submitted Resolution 19-1: Correlation between licensee USMLE or COMLEX passage attempt rate and reports of state medical board discipline:

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

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

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

At the Reference Committee meeting, the FSMB Board of Directors testified that research already exists to address some of the issues in the resolution, and that several streams of work were already underway to further address these issues. The Board of Directors further testified that is therefore unnecessary to constitute a formal task force or workgroup and proposed the following substitute resolution, which was subsequently adopted by the FSMB HOD:

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

(1) Identify current licensing requirements specific to USMLE and COMLEX, including time and/or attempt limits on these examinations;
(2) Identify existing, or facilitate additional, research evaluating whether time and/or attempt limitations on USMLE and COMLEX correlate with external measures such as a decrease in future medical board disciplinary action and/or medical malpractice;
(3) Begin work toward a long-term goal of research exploring the correlation between performance on these licensing examinations and other measures of clinical aptitude or outcomes; and

(4) Share initial findings back to the FSMB House of Delegates in 2020 and with subsequent periodic reports as research becomes available.

This report is divided into two sections: Section 1 dealing with licensing requirements specific to USMLE and COMLEX-USA and Section 2 addressing relevant research supportive of state medical boards' decisions to utilize attempt limits on their licensing examination. Future reports will provide updates on time and attempt limits and relevant research, as available or requested.

SECTION 1:

Licensing Requirements Specific to the United States Medical Licensing Examination (USMLE) and the Comprehensive Osteopathic Licensing Examination of the United States (COMLEX-USA)

Requirements and Recommendations from the USMLE and COMLEX-USA Programs

Both the USMLE and the COMLEX-USA programs limit candidates for each examination in each Step or Level, respectively. Specifically, candidates for the USMLE are limited to 4 attempts per exam per Step, while COMLEX-USA candidates are currently limited to 6 attempts per exam per Level (with plans to reduce to 4 attempts per exam per Level effective July 2022). The COMLEX-USA program allows a single exception (i.e., one additional attempt) per examinee per Level or Level component to the attempt limit policy upon sponsorship by a medical licensing authority. The USMLE exception policy, which allows for unlimited exceptions per examinee per Step or Step component upon sponsorship by a medical licensing authority, is currently under review.

Although neither the USMLE program nor the COMLEX-USA program imposes a time limit for completing their exam sequence, both make a recommendation to medical licensing authorities that the complete examination sequences be passed within a seven-year time period that begins when the examinee passes his/her first Step/Level.

The USMLE program also recommends to licensing jurisdictions that they consider allowing exceptions to the seven-year limit for MD/PhD candidates who meet the following requirements:

1. The candidate has obtained both degrees from an institution or program accredited by the LCME and a regional university accrediting body.
2. The PhD should reflect an area of study which ensures the candidate a continuous involvement with medicine and/or issues related, or applicable to, medicine.
3. A candidate seeking an exception to the seven-year rule should be required to present a verifiable and rational explanation for the fact that he or she was unable to meet the seven-year limit. These explanations will vary and each licensing jurisdiction will need to decide on its own which explanation justifies an exception. Students who pursue both degrees should understand that while many states' regulations provide specific exceptions to the seven-year rule for dual-degree candidates, others do not. Students pursuing a dual degree are advised to check the state-specific requirements for licensure listed by the FSMB.

These programmatic policies are consistent with FSMB policy in the *Guidelines for the Structure and Function of a State Medical and Osteopathic Board*, which states that a medical or osteopathic board should "be authorized to limit the number of times an examination may be taken, to require

applicants to pass all examinations within a specified period, and to specify further medical education required for applicants unable to do so."

Review of State Board Time and Attempt Limits for USMLE and COMLEX-USA

Staff reviewed all state medical and osteopathic boards' websites, statutes, and rules and regulations to identify time and attempt limits for USMLE and COMLEX-USA for initial licensure purposes. A detailed overview and explanation of the results of that review is provided below. A quick summary of the results is provided as **Attachment 1**.

Time Limits

Of the 69[1] state licensing authorities, 46 have a time limit for completion of the USMLE and/or COMLEX-USA sequence, specifically:

- 5-year limit: 1 board
- 7-year limit: 31 boards
- 10-year limit: 14 boards

For 19 of these boards, the statutes and/or rules and regulations state that time limit starts from the date of whichever Step or Level of the examination was successfully completed/passed first.

Almost half (20) of these boards allow additional time for dual degree candidates (MD/PhD, DO/PhD, MD/MPH, etc.), with the time limit ranging from 8 -15 years:

- 8-year time limit: 1 board
- 9-year time limit: 1 board
- 10-year time limit: 13 boards
    - One of these boards has a 7-year limit that can be extended to 10 years, so it was included in the 10-year count
- 12-year time limit: 1 board
- 15-year time limit: 1 board
    - This board has a 10-year limit that can be extended to 15 years, so the limit was counted as 15

Almost all of the boards allow some exception or wavier of the time limit. A listing of the exceptions and waivers identified is provided in **Attachment 2**.

Other requirements of note are:

- One composite board that licenses both allopathic and osteopathic physicians has a different time limit for USMLE and COMLEX-USA, specifically 10 years for USMLE and 7 years for COMLEX-USA.
- One board requires candidates to repeat the entire USMLE sequence if the entire examination is not passed within the stipulated time limit.

[1] For purposes of this report, the New York State Office of Professional Medical Conduct was not included, since it oversees discipline only. Licensure of physicians in New York is handled by the New York State Board for Medicine.

- One board does not accept scores from a re-examination of a previously passed Step. (The USMLE and COMLEX-USA programs allow examinees to retake a previously passed Step in order to comply with the time limit imposed by a medical licensing authority for the completion of all Steps.)

Attempt Limits

Forty-seven of the 69 boards have an attempt limit on one or more Steps of the USMLE and/or Levels of the COMLEX-USA. The remaining 22 boards do not have any attempt limits for the USMLE and/or COMLEX-USA; this encompasses 9 composite boards, 1 medical board and 12 osteopathic boards. One osteopathic board that accepts USMLE for purposes of licensing osteopathic physicians has attempt limits for USMLE and COMLEX-USA; therefore, this board was included in the attempt limit counts for both examinations.

Of the 47 boards that have attempt limits, 31 have limits for all Steps and/or Levels. Although one board has a different attempt limit for COMLEX-USA Levels 1, 2-CE and 2-PE than it does for Level 3, for the remaining boards the attempt limits are the same across Steps/Levels (e.g., two attempts on Step/Level 1, two attempts on Step/Level 2, and two attempts on Step/Level 3). The attempt limits range from 2 to 6, as follows:

Attempt limits on all USMLE Steps (30 boards[2]) –
- 2 attempts: 2 boards
- 3 attempts: 19 boards
- 4 attempts: 3 boards
- 5 attempts: 2 boards
- 6 attempts: 4 boards

Attempt limits on all COMLEX-USA Levels (23 boards[3],[4]) –
- 2 attempts: 1 board
- 3 attempts: 14 boards
- 4 attempts: 3 boards
- 5 attempts: 3 boards
- 6 attempts: 2 boards

An additional 15 boards have an attempt limit on only one Step and/or Level. Almost all of these 15 boards (14 out of 15) have an attempt limit only on Step/Level 3, which is the final examination in the USMLE/COMLEX-USA sequence. The other board has a 4-attempt limit on Step/Level 2 or 3. The required attempt limits for Step/Level 3 range from 3 to 6 attempts, as follows:

[2] The USMLE count does not equal 31 is because one of the boards is an osteopathic board that does not accept USMLE for licensure.
[3] One board allows 6 attempts for COMLEX-USA Level 1 and 6 attempts combined for Level 2-CE and Level 2 PE combined, but only 3 attempts for Level 3; this board is included in the count for both 3 attempts and 6 attempts.
[4] The reason the total for COMLEX-USA does not equal 31 is because (1) three of the boards are composite boards that have an attempt limit for USMLE but not for COMLEX-USA; (2) six of the boards only license allopathic physicians and, thus, do not accept COMLEX-USA for licensure; and (3) as noted in Footnote 3, one osteopathic board is counted twice.

Attempt limits on USMLE Step 3 only (15 boards) –

- 3 attempts: 9 boards
    - One of these boards also has an added stipulation of no more than a combined total of 10 attempts for all Steps
- 4 attempts: 3 boards
- 5 attempts: 2 boards
- 6 attempts: 1 board

Attempt limits on COMLEX-USA Level 3 only (4 boards[5]) –

- 3 attempts: 2 boards
- 4 attempts: 1 board
- 5 attempts: 1 board

Finally, one board requires no more than 7 attempts at all Steps/Levels combined. This board stipulates that persons who have taken the three parts of the examination more than a total of seven times shall not be eligible for licensure unless or until they successfully complete either one-year post-graduate training in addition to that already required for licensure, or one or more other comprehensive and suitably-rigorous assessment, training, and evaluation programs after passage of all parts of the examination.

As with the time limits discussed above, most of the boards have stipulations around the attempt limits and/or allow for exceptions or waivers to the attempt limit under a variety of circumstances. Only 10 boards do not allow for any exceptions to their attempt limit. Examples of the stipulations on and/or exceptions to the attempt limit policies are provided as **Attachment 3**.

In reviewing these exceptions and stipulations, it is possible that some are remnants from when Step 3 had to be taken under the sponsorship and eligibility requirements of a state medical or osteopathic board. Beginning November 2014, Step 3 applicants are no longer required to apply for Step 3 under the sponsorship of a board; the only requirements that must be met to apply for and take Step 3 are those set by the USMLE program:

- Pass USMLE Step 1, Step 2 CK and Step 2 CS; and
- Possess an MD, DO or equivalent degree; and
- If a graduate of a medical school outside of the US or Canada, obtain ECFMG certification; and
- All examinees are limited to 4 attempts, with one additional attempt at the request of a medical licensing authority; and
- All examinees are limited to three attempts within a 12-month period; and

[5] The reason the total for COMLEX-USA does not equal 15 is because seven of the fifteen boards only license allopathic physicians and, thus, do not accept COMLEX-USA for licensure. The remaining four boards have different attempt limits for USMLE and COMLEX-USA:

- 3 boards have a 3-attempt limit on USMLE Step 3 but no attempt limits on COMLEX-USA
- 1 board has a 6-attempt limit on USMLE Step 3 but no attempt limits on COMLEX-USA

- 4th and subsequent attempts must be at least 12 months after the first attempt and at least six months after the most recent attempt.

In other words, boards are no longer able to impose additional requirements such as additional education or training for eligibility for Step 3, unless done as part of the process to sponsor an applicant for an additional attempt beyond the 4 attempts allowed by the USMLE program. However, these requirements could still be used to qualify applicants for licensure.

The FSMB maintains a by-state summary of these and other state specific requirements for initial medical licensure on the FSMB website (https://www.fsmb.org/step-3/state-licensure/) as a guide for examinees and initial licensure applicants. A link to the boards' website addresses and contact information is also provided.

Section 2:

Research relevant to state medical boards' attempt limit policies

The following summarizes research into whether time and/or attempt limitations on USMLE and COMLEX-USA correlate with external measures such as a decrease in future medical board disciplinary action and/or medical malpractice claims, and other measures of clinical aptitude.

Published research

In 2017, *Academic Medicine* published a study by FSMB and National Board of Medical Examiners (NBME) staff showing a correlation with higher scores on USMLE Step 2 Clinical Knowledge (Step 2 CK) and a subsequent decrease in the likelihood of a disciplinary action. Physicians with higher Step 2 CK scores had lower odds of receiving an action. A 1-SD increase in Step 2 CK scores corresponded to a decrease in the chance of disciplinary action by roughly 25%. After accounting for Step 2 CK scores, Step 1 scores were unrelated to the odds of receiving an action[6]. The article is available on the *Academic Medicine* website at https://journals.lww.com/academicmedicine/Fulltext/2017/12000/Exploring_the_Relationships_Between_USMLE.41.aspx.

The National Board of Osteopathic Medical Examiners (NBOME) recently completed similar research with the assistance of FSMB staff. That study found that higher COMLEX-USA Level 3 scores were associated with significant decreased odds for all action categories: revoked license, imposed limitations to practice, and other action imposed, relative to not receiving an action. Higher COMLEX-USA Level 2 Performance Evaluation Biomedical/Biomechanical Domain scores decreased the odds for an action that revoked a license and imposed limitations to practice[7].

[6] Monica M. Cuddy, MA, Aaron Young, PhD, Andrew Gelman, PhD, David B. Swanson, PhD, David A. Johnson, MA, Gerard F. Dillon, PhD, and Brian E. Clauser, EdD. Exploring the Relationships Between USMLE Performance and Disciplinary Action in Practice: A Validity Study of Score Inferences from a Licensure Examination. *Academic Medicine*, Vol. 92, No. 12 / December 2017; 1780-1785.

[7] William L. Roberts EdD; Gretta A. Gross DO, MEd; John R. Gimpel DO, MEd; Larissa L. Smith PhD; Katie Arnhart PhD; Xiaomei Pei PhD; Aaron Young PhD. An Investigation of the Relationship Between COMLEX-USA Licensure Examination Performance and State Licensing Board Disciplinary Actions. *Academic Medicine*, 2019 Oct 15. [Epub ahead of print] doi: 10.1097/ACM.0000000000003046

The article is available on the *Academic Medicine* website at https://journals.lww.com/academicmedicine/Abstract/publishahead/An_Investigation_of_the_Relationship_Between.97413.aspx

State boards may also find the 2001 article by Clauser and Nungester regarding classification accuracy for tests that allow retakes of interest[8]. FSMB previously distributed this article to all state boards in 1999, when the USMLE program first issued recommendations to state boards regarding the potential impact of the USMLE program's seven-year time limit recommendation on medical students and graduates in dual degree programs and specifically recommended that boards consider exceptions to the seven-year time limit for dual degree candidates, and again in 2002 as a reference tool to medical boards when discussing or formulating policy recommendations regarding USMLE time limits for medical licensure. The article is available on the *Academic Medicine* website at https://journals.lww.com/academicmedicine/Fulltext/2001/10001/Classification_Accuracy_for_Tests_That_Allow.36.aspx

A listing of USMLE research is available on the USMLE website at https://www.usmle.org/data-research/.

Similarly, a listing of COMLEX-USA research is available on the NBOME website at https://www.nbome.org/publications/published-research/

Ongoing and future research

A study exploring the relationship between USMLE attempt limits and disciplinary action by state medical boards is in written draft form at this time and will be submitted for publication. USMLE staff are also in the early stages of studying the correlation between USMLE performance and residents' progress in meeting Accreditation Council for Graduate Medical Education (ACGME) Milestones.

Potential for research correlating USMLE performance with medical malpractice is currently being explored with staff at the National Practitioner Data Bank (NPDB). Similarly, FSMB staff are pursuing clinical outcomes data with the University of Texas-Southwestern that may supplement limited research in this area, i.e., a 2014 study by Norcini, et al., examining the relationship between performance on USMLE Step 2 CK and outcomes of care by international medical graduates. That study found that performance on Step 2 CK had a statistically significant inverse relationship with mortality; each additional point on the examination was associated with a 0.2% decrease in mortality[9]. The article is available on the *Academic Medicine* website at https://journals.lww.com/academicmedicine/Fulltext/2014/08000/The_Relationship_Between_Licensing_Examination.26.aspx

[8] Brian E. Clauser and Ronald J. Nungester. Classification Accuracy for Tests That Allow Retakes. *Academic Medicine*, Vol. 76, No 10 / October Supplement 2001; S108-110.

[9] John J. Norcini, John R. Boulet, Amy Opalek, and W. Dale Dauphinee. The Relationship Between Licensing Examination Performance and the Outcomes of Care by International Medical School Graduates. *Academic Medicine*. 2014; 89(8):1157–62. doi: 10.1097/ACM.0000000000000310

Summary

The majority of medical licensing authorities (46:69 or 67%) have a time limit completion of the USMLE and/or COMLEX-USA examinations for licensure purposes. Most of these boards (31) have a 7-year time limit, although the limit can range from 5 to 7 years. Almost half of these boards (20) have an extended time limit for dual degree candidates. The time limit for completion of USMLE and/or COMLEX-USA for dual degree candidates ranges from 8 to 15 years, with 10 years being utilized most often (13 boards). Almost all of the boards provide a wavier of the time limit in other limited circumstances.

Additionally, the majority of boards (47:69 or 68%) also have an attempt limit for completion of all or parts of the USMLE and/or COMLEX-USA sequence for purposes of licensure. 30 boards have an attempt limit on all USMLE Steps, while 23 boards have a limit on all COMLEX-USA Levels. The most common attempt limit for both examinations is 3, with 19 boards stipulating a 3-attempt limit for exams on all USMLE Steps and 14 boards stipulating a 3-attempt limit for exams on all COMLEX-USA Levels. A handful of boards have adopted an attempt limit on USMLE Step 3 only (15 boards) or on COMLEX-USA Level 3 only (4 boards). Regardless of the attempt limit adopted, most boards allow for a waiver of the attempt limit requirement under some circumstances.

This report summarizes research that currently exists or is in progress regarding performance on USMLE or COMLEX-USA and future medical board disciplinary action and/or medical malpractice claims, and other measures of clinical aptitude. Future reports will provide updates on that and other research as available or requested.

ITEM FOR ACTION:

This report is for information only.

ATTACHMENT 1

Count of boards with time and/or attempt limits on USMLE and/or COMLEX-USA

Time Limits for Completion of USMLE and/or COMLEX-USA (46 boards)

- 5-year limit: 1 board
- 7-year limit: 31 boards
- 10-year limit: 14 boards

Time Limits for Completion of USMLE and/or COMLEX-USA for Dual Degree Candidates (20 boards)

- 8-year time limit: 1 board
- 9-year time limit: 1 board
- 10-year time limit: 13 boards
- 12-year time limit: 1 board
- 15-year time limit: 1 board

Attempt limits on all USMLE Exams per Step (attempt limit is the same for all exams) (30 boards)

- 2 attempts: 2 boards
- 3 attempts: 19 boards
- 4 attempts: 3 boards
- 5 attempts: 2 boards
- 6 attempts: 4 boards

Attempt limits on all COMLEX-USA Exams per Level (attempt limit is the same for all exams) (23 boards)

- 2 attempts: 1 board
- 3 attempts: 14 boards
- 4 attempts: 3 boards
- 5 attempts: 3 boards
- 6 attempts: 2 boards

Attempt limits on USMLE Step 3 only (15 boards)

- 3 attempts: 9 boards
- 4 attempts: 3 boards
- 5 attempts: 2 boards
- 6 attempts: 1 board

Attempt limits on COMLEX-USA Level 3 only (4 boards)

- 3 attempts: 2 boards
- 4 attempts: 1 board
- 5 attempts: 1 board

ATTACHMENT 2

Exceptions and Waivers Allowed for USMLE and/or COMLEX-USA Time Limits

- Applicants who are ABMS or AOA board certified are not required to pass the examination within 7 years; however, they are limited to combined total of 10 attempts.
- Upon applicant's showing of good cause, the Board may waive the time requirements. Any such waiver shall be based upon the circumstances relating to the particular individual's application.
- In very limited & extraordinary circumstances, the board may grant exception to the 7-year rule on a case-by-case basis to those who demonstrate: 1) a verifiable and rational explanation for the failure to satisfy the regulation, 2) strong academic and post graduate record, and 3) a compelling totality of circumstances.
- The board may waive the time limit if the applicant is licensed to practice as a physician and surgeon in another state of the United States, the District of Columbia or Canada and the applicant has achieved a passing score on a licensing examination administered in a state or territory of the United States or the District of Columbia and no license issued to the applicant has been disciplined in any state or territory of the United States or the District of Columbia.
- Board may allow an exception to attempt and time limit rule if it finds that it is in the best interest of the state and the applicant: 1) is validly licensed in another state, 2) has practiced a minimum of 10 years, 3) has no disciplinary actions imposed by another state medical board, 4) is certified by a specialty board recognized by ABMS or the Royal College of Physicians and Surgeons of Canada, and 5) meets requirements regarding time limit for exam attempts.
- A waiver of this rule may be requested if one of the following applies to applicant:
  - Current certification by the ABMS or AOA-BOS,
  - Suffered from a documented significant health condition which delayed applicant's medical study,
  - Participated in a combined MD/DO/PhD program,
  - Completed continuous approved postgraduate training with equivalent number of years to an MD/DO/PhD program, or
  - Experienced other extenuating circumstances that do not indicate an inability to safely practice medicine as determined by the Board.
- Time frame waived if practicing in a medical underserved area (MUA) or Health Professional Shortage Areas (HPSA).
- 10 years if the applicant:
  - is specialty board certified by a specialty board that (a) is a member of the American Board of Medical Specialties; or (b) is a member of the Bureau of Osteopathic Specialists; or
  - has been issued a faculty temporary license, as prescribed by board rule, and has practiced under such a license for a minimum of 12 months and, at the conclusion of the 12-month period, has been recommended to the board by the chief administrative officer and the president of the institution in which the applicant practiced under the faculty temporary license.
- If the applicant does not meet the time limit, the applicant shall not be eligible for licensure unless or until they successfully complete either one-year post-graduate training in addition to

that already required for licensure, or one or more other comprehensive and suitably-rigorous assessment, training, and evaluation programs after passage of all parts of the examination.

- The amount of time an applicant has actively served while in continuous training and practice in the armed forces of the United States shall not be counted in calculating the ten (10) year limitation.
- The time limit will also not apply to applicants who: 1) are board certified by a board recognized by ABMS, or 2) have been & are at the time of application currently in active clinical practice in a state or territory for a period of at least one year and have held a full, unencumbered license in that state for at least one year since successfully completing USMLE; or 3) present satisfactory evidence of extraordinary circumstances as determined by the board which prevented the applicant from timely completing the examination.

ATTACHMENT 3

Stipulations on and Exceptions to USMLE and/or COMLEX-USA Attempt Limits

- Further education and training.
- Minimum of 4 years continuous licensure in another state and ABMS certified.
- Hold a full unrestricted license in another US or Canadian jurisdiction; hold an active ABMS, RCPSC, or CFPC specialty certification; and have successfully completed an ACGME, RCPSC, CFPC approved post-graduate training program.
- After 3 failed attempts on Step 3, must complete one additional year ACGME- or AOA-approved graduate medical education before being eligible to take step 3 again.
- After 5 attempts, the board may require an applicant to complete additional remedial education or training. The board shall prescribe the additional requirements in a manner that permits the applicant to complete the requirements and be reexamined within 2 years after the date the applicant petitions the board to retake the examination a sixth or subsequent time.
- Applicants who have failed the USMLE Step 3 a total of three (3) times since January 1, 1994 must have one year of additional Board-approved clinical training. The training must be completed prior to taking USMLE Step 3 again.
- After 3 failed attempts, must appear before Board for approval to take a fourth or subsequent attempt. If additional attempts are required, applicant must complete additional educational requirements.
- An applicant who passes any of the required exams after having failed any part, step, level, or component three or more times must meet the requirements in numbers 1-3 or 4 below. (1) No disciplinary action pending and no disciplinary action taken against the applicant that would be grounds for discipline; and (2) Successful completion of 2 or more years of an ACGME or AOA-accredited residency or fellowship; and (3) A minimum of 5 years of clinical medicine experience in the U.S. or in Canada under a full unrestricted medical license with at least 3 of the 5 years having occurred within 5 years of the date of the application; or (4) Board certification.
- No candidate shall be permitted more than five attempts to pass Step 3 of USMLE without demonstration of additional education, experience or training acceptable to the Board.
- If an individual fails to secure a passing score on Step 3 in a third attempt, the individual shall repeat a year of graduate medical training at a first or second-year level before retaking Step 3. An applicant who did not have a year of Board approved training between third and fourth attempt to pass Step 3, or took more than four attempts to pass Step 3, may request a waiver based on current certification by the ABMS or AOA-BOS.
- A year of board approved postgraduate training between the 3rd and 4th (final) attempt to pass. An applicant who did not have a year of Board approved training between third and fourth attempt to pass Step/Level 3, or took more than four attempts to pass Step 3/Level, may request a waiver based on current certification by the ABMS or AOA-BOS.
- Applicants who do not pass Step 3 after three sittings within seven years after passing the first examination, either Step 1 or Step 2, or acceptable combination, shall demonstrate evidence satisfactory to the commission of having completed a remedial or refresher medical course approved by the board prior to being permitted to sit for the examination again. Applicants who do not pass Step 3 after the fourth sitting may not sit for another examination without

completing an additional year of postgraduate training or satisfying any other conditions specified by the board.

- If fail any step or component on second attempt, must complete supervised course of study acceptable to the board before permission to retake the step will be given.
- After 2 failed attempts at any Step, licensee may be interviewed or evaluated by the Board. If an applicant fails to pass the exam on 2 separate occasions, the applicant will not be eligible for re-examination for at least 1 year and before taking the examination again the applicant must make a showing to the board of successfully engaging in a course of study for the purpose of improving the applicants ability to engage in the practice of medicine.
- Waiver of 3 attempts can be granted if applicant can show documentation and proof that they suffered from significant health condition or personal problem that delayed medical education and successful completion of Step testing. Waiver will not exceed 4 attempts per Step. Waiver may also be granted on Step 3 to not exceed 4 attempts if applicant 1) has completed one year of approved GME after 3rd failed attempt or before 4th and final attempt and 2) can show proof is certified by ABMS specialty board. Limitation on number of attempts of the step exams may begin anew, if the applicant begins his or her entire medical school education anew.
- Four attempts are allowed if currently licensed in another state and currently certified by a specialty board of ABMS, AOABPE, RCPSC, or CFPC.
- After 3 failed attempts, 1 additional year of ACGME- or AOA-approved graduate medical education.
- The board may waive the provisions of this section if the applicant is licensed to practice as a physician and surgeon in another state of the United States, the District of Columbia or Canada and the applicant has achieved a passing score on a licensing examination administered in a state or territory of the United States or the District of Columbia and no license issued to the applicant has been disciplined in any state or territory of the United States or the District of Columbia.
- 3 attempts each section/step USMLE/COMLEX-USA - if not met, must start complete sequence over. Attempt limit may be waived by the board for those applicants who are board certified.
- The board shall raise the 3-attempt requirement if the applicant has been certified or recertified by an ABMS/CCFP/FRCP/FRCS/AOA/ABOMS or specialty board within the past 10 years.
- Board may allow an exception to attempt and time limit rule if it finds that it is in the best interest of the state and the applicant: 1) is validly licensed in another state, 2) has practiced a minimum of 10 years, 3) has no disciplinary actions imposed by another state medical board, 4) is certified by a specialty board recognized by ABMS or the Royal College of Physicians and Surgeons of Canada, and 5) meets requirements regarding time limit for exam attempts.
- After third failure, applicant must complete additional requirements as recommended by the Board on a case by case basis.
- If an applicant fails any step of the USMLE or FLEX examinations more than three (3) times, then the Board shall require proof of board-certification by an ABMS-recognized specialty board and proof of meeting requirements for Maintenance of Certification prior to application before consideration for licensure.
- Attempt limit does not apply an applicant who meets the following criteria: (A) holds a license to practice medicine in another state(s); (B) is in good standing in the other state(s); (C) has been licensed in another state(s) for at least five years; (D) such license has not been restricted, cancelled, suspended, revoked, or subject to other discipline in the other state(s); (E) has never

held a medical license that has been restricted for cause, canceled for cause, suspended for cause, revoked or subject to another form of discipline in a state or territory of the United States, a province of Canada, or a uniformed service of the United States; and (F) has passed all but one part of the examination approved by the board within three attempts and: (i) passed the remaining part of the examination within one additional attempt; or (ii) passed the remaining part of the examination within six attempts if the applicant: (I) is specialty board certified by a specialty board that: (-a-) is a member of the American Board of Medical Specialties; or (-b-) is approved by the American Osteopathic Association; and (II) has completed in this state an additional two years of postgraduate medical training approved by the board.

- Board review. An applicant that fails may request reexamination and may be reexamined not more than twice at not less than 4-month intervals. An applicant who fails after the 2nd reexamination may not be admitted to further examination until the applicant reapplies for licensure or certification and also presents to the board evidence of further professional training/education as the board may deem appropriate. If an applicant has been examined 4 or more times in another licensing jurisdiction in the United States or Canada before achieving a passing grade in written or computer−based examinations also required under this chapter, the board may require the applicant to submit evidence satisfactory to the board of further professional training or education in examination areas in which the applicant had previously demonstrated deficiencies. If the evidence provided by the applicant is not satisfactory to the board, the board may require the applicant to obtain further professional training or education as the board deems necessary to establish the applicant's fitness to practice medicine and surgery in this state. In order to determine any further professional training or education requirement, the board shall consider any information available relating to the quality of the applicant's previous practice, including the results of the applicant's performance on the oral examination.
- If an applicant failed Step 3/Level 3 on the 3rd attempt, he/she must complete a year of ACGME/AOA postgraduate training prior to his/her 4th attempt. The Board may, in certain circumstances, grant a waiver of this requirement.
- 1 additional year of post graduate training required if attempt limit is exceeded.
- A person who has failed any combination of steps 5 times must undergo remedial education.
- Ineligible for further examination and/or licensure until the Division is in receipt of proof that the applicant has completed, subsequent to his/her fifth failure: A) a course of clinical training of not less than 12 months in an accredited clinical training program in the United States or Canada in accordance with Section…; or B) a course of study of 9 months in length (one academic year) that includes no less than 25 clock hours per week of basic sciences as set forth in Section 1285.20(b) of this Part and no less than 40 clock hours per week of clinical sciences as set forth in Section…; or C) any other formal professional study or training in an accredited medical college or hospital, deemed by the Division to meet the requirements of subsection…
- After 3 failed attempts, 3 year of progressive GME are required.
- If the applicant has taken the three parts of the exam more than a total of 7 times, the applicant shall not be eligible for licensure unless or until they successfully complete either one-year post-graduate training in addition to that already required for licensure, or one or more other comprehensive and suitably-rigorous assessment, training, and evaluation programs after passage of all parts of the examination.

- A candidate who fails any combination of the USMLE, FLEX, NBME and NBOME three times shall provide a narrative regarding the failure and may be requested to meet with the Board and Division.
- 4 attempts allowed with ABMS/AOA certification. Before the 4th attempt the applicant must submit special/compelling circumstances.

BRD RPT 20-4

REPORT OF THE BOARD OF DIRECTORS

Subject: **Report on Resolution 19-4: Emergency Licensure Following a Natural Disaster (North Carolina Medical Board)**

Referred to: **Reference Committee**

Introduction

During the 2019 Annual Business of the FSMB House of Delegates, Resolution 19-4: Emergency Licensure Following a Natural Disaster, submitted by the North Carolina Medical Board, was presented and the following substitute resolution was adopted:

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

The Board of Directors tasked the FSMB Advisory Council of Board Executives (Advisory Council) to complete the charge of Resolution 19-4 and report its findings and recommendations. The Advisory Council met in August 2019 and, in completing the charge, reviewed state and federal statutes, rules, and board policies currently in place regarding licensure following disasters and emergencies.

Because of the varied approaches that are currently in place, statutorily and otherwise, the Advisory Council did not recommend the development and dissemination of model legislation but rather, favored providing an informational report to include resources and examples for boards to use in determining an approach that best meets the needs of the residents and licensees in their respective states.

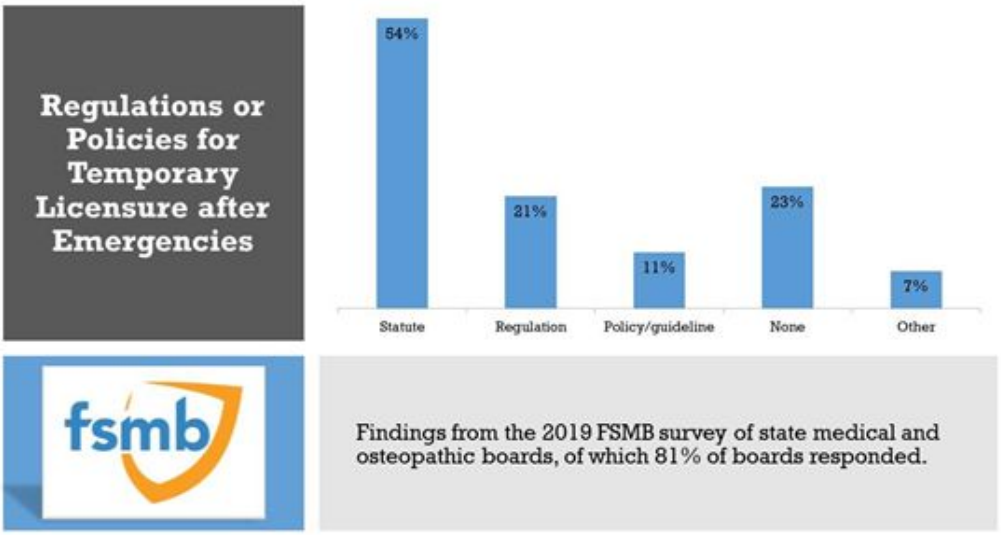
Section 1. Overview

In 2019, there were 101 state-level major disaster, emergency, and fire management assistance declarations throughout the United States and its territories. Since 2010, there have been more than 1,100 declarations.[1] These declarations were issued in response to a wide range of disasters and emergencies, including, but not limited to, tropical storms and hurricanes, earthquakes, forest fires, and tornados. Each of these disasters required varying degrees of interstate and federal assistance.

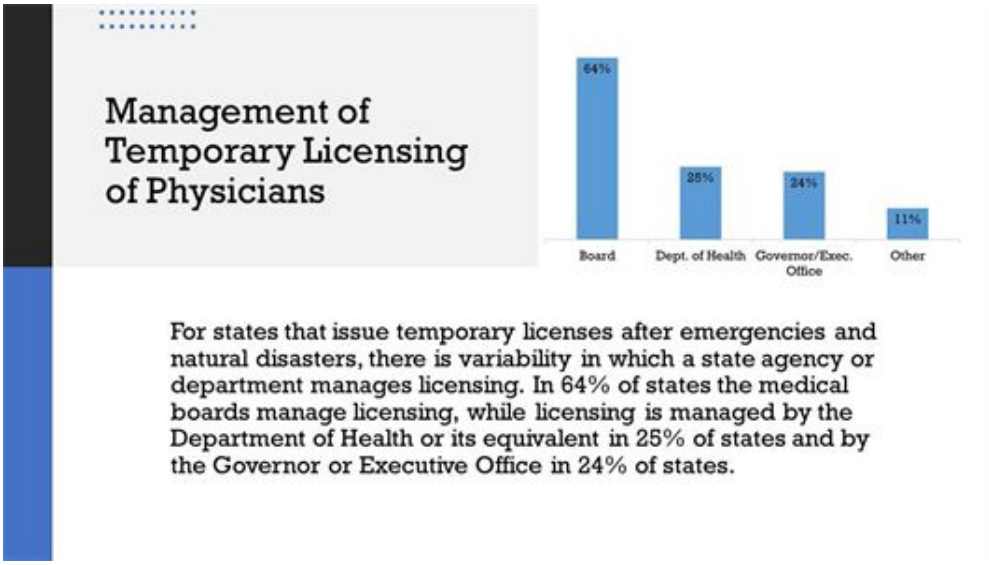
States often differ on the statutory and regulatory framework in how to respond to natural disasters, but there are areas where they share commonalities, including mutually agreed upon interstate compacts. These compacts and programs provide frameworks for deploying and utilizing

[1] Disaster Declarations by Year. U.S. Department of Homeland Security, Federal Emergency Management Agency. https://www.fema.gov/disasters/year/2019

resources, including the use of physicians and other health professionals from other states to provide medical services. According to an FSMB survey of state medical and osteopathic boards conducted in 2019, of which 81 percent responded, 54 percent of boards have statutes in place for the temporary licensure of physicians after an emergency or natural disaster, while 21 percent have regulations and 11 percent have polices or guidelines for the temporary licensure after an emergency or natural disaster. Twenty-three percent of respondents stated that there are no statutes, regulations, or policies on the topic.[1] For states that issue temporary licenses after emergencies and natural disasters, there is no uniformity in which a state agency or department manages licensing. Sixty-four percent of boards manage licensing, while licensing is managed by the Department of Health, or its equivalent, in 25 percent of states. In 24 percent of states, licensing is managed by the Governor or Executive Office.



[1] Federation of State Medical Boards. "Annual Survey of State Medical and Osteopathic Boards," November 2019.



Section 2. Interstate Compacts and Federal Assistance

When public policy issues cross jurisdictional boundaries, states may explore opportunities to establish interstate compacts that encourage multistate cooperation while maintaining state sovereignty. These Compacts can address critical issues by establishing uniform guidelines, standards, or procedures in the Member states. Historically, Compacts require the consent of the U.S. Congress when a power delegated to the federal government may be affected. Interstate compacts have been established and successfully utilized to support states in responding to natural disasters and emergencies.

Emergency Management Assistance Compact (EMAC)

In 1996, Public Law 104-321 was signed into law, which granted the consent of the United States Congress for the Emergency Management Assistance Compact ("EMAC").[2] EMAC provides a pathway for interstate recognition of licenses held by out-of-state health care professionals when responding to governor-declared states of emergency or disaster.. Since becoming law, all 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands have enacted legislation to become EMAC members.

Each state and territory that utilizes EMAC has done so through one of five enabling mechanisms. Those mechanisms, which can change over the course of time, include state legislation; memorandums of agreement/understanding; intergovernmental agreements; pre-disaster contracts; and governor executive orders.[3]

[2] Public Law 104-321 – Joint resolution granting the consent of Congress to the Emergency Management Assistance Compact. https://www.govinfo.gov/app/details/PLAW-104publ321

[3] Federation of State Medical Boards Roundtable Webinar. "When Disaster Strikes: the Emergency Management Assistance Compact." August 28, 2019.

EMAC is comprised of 13 articles and standardized procedures, including its purpose and authority, implementation, state responsibilities, limitations, and licenses and permits, among other topics. Regarding licensure and permitting, Article V of EMAC states:

> "Article V: License and Permits
> Whenever any person holds a license, certificate, or other permit issued by any state party to the compact evidencing the meeting of qualifications for professional, mechanical, or other skills, and when such assistance is requested by the receiving party state, such person shall be deemed licensed, certified, or permitted by the state requesting assistance to render aid involving such skill to meet a declared emergency or disaster, subject to such limitations and conditions as the Governor of the requesting state may prescribe by executive order or otherwise."

State licensing boards do not have the authority to set aside EMAC; only the governor of the state can set aside law through an executive order. Licensees that are deployed through EMAC should bring a copy of their license, certificate, or permit with them, as it may be needed for insurance purposes.

In cooperation with the Association of State & Territorial Health Officials and the National Association of County & City Health Officials, the National Emergency Management Association (NEMA) developed two webinars focused on EMAC and public health and medical professionals. These webinars, available on EMAC's website, are intended to provide an overview about utilizing the Compact. The first webinar is titled "EMAC: A Basic Understanding & Use of the System by Public Health & Medical Professionals" and the second is titled "Use of the EMAC System by Public Health & Medical Professionals: A Discussion."[4] On August 28, 2019, the FSMB hosted a Roundtable Webinar for state medical boards titled, "When Disaster Strikes: The Emergency Management Assistance Compact," featuring Angela Coppel, Program Director for NEMA.

Emergency System for the Advance Registration of Volunteer Health Professions (ESAR-VHP)

In 2002, after authorities in New York City had difficulty distinguishing qualified volunteers responding to the September 11 terrorist attacks, the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Public Law 107-188, was signed into law and mandated the creation of the Emergency System for the Advance Registration of Volunteer Health Professions ("ESAR-VHP").[5] The purpose of the electronic database system is to verify the credentials, licenses, accreditations, and hospital privileges of health professionals when, during public health emergencies, the professionals volunteer to provide health services in another state.

Initially administered by the Health Resources and Services Administration (HRSA) at the U.S Department of Health and Human Services (HHS), ESAR-VHP is now administered at the federal level by the Office of the Assistant Secretary for Preparedness and Response (ASPR) at HHS.

[4] Learn More About EMAC & Public Health and Medical Professionals from Past Webinars. Emergency Management Assistance Compact. https://www.emacweb.org/index.php/training-education/learn-about-emac-your-discipline/public-health-medical

[5] Public Law 107-188 - Public Health Security and Bioterrorism Preparedness and Response Act of 2002. https://www.govinfo.gov/app/details/PLAW-107publ188

ASPR leads the nation's medical and public health preparedness for, response to, and recovery from disasters and public health emergencies. ASPR assists each state and territory in establishing a standardized, volunteer registration program.[6] Each state and territory maintains their volunteer database, which allows health professionals in their state to register and have their credentials verified and stored for when an emergency arises (*See Appendix A*).

To maximize the use of health professionals with varying levels of clinical competency, ESAR-VHP developed a uniform process for classifying and assigning volunteers into one of four credential levels, based upon the provided and verified credentials. The credential levels are as follows:

> Level 1: Volunteers who are clinically active in a hospital, either as an employee or by having hospital privileges.
> Level 2: Volunteers who are clinically active in a wide variety of settings, such as clinics, nursing homes, and shelters.
> Level 3: Volunteers who meet the basic qualifications necessary to practice in the state in which they are registered.
> Level 4: Volunteers who have healthcare experience or education that would be useful for assisting clinicians and providing basic healthcare not controlled by the scope of practice laws (may include health professions students or retired health professionals who no longer hold a license).[7]

Once an emergency is declared and it is determined what resources are needed, ESAR-VHP state coordinators can work with the organizations to identify, match, and send notification to the best volunteer candidates. Those registered with ESAR-VHP are not required to deploy; it is up to the individual if they wish to assist.

Pandemic and All-Hazards Preparedness and Advancing Innovation Act (PAHPA) of 2019

Enacted into law on June 24, 2019, Public Law 116-22, the Pandemic and All-Hazards Preparedness and Advancing Innovation Act (PAHPA) of 2019, reauthorized certain programs under the Public Health Services Act and the Federal Food, Drug, and Cosmetic Act.[8] Included in the provisions of the law are several pertaining to licensure following an emergency.

The law seeks to improve hazard preparedness and response by making additional information available to states seeking to implement mechanisms to waive licensing requirements during emergencies after verifying that a volunteer professional's license is in good standing in another state. The law also adds a provision that includes making information available to professionals on how to register or enroll in volunteer services during a public health emergency. PAHPA also clarifies that when members of the Medical Reserve Corps or participants in ESAR-VHP are acting

[6] Office of the Assistant Secretary for Preparedness and Response (ASPR), U.S. Department of Health and Human Services (HHS). https://www.phe.gov/about/aspr/Pages/default.aspx
[7] Health Professionals Registration, The Emergency System for Advance Registration of Volunteer Health Professionals. https://www.phe.gov/esarvhp/Pages/registration.aspx
[8] Public Law 116-22 – Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019. https://www.congress.gov/bill/116th-congress/senate-bill/1379?r=51

during an emergency, they are liable under the laws of the state in which they are acting with an exception with regard to licensure.

Included in PAHPA is a required Government Accountability Office (GAO) study on several emergency response factors including the:

- Number of heath care providers who register under ESAR-VHP in advance to provide services during an emergency
- Number of health care providers credentialed to provide services during an emergency, including those through ESAR-VHP and authorities with the state
- Average time to verify credentials of a health care provider during the period of a public health declaration through ESAR-VHP and individuals verified by an authority within the state
- Whether states, including physician or medical groups, associations, or other relevant provider organization utilize ESAR-VHP for purposes of volunteering during public health emergencies.

As required by PAHPA, the GAO shall conduct the required review by no later than June 24, 2020.

Section 3. State Examples

The process, as well as the eligibility, to be temporarily licensed during and after an emergency or natural disaster varies across individual states. These variations can be associated with, but not limited to, scope of practice, duration of licensure, and supervision requirements. The following are a few examples of approaches states have put in place and/or used during a natural disaster.

Texas

In Texas, in cases of declared emergency disasters, the executive director of the Texas Medical Board may issue a temporary permit to practice medicine to an applicant who intends to practice under the supervision of a licensed Texas physician, excluding trainees in postgraduate programs.[9] To be eligible for such permits, the applicant must have an active license in another state, territory, or country; must not have any action taken against their medical license; and must be supervised by a physician with an unrestricted medical license in Texas. Applicants must present verification to the Texas Medical Board from the supervising physician as to the purpose for the requested permit and an attestation that they will be continually supervised.

Visiting physicians seeking a temporary permit during a declared emergency disaster must complete the appropriate application (*See Appendix B*). If a visiting physician is granted a temporary permit in response to a declared emergency disaster, the permit is valid for 30 days and there is no licensure fee.

North Carolina

[9] 22 Texas Admin. Code § 172.5

In 2018, the North Carolina Medical Board approved board rules regarding licensing after disasters and emergencies.[10] These rules were adopted in addition to the already established emergency provisions currently managed by the state's Office of Emergency Medical Services (NCOEMS), which has a network and process for bringing medical assistance into North Carolina.

The adopted rules allow for the following two pathways for out-of-state physicians to practice in North Carolina following a disaster or emergency:

Hospital to Hospital Credentialing

This pathway allows physicians holding a full, unlimited, and unrestricted license to practice medicine (in any U.S. jurisdiction), and has unrestricted hospital credentials and privileges to practice medicine in their home state, to practice at a hospital licensed by the North Carolina Department of Health and Human Services. Each licensed hospital shall verify physician credentials and privileges, keep a list of all out-of-state physicians practicing at the hospital, and provide that list to the Board within 10 days of beginning and ending practicing medicine at the hospital. Physicians are permitted to practice for either 30 days from the date the physician begins practicing at the hospital or until the emergency or disaster declaration is withdrawn or ended by the appropriate authority, whichever is shorter.

Limited Emergency License

Physicians who hold a full, unlimited, and unrestricted license to practice medicine in any state, territory, or district, but do not have credentials or privileges at a hospital in their home state may complete a limited emergency license application with the Board (*See Appendix C*). The Board must verify the physician's license and may limit the physician's scope of practice. Additionally, the Board shall have jurisdiction over all physicians practicing under this pathway, even after such physicians have stopped practicing medicine under the rule or the limited emergency license has expired. Physicians are permitted to practice for either 30 days from the date the license is issued or until the emergency or disaster declaration is withdrawn or ended, and at which time the issued license shall become inactive, whichever is shorter.

District of Columbia

The Public Health Emergency Law Manual was adopted in June 2017 by the Department of Health, in collaboration with representatives from the Office of the Chief Medical Examiner, the DC Office of the Attorney General, and the DC Courts. The Manual details the laws and regulations relevant to all sectors that may be engaged in emergency response. Included in the Manual is the framework for the scope of practice and license portability for volunteer health practitioners.

In DC, scopes of practice are defined by the Health Occupations Board. However, during disasters and emergencies, the Mayor may determine that it is necessary to modify scopes of practice to address demand. In such instances, the Mayor may issue an Order to expand health care

[10] 21 NCAC 32B.1706 – Physician Practice and Limited License for Disasters and Emergencies. http://reports.oah.state.nc.us/ncac/title%2021%20-%20occupational%20licensing%20boards%20and%20commissions/chapter%2032%20-%20north%20carolina%20medical%20board/subchapter%20b/21%20ncac%2032b%20.1706.pdf

practitioners' ability to perform certain activities, such as permitting a physician assistant to provide certain services without the supervision of a physician.[11]

License portability during and after a disaster or emergency is addressed through the EMAC. Additionally, DC adopted portions of the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) which states that when an emergency declaration is in effect, volunteer healthcare practitioners who are licensed and in good standing in their state of licensure, and are registered with a qualified registrations, they may practice while located in DC. The provision further states that volunteers may only practice within their scope of practice in the state of licensure.[12]

The UEVHPA is model legislation developed in 2006 by the Uniform Law Commission in response to criticisms made after Hurricane Katrina regarding health practitioner licensure. Nineteen (19) states have enacted the UEVHPA.[13]

Louisiana

Regulations for the Louisiana State Board of Medical Examiners authorize the board to issue emergency temporary permits to out-of-state individuals to practice as a physician or allied health care practitioner for upwards of 60 days to provide voluntary medical services in the state during a public health emergency.[14] In order to obtain an emergency temporary permit, individuals must complete an application (*See Appendix D*) and provide a copy of their current, unrestricted license in good standing from another state. For other healthcare professionals that require physician supervision by Louisiana state law, a physician must be designated on their application.

The Louisiana Department of Health and Hospitals may extend the temporary permit if it deems that emergency services are needed for more than 60 days. The Board may extend or renew an expired emergency temporary permit for one or two additional 60-day periods.

Section 4. Conclusion

This informational report is intended to provide boards with resources and examples to assist in their efforts in assessing and/or enhancing the board's disaster readiness. In keeping with the intent of Resolution 19-4, the FSMB will continue to collect and maintain information, including state and federal legislation, rules, policies and procedures pertinent to the deployment of health personnel in response to disasters, public health emergencies, and mass casualties. State medical and osteopathic boards are encouraged to proactively share their experiences and best practices with FSMB to facilitate the collection of state specific information.

[11] Public Health Emergency Law Manual. District of Columbia Department of Health. June 2017. http://dclaw.dohcloudservices.com/sites/default/files/District%20of%20Columbia%20Public%20Health%20Emergency%20Law%20Manual_FINAL.pdf

[12] D.C. Code §§ 7-2361.01 – 7-2361.12

[13] Uniform Emergency Volunteer Health Practitioners Act. https://www.uniformlaws.org/committees/community-home?CommunityKey=565933ce-965f-4d3c-9c90-b00246f30f2d

[14] La. Admin. Code tit. 46, § 412

BRD RPT 20-4

ITEM FOR ACTION:

This report is for information only.

Appendix A. State Healthcare Volunteer Registries

	Registry Name	Registry Link
AL	ALResponds	http://www.alabamapublichealth.gov/volunteer/
AK	Alaska Respond	https://www.akrespond.alaska.gov/
AZ	Arizona ESAR-VHP	https://esar-vhp.health.azdhs.gov/
AR	State Emergency Registry of Volunteers and Healthcare Personnel Arkansas (SERV Arkansas)	https://www.healthy.arkansas.gov/programs-services/topics/adh-volunteer-program
CA	Disaster Healthcare Volunteers	https://healthcarevolunteers.ca.gov/
CO	Colorado Volunteer Mobilizer for Medical and Public Health Professionals	https://covolunteers.state.co.us/
CT	State of Connecticut Emergency Credentialing Program for Healthcare Professionals	http://www.ct-esar-vhp.org/
DE	State Emergency Registry of Volunteers and Healthcare Personnel for Delaware (SERVDE)	https://www.servde.org/
DC	DC RESPONDS	https://www.dcresponds.org/
FL	State Emergency Responders & Volunteers of Florida (SERVFL)	http://servfl.com/
GA	Georgia Responds	https://www.servga.gov/
GU		
HI	Nā Lima Kāko'o	https://nlk.doh.hawaii.gov/
ID	Volunteer Idaho	https://www.volunteeridaho.com/
IL	Illinois Helps	https://www.illinoishelps.net/
IN	State Emergency Registry of Volunteers for Indiana (SERV-IN)	http://ser-in.org
IA	Iowa Statewide Emergency Registry of Volunteers (i-SERV)	http://iaserv.org
KS	Kansas System for the Early Registration of Volunteers (K-SERV)	http://www.kdheks.gov/it_systems/k-serve.htm
KY	Kentucky Helps	http://www.kentuckyhelps.com/
LA	Louisiana Volunteers in Action (LAVA)	https://www.lava.dhh.louisiana.gov/
ME	Maine Responds	https://www.maineresponds.org/
MD	Maryland Responds	https://mdresponds.health.maryland.gov/
MA	MA Responds	https://maresponds.org/
MI	MI Volunteer Registry	https://www.mivolunteerregistry.org/
MN	Minnesota Responds	https://www.mnresponds.org/
MS	Mississippi Responder Management System	https://www.signupms.org/
MO	Missouri Show-Me Response	https://www.showmeresponse.org/
MP		
MT	Montana Volunteer Registry	https://dphhs.mt.gov/mtvr/volunteerresources
NE	Nebraska ESAR-VHP	https://volunteers.ne.gov/ESAR-VHP/faces/jsp/login.jsp
NV	State Emergency Registry of Volunteers-Nevada (SERV-NV)	http://servnv.org
NH	New Hampshire Responds	https://www.nhresponds.org/
NJ	New Jersey ESAR-VHP	https://njmrc.nj.gov/hcpr/
NM	New Mexico Medical Reserve Corps	https://nmhealth.org/about/erd/bhem/mrc/
NY	State Emergency Registry of Volunteers-New York (SERV-NY)	https://apps.health.ny.gov/pub/servny/
NC	State Emergency Registry of Volunteers- North Carolina (SERV-NC)	https://www.servnc.org/

ND	North Dakota Public Health Emergency Volunteer Reserve/Medical Reserve Corps	http://www.ndhealth.gov/epr/hp/PHEVR/
OH	Ohio Responds Volunteer Registry	https://www.ohioresponds.odh.ohio.gov/
OK	Oklahoma Medical Reserve Corps	https://www.okmrc.org/
OR	State Emergency Registry of Volunteers in Oregon (SERV-OR)	http://serv-or.org
PA	State Emergency Registry of Volunteers – Pennsylvania (SERV-PA)	https://www.serv.pa.gov/
PR	Puerto Rico Medical Reserve Corps Registry	http://www.salud.gov.pr/Estadisticas-Registros-y-Publicaciones/Pages/Registros/Cuerpo-de-Reserva-Medica.aspx
RI	RI Responds	https://www.riresponds.org
SC	South Carolina Statewide Emergency Registry of Volunteers (SCSERV)	https://www.scserv.gov/UserRegistration.aspx
SD	State Emergency Registry of Volunteers for South Dakota (SERV SD)	https://volunteers.sd.gov/
TN	State of Tennessee Medical Reserve Corps (MRC) Volunteer Program	http://www.tnmrc.org/
TX	Texas Disaster Volunteer Registry	https://www.texasdisastervolunteerregistry.org/
UT	Utah Responds	https://www.utahresponds.org/
VT	Vermont Volunteer Responder Management System	https://rms.vermont.gov/
VI		
VA	Virginia Medical Reserve Corps	http://www.vdh.virginia.gov/mrc/
WA	Washington State Emergency Registry of Volunteers	http://waserv.org
WV	West Virginia Responder Emergency Deployment Information Site	http://wvredi.org
WI	Wisconsin Emergency Assistance Volunteer Registry	https://weavrwi.org/
WY	Wyoming Activation of Volunteers in Emergencies (WAVE)	https://volunteerwave.org/

Appendix B. Texas Medical Board – Visiting Physician Temporary Permit Application

TEXAS MEDICAL BOARD

INFORMATION NEEDED FOR VISITING PHYSICIAN TEMPORARY PERMIT
(Except in emergency cases, applicants should allow 30 days for processing of a Visiting Physician Temporary Permit)

Visiting Physician's Information

Name: _____

Social Security #:_____

DOB:_____ Place of Birth (State/Province/Country):_____

Medical School of Graduation: _____

Date of Graduation (mm/dd/yy):_____

Medical License Number(s) and State(s) held, or applied for

_____

Sponsoring Physician Information

Name _____ Texas license number:_____
(As imprinted on Texas medical license)

Point of Contact for this Application (this will be the individual TMB staff will contact for additional information and purposes of sending the Visiting Physician Temporary Permit)

Name: _____

Email Address: _____

Telephone Number: _____ Fax Number: _____

Mailing Address:
(**Note** – all correspondence, including the Visiting Physician Temporary Permit, will be sent to this address)

_____

Procedure Information

Date(s) of procedure: _____

Location of procedure - Hospital/Facility Name _____

Location of procedure - Complete Address: _____

_____TX._____

Name of proposed procedure: _____

Brief explanation of procedure:_____

_____

Location Address:
333 Guadalupe, Tower 3, Suite 610
Austin, Texas 78701

Mailing Address
P.O. Box 2029
Austin, Texas 78768-2029

Phone 512.305.7030
Fax 512.463-9416
Licensure Fax 512.305.7009
www.tmb.state.tx.us

BRD RPT 20-4

DPS Computerized Criminal History (CCH) Verification

I, _____ have been notified that a computerized criminal
APPLICANT NAME (Please print)
history (CCH) verification check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB information I supply.

Because the name based information is not an exact search and only fingerprint record searches represent true identification to criminal history, the organization (as listed below) conducting the criminal history check is not allowed to discuss any information obtained using this method, therefore the agency may offer the opportunity to have a fingerprint search performed to clear any misidentification based on the name search, if the search provides a criminal report I know could not be mine.

For the fingerprinting process I will be required to submit a full and complete set of my fingerprints for analysis through the Texas Department of Public Safety AFIS (automated fingerprint identification system). I have been made aware that in order to complete this process I must have the correct fingerprinting (FAST) form from this agency, make an online appointment, submit a full and complete set of my fingerprints, and pay a fee to the fingerprinting services company, L1Enrollment Services.

Once this process is completed and the agency receives the data from DPS, the information on my fingerprint criminal history record may be discussed with me.

_____
Signature of Applicant

_____
Date

Texas Medical Board
Agency Name (Please print)

_____
Agency Representative Name (Please print)

_____
Signature of Agency Representative

_____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES _____ NO _____ _____ initial

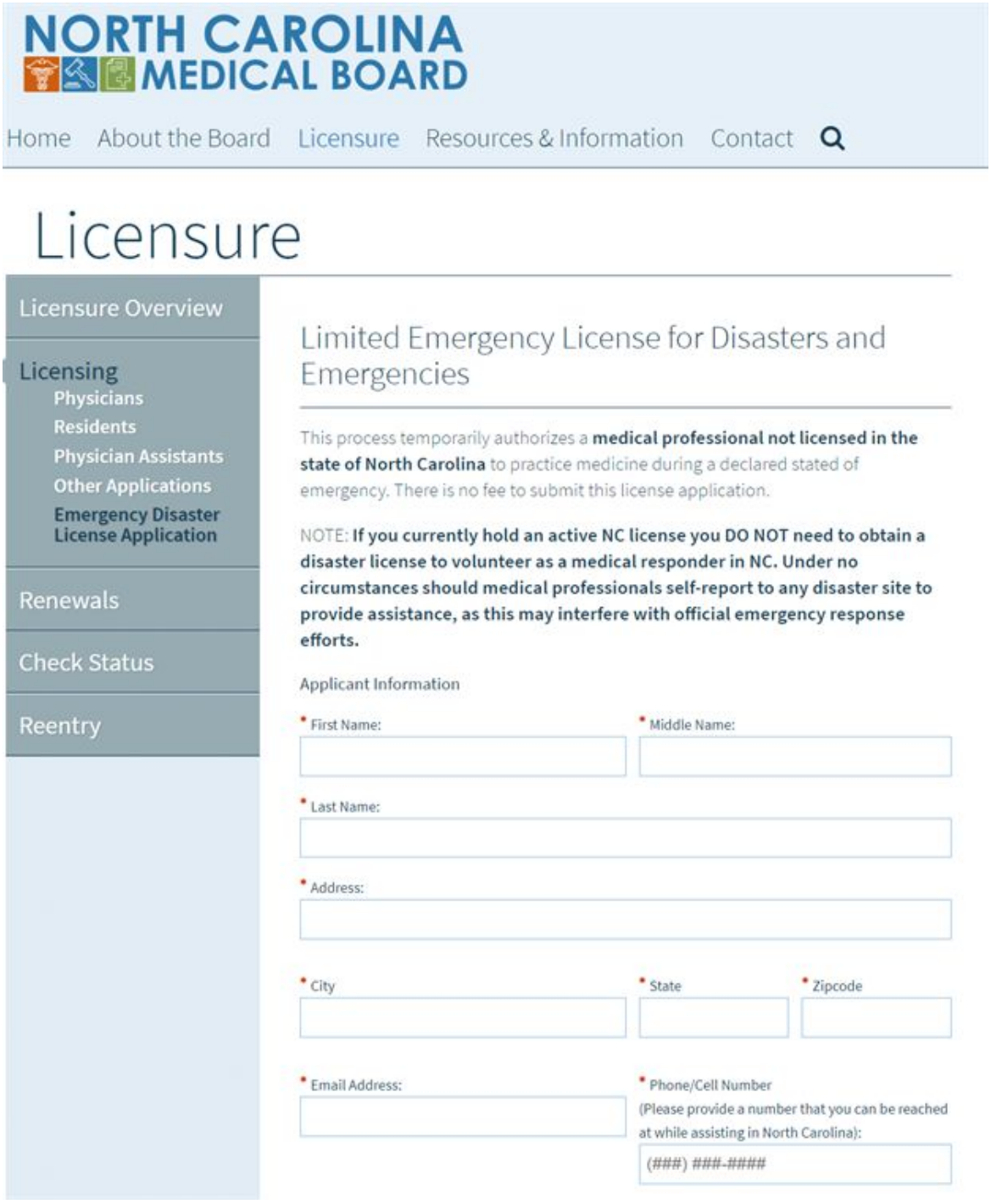
Purpose of CCH: Applicant background check

Date Printed: _____ _____ initial

Destroyed Date: _____ _____ initial

Retain in your files

Appendix C. North Carolina Limited Emergency License for Disasters and Emergencies Application



NORTH CAROLINA MEDICAL BOARD

Home About the Board Licensure Resources & Information Contact

Licensure

Licensure Overview

Licensing
- Physicians
- Residents
- Physician Assistants
- Other Applications
- Emergency Disaster License Application

Renewals

Check Status

Reentry

Limited Emergency License for Disasters and Emergencies

This process temporarily authorizes a **medical professional not licensed in the state of North Carolina** to practice medicine during a declared stated of emergency. There is no fee to submit this license application.

NOTE: **If you currently hold an active NC license you DO NOT need to obtain a disaster license to volunteer as a medical responder in NC. Under no circumstances should medical professionals self-report to any disaster site to provide assistance, as this may interfere with official emergency response efforts.**

Applicant Information

* First Name:
* Middle Name:
* Last Name:
* Address:
* City
* State
* Zipcode
* Email Address:
* Phone/Cell Number
(Please provide a number that you can be reached at while assisting in North Carolina):
(###) ###-####

* Social Security Number:

* Date of Birth:

* Place of Birth:

* Name of Medical School:

* Date of Graduation:

* Medical License Number(s) and State(s) Held:

* Volunteer Plans:

Please indicate how you plan to use your NC limited emergency license. If you will be working with a specific organization or at a specific practice site, please provide the name and location.

Waiver

☐ I waive confidentiality, authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the NCMB any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit the NCMB or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges. I hereby release, discharge and exonerate the NCMB, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the NCMB.

Submit

Appendix D. Louisiana State Board of Medical Examiners Emergency Temporary Permit Application

LOUISIANA STATE BOARD OF MEDICAL EXAMINERS
630 Camp Street, New Orleans, LA 70130
PHONE (504) 568-6820 FAX (504) 599-0503
Email: LICENSING@LSBME.LA.GOV
Web site: WWW.LSBME.LA.GOV

Emergency Temporary Permit Application

**** Complete this form PRIOR to printing****

What category of licensure are you applying for:

Physician	Allied Health		Clinical Laboratory
☐ Physician	☐ Acupuncture Detoxification Specialist	☐ Occupational Therapy Assistant	☐ CLS-Generalist
☐ Osteopathy	☐ Athletic Trainer	☐ Perfusionist	☐ CLS-Specialist
☐ Medical Psychologist	☐ Clinical Exercise Physiologist	☐ Physician Assistant	☐ CLS-Technician
☐ Physician Acupuncturist	☐ Licensed Acupuncturist	☐ Podiatrist	☐ Cytotechnologist
	☐ Licensed Respiratory Therapist	☐ Polysomnography	☐ Laboratory Assistant
	☐ Midwife	☐ Private Radiological Technology	☐ Phlebotomist
	☐ Occupational Therapist		

NAME: LAST	FIRST	MIDDLE	SUFFIX (SR, JR)	TITLE
SOCIAL SECURITY NUMBER:	DRIVER'S LICENSE # & STATE:			

HOME ADDRESS: STREET & NO.	CITY	STATE & ZIP CODE
HOME PHONE:	CELL:	EMAIL:
MAILING ADDRESS: STREET & NO.	CITY	STATE & ZIP CODE

FACILITY IN LOUISIANA WHERE YOU WILL BE PROVIDING HEALTHCARE SERVICES:

NAME OF FACILITY / STREET & NO.	CITY	STATE & ZIP CODE

IDENTIFICATION:

RACE: _____ SEX_____ WEIGHT: _____ HEIGHT: _____
EYES: _____ HAIR: _____ MARKS: _____
PLACE OF BIRTH: _____ DATE OF BIRTH: _____

OTHER STATE LICENSES: Have you ever been licensed to practice in any other state, territory, province, or country?

STATE: _____ LICENSE #: _____ ISSUE DATE: _____ EXPIRATION DATE: _____
STATE: _____ LICENSE #: _____ ISSUE DATE: _____ EXPIRATION DATE: _____
STATE: _____ LICENSE #: _____ ISSUE DATE: _____ EXPIRATION DATE: _____
STATE: _____ LICENSE #: _____ ISSUE DATE: _____ EXPIRATION DATE: _____

Do you have a supervising physician: ☐ Yes ☐ No
If yes, list: _____

Federation of State Medical Boards
Report of the Nominating Committee
January 23, 2020

The Nominating Committee met on Thursday, January 23, 2020 at the FSMB Texas office in Euless, Texas at 8:30 am CST. FSMB Immediate Past Chair Patricia King, MD, PhD, FACP serves as Chair of the Committee. Other members of the Committee include Nathaniel Berg, MD; Ahmed Faheem, MD; Robert Giacalone, RPh, JD; Maroulla Gleaton, MD; Joy Neyhart, DO; and Kenneth Walker, MD. Providing staff support were FSMB President and CEO Humayun Chaudhry, DO, MACP; Chief Legal Officer Eric Fish, JD; Director of Leadership Services Pat McCarty, MM; and Governance Support Associate Pam Huffman.

Dr. King expressed her heartfelt appreciation for the Committee's dedication and emphasized the significance of their work in selecting highly qualified candidates for the elected office positions.

The Committee reviewed all submitted nomination materials; considered the results of the one-on-one interviews between the Committee members and nominees; and discussed the importance of selecting candidates who fulfill the qualifications for FSMB leadership positions as outlined in the Committee's charge. The Committee also shared ideas for strengthening the process of finding good candidates in the future. After thoughtful and careful deliberation throughout the vetting process, the Nominating Committee unanimously approved the following roster of candidates:

Chair-elect – 1 fellow, to be elected for three years: a one-year term as Chair-elect; a one-year term as Chair; and a one-year term as Immediate Past Chair

Assists the Chair in the discharge of the Chair's duties and performs the duties of the Chair at the Chair's request or, in the event of the Chair's temporary absence or incapacitation, at the request of the Board of Directors.

Kenneth B. Simons, MD – Wisconsin

With only one candidate for Chair-elect, Dr. Simons will be elected by acclamation. His current term on the FSMB Board of Directors expires on May 2, 2020.

Board of Directors – 3 fellows, each to be elected for a three-year term*

Control and administration of the corporation is vested in the Board of Directors, which is the fiscal agent of the corporation; the Board acts for the FSMB between Annual Meetings.

Jeffrey D. Carter, MD – Missouri
Katie L. Templeton, JD – Oklahoma Osteopathic
Barbara E. Walker, DO – North Carolina
Richard A. Whitehouse, JD – Kentucky
Sherif Z. Zaafran, MD – Texas

*In accordance with the FSMB Bylaws, *"At least three members of the Board, who are not Staff Fellows, shall be non-physicians, at least two of whom shall be a Member Medical Board public member."* Two out of the three current non-physician public members on the Board will continue their service in FY 2021 (May 2020-April 2021); therefore, **at least one non-physician will need to be elected**.

Nominating Committee – 3 fellows**,** each to be elected for a two-year term** / ***

Nominating Committee members select a roster of nominees for each of the elected positions to be filled at the annual business meeting of the House of Delegates.

Alexander S. Gross, MD – Georgia
Reverend Janet Harman – West Virginia Medical
John "Jake" M. Manahan, JD – Minnesota
J. Michael Wieting, DO – Tennessee Osteopathic

In accordance with the FSMB Bylaws, *"At least one elected member of the Nominating Committee shall be a public member."* The term of the Nominating Committee's current public member will end on May 2, 2020; therefore, **at least one public member will need to be elected.

***No two Nominating Committee members shall be from the same member board. Continuing members of the Committee are from Alaska, Guam and Maine Medical.

Respectfully submitted,

Patricia A. King, MD, PhD, FACP
Chair, Nominating Committee

GUIDE TO THE FSMB HOUSE OF DELEGATES MEETING

TABLE OF CONTENTS

Preface

The House of Delegates is the official public policy-making body of the FSMB. A “public policy” is defined in the FSMB Bylaws as *the official public position of the FSMB on a matter that may be reasonably expected to affect Member Boards when dealing with their licensees, other health care providers, health-related special interest groups, governmental bodies or the public.* At its Annual Meeting each spring, the House acts on numerous reports and resolutions and establishes policy to guide the organization and its members.

This *Guide* provides information about the House’s policy development process and is designed to help those attending the annual business meeting of the House of Delegates better understand and/or participate in that process.

Chapter 1: FSMB's Governance Structure

Two characteristics distinguish the FSMB from most other nonprofit organizations: it is a membership association and it has a national scope. The FSMB Bylaws distribute the authority to govern across six levels. The organizational elements that participate in the FSMB's system of governance and policymaking process include: Member Medical Boards, House of Delegates, Board of Directors, Executive Committee, Standing and Special Committees/Workgroups, and the Executive Office. (see FSMB's Organizational Chart on page 4)

The roles and responsibilities of each of these components of the FSMB's governance structure are described below.

I. Member Medical Boards

The term *Member Medical Board* as used in the FSMB's Articles of Incorporation and Bylaws, refer to *any board, committee or other group in any state, territory, the District of Columbia or possession of the United States of America that is empowered by law to pass on the qualifications of applicants for licensure to practice allopathic or osteopathic medicine or to discipline such licensees. If a state or other jurisdiction has more than one such entity and if each is an independent agency unrelated to the others, each is eligible for membership. Any eligible Medical Board may become a Member Medical Board upon approval of its application by the Board of Directors*.

A Member Medical Board's participation in the policymaking process of the FSMB takes place at the corporation's annual business meeting of the House of Delegates. The right to vote at meetings of the House of Delegates is vested in, and restricted to, Member Medical Boards. All classes of FSMB membership (Fellows, Honorary Fellows, Associate Members, Courtesy Members, Affiliate Member Boards and Official Observers) shall have the right of the floor at meetings of the House upon request of a delegate and approval of the presiding officer; however, the right to introduce resolutions for the House of Delegates to act upon is restricted to Member Medical Boards and the Board of Directors. Except as otherwise noted in the FSMB Bylaws, rights, duties, privileges and obligations of a member of the FSMB may be exercised only by a Member Medical Board.

II. House of Delegates

A delegate is the president/chair of a Member Medical Board or his/her designated alternate (Board Member Fellow, Staff Fellow or Associate Member). Each Member Medical Board is entitled to one vote at the meetings of the House of Delegates, which is to be cast by the delegate of the Member Medical Board.

III. Board of Directors

As the body responsible for the control and administration of the FSMB, the Board of Directors reports to the House of Delegates. The Board represents the interests of the House of Delegates and FSMB membership between Annual Meetings. The responsibilities of the Board include: providing leadership in the development and implementation of the FSMB's Strategic Plan; governing and conducting the business of the corporation, including supervising the President/Chief Executive Officer (President/CEO); and, under the leadership of the FSMB's Chair and President/CEO, representing the FSMB to the leadership of other organizations and speaking on behalf of the FSMB to promote recognition of the FSMB as the premier organization concerned with medical licensure and discipline.

IV. Executive Committee

Under the leadership of the Chair, the Executive Committee, which also includes the Chair-elect, Treasurer, Immediate Past Chair and three Directors-at-Large, represents the Board of Directors between Board meetings. The members of the Executive Committee, either collectively or individually, provide leadership on behalf of the Chair in scheduling and conducting Board committee meetings; provide leadership on behalf of the Chair to the Directors-at-Large and Staff Fellows serving on the Board in the fulfillment of their responsibilities, including governing and conducting the business of the corporation and supervising the President/CEO; and, at the direction of the Chair, represent the FSMB to the leadership of other organizations, promoting recognition of the FSMB as the premier organization concerned with medical licensure and discipline.

V. Standing and Special Committees/Workgroups/Taskforces

The Board of Directors governs by making decisions about goals and objectives, programs and services, personnel, finances, facilities and equipment and then seeing to it that those decisions are carried out. To assure that the Board conducts its business efficiently and democratically, assistance is provided through the FSMB's committee and workgroup structure. The Board oversees the work of two types of committees: standing and special.

Standing committees are permanent and assist the House of Delegates and Board of Directors with overseeing a specific aspect of governance such as finance. All standing committees are either specifically mentioned in the Bylaws or must be created by resolution of the FSMB and/or amendment to the Bylaws. Membership on standing committees is determined by the Bylaws (as approved by the House of Delegates) or Chair.

The FSMB standing committees include:

Audit Committee
Bylaws Committee
Editorial Committee
Education Committee
Ethics and Professionalism Committee
Finance Committee
Nominating Committee

Special committees, workgroups and taskforces are temporary and are created for some special purpose such as overseeing the development of a program or conducting research on a specific subject. The Chair determines the membership of these groups. Those for FY 2020 include:

Ad Hoc Task Force on Pandemic Response
Artificial Intelligence Taskforce
Special Committee on Strategic Planning
Workgroup on Board Education, Service and Training (BEST)
Workgroup on Physician Sexual Misconduct
Workgroup on Physician Impairment
Workgroup to Study Risk and Support Factors Affecting Physician Performance

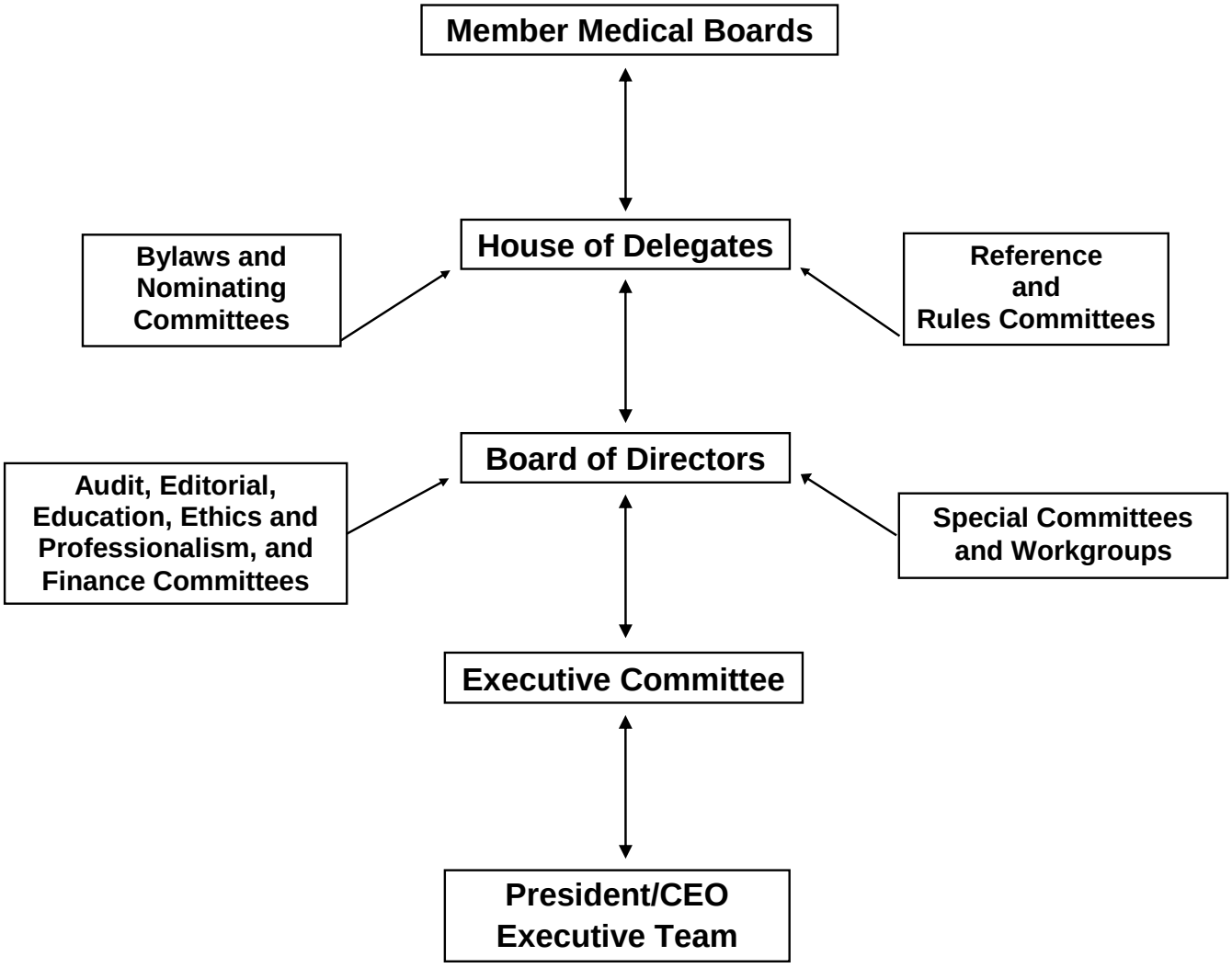
In addition to the existence of standing and special committees, workgroups and taskforces, a Rules Committee and Reference Committee(s) meet for each Annual Meeting to help facilitate the progress of business at the House of Delegates meeting.

VI. Executive Office

The President/CEO reports to the Board of Directors. The President/CEO supports and assists the Board and its committees in the conduct of its corporate business and 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 Assessment Officer, Chief Financial Officer, Chief Legal Officer, and Chief Operating Officer.

FSMB Organizational Chart



Chapter 2: The House of Delegates Policy Development Process

I. Reports and Proposals

Reports of the FSMB Board of Directors, Executive Office, committees, workgroups, taskforces and representatives to other organizations are transmitted to the House of Delegates for information or action. Informational reports provide highlights or an update on activities or projects that have been completed or are in progress, and do not require any decision-making on the part of the House. Action reports recommend a new or modified policy or that a particular action be carried out by the FSMB.

While the full text of reports and proposals is published, only the recommendations are subject to amendment, and only the recommendations adopted by the House become FSMB policy.

II. Resolutions

Member Medical Boards may wish to submit resolutions for consideration at the annual business meeting of the House of Delegates. A resolution is a way to express an idea or to identify a problem or opportunity. Although resolutions may deal with complex issues, most resolutions begin simply when a problem is recognized, and a solution is suggested. Resolutions are structured to express the background of the problem and to lay out a course of action in a logical way so that the need for action on the issue is clear. To set the tone for discussion, each *Whereas* clause should carry a message and develop statements that require a solution. *Resolved* clauses should reflect what has just been stated and then go on to address what the FSMB should do or what position the FSMB should take on the identified topic.

Member Medical Boards wishing to submit resolutions are requested to forward all proposed resolutions to the FSMB's Executive Office. In order to streamline the processing of business for the meeting and increase the efficiency with which the House of Delegates agenda materials are produced, resolutions must be submitted in writing or via e-mail to the FSMB at least 60 days prior to the meeting. **The FSMB cannot accept resolutions after the published deadline.**

When drafting resolutions for submission:

- The title of the resolution should appropriately and concisely reflect the action for which it calls.

- The date on which the resolution was approved by the Member Medical Board should appear beneath the title.
- Information contained in the resolution should be checked for accuracy.
- The *Resolved* portions should stand alone, since the House adopts only the *Resolved* portions and the *Whereas* portions are not subject to adoption.

III. Reference Committees **[in 2020, the Reference Committee will be meeting virtually on April 30 in place of a Reference Committee hearing – written testimony may be submitted by the Member Medical Boards for the Committee's consideration by April 23. The report of the Reference Committee will be posted on the Member Portal on May 1.]**

One or more Reference Committee hearings are scheduled prior to the House of Delegates annual business meeting. An agenda for the items to be heard by each Committee is posted with the Annual Meeting materials on the FSMB Member Portal, as well as on the Annual Meeting app.

All interested Annual Meeting participants may attend Reference Committee hearings and make statements on items being considered. Agenda items can include resolutions, Board reports, Bylaws amendments or other proposals that require a vote by the House of Delegates. All items heard in Reference Committee hearings will be voted upon by the full House of Delegates at the annual business meeting. Reference Committees are not empowered to take any action on items of business. Their role is to make recommendations to the House of Delegates. Only those items acted upon by the House of Delegates are considered official.

Each Reference Committee will be appointed by the Chair of the FSMB Board of Directors and will be composed of three to five members. However, the Chair may appoint additional members as needed. The Chair(s) of the Reference Committee(s) introduces each item of business, opens the floor for comment and recognizes individuals from the floor. While the purpose of the Reference Committee(s) is to hear as much testimony as necessary for a full discussion of each item, the Committee Chair(s) may set time limits on the testimony, as deemed necessary.

Members of the FSMB's Board of Directors, standing committees, special committees, workgroups, taskforces and staff are present at Reference Committee hearings to provide any requested resources or information. The Reference Committee(s) is to listen and, if necessary, seek out any appropriate information and/or viewpoints on each item under discussion. Members of the Reference Committee(s) are not allowed to engage in debate or express their own opinions during the hearing(s), and they are not empowered to entertain motions or make decisions on items of business.

At the close of the hearing(s), Reference Committee members meet in Executive Session to formulate their recommendations on each item. These recommendations are based on what is in the best interest of the FSMB, and not on the amount of testimony for or against a particular proposal.

During the House of Delegates business meeting, the Chair(s) of each Reference Committee(s) presents the Committee's report. The Reference Committee(s) may recommend that a proposal be adopted, rejected, amended or otherwise disposed of, and give reasons, therefore. It may also recommend amendments to proposals that have been referred and/or make substitute proposals of its own. The Reference Committee(s) must forward a recommendation to the House of Delegates on each item of business, and the House must take action on these recommendations. Any "whereas" portions or preambles of resolutions before the Committee(s) are informational and explanatory, and only the "resolve" portions are considered by the House of Delegates. Recommendations of the Reference Committee(s) are advisory, and it is important that the House of Delegates has the opportunity to consider all proposals submitted to it and make the final decision on each.

The use of Reference Committee hearings allows for a more detailed and thorough discussion of items of business to come before the House of Delegates, thereby facilitating the progress of the annual House of Delegates business meeting.

IV. Setting Policy

A simple majority vote of the House is required for most items of business. Some actions, such as changes to the Bylaws, require a two-thirds majority vote of those voting.

The House of Delegates may act on items before it in one of the following ways:

- The House may **adopt** the recommendations of reports and resolves of resolutions or **not adopt** if a majority of the House votes against them.
- The House may **amend and then adopt** the amended recommendations of reports and resolves of resolutions.
- The House may **propose amendments by substitution and then adopt** the substitute amendments to recommendations of reports and resolves of resolutions.
- The House may **refer the items back to the Board** (or through the Board to the appropriate committee) **for further review**. If an item is referred for further study, then all pending information (i.e., amendments) relating to that item is referred as well. A specific time for reporting back to the House should be indicated.
- The House may **refer the items back to the Board for decision**, which gives the Board the authority and responsibility for making a determination on the matter.

- The House may **file an informational report** (acknowledging that a report has been received and considered, but that no action has been necessary or taken).
- The House may **table** a recommendation, which sets aside the recommendation for the current meeting unless the House votes to resume its consideration. A tabled recommendation is postponed to an undetermined time and may be proposed again, as a new recommendation at any future meeting; however, if a recommendation is tabled as a means of closing debate indefinitely, it would require a two-thirds majority vote.

V. Elections

Elections for filling vacancies within the Board of Directors and Nominating Committee are conducted at the annual business meeting of the House of Delegates in accordance with the Bylaws of the FSMB, the process of which is described in Section VII of this chapter (Rules Committee). **Only individuals who are Board Member Fellows of the FSMB at the time of the election may run for elective office**. A Board Member Fellow is an individual member who as a result of appointment or confirmation is designated to be a member of a Member Medical Board. A Board Member Fellow shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of thirty-six months thereafter.

a. Officers:

The Chair and Chair-elect may serve for terms of one (1) year or until their successors assume office. The Chair then serves one year as Immediate Past Chair, and the Chair-elect serves one year as Chair. The Treasurer may serve for a single term of three (3) years or until his/her successor assumes office. At each annual business meeting of the House of Delegates the Chair-elect will be elected and every third year at the Annual Meeting the Treasurer will be elected. (The position of Secretary is an ex-officio office, without vote, and the President/CEO serves as Secretary.) Officers assume office upon final adjournment of the Annual Meeting at which they were elected.

b. Directors-at-Large and Staff Fellows serving on the Board

In addition to the Officers, the Board of Directors is comprised of nine (9) Directors-at-Large who are elected by the House of Delegates, and two Staff Fellows who are appointed by the Board of Directors. At least two members of the Board, who are not Staff Fellows, shall be non-physicians, at least one of whom shall be a public/consumer member. Directors-at-Large shall serve for a term of three (3) years and are eligible to be re-elected for one additional term. A partial term of one-and-a-half years or more counts as a full term. At least three (3) of the Directors-at-Large are to be elected each year at the Annual Meeting. Staff Fellows

shall serve for a term of two years and shall be eligible to be reappointed to one additional term. A partial term of one-and-a-half years or more counts as a full term.

c. Nominating and Other Standing Committee Members:

At least three Board Member Fellows are elected at each Annual Meeting to serve on the Nominating Committee, each for a two-year term. With the exception of the Immediate Past Chair, who chairs the Committee without vote, no two Nominating Committee members are to be from the same Member Medical Board.

With the exception of the Nominating Committee, chairs and members of all standing committees are appointed by the FSMB Chair, with the approval of the Board of Directors, for a term of one (1) year, unless otherwise provided for in the Bylaws. Reappointment, unless specifically prohibited, is permissible. Members of the Editorial Committee serve staggered three-year terms and are limited to two full terms. The Chair appoints the chair of the Audit, Bylaws, and Ethics and Professionalism Committees. The FSMB Treasurer serves as chair of the Finance Committee. The FSMB Chair serves as the chair of the Education Committee. The Immediate Past Chair serves as the chair of the Nominating Committee. The Editorial Committee elects its own chair, who serves as the Editor-in-Chief of the *Journal of Medical Regulation.* No officer or member of the Board of Directors shall serve on the Editorial Committee.

VI. House of Delegates Meeting Materials

The House of Delegates business meeting materials include the agenda, minutes of the previous meeting, reports and resolutions, management notes (summaries of agenda items with any recommendations by FSMB management on appropriate actions to be taken by the House of Delegates), and reference information. **The House of Delegates business meeting materials will be posted on the FSMB Member Portal approximately one month prior to the Annual Meeting. [This year, due to Covid-19, the posting of materials other than those going before the Reference Committee were delayed.]**

VII. Rules Committee **[The 2020 Rules Committee drafted rules for ratification for conducting a virtual meeting of the House of Delegates]**

The role of the Rules Committee is to develop the rules for conducting business during the House of Delegates annual business meeting and to develop a Report of the Rules Committee for ratification by the House of Delegates.

The 2019 Report of the Rules Committee as ratified by the House of Delegates states the following:

I. House Security:

Maximum security shall be maintained at all times to prevent disruptions of the Annual Business Meeting. Only those individuals with proper badges or secure log-in shall be permitted to attend or participate using an electronic platform. The presiding officer may appoint three (3) sergeants-at-arms to maintain order in the meeting room and escort any special guests to the podium.

II. Credentials:

Only properly registered voting representatives with marked badges shall be allowed to sit in the voting section at the Annual Meeting. Only those voting representatives registered as remote participants shall be allowed to cast votes using remote electronic means. Voting credentials cannot be transferred from the official voting delegate to another after the meeting is called to order.

III. Order of Business:

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

IV. Privilege of the Floor:

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

V. Procedures of the Annual Business Meeting:

The presiding officer shall appoint tellers for the purpose of assisting in the election process and certification of votes. Tellers shall not be designated voting delegates of the Annual Business Meeting.

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

All issues not decided by voice vote shall be decided by electronic balloting. In the event electronic balloting is not possible because of technical or other reasons, voting shall be conducted by written ballot. In the occurrence of such event, voting representatives participating using the remote electronic platform shall communicate their vote to the preassigned teller.

VI. Nominations:

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

VII. Elections:

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

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

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

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

When it is necessary to meet the minimum Bylaws requirement for election of a non-physician director, election of a non-physician director from the field of non-physicians shall precede election of other at-large candidates to the Board of Directors. Non-physician candidates not elected to the required seat shall join the slate of physician candidates for the remaining at-large positions on the Board of Directors. The same procedures shall be used for election of the Nominating Committee.

If more than one seat on the Board of Directors is to be filled from a single list of candidates, and if one or more seats are not filled by majority vote on the first ballot, a runoff election shall be held with the ballot listing candidates equal in number to twice the number of seats remaining to be filled. These candidates shall be those remaining who

received the most votes on the first ballot. The same procedures shall be used for any subsequent runoff elections.

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

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

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

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

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

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

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

Chapter 3: Designated Annual Meeting Attendees **[In 2020, due to COVID-19, the Annual Meeting was cancelled apart from the virtual meeting of the House of Delegates]**

I. Designation of Voting Delegates and Member Medical Board Senior Staff Representatives

During the month of December prior to the Annual Meeting, the presidents/chairs (Board Member Fellows) and executive directors (Staff Fellows) of each Member Medical Board are sent an email communication requesting they begin the process of identifying the individuals who will participate in the FSMB House of Delegates meeting as their board's voting delegate (president/chair/another board member) and senior staff representative (executive director/another staff member). In the event the board president/chair cannot attend as voting delegate, an alternate member of the medical board may be identified by the board president/chair to attend as the designated voting delegate. In the event the chair/president nor alternate member of the medical board cannot attend, a Staff Fellow or Associate Member may be identified by the board chair/president to attend as their designated voting delegate. The designated attendee's name must be communicated to FSMB prior to the start of the Annual Meeting. Only board members, Staff Fellows or Associate Members of the FSMB may be designated as an alternate voting delegate. If the Staff Fellow cannot attend, another senior staff member may be identified by the board president/chair to attend in lieu of the Staff Fellow.

Scholarship and related Annual Meeting information is forwarded to the presidents/chairs (Board Member Fellows) and executive directors (Staff Fellows) of each Member Medical Board in early January to assist when identifying designated attendees.

II. Registration and Program Information

Upon notification of a designated attendee, the FSMB will forward a confirmation email, Scholarship Registration Link, reimbursement policy and travel information to the selected individuals. The Annual Meeting registration fee is waived for scholarship recipients.

2019 FSMB BYLAWS

ARTICLE I. NAME

The corporation shall be known as the Federation of State Medical Boards of the United States, Inc. ("FSMB").

ARTICLE II. CLASSES OF MEMBERSHIP, ELECTION AND MEMBERSHIP RIGHTS

SECTION A. MEMBER MEDICAL BOARDS

The term "Member Medical Board" as used in the Articles of Incorporation and in these Bylaws shall refer to any board, committee or other group in any state, territory, the District of Columbia or possession of the United States of America that is empowered by law to pass on the qualifications of applicants for licensure to practice allopathic or osteopathic medicine or to discipline such licensees. If a state or other jurisdiction has more than one such entity and if each is an independent agency unrelated to the others, each is eligible for membership. Any eligible Medical Board may become a Member Medical Board upon approval of its application by the Board of Directors.

SECTION B. FELLOWS

There shall be two categories of Fellow of the FSMB:

1. BOARD MEMBER FELLOW. A Board Member Fellow is an individual member who as a result of appointment or confirmation is designated to be a member of a Member Medical Board. A Board Member Fellow shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of thirty-six months thereafter, and
2. STAFF FELLOW. A Staff Fellow is an individual hired or appointed and who is responsible for the day-to-day supervision and performance of the administrative duties and functions for which a medical board is responsible. Each member board may denote only one individual to serve as a Staff Fellow of the FSMB. No individual shall continue as a Staff Fellow upon termination of employment by or service to the Member Medical Board.

SECTION C. HONORARY FELLOWS

A Board Member Fellow as defined in Section B, paragraph 1 shall become an Honorary Fellow of the FSMB thirty-six months after completion of service on a Member Medical Board. A Staff Fellow as defined in Section B, paragraph 2 shall become an Honorary Fellow of the FSMB upon

termination of employment by or service to the Member Medical Board. An Honorary Fellow of the FSMB may be appointed by the Chair to serve as a member of any committee or in any other appointive capacity.

SECTION D. ASSOCIATE MEMBERS

A Member Medical Board may designate one or more employees or staff members, other than an individual designated as a Staff Fellow, to be an Associate Member of the FSMB. No individual shall continue as an Associate Member upon termination of employment by or service to the Member Medical Board.

SECTION E. COURTESY MEMBERS

Any physician or physician assistant licensed by a Member Medical Board or an Affiliate Member Board and not eligible for any other type of membership may become a Courtesy Member of the FSMB upon approval of the candidate's application. A Courtesy Member may serve as a member of a committee and in any other capacity upon appointment by the Chair.

SECTION F. AFFILIATE MEMBERS BOARDS

A board or authority that is not otherwise eligible for membership may become an Affiliate Member Board of the FSMB upon approval of its application by the Board of Directors if the board or authority licenses either:

1. Allopathic or osteopathic physicians or physician assistants in the United States; or
2. Allopathic or osteopathic physicians if the board or authority is located in another country.

SECTION G. OFFICIAL OBSERVERS

An organization may apply for Official Observer status at meetings of the House of Delegates. The Board of Directors shall prescribe rules and procedures to govern the application for, the granting of and the exercise of Official Observer status.

SECTION H. RIGHTS OF MEMBERS

Except as otherwise provided in these Bylaws, rights, duties, privileges and obligations of a member of the FSMB may be exercised only by a Member Medical Board.

SECTION I. METHODS OF NOMINATION TO ELECTED OFFICE

Nomination by the Nominating Committee or Nomination by Petition pursuant to Articles III, IV, V and VIII shall be the sole methods of nomination to an elected office of the FSMB. A candidate

who runs for and is not elected to an elected office shall be ineligible to be nominated for any other elected office during the same election cycle.

ARTICLE III. OFFICERS: ELECTION AND DUTIES

SECTION A. OFFICERS OF THE FSMB

1. OFFICERS. The officers of the FSMB shall be that of Chair, Chair-elect, Immediate Past Chair, Treasurer and Secretary.
2. Only an individual who is a Fellow as defined in Article II, Section B, paragraph 1 at the time of the individual's election or appointment shall be eligible for election or appointment as an Officer of the FSMB, except for the position of Secretary.
3. The position of Secretary shall be an ex-officio office, without vote, and the President of the FSMB shall serve as Secretary.

SECTION B. ELECTION OF OFFICERS

1. The Chair-elect shall ascend to the position of Chair at the Annual Meeting following the meeting in which the Chair-elect was elected.
2. The Chair-elect shall be elected at each Annual Meeting of the House of Delegates.
3. The Immediate Past Chair assumes that position upon the Chair-elect ascending to the position of Chair.
4. The Treasurer shall be elected every third year at the Annual Meeting of the House of Delegates.
5. Officers shall be elected by a majority of the members of the House of Delegates present and voting.
6. In any election, should no candidate receive a majority of the votes cast, a runoff election shall be held between the two candidates who receive the most votes for that office on the first ballot. Up to two additional runoff elections shall be held.
7. Prior to each election, the presiding officer shall cast a sealed vote that shall be counted only to resolve a tie that cannot be decided by the process set forth in this section.

SECTION C. DUTIES OF OFFICERS

1. The duties of the Chair shall be as follows:

a. Preside at all meetings and sessions of the House of Delegates and the Board of Directors;

b. Perform the duties customary to the office of the Chair;

c. Make appointments to committees and define duties of committee members in accordance with these Bylaws, except as otherwise provided herein;

d. Serve, ex officio, on all committees except as otherwise provided herein; and

e. Exercise such other rights and customs as the Bylaws and parliamentary usage may require or as the FSMB or the Board of Directors shall deem appropriate.

2. The duties of the Chair-elect shall be as follows:

a. Assist the Chair in the discharge of the Chair's duties; and

b. Perform the duties of the Chair at the Chair's request or, in the event of the Chair's temporary absence or incapacitation, at the request of the Board of Directors.

3. The duties of the Immediate Past Chair shall be as follows:

a. Assist the Chair in the transition from Chair-elect to Chair;

b. Serve as chair of the Nominating Committee; and

c. Perform such other duties and responsibilities as the Chair shall determine.

4. The duties of the Treasurer shall be as follows:

a. Perform the duties customary to that office;

b. Perform such other duties as the Bylaws and custom and parliamentary usage may require or as the Board of Directors shall deem appropriate;

c. Serve as an ex officio member of the Audit Committee; and

d. Serve as chair of the Finance Committee.

5. The duties of the Secretary shall be as follows:

a. Administer the affairs of the FSMB; and

b. Such duties and responsibilities as the FSMB and the Board of Directors shall determine.

SECTION D. TERMS OF OFFICE AND SUCCESSION

1. The Chair and Chair-elect shall serve for single terms of one year or until their successors assume office.

2. The Immediate Past Chair shall serve until a successor to the current Chair assumes office.
3. The Treasurer shall serve for a single term of three years or until the Treasurer's successor assumes the office.
4. Officers shall assume office upon final adjournment of the Annual Meeting of the House of Delegates at which they were elected.
5. The term of the Secretary is co-terminus with that of the President.

SECTION E. VACANCIES

1. In the event of a vacancy in the office of the Chair, the Chair-elect shall assume the position of Chair for the remainder of the unexpired term, and shall then serve a full one-year term as Chair.
2. In the event of a vacancy in the office of the Chair-elect, the Board of Directors shall appoint a Director-at-Large to assume the duties, but not the office, of Chair-elect for the remainder of the unexpired term. At the next Annual Meeting of the House of Delegates, both a Chair and a Chair-elect shall be elected in accordance with the provisions in Section B of this Article.
3. In the event of a vacancy in the office of Immediate Past Chair, the office shall remain open until a new Chair assumes the office.
4. In the event of a vacancy in the office of the Treasurer, the Board of Directors shall elect one of the Directors-at-Large to serve as Treasurer, with one vote on the Board of Directors and one vote on the Executive Committee, until the next year's Annual Meeting of the House of Delegates, at which time a Treasurer shall be elected.

ARTICLE IV. BOARD OF DIRECTORS

SECTION A. MEMBERSHIP AND TERMS

1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, nine Directors-at-Large and two Staff Fellows. At least three members of the Board, who are not Staff Fellows, shall be non-physicians, at least two of whom shall be a Member Medical Board public member.
2. NOMINATION OF STAFF FELLOWS: Nominations for Staff Fellow positions shall be accepted from Member Boards, the Board of Directors and the Administrators in Medicine. Staff Fellows shall be appointed by the Board of Directors in staggered terms in accordance with policies and procedures established by the Board of Directors.

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

SECTION B. NOMINATIONS

1. The Nominating Committee shall submit a roster of one or more candidates for each of the offices and positions to be filled by election at the Annual Meeting of the House of Delegates.
2. The Nominating Committee shall mail its roster of candidates to Member Boards not fewer than sixty days prior to the Annual Meeting of the House of Delegates.

SECTION C. ELECTION OF DIRECTORS-AT-LARGE

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

SECTION D. DUTIES OF THE BOARD OF DIRECTORS

1. The control and administration of the FSMB is vested in the Board of Directors and it shall act for the FSMB between Annual Meetings.
2. The Board of Directors shall carry out the mandates of the FSMB as established by the House of Delegates, and it shall have full and complete authority to perform all acts and to transact all business for and on behalf of the FSMB.
3. The Board of Directors shall conduct and manage all property, affairs, work and activities of the FSMB, subject only to the provisions of the Articles of Incorporation and these Bylaws and to resolutions and enactments of the House of Delegates.
4. The Board of Directors shall be the fiscal agent of the FSMB.
5. The Board of Directors shall establish rules for its operations and meetings.
6. The FSMB shall indemnify Directors, Officers and other individuals acting on behalf of the FSMB if such indemnification is in accordance with the laws of the State of Nebraska and the operational policies and procedures of the Board of Directors, as adopted. The Board shall report to the membership of the FSMB at the Annual Meeting of the House of Delegates.
7. The Board of Directors shall establish a strategic plan for the FSMB that states the FSMB mission and objectives and shall submit that plan to the House of Delegates for ratification, modification or rejection. The Board shall review the current strategic plan annually and propose any amendments to the Annual Meeting of the House of Delegates for ratification, modification or rejection. The President shall report to the Annual Meeting of the House of Delegates on the extent to which the FSMB's stated objectives have been accomplished in the preceding year.

SECTION E. REMOVAL FROM OFFICE

1. REMOVAL: Any officer or member of the Board of Directors may be removed for any cause deemed sufficient by an affirmative vote of two-thirds of the total members of the Board of Directors entitled to vote and who are not subject to removal from office.
2. PROCEDURE: The procedure for removal shall be as follows:
    a. The Board shall file with the Secretary of the Board and deliver a written statement of the cause for removal to the officer or board member in sufficient detail as to state the grounds

for the removal. Delivery to the officer or board member shall be by certified mail, return receipt requested, to the last address known to the Board.

b. The officer or board member shall deliver a sworn written response to the Board no later than thirty calendar days after the written statement of the cause for removal is delivered to the officer or board member in question. Delivery to the Board shall be by certified mail, return receipt requested, directed to the Secretary of the Board at the FSMB corporate office.

c. At the Board meeting following the date the response is due, the Board shall determine whether or not to proceed with removal. Notice of the Board's action shall be delivered to the officer or board member by certified mail, return receipt requested. If the officer or board member does not file a written response, the Board shall proceed with a determination.

d. If the Board votes to proceed with removal of the officer or board member, at a Board meeting the board member shall be afforded the opportunity to address the Board on the merits of the allegations and produce any relevant information to the Board after which the Board shall make a determination. The Board meeting at which the officer or board member has the opportunity to address the Board shall be held no less than thirty days after delivery of the notice of removal.

3. APPEAL: Any officer or member of the Board of Directors removed by the Board of Directors may appeal to the House of Delegates at its next business meeting. The officer or member may be reinstated by a two-thirds vote of the House of Delegates.

4. DELIVERY: For the purposes of this section, "Delivery" is effective upon mailing.

SECTION F. VACANCIES

1. DIRECTORS-AT-LARGE: In the event of a vacancy in the membership of the Directors-at-Large, the Board of Directors may appoint a Fellow who meets the qualifications for the position to serve until the next annual meeting of the House of Delegates, at which time a Fellow shall be elected and shall serve the remainder of the unexpired term. In the event a Director-at-Large is elected to the office of Treasurer or Chair-elect, that vacancy shall be filled by an election at the same annual meeting of the House of Delegates.

2. STAFF FELLOWS: In the event of a vacancy of a Staff Fellow, the Board of Directors may appoint a substitute to complete the Staff Fellow's term in accordance with the policies established by the Board of Directors.

SECTION G. EXECUTIVE COMMITTEE OF THE BOARD

1. MEMBERSHIP: The Board of Directors shall establish an Executive Committee of the Board, which shall consist of the Chair as Chair, Chair-elect, Treasurer, Immediate Past Chair and three Directors-at-Large. The Directors-at-Large shall be elected for a one-year term by majority vote of the Directors-at-Large and the Staff Fellows serving on the Board of Directors at the first regular meeting of the Board following the annual meeting of the House of Delegates. In the event of a vacancy in a Director-at-Large position, the Directors-at-Large and the Staff Fellows serving on the Board, by majority vote~~,~~ shall choose another Director-at-Large to serve the remainder of the one-year term. A Staff Fellow may serve in one of the Director-at-Large positions. No more than one Staff Fellow may serve on the Executive Committee at any one time. In the event of vacancy in the position of Immediate Past Chair, this position shall remain vacant until the next annual meeting of the House of Delegates.
2. DUTIES: In intervals between Board meetings, the Executive Committee shall act for and on behalf of the Board in any matters that require prompt attention. It shall not modify actions previously taken by the Board unless additional information or a change of circumstances is presented and warrants additional action.
3. MEETINGS: The Executive Committee may meet as often as it deems necessary or appropriate, either in person, telephonically, electronically or by unanimous written consent, and at such times and places and manner as the Chair may determine. Minutes must be kept of all meetings.
4. REPORTING: The Executive Committee shall report in writing all formal actions taken by it to the Board of Directors within five working days of taking those actions. At each meeting of the Board, the Executive Committee shall present to the Board a written report of all its formal actions since the previous meeting of the Board.

SECTION H. PUBLIC POLICY STATEMENTS

A “public policy” is defined as the official public position of the FSMB on a matter that may be reasonably expected to affect Member Boards when dealing with their licensees, other health care providers, health-related special interest groups, governmental bodies or the public. The House of Delegates is the official public policy-making body of the FSMB. When the interests of the FSMB require more immediate action, the Board of Directors, or the President in consultation with the Chair, if feasible, is authorized to issue statements on matters of public policy between Annual Meetings.

ARTICLE V. NOMINATION BY PETITION FOR BOARD OF DIRECTORS AND NOMINATING COMMITTEE

SECTION A. SUBMISSION OF A PETITION

1. At the time the Nominating Committee's roster of candidates is distributed to the Member Boards, the Boards will be informed that a Fellow who is qualified for nomination, but not otherwise nominated by the Nominating Committee, may seek to run for a position on the Board of Directors as an Officer or Director-at-Large, or for a position on the Nominating Committee.
2. In order to be placed on the ballot, the Fellow seeking nomination is required to present a petition to Administrative Staff that is signed by at least one Fellow from at least four Member Boards as well as a fellow from the Board of the member seeking nomination.
3. The deadline to submit petitions to the Administrative Staff is twenty-one days prior to the Annual Meeting.

SECTION B. VALIDATION AND PLACEMENT ON BALLOT

1. The Administrative Staff shall verify that all signatures on the petition are valid. "Valid" is defined as the person who is seeking nomination and the persons who signed the petition are Fellows as defined in the FSMB Bylaws.
2. Once verified, the petitions are deemed valid and the candidate is placed on the ballot.
3. The names of those seeking to run by petition whose petitions are deemed valid shall be distributed to the Voting Delegates not fewer than fourteen days prior to the Annual Meeting.
4. Once a candidate seeking to run by petition is added to the ballot, the candidate shall be afforded the same privileges and be bound by the same rules in the campaign process as candidates who were nominated by the Nominating Committee.

ARTICLE VI. PRESIDENT

The Board of Directors may, by a two-thirds majority vote of the full Board, appoint a President of the FSMB, who shall be a physician, to serve without term. The President shall administer the affairs of the FSMB and shall have such duties and responsibilities as the Board of Directors and the FSMB shall direct. The President shall serve as Secretary of the FSMB and shall be an ex-officio member, without vote, of the Board of Directors.

ARTICLE VII. MEETINGS

SECTION A. ANNUAL MEETING OF THE HOUSE OF DELEGATES

The annual meeting of the House of Delegates of the FSMB, which shall be called the House of Delegates, shall be held at such time and place as may be fixed by the Board of Directors. Written notice of the time and place of the meeting shall be given to all Member Medical Boards by mail not fewer than ninety days prior to the date of the meeting. Notice is effective upon mailing.

SECTION B. SPECIAL MEETINGS OF THE HOUSE OF DELEGATES

Special meetings of the House of Delegates may be called at any time by the Chair, on the written request of ten Member Medical Boards or by action of the Board of Directors. Written notice of the time and place of such meetings shall be given to all Member Medical Boards by mail not fewer than thirty days prior to the date of the meeting. Notice is effective upon mailing.

SECTION C. RIGHT TO VOTE

1. The right to vote at meetings of the House of Delegates is vested in, and restricted to, Member Medical Boards. Each Member Medical Board is entitled to one vote, said vote to be cast by the delegate of the Member Board. The delegate shall be the president of the Member Medical Board or the President's designated alternate. In order for a delegate to be permitted to vote, the delegate shall present a letter of appointment to the Secretary of the Board of Directors.
2. All classes of membership shall have the right of the floor at meetings of the House upon request of a delegate and approval of the presiding officer; however, the right to introduce resolutions is restricted to Member Medical Boards and the Board of Directors and the procedure for submission of such resolutions shall be in accordance with FSMB Policy.

SECTION D. QUORUM

A majority of Member Medical Boards shall constitute a quorum at any meeting of the House of Delegates. A majority of the voting members of the Board of Directors or any committee or other constituted group shall constitute a quorum of the Board, committee or group.

SECTION E. RULES OF ORDER

Meetings of the House of Delegates, Board of Directors and all committees shall be conducted in accordance with the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure*, current edition, except when in conflict with the Articles of Incorporation or these Bylaws, in which case the Articles of Incorporation or these Bylaws shall prevail.

ARTICLE VIII. STANDING AND SPECIAL COMMITTEES

SECTION A. STANDING COMMITTEES

1. The Standing Committees of the FSMB shall be:
    a. Audit Committee
    b. Bylaws Committee
    c. Editorial Committee
    d. Education Committee
    e. Ethics and Professionalism Committee
    f. Finance Committee
    g. Nominating Committee
2. ADDITIONAL STANDING COMMITTEES. Additional standing committees may be created by resolution of the FSMB and/or amendment to the Bylaws. Chairs and members of all standing committees, with the exception of the Nominating Committee, shall be appointed by the Chair, with the approval of the Board of Directors, for a term of one year, unless otherwise provided for in these Bylaws. Reappointment, unless specifically prohibited, is permissible.
3. MEMBERSHIP. Honorary Fellows, Associate Members and Courtesy Members may be appointed by the Chair to serve on a standing committee in addition to the number of committee members called for in the following sections of this chapter. No more than one Honorary Fellow, Associate or Courtesy Member or non-member subject matter expert may be appointed by the Chair to serve in such a capacity on any standing committee unless otherwise provided for in these Bylaws. All committee members shall serve with vote. Honorary Fellows, Associate or Courtesy Members, and non-members appointed to standing committees by the Chair shall serve for a term concurrent with the term of the Chair. No individual shall serve on more than one standing committee except as specified in the Bylaws. With the exception of the Nominating Committee and the Editorial Committee, the Chair and the Chair-elect shall serve, ex-officio, on all committees.
4. VACANCIES. In the event a vacancy occurs in an elected position on a standing committee, the Chair, with the approval of the Board of Directors, shall appoint a Fellow to serve on the committee until the next meeting of the House of Delegates, at which time an election will be held to fill the vacant position for the remainder of the unexpired term. In the event a vacancy occurs in an appointed position on a standing committee, the Chair, with the approval of the

Board of Directors, shall appoint a Fellow to serve on the committee for the remainder of the unexpired term. In the event the Chairmanship of the Nominating Committee becomes vacant, the FSMB Chair, with the approval of the FSMB Board of Directors, shall appoint a Past Chair of the FSMB Board of Directors to serve in that capacity for the remainder of the unexpired term.

SECTION B. AUDIT COMMITTEE

The Audit Committee shall:

1. Be composed of five Fellows, three of whom shall be members of the Board of Directors. The Treasurer of the FSMB shall serve ex-officio without vote. The Chair of the FSMB shall appoint the Chair of the Audit Committee from one of the three sitting Board Members.
2. Ensure that an annual audit of the financial accounts and records of the FSMB is performed by an independent Certified Public Accounting firm.
3. Recommend to the Board of Directors the appointment, retention or termination of an independent auditor or auditors and develop a schedule for periodic solicitation of audit firms consistent with Board policies and best practices.
4. Oversee the independent auditors. The independent auditors shall report directly to the Committee.
5. Review the audit of the FSMB. Submit such audit and Committee's report to the Board of Directors.
6. Report any suggestions to the Board of Directors on fiscal policy to ensure the continuing financial strength of the FSMB.
7. When the finalized committee report to the Board of Directors is made, suggestions and feedback will be forwarded to the Finance Committee.

SECTION C. BYLAWS COMMITTEE

The Bylaws Committee, composed of five Fellows, shall continually assess the Articles of Incorporation and the Bylaws and shall receive all proposals for amendments thereto. It shall, from time to time, make recommendations to the House of Delegates for changes, deletions, modifications and interpretations thereto.

SECTION D. EDITORIAL COMMITTEE

1. An Editorial Committee, not to exceed twelve Fellows and three non-Fellows, at least two of whom shall be subject matter experts, shall advise the Editor-in-Chief on editorial policy for the FSMB's official publication, and shall serve as the editorial board of that publication and otherwise assist the Editor-in-Chief in the performance of duties as appropriate and necessary. No officer or member of the Board of Directors shall serve on this Committee.
2. Service on the Editorial Committee is by nomination and appointment by the FSMB Chair, subject to approval of the Board of Directors, immediately following the Annual Meeting of the House of Delegates. Candidates are allowed to express their interest in serving on the Committee through self-nomination. Committee members shall serve staggered three-year terms and shall be limited to two full terms.
3. The Editor-in-Chief shall be elected by the Editorial Committee to a three-year term beginning on the date of the annual Editorial Committee meeting, with the Editor-in-Chief's term on the Editorial Committee being automatically extended to allow the Editor-in-chief to serve for three years. A member of the Editorial Committee whose term is expiring shall continue to serve until the member's replacement meets at the next annual Editorial Committee meeting.
4. The Editorial Committee will elect its Chair, who will serve as the Editor-in-Chief of the *Journal of Medical Regulation.* The Editor-in-Chief will serve without compensation and will coordinate decisions on the *Journal* content, among other duties to be determined by the Bylaws Committee.

SECTION E. EDUCATION COMMITTEE

The Education Committee shall be composed of eight Fellows, to include the Chair as chair, the Immediate Past Chair and the Chair-elect. The Committee shall be responsible for assisting in the development of educational programs for the FSMB.

SECTION F. ETHICS AND PROFESSIONALISM COMMITTEE

The Ethics and Professionalism Committee shall be composed of up to five Fellows and up to two subject matter experts. The Ethics and Professionalism Committee shall address ethical and professional issues pertinent to medical regulation.

SECTION G. FINANCE COMMITTEE

The Finance Committee shall be composed of five Fellows, to include the Treasurer as Chair. The Finance Committee shall review the financial condition of the FSMB, review and evaluate the costs of the activities and programs to be undertaken in the forthcoming year, present a budget for the FSMB to the Board of Directors for its recommendation to the House of Delegates at the Annual Meeting and perform such other duties as are assigned to it by the Board of Directors. Except for the Treasurer, no Fellow shall serve on both the Audit and Finance Committees.

SECTION H. NOMINATING COMMITTEE: PROCESS FOR ELECTION

1. MEMBERSHIP: The Nominating Committee shall be composed of six Fellows and the Immediate Past Chair, who shall chair the Committee and serve without vote except in the event of a tie. At least one elected member of the Nominating Committee shall be a public member. With the exception of the Immediate Past Chair, no two Committee members shall be from the same member board and no officer or member of the Board of Directors shall serve on the Committee. A member of the Nominating Committee may not serve consecutive terms.
2. ELECTION: At least three Fellows shall be elected at each Annual Meeting of the House of Delegates by a plurality of votes cast, each to serve for a term of two years. Only an individual who is a Board Member Fellow at the time of the individual's election shall be eligible for election as a member of the Nominating Committee. In the event of a tie vote in a runoff election, up to two additional runoff elections shall be held. Prior to the election, the presiding officer shall cast a sealed vote, ranking each candidate in a list. The presiding officer's vote is counted for the candidate in the runoff election who is highest on the list. The presiding officer's vote is counted only to resolve a tie that cannot be decided by the process set forth in this section.
3. Members of the Nominating Committee are not eligible for inclusion on the roster of candidates for offices and positions to be filled by election at the Annual Meeting of the House of Delegates.

SECTION I. SPECIAL COMMITTEES

Special committees may be appointed by the Chair, from time to time, as may be necessary for a specific purpose.

SECTION J. REPRESENTATIVES TO OTHER ORGANIZATIONS AND ENTITIES

Appointment of all representatives of the FSMB to other official organizations or entities shall be made or nominated by the Chair, with the approval of the Board of Directors, as applicable, and shall serve for a term of three years unless the other organization shall specify some other term of appointment. Representatives to these organizations shall be Fellows, Honorary Fellows, Associate Members or Courtesy Members at the time of their appointment or nomination.

ARTICLE IX. UNITED STATES MEDICAL LICENSING EXAMINATION (USMLE)

SECTION A. Except as otherwise set forth in this Article, the composition of committees and subcommittees for the USMLE are subject to agreements with and the advice and consent of the National Board of Medical Examiners (NBME) and/or the USMLE Composite Committee. The Chair, with the approval of the Board of Directors, shall make appointments to the following USMLE committees in appropriate numbers and at appropriate times as required by the FSMB/NBME Agreement establishing the USMLE and by other agreements as may apply:

1. USMLE Composite Committee, which shall be responsible for the development, operation and maintenance of policies governing the three-step USMLE. The President shall be one of the FSMB's representatives on this Committee.
2. USMLE Budget Committee, which shall be responsible for the development and monitoring of USMLE revenues and expenses, including the establishment of fees. FSMB representatives on the Committee will be the Chair, Chair-elect, Treasurer, President and the senior FSMB financial staff member.
3. The USMLE Management Committee shall be responsible for overseeing the design, development, scoring and standard setting for the USMLE Step examinations, subject to policies established by and reporting to the USMLE Composite Committee. Appointments to the Management Committee shall be made consistent with the FSMB/NBME Agreement Establishing the USMLE.

SECTION B. The President shall provide FSMB advice and consent to the NBME for NBME's appointments to the USMLE Management Committee and/or any appointments made jointly under the FSMB/NBME Agreement Establishing the USMLE.

ARTICLE X. POST-LICENSURE ASSESSMENT SYSTEM

The Post-Licensure Assessment Governing Committee shall be responsible for the development, operation and maintenance of policies governing the Post-Licensure Assessment System (PLAS) established by joint agreement between FSMB and NBME. The Chair, with the approval of the Board of Directors, shall make appointments to the Post-Licensure Assessment Governing Committee and its program committees in appropriate numbers and at appropriate times as required by the FSMB/NBME joint agreement establishing the Post-Licensure Assessment System and by other agreements as may apply.

ARTICLE XI. FINANCES AND DUES

SECTION A. SOURCES OF FUNDS

Funds necessary for the conduct of the affairs of the FSMB shall be derived from but not be limited to:

1. Annual dues imposed on the Member Medical Boards, Affiliate Members, Courtesy Members and Official Observers;
2. Special assessments established by the House of Delegates;
3. Voluntary contributions, devices, bequests and other gifts;
4. Fees charged for examination services, data base services, credentials verification services and publications.

SECTION B. ANNUAL DUES, ELIGIBILITY TO SERVE AS A DELEGATE

The annual dues for Member Medical Boards shall be established, from time to time, by a majority vote of the House of Delegates.

1. Annual dues for Member Medical Boards shall be the same for all Members regardless of their physician populations. Annual dues are due and payable not later than January 1.
2. Any Member Medical Board whose dues are in default at the time of the Annual Meeting of the House of Delegates shall be ineligible to have a seated delegate.

ARTICLE XII. DISCIPLINARY ACTION

SECTION A. MEMBER

For the purposes of this Article, a member shall be defined as a Member Medical Board, a Fellow, an Honorary Fellow, an Associate Member, an Affiliate Member, Courtesy Member or Official Observer.

SECTION B. AUTHORIZATION

The Board of Directors, on behalf of the House of Delegates, may enforce disciplinary measures, including expulsion, suspension, censure and reprimand, and impose terms and conditions of probation or such sanctions as it may deem appropriate, for any of the following reasons:

1. Failure of the member to comply or act in accordance with these Bylaws, the Articles of Incorporation of the FSMB, or other duly adopted rules or regulations of the FSMB;
2. Failure of the member to comply with any contract or agreement between the FSMB and such member or with any contract or agreement of the FSMB that binds such member;
3. Failure of the member to maintain confidentiality or security, or the permitting of conditions that allow a breach of confidentiality or security, in any manner dealing with the licensing examination process or the confidentiality of FSMB records, including the storage, administration, grading or reporting of examinations and information relating to the examination process; or
4. The imposition of a sanction, judgment, disciplinary penalty or other similar action by a Member Medical Board that licenses the member or by a state or federal court, or other competent tribunal, whether or not related to the practice of medicine and including conduct as a member of a Member Medical Board.

SECTION C. PROCEDURE

Any member alleged to have acted in such manner as to be subject to disciplinary action shall be accorded, at a minimum, the procedural protection set forth in the Manual for Disciplinary Procedures, which is available from the FSMB upon the written request of any member.

SECTION D. REINSTATEMENT

In the event a member is suspended or expelled from the FSMB, the member may apply to the President for reinstatement after one year following final action on expulsion. The President shall review the application and the reason for the suspension or expulsion and forward a report to the

Board. The Board may accept application for reinstatement under such terms and conditions as it may deem appropriate, reject the application or request further information from the President. The Board's decision to accept or reject an application is final.

ARTICLE XIII. CORPORATE SEAL

The Board of Directors shall adopt a corporate seal that meets the requirements of the state in which the FSMB is incorporated.

ARTICLE XIV. ADOPTION AND AMENDMENT OF BYLAWS, EFFECTIVE DATE

SECTION A. AMENDMENT

These Bylaws may be amended at any annual meeting of the House of Delegates by two-thirds of those present and voting. Bylaws changes may be proposed only by the Board of Directors, Member Medical Boards or the Bylaws Committee and its members. All such proposals must be submitted in writing to the Bylaws Committee, in care of the Secretary of the FSMB. The Bylaws Committee shall inform the Member Medical Boards of its meeting dates not fewer than sixty days in advance of the meeting. The recommendations of the Bylaws Committee and the full texts of all proposed amendments recommended to the Committee shall be sent to each Member Medical Board not fewer than sixty days prior to the annual meeting of the House of Delegates at which they are to be considered.

SECTION B. EFFECTIVE DATE

These Bylaws and any other subsequent amendments thereto, shall become effective upon their adoption, except as otherwise provided herein.

Bylaws last amended in April 2019