American Association of Osteopathic Examiners


***AAOE Officers***

Geraldine T. O'Shea, DO
*President*

Anna Z. Hayden, DO
*Vice-President*

Ernest Miller, DO
*Secretary-Treasurer*

Dana Shaffer, DO
*Immediate Past President*


# ANNUAL MEETING

## Omni Forth Worth Hotel ▪ Fort Worth Ballroom 5
## April 22, 2015 ▪ 4:00-6:00 PM

## BUSINESS MEETING AGENDA

Geraldine T. O'Shea DO, President, Presiding

| | | TAB |
|---|---|---|
| I. | Call to Order/Approval of Agenda | |
| II. | Approval of January 10, 2015 Minutes - Action Item | **1** |
| III. | NBOME Update – Janice Knebl, DO/Sandra Waters | |
| IV. | North Carolina Board of Dental Examiners v. Federal Trade Commission Update | **2** |
| V. | Changes Required to State Laws/Regulations Necessary for Single GME Accreditation | |
| | a. Pending AOA Resolution | **3** |
| | b. AOA State Government Affairs Analysis | **4** |

**(AAOE Fellows Only)**

| | | |
|---|---|---|
| VI. | AAOE Elections | |
| | a. President | |
| | b. Vice President | |
| | c. Secretary/Treasurer | |
| VII. | FSMB Annual Meeting | |
| | a. Resolutions | **5** |
| | b. Elections | **6** |
| VIII. | Osteopathic Medical Regulation/Licensure Roundtable | |
| | a. Interstate Compact | |
| | b. State Issues Update | |
| IX. | Announcements | |

**Future Meeting Dates**

OMED—October 19, 2015, Orlando, FL

AAOE Summit—January 2016, Date & Location TBD


*142 E. Ontario*
*Chicago, IL*
*60611*

www.aaoe-net.org

*312-202-8185*
*312-202-8485 fax*

# ANNUAL MEETING
# OMNI FORT WORTH HOTEL ▪ FORT WORTH, TX
# April 22, 2015

List of Attendees

Humanya Chaudhry, DO – President & CEO, Federation of State Medical Boards
James F. Griffin, DO – Rhode Island Board of Medical Licensure and Discipline
Anna Hayden, DO – Vice President, AAOE
Janice A. Knebl, DO, MBA – Immediate Past Chair, National Board of Osteopathic Medical Examiners
Linda Mascheri, Vice President, AOA State, Affiliate and International Affairs
Ernest Miller, DO –Secretary-Treasurer, AAOE
Geraldine O'Shea, DO –President, AAOE
Donald Polk, DO – Chair, Federation of State Medical Boards
Wayne Reynolds, DO – President, Virginia Board of Medicine
Nicholas A. Schilligo, MS – Associate Vice President, AOA State Government Affairs
Dana C. Shaffer, DO, FACOFP – Immediate Past President, AAOE
Anita Steinbergh, DO – President, State Medical Board of Ohio
Michael Vasovski, DO – South Carolina Board of Medical Examiners
Barbara Walker, DO – North Carolina Medical Board
Sandra Waters, MEM – Vice President, Collaborative Initiatives, National Board of Osteopathic Medical Examiners
Joseph Willett, DO – Minnesota Board of Medical Practice
Joseph A. Zummato, DO – President, Osteopathic Medical Board California

*142 E. Ontario*
*Chicago, IL*
*60611*

*www.aaoe-net.org*

*312-202-8185*
*312-202-8485 fax*

# BUSINESS MEETING MINUTES

Saturday, January 10, 2015
Heinsbergen Room– Millennium Biltmore Hotel
2:30 PM – 4:30 PM



**Fellows Present:**
Geraldine O'Shea, DO, President, AAOE
Ronald Burns, DO, Florida Board of Osteopathic Medicine
Boyd Buser, DO, Kentucky Board of Medical Licensure
Mary Jo Capodice, DO, Wisconsin Medical Examining Board
James Griffin, DO, Rhode Island Board of Medical Licensure and Discipline
Anna Hayden, DO, Vice President, AAOE; Florida Board of Osteopathic Medicine
Ernest Miller Jr., DO, Secretary-Treasurer, AAOE; West Virginia Board of Osteopathic Medicine
Karen O'Mara, DO, Illinois State Medical Disciplinary Board
C. Michael Ogle, DO, Oklahoma State Board of Osteopathic Examiners
Donald Polk, DO, Chair, Federation of State Medical Boards; Tennessee Board of Osteopathic Examination
Wayne Reynolds, DO, Virginia Board of Medicine
Joel Rose, DO, Florida Board of Osteopathic Medicine
Dana Shaffer, DO, Immediate Past President, AAOE
Anita Steinbergh, DO, State Medical Board of Ohio
Scott Steingard, DO, Arizona Board of Osteopathic Examiners in Medicine and Surgery
David Tannehill, DO, Missouri State Board of Registration for the Healing Arts
Barbara E. Walker, DO, North Carolina Medical Board
Michael Wieting, DO, Tennessee Board of Osteopathic Examiners
Joseph Willett, DO, Minnesota Board of Medical Practice
Joseph Zammuto, DO, California Osteopathic Medical Board

**AOA Leaders/Staff:**
Cheryl Gross, Associate Vice President, Education
Linda Mascheri, Vice President, State, Affiliate & International Affairs
Nicholas A. Schilligo, MS, Associate Vice President, State Government Affairs
James Swartwout, Senior Vice President, Education and Accreditation

I. AAOE President Geraldine T. O'Shea, DO called the Business Meeting to order at 2:30 PM.

II. Dr. O'Shea presented the proposed agenda, Boyd Buser, DO made a motion to adopt the agenda; seconded by Ronald Burns, DO. The motion unanimously adopted.

III. Anna Hayden, DO made a motion to approve the draft minutes from October 27, 2014 AAOE Business Meeting; seconded by Dana Schaffer, DO and approved unanimously.

IV. Dr. O'Shea provided an update on AAOE activities.

a. Dr. O'Shea asked Nicholas Schilligo to report on the development and progress of an AAOE CME Attestation Form. Mr. Schilligo reported that this form will be used to assist Fellows with claiming Category 1-B CME for participation in state licensing board activities.
    i. Mr. Schilligo discussed the issue and presented the final form.
b. Dr. O'Shea also presented a new AAOE travel reimbursement policy. The policy was discussed and approved.

V. Dr. O'Shea asked Donald Polk, DO to provide an update on the activities of the Federation of State Medical Boards (FSMB). Dr. Polk discussed the progress of the Interstate Medical Licensure Compact initiative. He stated that there is a need for seven states to participate through the adoption of model legislation. Dr. Polk said that Minnesota, Montana, Nebraska, Oklahoma, South Dakota, Texas, Utah, Vermont, West Virginia and Wyoming introduced legislation to join the Compact, however, legislation in Arizona has been introduced in opposition to the Compact.

VI. Dr. O'Shea discussed the upcoming 2015 FSMB's elections, committee nominations and appointments, Annual Meeting and related activities.

VII. Dr. O'Shea discussed the AAOE leadership nominations and election that will be held at the next AAOE Annual Meeting on April 22, 2015. These candidates were nominated for the following positions:

a. Anna Hayden, DO (President) – nominated by Ernest Miller, DO
b. Barbara Walker, DO (Vice President) – nominated by Dr. Shaffer
c. Ernest Miller, DO (Vice President) – nominated by Anita Steinbergh, DO
d. Ernest Miller, DO (Secretary/Treasurer) – nominated by Dr. Hayden

VIII. Dr. O'Shea provided the AAOE's future meeting dates, AAOE Annual Meeting (at FSMB Meeting) on April 22, 2015 in Fort Worth, TX and AAOE Business Meeting (at OMED) on October 19, 2015 in Orlando, FL.

IX. Dr. O'Shea led a roundtable open discussion regarding the issues impacting osteopathic medical regulation and licensure.

X. Following the open discussion, Dr. O'Shea asked for any new business items or announcements. There being no further business, Dr. O'Shea adjourned the meeting at 4:30 PM.

**From:** Kuman, Kim
**Sent:** Monday, March 09, 2015 10:34 AM
**Subject:** SPECIAL ALERT: Supreme Court Rules Against North Carolina Dental Board

**SPECIAL ALERT: Supreme Court Rules Against North Carolina Dental Board**
Last week, the United States Supreme Court released its opinion (No. 13-534) in *North Carolina State Board of Dental Examiners v. Federal Trade Commission*. The case, brought forward by the Federal Trade Commission (FTC), was in response to actions by the dental board in North Carolina to limit non-dentists from offering teeth whitening services. The Board argued that this was considered the practice of dentistry, while the FTC believed it to be an effort to suppress competition in violation of the Sherman Antitrust Act.

In arguments before the Court, the Board stated that its actions were immune from antitrust prosecution because they were state actions taken with authority given by the state legislature. In a 6-3 split, the Court found that the Board lacked sufficient supervision by the State of North Carolina to allow for antitrust immunity. However, they offered limited guidance on expectations for what would be expected to meet "active supervision" requirements for state licensing boards engaging in scope of practice issues. It is unclear on the widespread impact this finding will have on the makeup and procedures of state licensing and regulatory boards at this time.

The American Osteopathic Association supports state's ability to regulate appropriate licensing and the care their citizens receive. The AOA, working with the American Dental Association, American Medical Association and others submitted an amicus brief in support of the North Carolina State Board of Dental Examiners. The AOA will continue to monitor this issue as it works to promote the physician-led, patient-centered model of health care and maintain appropriate scope of practice laws that are based on education, training and competency demonstration.

For more information, please contact Nick Schilligo, Associate Vice President of State Government Affairs at nschilligo@osteoapthic.org.

SUBJECT: AOA APPROVAL OF OGME-1 TRAINING

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: AOA Board of Trustees

---

WHEREAS, the American Osteopathic Association (AOA), Accreditation Council for Graduate Medical Education (ACGME) and the American Association of Colleges of Osteopathic Medicine (AACOM) have agreed to pursue a single accreditation system; and

WHEREAS, as of June 30, 2020, graduate medical education training programs will be accredited by the ACGME and the AOA will cease accreditation activities; now, therefore, be it

RESOLVED, that the AOA recognizes the Accreditation Council for Graduate Medical Education (ACGME) PGY-1 as meeting the training requirements of AOA OGME-1.

Explanatory Statement:
The resolution was approved by electronic ballot. In a subsequent conference call discussion (without a quorum present), the following additional clarification was suggested:

This resolution is intended to proactively address only osteopathic training programs which seek ACGME accreditation from July 1, 2015 through June 30, 2020. The intent is to protect osteopathic interns and residents from problems obtaining state licensure as a result of the single accreditation system, and is not to retroactively approve training completed prior to the start of the single accreditation system.

The Bureau of Osteopathic Education (BOE) encourages that the AOA review all state statutes regarding osteopathic physician licensure so that other potential concerns relating to the single accreditation system can be addressed.

The BOE intends to further discuss licensure concerns at its upcoming meeting in May 2015.

ACTION TAKEN **Postponed definitely – 2015 BOT annual meeting (July 2015)**

DATE **February 26, 2015**

| State | Statute | Rules | Analysis and Notes |
|---|---|---|---|
| **AL** | AL Code § 34-24-70 (2013) (2) POSTGRADUATE EDUCATION REQUIREMENT. 1. Applicants for a certificate of qualification who graduated from a college of medicine accredited by the Liaison Committee on Medical Education of the American Medical Association or a college of osteopathy accredited by the American Osteopathic Association shall present evidence satisfactory to the board that the applicant has completed one year of postgraduate or residency training in any of the following programs: a. A program listed in the directory of approved residency training programs published by the American Medical Association. b. A program accredited by the American Osteopathic Association. c. A program accredited by the Accreditation Committee of Royal College of Physicians and Surgeons of Canada. d. A program accredited by the College of Family Physicians of Canada. http://law.justia.com/codes/alabama/2013/title-34/chapter-24/section-34-24-70/ | 540-X-3-.03 (1): Has completed one (1) year of post-graduate or residency training in any of the following programs: (a) A program listed in the directory of approved residency training programs published by the American Medical Association. (b) A program accredited by the American Osteopathic Association. (c) A program accredited by the Accreditation Committee of Royal College of Physicians and Surgeons of Canada. (d) A program accredited by the College of Family Physicians of Canada. (e) Documentation submitted through the Federation Credentials Verification Service (FCVS) may be accepted to demonstrate compliance with subparagraphs (a), (b), (c), and (d) above. | No changes needed. |

| | | | |
|---|---|---|---|
| **AK** | AS 08.64.205 (2) an applicant must submit a certificate from a hospital approved by the American Medical Association or the American Osteopathic Association that certifies that the osteopath has satisfactorily completed and performed the duties of intern or resident physician for (A) one (1) year if the applicant graduated from a school of osteopathy before January 1, 1995, as evidenced by a certificate of completion of the first year of postgraduate training from the facility where the applicant completed the first year of internship or residency; or (B) two (2) years if the applicant graduated from a school of osteopathy on or after January 1, 1995, as evidenced by a certificate of completion of the first year of postgraduate training from the facility where the applicant completed the first year of internship or residency and a certificate of successful completion of one (1) additional year of postgraduate training at a recognized hospital. http://commerce.state.ak.us/dnn/Portals/5/pub/MedicalStatutes.pdf | 12 AAC 40.010 (h) An applicant for licensure under this section who graduated from a medical school described in AS 08.64.200 (a)(1) or a school of osteopathy described in AS 08.64.205 (1), must submit a certified true copy of a certificate documenting successful completion of the post-graduate training required under AS 08.64.200 (a)(2) or AS 08.64.205 (2). Any other applicant must submit a certified true copy of a certificate documenting successful completion of the post-graduate training required under AS 08.64.225 (2). Training periods of less than 12 months will not be accepted. An original letter with an original signature submitted on program letterhead will be accepted in lieu of a certified true copy of a certificate if the letter is submitted directly to the board by the recognized hospital or facility. | Change is needed, "AMA" to "ACGME" |
| **AZ** | A.R.S. § 32-1822 A(4): Has successfully completed an approved internship, the first year of an approved multiple year residency or board approved equivalency. http://www.azleg.gov/ars/32/01822.htm | *R4-22-103. Approved Internships and Residencies:* For purposes of A.R.S. § 32-1822, the equivalent of an approved internship or approved residency is any of the following: 1. One (1) or more years of a postgraduate training program approved by the American Osteopathic Association (AOA) or the Accreditation Council on Graduate Medical Education (ACGME); 2. A current certification by the AOA in an osteopathic medical specialty; or 3. For those who were awarded a Doctor of Osteopathy degree in 1946 or earlier, a minimum of 10 years of continuous active practice of osteopathic medicine and surgery immediately before applying for licensure. | No changes needed. |

| | | | |
|---|---|---|---|
| **AR** | A.C.A. § 17-91-101 (a)(6) Has completed a one (1) year internship in a hospital approved by the AMA or the AOA. http://www.armedicalboard.org/Professionals/pdf/MPA.pdf | None | Change is needed, "AMA" to "ACGME" |
| **CA** | Cal Bus & Prof Code § 2096: "(c) The postgraduate training required by this section shall include at least four (4) months of general medicine and shall be obtained in a postgraduate training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada (RCPSC)."* **This section applies to both the allopathic and osteopathic boards. The osteopathic board is interpreting this section to mean AOA or ACGME postgraduate training. Postgraduate training must include 4 months of general medicine. http://www.oclaw.org/research/code/ca/BPC/2096./content.html#.VQxUPY7F-4g* | 16 CA ADC § 1611. (e) First Year Postgraduate Training. The first year postgraduate training from Certificate of Completion of Accreditation Council for Graduate Medical Education (ACGME) Postgraduate Training or American Osteopathic Association (AOA) Rotating Internship OMB.3.1 Rev. 04/00), shall be certified and submitted directly from the Director of Medical Education to the Board. | AOA should be added to Statute before 2020 to ensure that DOs through current system remain eligible. Additional informaiton is needed--do all ACGME programs include 4 months of training in general medicine? |
| **CO** | C.R.S. § 12-36-107. (2)(c) Has completed either an approved internship of at least one (1) year or at least one (1) year of postgraduate training approved by the board. http://cdn.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22Colorado+Revised+Statutes+for+Physicians+and+Physician+Assistants%2C+effective+July+1%2C+2011.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251933592978&ssbinary=true | None | No changes needed. |

| | | | |
|---|---|---|---|
| **CT** | Conn. Gen. Stat. § 20-10 (2) has successfully completed not less than two (2) years of progressive graduate medical training as a resident physician in a program accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association or an equivalent program approved by the board with the consent of the department. http://law.justia.com/codes/connecticut/2012/title-20/chapter-370/section-20-10/ | None | No changes needed. |
| **DE** | 24 Del. C. § 1720 (b)(3) Have satisfactorily completed an internship or equivalent training in an institution, which internship or equivalent training and institution are approved by the Board. http://delcode.delaware.gov/title24/c017/sc03/index.shtml | None | No changes needed. |
| **FL** | Fla. Stat. § 459.0055(1)(I). Requires applicant for licensure as an osteopathic physician to demonstrate that she or he has successfully completed a resident internship of not less than 12 months in a hospital approved for this purpose by the Board of Trustees of the American Osteopathic Association or any other internship program approved by the board upon a showing of good cause by the applicant. http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0459/Sections/0459.0055.html | Florida Administrative Code R. 64B15-16.002 (1). Any applicant who has failed to complete an AOA approved internship must apply to the AOA for approval of the PGY-1 year of the ACGME residency for educational equivalence. Upon acceptance of the PGY-1 year for educational equivalence of the ACGME residency by the AOA, the Board of Osteopathic Medicine will approve for licensure applicants who are otherwise qualified for licensure, and who demonstrate good cause as delineated below for having taken the ACGME residency in lieu of an AOA internship. | ACGME language should be added. The Board may interpret the AOA's approval of ACGME First Year as meeting the state's requirement however, that cannot be confirmed at this time. |

| | | | |
|---|---|---|---|
| **GA** | O.C.G.A. § 43-34-26 (a) (3) Graduates of board approved medical schools or osteopathic medical schools and persons who graduated on or before July 1, 1985, from medical schools or osteopathic medical schools which are not approved by the board must complete one (1) year of a postgraduate residency training program. Persons who graduated after July 1, 1985, from medical schools or osteopathic medical schools which are not approved by the board must complete three (3) years of residency, fellowship, or other postgraduate medical training that is approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or the board to be eligible for a license to practice medicine in this state.https://medicalboard.georgia.gov/sites/medicalboard.georgia.gov/files/related_files/site_page/Medical%20Practice%20Act%202013.pdf | Georgia Rules 360-2-.01(1) (g) Verification of post-graduate/residency training as follows: i. Graduates of approved medical schools must show completion of one (1) year of postgraduate training in a program approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) or the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC). ii. Graduates of medical schools not approved by the Board must show completion of three (3) years of postgraduate training in a program approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), the Royal College of Physicians and Surgeons of Canada (RCPSC), or the College of Family Physicians of Canada (CFPC). The Board may consider current certification of any applicant by a member board of the American Board of Medical Specialties (ABMS) as evidence that such applicant's postgraduate medical training has satisfied the requirements of this paragraph. iii. Applicants who were licensed in another State on or before July 1, 1967 are not required to supply proof of any postgraduate/residency training. | No changes needed. |
| **HI** | HRS §453-4 (b)(2)(A): has served a residency of at least one (1) year in a program that has been accredited for the training of resident physicians or osteopathic physicians by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, respectively, or a residency of at least one (1) year in a program in Canada that has been accredited for the training of resident physicians by the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada. http://cca.hawaii.gov/pvl/files/2013/08/hrs_pvl_453.pdf | None | No changes needed. |

| | | | |
|---|---|---|---|
| **ID** | I.C. § 54-1810 (1) Each applicant must submit a completed written application to the board on forms furnished by the board which shall require proof of graduation from a medical school acceptable to the board and successful completion of a postgraduate training program acceptable to the board. http://www.legislature.idaho.gov/idstat/Title54/T54CH18SECT54-1810.htm | IDAPA 22.01.01 050-04. (b) An original certificate or document of graduation from an acceptable school of medicine, and evidence of satisfactory completion of postgraduate training of one (1) year at one (1) training program accredited for internship, residency or fellowship training by the ACGME, AOA or Royal College of Physicians and Surgeons of Canada | No changes needed. |
| **IL** | 225 ILCS 60/11(A)(1)(a): Has completed a course of postgraduate clinical training of not less than 12 months as approved by the Department. http://ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1309&ChapAct=225%C2%A0ILCS%C2%A060/&ChapterID=24&ChapterName=PROFESSIONS+AND+OCCUPATIONS&ActName=Medical+Practice+Act+of+1987. | 68 Ill. Admin. Code pt. 1285.70 (a)(7) Proof of satisfactory completion of an approved program of clinical training in accordance with Section 1285.40. Section 1285.40 Approved Postgraduate Clinical Training Programs: d) The Division, upon the recommendation of the Medical Licensing Board, has determined that all clinical training programs accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada and the Federation of Medical Licensing Authorities of Canada as of January 1, 1999 meet the minimum criteria set forth in this Section and are, therefore, approved, except as provided in subsection (e). | No changes needed. |
| **IN** | I.C. § 25-22.5-3-1(i) The applicant shall have completed one (1) year of postgraduate training in a hospital or institution located in the United States, its possessions, or Canada that meets standards set by the board under IC 25-22.5-2-7. http://www.in.gov/pla/files/Microsoft_Word_-_Medical_Licensing_Board.2012.pdf | Sec. 4. An approved internship or residency program is one that was, at time the applicant was enrolled in the internship or residency program accepted by the: (1) Accreditation Council for Graduate Medical Education; (2) Executive Committee of the Council on Postdoctoral Training of the American Osteopathic Association; or (3) Royal College of Physicians and Surgeons of Canada | No changes needed. |

| | | | |
|---|---|---|---|
| **IA** | Iowa Code §148.3 (1) c. Satisfactory evidence that the applicant has successfully completed one (1) year of postgraduate internship or resident training in a hospital approved for such training by the board. An applicant who holds a valid certificate issued by the educational commission for foreign medical graduates shall submit satisfactory evidence of successful completion of two years of such training. http://search.legis.state.ia.us/NXT/gateway.dll/ic?f=templates&fn=default.htm | IAC 653—9.3(1) c. c. Have successfully completed one (1) year of resident training in a hospital-affiliated program approved by the board at the time the applicant was enrolled in the program. An applicant who is a graduate of an international medical school shall have successfully completed 24 months of such training.<br>(1) For those required to have 12 months of training, the program shall have been 12 months of progressive training in not more than two (2) specialties and in not more than two (2) programs approved for resident training by the board. For those required to have 24 months of training, the program shall have been 24 continuous months of progressive training in not more than two (2) specialties and in not more than two (2) programs approved for resident training by the board.<br>(2) Resident training approved by the board shall be accredited by an accrediting agency recognized by the board for the purpose of accrediting resident training programs.<br>(3) The board approves resident training programs accredited by:<br>1. ACGME;<br>2. AOA;<br>3. RCPSC; and<br>4. CFPC. | No changes needed. |
| **KS** | K.S.A. § 65-2873 b. Any person seeking a license to practice medicine and surgery shall present proof that such person has completed acceptable postgraduate study as may be required by the board by regulations. http://www.ksbha.org/statutes/healingartsact.shtml#ksa652806 | K.A.R. 100-6-2. Each applicant for licensure in medicine and surgery who is a graduate of an accredited school of medicine shall present to the board proof of completion of a postgraduate training or residency training program that is at least one (1) year in length. This program shall have been approved by the council of education of the American Medical Association or its equivalent in the year in which the training took place. | Change is needed, "AMA" to "ACGME"; also inclde AOA. |

| | | | |
|---|---|---|---|
| **KY** | KRS § 311.571(1)(d) Has satisfactorily completed a prescribed course of postgraduate training of a duration to be established by the board in an administrative regulation promulgated in accordance with KRS Chapter 13A, after consultation with the University of Kentucky College of Medicine, the University of Louisville School of Medicine, and the Pikeville College School of Osteopathic Medicine. http://www.lrc.ky.gov/statutes/statute.aspx?id=30525 | 201 KAR 9:021 Section 9. Postgraduate Training Programs Approved by the Board. The following postgraduate training programs shall meet the postgraduate training requirement for licensure: (1) All postgraduate training programs in hospitals and institutions located in the United States and approved by the Accreditation Council for Graduate Medical Education; (2) All postgraduate training programs in hospitals and institutions located in Canada; and (3) All postgraduate training programs in hospitals and institutions located in the United States or Canada and approved by the American Osteopathic Association. | No changes needed. |
| **LA** | La. Rev. Stat. §1274. Issuance of license: If the requirements of R.S. 37:1272 or R.S. 37:1276 are met to the satisfaction of the board, the board shall issue to the applicant a license to practice medicine. (Neither section mentions postgraduate training) http://www.lsbme.la.gov/sites/default/files/documents/Laws/Practice%20Act%20%20Physician%2010%2013%202011/Physician%20Practice%20Act%2010%2013%202011%20.pdf | §311. 6. have completed at least one (1) year of postgraduate clinical training in a medical internship or equivalent program accredited by the American Council on Graduate Medical Education (ACGME) of the American Medical Association, or by the American Osteopathic Association (AOA), or by the Royal College of Physicians and Surgeons (RCPS) of Canada, and approved by the board. A combined postgraduate year one (1) training program that is not accredited shall be deemed to satisfy the requirements of this Section provided each program comprising the combined program is accredited by the ACGME or by the AOA or by the RCPS. http://www.lsbme.la.gov/sites/default/files/documents/Laws/Practice%20Act%20%20Physician%2010%2013%202011/Physician%20Practice%20Act%2010%2013%202011%20.pdf | No changes needed. |

| | | | |
|---|---|---|---|
| **ME** | 32 M.R.S. §2571. That applicant shall present evidence of having completed an internship of at least 12 months in a hospital conforming to the minimal standards for accreditation by the American Osteopathic Association, or the equivalency, as determined by the board.** The osteopathic board recognizes ACGME postgraduate training as equivalent to AOA. http://www.mainelegislature.org/legis/statutes/32/title32sec2571-1.html | None | Amend to specifcially include ACGME; maintain AOA for DOs who complete postgraduate training prior to 2020. |
| **MD** | Md. Code Ann. § 14-307 (ii)(d)(2) Submit evidence acceptable to the Board of successful completion of one (1) year of training in a postgraduate medical training program accredited by an accrediting organization that the Board recognizes in its regulations. http://mgaleg.maryland.gov/2015RS/Statute_Web/gho/gho.pdf | 10.32.01.03 D. (2)Have a doctor of osteopathy degree from a school of osteopathy in the United States, its territories or possessions, Puerto Rico, or Canada that has standards for graduation equivalent to those established by the American Osteopathic Association (AOA) and have successfully completed one (1) year of postgraduate training at an accredited training program; | Amend to specifcially include ACGME; maintain AOA for DOs who complete postgraduate training prior to 2020. |
| **MA** | Mass. Gen. Laws ch. 112, § 2: has completed one (1) year of graduate medical education in a program approved by the Liaison Committee on Graduate Medical Education of the American Medical Association. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter112/Section2 | 243 CMR 2.02 (2)(c): have completed two (2) years of post-graduate medical training in an ACGME or AOA approved, or accredited Canadian program. | No changes needed. |
| **MI** | Mich. Comp. Laws § 333.17531. An applicant, in addition to completing the requirements for the degree in osteopathic medicine and surgery, shall complete a period of postgraduate education to attain proficiency in the practice of the profession as prescribed by the board in rules as a condition for more than limited licensure. http://www.legislature.mi.gov/(S(plqs3zjiggs2kx0gpi4cieh0))/mileg.aspx?page=getobject&objectname=mcl-333-17531 | Michigan Administrative Code § 338.102(3). The applicant shall have satisfactorily completed one (1) year of postgraduate clinical training in an internship program approved by the board in a board-approved hospital institution.<br><br>Michigan Administrative Code § 338.106(3). The board shall consider any hospital or institution that is accredited by the American Osteopathic Association as a hospital or institution approved by the board. | Amend to specifcially include ACGME; maintain AOA for DOs who complete postgraduate training prior to 2020. |

| | | | |
|---|---|---|---|
| **MN** | Minn. Stat. § 147.02 Subdivision 1 (d) The applicant shall present evidence satisfactory to the board of the completion of one (1) year of graduate, clinical medical training in a program accredited by a national accrediting organization approved by the board or other graduate training approved in advance by the board as meeting standards similar to those of a national accrediting organization. https://www.revisor.mn.gov/statutes/?id=147.02 | None | No changes needed; may want to consider specifying AOA/ACMGE. |
| **MS** | Miss. Code Ann. § 73-25-3: No postgraduate educational requirement mandated. https://www.msbml.ms.gov/msbml/web.nsf/webpages/Regulations_Laws/$FILE/072014Laws.pdf?OpenElement | Part 2601 Ch. 2, Rule 2.1 A. 3. Applicants for licensure by examination must present documentation of having completed at least one (1) year of postgraduate training in the United States accredited by the Accreditation Council for Graduate Medical Education (ACGME) or by the AOA; or training in Canada accredited by the Royal College of Physicians and Surgeons. | No changes needed. |
| **MO** | Mo. Rev. Stat. § 334.035. Except as otherwise provided in section 334.036, every applicant for a permanent license as a physician and surgeon shall provide the board with satisfactory evidence of having successfully completed such postgraduate training in hospitals or medical or osteopathic colleges as the board may prescribe by rule. http://www.moga.mo.gov/mostatutes/stathtml/33400000351.HTML | 20 CSR 2150-2.004 Postgraduate Training Requirements for Permanent Licensure (1) Every applicant for a permanent license as a physician and surgeon who is a graduate of a medical college, approved and accredited by the American Medical Association (AMA) or its Liaison Committee on Medical Education, or an osteopathic college approved and accredited by the American Osteopathic Association (AOA), must present a certificate with his/her application evidencing the satisfactory completion of one (1) year of postgraduate training in a program which is approved and accredited to teach postgraduate medical education by the accreditation counsel on graduate medical education of the AMA or the education committee of the AOA. | No changes needed; may want to consider removing "AMA". |

| | | | |
|---|---|---|---|
| **MT** | Mont. Code Ann. § 37-3-305 (1)(c): has successfully completed an approved residency program of at least two (2) years or, for an applicant who graduated from medical school prior to 2000, has had experience or training that in the opinion of the board is at least the equivalent of a two (2) year approved residency program; http://leg.mt.gov/bills/mca/37/3/37-3-305.htm | **37-3-102. Definitions.** Unless the context requires otherwise, in this chapter, the following definitions apply: (1) "Approved internship" means an internship training program of at least one (1) year in a hospital that is either approved for intern training by the American Osteopathic Association or conforms to the minimum standards for intern training established by the Council on Medical Education of the American Medical Association or successors. However, the board may, upon investigation, approve any other internship. (3) "Approved residency" means a residency training program in a hospital conforming to the minimum standards for residency training established by the Council on Medical Education of the American Medical Association or successors or approved for residency training by the American Osteopathic Association. | No changes needed. |
| **NE** | Neb. Rev. Stat. § 38-2032 (c) has served one (1) year of internship or its equivalent at an institution approved for such training by the board. http://dhhs.ne.gov/publichealth/Documents/Medicine%20and%20Surgery.pdf | Approved Graduate Medical Education means a program of graduate medical education, approved by the Board, that is accredited by the Accreditation Council for Graduate Medical Education (ACGME), the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, or has been deemed by the Board as comparable to the requirements of ACGME. Approved Graduate Osteopathic Medical Education means a program of graduate medical education approved by the Council on Postdoctoral Training (COPT) served in the United States, or has been deemed by the Board as comparable to the requirements of COPT. | No changes needed. |

| | | | |
|---|---|---|---|
| **NV** | NRS 633.311. 4. The applicant:<br>(a) Has graduated from a school of osteopathic medicine before 1995 and has completed:<br>(1) A hospital internship; or<br>(2) One (1) year of postgraduate training that complies with the standards of intern training established by the American Osteopathic Association;<br>(b) Has completed three (3) years, or such other length of time as required by a specific program, of postgraduate medical education as a resident in the United States or Canada in a program approved by the Board, the Bureau of Professional Education of the American Osteopathic Association or the Accreditation Council for Graduate Medical Education; or<br>(c) Is a resident who is enrolled in a postgraduate training program in this State, has completed 24 months of the program and has committed, in writing, that he or she will complete the program; http://www.leg.state.nv.us/nrs/nrs-633.html#NRS633Sec311 | None | No changes needed. |

| | | | |
|---|---|---|---|
| **NH** | RSA 329:12 I. (5) Has completed at least two (2) years of postgraduate training approved by the Accreditation Council on Graduate Medical Education, or its equivalent as determined by the Board. Each applicant who has graduated from an accredited medical school prior to January 1, 1970, is required to have satisfactorily completed at least 12 months in a graduate educational program approved by the Accreditation Council on Graduate Medical Education, the Canadian Medical Association, or the Royal College of Physicians and Surgeons of Canada. http://www.gencourt.state.nh.us/rsa/html/XXX/329/329-12.htm | (d) Applicants shall have completed at least two (2) years of postgraduate medical training (postgraduate year 1, postgraduate year 2) in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA); or its equivalent which shall include, at a minimum, the following: | No changes needed. |

| | | | |
|---|---|---|---|
| **NJ** | N.J.S.A. 45:9-8 (2) b. (1) The applicant, if he has graduated from a professional school or college after July 1, 1916 and before July 1, 2003, shall further prove to the board that, after receiving such diploma or license, he has completed an internship acceptable to the board for at least one (1) year in a hospital approved by the board, or in lieu thereof he has completed one (1) year of post-graduate work acceptable to the board in a school or hospital approved by the board, unless required by regulation to complete additional post-graduate work; or (2) The applicant, if he has graduated from a medical school after July 1, 2003, shall further prove to the board that, after receiving his diploma, he has completed and received academic credit for at least two (2) years of post-graduate training in an accredited program and has signed a contract for a third year of post-graduate training in an accredited program, and that at least two (2) years of that training are in the same field or would, when considered together, be credited toward the criteria for certification by a single specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association or another certification entity with comparable standards that is acceptable to the board. http://www.njconsumeraffairs.gov/laws/BME_Laws.pdf | 13:35-3.11A (a) has successfully completed at least one (1) year of post-graduate training in a program accredited by the Accreditation Council on Graduate Medical Education (ACGME), the AOA, or any other equivalent group or agency | No changes needed. |
| **NM** | N.M. Stat. § 61-10-8. Have completed an American Osteopathic Association or American Medical Association approved post-graduate one (1) year residency program or rotating internship program. http://law.justia.com/codes/new-mexico/2011/chapter61/article10/section61-10-8 | Rule 16.17.1.8 establishes qualifications for licensure, and says “shall have completed one (1) year AOA accredited internship program.<br>Rule 16.17.2.8, sets rules for application for licensure and says "certification of one year of post-graduate training." | Amend to specifcially include ACGME; maintain AOA for DOs who complete postgraduate training prior to 2020. |

| | | | |
|---|---|---|---|
| **NY** | N.Y. Article 131 §6524. Experience: have experience satisfactory to the board and in accordance with the commissioner's regulations; http://www.op.nysed.gov/prof/med/article131.htm#6524 | Postgraduate Training Requirements: I. Graduates of Registered or Accredited Medical ProgramsIf you graduated from a NYS- registered or LCME- or AOA-accredited medical program, you must complete at least one (1) year of postgraduate hospital training in an accredited residency program approved by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada. | No changes needed. |
| **NC** | N.C. Gen. Stat. § 90-9.1 (a) (2) a. has successfully completed one (1) year of training in a medical education program approved by the Board after graduation from medical school. http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/ByArticle/Chapter_90/Article_1.html | None | No changes needed; may want to consider specifying AOA/ACMGE. |
| **ND** | N.D. Cent. Code § 43-17-18 2. b. An applicant who is a graduate of an approved medical or osteopathic school located in the United States, its possessions, territories, or Canada, must present evidence, satisfactory to the board, that the applicant has successfully completed one (1) year of postgraduate training in the United States or Canada in a program approved by the board or by an accrediting body approved by the board. http://www.legis.nd.gov/cencode/t43c17.pdf?20150326135516 | None | No changes needed; may want to consider specifying AOA/ACMGE. |

| | | | |
|---|---|---|---|
| **OH** | R.C. 4731.091 (B) (1) have successfully completed not less than nine (9) months of graduate medical education or its equivalent as determined by the board. (1) "Graduate medical education" means education received through any of the following: (a) An internship or residency program conducted in the United States and accredited by either the accreditation council for graduate medical education of the American Medical Association or the American Osteopathic Association;<br>(b) A clinical fellowship program conducted in the United States at an institution with a residency program accredited by either the Accreditation Council for Graduate Medical Education of the American Medical Aassociation or the American Osteopathic Association that is in a clinical field the same as or related to the clinical field of the fellowship program;http://codes.ohio.gov/orc/4731.091 | None | No changes needed. |

| | | | |
|---|---|---|---|
| **OK** | 59 O.S. § 630. To practice as an osteopathic physician, the applicant shall be a graduate of a school or college of osteopathic medicine which is accredited by the Bureau of Professional Education of the American Osteopathic Association and shall have completed at least one (1) year of rotating internship or the equivalent thereof, in an accredited internship or residency program acceptable to the Board. http://law.justia.com/codes/oklahoma/2014/title-59/section-59-630 | Oklahoma Administrative Code 510:10-3-1(c). One (1) year of postgraduate training is a requirement for licensure. This experience must be in the form of a rotating internship or its equivalent, in an accredited internship or residency program acceptable to the Board. To be deemed equivalent to a rotating internship and, acceptable to the Board, a program must provide the following: (1) The program must provide the following core experience: (A) One (1) month - General Practice (B) Two (2) months - General Internal Medicine (C) One (1) month - General Surgery (D) One (1) month - Obstetrics/Gynecology (E) One (1) month - Pediatrics (2) This core experience must be supplemented by three (3) months of Selectives and three (3) months of Electives, accounting for a total of twelve (12) months. A Selective may be defined as any core category or Emergency Medicine. An Elective may be any category of experience chosen by the intern or resident. (3) If an applicant has completed an ACGME accredited residency training program and become specialty board eligible or attained specialty board certification, the Board may consider these standing as equivalent training. | Practice Act needs to be amended to include ACGME; langauge should also be updated: "Bureau of Professional Education of the American Osteopathic Association" to Commission on Osteopathic College Accreditation". |
| **OR** | ORS 677.100(1)(b)(A) Satisfactory completion of an approved rotating internship if a graduate of an approved school of medicine; or (B) One (1) year of training in an approved program if a graduate of an approved school of medicine. https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2013ors677.html | 847-020-0120 (2) Must satisfactorily complete an approved internship, residency or fellowship in the United States or Canada of at least one (1) year in not more than one (1) training program accredited for internship, residency or fellowship training by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, the College of Family Physicians of Canada, or the Royal College of Physicians and Surgeons of Canada | No changes needed. |

| | | | |
|---|---|---|---|
| **PA** | 63 Pa.C.S. § 271.10 (a). Physicians who have complied with the requirements of the board, have passed a final examination, and have otherwise complied with the provisions of this act shall receive . . . a license entitling them to practice osteopathic medicine and surgery without restriction in this Commonwealth. | Pennsylvania Administrative Code § 25.241. To secure an unrestricted license by examination, the applicant shall have (4) Successfully completed an approved internship. Pennsylvania Administrative Code § 25.1. Approved internship -- An osteopathic rotating internship program approved by the AOA and the Board. | Rules need to be amedned to include ACGME. NOTE: use of AOA and Board approval. |
| **RI** | R.I. Gen. Laws § 5-37-2: shall meet post graduate training requirements and any other requirements that the board or director establishes by regulation… http://webserver.rilin.state.ri.us/Statutes/title5/5-37/5-37-2.HTM | R5-37-MD/DO 3.2.1 Osteopathic Physicians: (c) have satisfactorily completed two (2) years of progressive post graduate training, internship and residency in a program approved by the American Osteopathic Association or the Accreditation Council for Graduate Medical Education. | No changes needed. |

| | | | |
|---|---|---|---|
| **SC** | S.C. Code Ann. § 40-47-32 (ii) a minimum of three (3) years of progressive postgraduate medical residency training in the United States approved by the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), or postgraduate training in Canada approved by the Royal College of Physicians and Surgeons, except that if an applicant has been actively licensed in another state for the preceding five (5) years or more without significant disciplinary action, the applicant need only document one (1) year of postgraduate residency training approved by the board; or (b)(i) document successful completion of a Fifth Pathway program; and (ii) complete a minimum of three (3) years progressive postgraduate medical residency training in the United States approved by the ACGME or AOA or postgraduate training in Canada approved by the Royal College of Physicians and Surgeons or be board eligible or board certified by a specialty board recognized by the American Board of Medical Specialties (ABMS), the AOA, or another organization approved by the board. http://www.scstatehouse.gov/code/t40c047.php | None | No changes needed. |

| | | | |
|---|---|---|---|
| **SD** | SDCL 1-26. 36-4-11 The applicant shall also present evidence satisfactory to the board of successful completion of a program as an intern or resident, or of equivalent service approved by the board, in a hospital approved by the board, for such time as the board requires by rule adopted pursuant to chapter 1-26. http://legis.sd.gov/Statutes/Codified_Laws/DisplayStatute.aspx?Type=Statute&Statute=36-4-11 | ARSD 20:47:03:03 (11) If the applicant completed graduate medical education training after July 1, 1987, submit a certificate showing that the applicant has successfully completed a program of graduate medical education of at least two (2) years through a hospital approved by the board. The records of the graduate medical education program must establish the degree of proficiency of the applicant's performance. Applicants who completed graduate medical education before July 1, 1987, must submit a certificate of internship or residency showing that the applicant has served not less than one (1) year as an intern or resident in a hospital approved by the board or its equivalent. http://legis.sd.gov/Rules/DisplayRule.aspx?Rule=20:47:03:03 | No changes needed; may want to consider specifying AOA/ACMGE. |
| **TN** | Nothing specified under T.C.A. § 63-9. http://law.justia.com/codes/tennessee/2010/title-63/chapter-9/ | TN Rules 1050-02-.03. Evidence satisfactory to the Board of successful completion of a one (1) year internship or postgraduate year one (PGY-1) in a hospital approved by the American Osteopathic Association, American Medical Association or its accreditation program for medical education, or the Joint Commission on the Accreditation of Hospitals. | Change is needed, "AMA" to "ACGME" |
| **TX** | TEX. Code § 3 155.003 (A) successfully completed one (1) year of graduate medical training approved by the board in the United States or Canada. http://www.statutes.legis.state.tx.us/Docs/OC/htm/OC.155.htm | TX. Admin. Code § 163.2 (a) (5) have successfully completed a one (1) year training program of graduate medical training in the United States or Canada as defined under §163.1(9) of this title; §163.1 (9) One (1) year training program--A program that is one (1) continuous year of postgraduate training approved by the board that is:<br>(A) accepted for certification by a specialty board that is a member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists; or<br>(B) accredited by one of the following: (i) the Accreditation Council for Graduate Medical Education, or its predecessor; (ii) the American Osteopathic Association; | No change needed. |

| | | | |
|---|---|---|---|
| **UT** | Utah Code § 58-68-302. (e)(i) has successfully completed 24 months of progressive resident training in an ACGME or AOA approved program after receiving a degree of doctor of osteopathic medicine required under Subsection (1)(d); or (ii) (A) has successfully completed 12 months of resident training in an ACGME or AOA approved program after receiving a degree of doctor of osteopathic medicine as required under Subsection (1)(d) http://law.justia.com/codes/utah/2010/title-58/chapter-68/58-68-302 | None | No change needed. |
| **VT** | 26 V.S.A. § 33 § 1831. Documentation of no less than one (1) year of an approved program of postgraduate training. http://law.justia.com/codes/vermont/2014/title-26/chapter-33/section-1831 | CVR 04-030-220. Has satisfactorily completed one (1) year's post-graduate training in a rotating internship program approved by the AOA or has satisfactorily completed three (3) years of postgraduate training in an AOA or ACGME-approved residency program. | No change needed. |
| **VA** | Conde § 54.1-2930 4. Has completed one (1) year of satisfactory postgraduate training in a hospital approved by an accrediting agency recognized by the Board for internships or residency training. https://www.dhp.virginia.gov/medicine/medicine_laws_regs.htm#Reg | 18VAC85-20-121 3. B. Such an applicant for licensure in medicine, osteopathic medicine, or podiatry shall provide evidence of having completed one (1) year of satisfactory postgraduate training as an intern or resident in a hospital or health care facility offering approved internship and residency training programs when such a program is approved by an accrediting agency recognized by the board for internship and residency training. | No changes needed; may want to consider specifying AOA/ACMGE. |
| **WA** | RCW 18.57.020. An applicant for a license to practice osteopathic medicine and surgery must furnish evidence satisfactory to the board that he or she has served for not less than one (1) year in a postgraduate training program approved by the board. http://apps.leg.wa.gov/rcw/default.aspx?cite=18.57.020 | WAC 246-853-030. The board accepts the following training programs. (1) Nationally approved one-year internship programs; (2) The first year of a residency program approved by the American Osteopathic Association, the American Medical Association or by their recognized affiliate residency accrediting organizations. | Change is needed, "AMA" to "ACGME" |

| | | | |
|---|---|---|---|
| **WV** | W. Va. Code § 30-14-4(b). (4) The applicant has successfully completed either of the following: (A) A minimum of one (1) year of post-doctoral, clinical training in a program approved by the American Osteopathic Association; or (B) A minimum of one (1) year of post-doctoral, clinical training in a program approved by the Accreditation Council for Graduate Medical Education and forty (40) hours of continuing medical education in osteopathic manipulative medicine and osteopathic manipulative treatment in courses approved, and classified as Category 1A, by the American Osteopathic Association. http://www.legis.state.wv.us/wvcode/ChapterEntire.cfm?chap=30&art=14&section=4 | WV Rules § 24-1-4. 4.2.d. Evidence of completion of a minimum of 1 year of clinical training under either of the following options: 4.2.d.1. Post-graduate, clinical training in a program approved by the American Osteopathic Association, which may also include a program approved under the Association's Resolution 42 procedure; Or 4.2.d.2. Post-graduate, clinical training in a program approved by the Accreditation Council for Graduate Medical Education and 40 hours of continuing medical education in osteopathic medicine with osteopathic manipulative treatment in courses approved, and classified as Category 1A, by the American Osteopathic Association. | NOTE: After 2020 every DO would have to complete 40 hours of AOA Category 1A CME in order to obtain a license. |

| | | | |
|---|---|---|---|
| **WI** | Wis. Stat. § 448.05(2) 2. That the applicant satisfies one of the following: a. The applicant has successfully completed and received credit for 24 months of postgraduate training in one (1) or more programs accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or a successor organization. b. The applicant is currently enrolled in a postgraduate training program accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or a successor organization; the applicant has successfully completed and received credit for 12 consecutive months of postgraduate training in that program; and the applicant has received an unrestricted endorsement from the postgraduate training program director that includes confirmation that the applicant is expected to continue in the program and complete at least 24 months of postgraduate training. 3. That the applicant satisfies any other requirement established by the board by rule for issuing the license. http://docs.legis.wisconsin.gov/statutes/statutes/448/II/05 | WI Admin. Code: Med. 1.02 (3) A verified certificate showing satisfactory completion by the applicant of 12 months' postgraduate training in a facility approved by the board. | No change needed. |
| **WY** | Wyo. Stat. § 26 Art. 1 33-26-303. (iv) Has provided written evidence that he has completed at least one (1) year of postgraduate training in an A.C.G.M.E, A.O.A. or R.C.P.S.C. accredited program. http://legisweb.state.wy.us/statutes/statutes.aspx?file=titles/Title33/T33CH26.htm | Ch. 1 Sec. 4 (j)(A) Successful completion of not less than two (2) years of postgraduate training in an A.C.G.M.E., A.O.A. or R.C.P.S.C. accredited program; or, (B) Successful completion of not less than one (1) year of postgraduate training in an A.C.G.M.E., A.O.A. or R.C.P.S.C. accredited program and: (1) Current certification by a medical specialty board that is a member of the A.B.M.S. or the B.O.S.B.O.C.; or (2) Continuous full and unrestricted medical licensure in good standing in one or more states and/or the District of Columbia for the preceding five (5) years. https://drive.google.com/file/d/0BxgGvgRMOUrUTUhhNkNpd3RLVDg/view?pli=1 | No change needed. |

**TAB G: Report of Reference Committee A**

**MANAGEMENT NOTE:**

The following resolutions and reports will be submitted to Reference Committee A:

1. Report of the Bylaws Committee

2. BRD RPT 15-5: Report of the Special Committee on Strategic Positioning: *FSMB 2015-2020 Strategic Plan*

3. BRD RPT 15-1: Report on Resolution 13-2; Higher Standards for Unrestricted Medical Licensure

4. BRD RPT 15-2: Report on Resolution 13-3; Shortening Undergraduate Medical Education

5. Resolution 15-3: Developing Model Language in Board Actions and Coordinating with ABMS on the Effects of Board Actions on Specialty Board Certification (WA-Medical)

6. Resolution 15-4: Revision of *FSMB Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain* (WA-Medical)

# REPORT OF THE BYLAWS COMMITTEE

**Subject:** **FSMB Bylaws Amendments**

**Referred to:** **Reference Committee A**

---

The Bylaws Committee, chaired by Anita M. Steinbergh, DO, is charged with considering the current Bylaws **(Attachment 1)** and proposed amendments thereto, and, from time to time, making recommendations to the House of Delegates for changes that will maintain the integrity and consistency of the Bylaws. Bylaws amendments may be proposed only by the Board of Directors, Member Medical Boards or the Bylaws Committee. Other members of the Committee include Jodi A. Bain, JD; Maroulla S. Gleaton, MD; Margaret B. Hansen, PA-C; Cheryl L. Walker-McGill, MD; and Michael D. Zanolli, MD.

Calls for Bylaws Amendments were announced to the FSMB membership in advance of a Bylaws Committee meeting scheduled for November 13, 2014 seeking suggestions and specific language for proposed changes to the Bylaws. The Calls for Bylaws Amendments were communicated to the Member Medical Boards and Board of Directors via memo and email on September 10 and October 16 and 30, 2014, and published in *eNews* on September 23 and October 7, 2014. This year, there were no recommended amendments submitted to the Bylaws Committee for consideration by the Board of Directors or Member Medical Boards, nor did the Bylaws Committee itself suggest any recommended changes. Consequently, there are no amendments being presented to the 2015 House of Delegates for approval.

Respectfully submitted,

Anita M. Steinbergh, DO
Chair, Bylaws Committee

**ITEM FOR ACTION:**

**For information.**

# Attachment 1

# 2014 FSMB BYLAWS

## ARTICLE I. NAME

The corporation shall be known as the Federation of State Medical Boards of the United States, Inc. ("FSMB").

## ARTICLE II. CLASSES OF MEMBERSHIP, ELECTION AND MEMBERSHIP RIGHTS

### SECTION A. MEMBER MEDICAL BOARDS

The term "Member Medical Board" as used in the Articles of Incorporation and in these Bylaws shall refer to any board, committee or other group in any state, territory, the District of Columbia or possession of the United States of America that is empowered by law to pass on the qualifications of applicants for licensure to practice allopathic or osteopathic medicine or to discipline such licensees. If a state or other jurisdiction has more than one such entity and if each is an independent agency unrelated to the others, each is eligible for membership. Any eligible Medical Board may become a Member Medical Board upon approval of its application by the Board of Directors.

### SECTION B. FELLOWS

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

### SECTION C. HONORARY FELLOWS

Thirty-six months after completion of service on a Member Medical Board, a Fellow shall become an Honorary Fellow of the FSMB and may be appointed by the Chair to serve as a member of any committee or in any other appointive capacity.

### SECTION D. ASSOCIATE MEMBERS

A Member Medical Board may designate one or more employees or staff members to be an Associate Member of the FSMB. No Associate Member shall continue in that capacity upon termination of employment by or service to the Member Medical Board.

### SECTION E. COURTESY MEMBERS

Any physician licensed by a Member Board and not eligible for any other type of membership may become a Courtesy Member of the FSMB upon approval of the physician's 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

A board or authority that is not otherwise eligible for membership may become an Affiliate Member 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. OFFICES OF THE FSMB

1. OFFICERS. The officers of the FSMB shall be that of Chair, Chair-elect, Treasurer and Secretary.
2. Only an individual who is a Fellow at the time of the individual's election or appointment shall be eligible for election or appointment as an Officer of the FSMB, except for the position of Secretary.
3. The position of Secretary shall be an ex-officio office, without vote, and the President of the FSMB shall serve as Secretary.

### SECTION B. ELECTION OF OFFICERS

1. The Chair-elect shall ascend to the position of Chair at the Annual Meeting following the meeting in which the Chair-elect was elected.
2. The Chair-elect shall be elected at each Annual Meeting of the House of Delegates.
3. The Treasurer shall be elected every third year at the Annual Meeting of the House of Delegates.
4. Officers shall be elected by a majority of the members of the House of Delegates present and voting.
5. In any election, should no candidate receive a majority of the votes cast, a runoff election shall be held between the two candidates who receive the most votes for that office on the first ballot.

**SECTION C. DUTIES OF OFFICERS**

1. The duties of the Chair shall be as follows:
    a. Preside at all meetings and sessions of the House of Delegates and the Board of Directors;
    b. Perform the duties customary to the office of the Chair;
    c. Make appointments to committees and define duties of committee members in accordance with these Bylaws, except as otherwise provided herein;
    d. Serve, ex officio, on all committees except as otherwise provided herein; and
    e. Exercise such other rights and customs as the Bylaws and parliamentary usage may require or as the FSMB or the Board of Directors shall deem appropriate.
2. The duties of the Chair-elect shall be as follows:
    a. Assist the Chair in the discharge of the Chair's duties; and
    b. Perform the duties of the Chair at the Chair's request or, in the event of the Chair's temporary absence or incapacitation, at the request of the Board of Directors.
3. The duties of the Treasurer shall be as follows:
    a. Perform the duties customary to that office;
    b. Perform such other duties as the Bylaws and custom and parliamentary usage may require or as the Board of Directors shall deem appropriate;
    c. Serve as an ex officio member of the Audit Committee; and
    d. Serve as chair of the Finance Committee.
4. The duties of the Secretary shall be as follows:
    a. Administer the affairs of the FSMB; and
    b. Such duties and responsibilities as the FSMB and the Board of Directors shall determine.

**SECTION D. TERMS OF OFFICE AND SUCCESSION**

1. The Chair and Chair-elect shall serve for single terms of one year or until their successors assume office.
2. The Treasurer shall serve for a single term of three years or until the Treasurer's successor assumes the office.
3. Officers shall assume office upon final adjournment of the Annual Meeting of the House of Delegates at which they were elected.
4. The term of the Secretary is co-terminus with that of the President.

### SECTION E. VACANCIES

1. In the event of a vacancy in the office of the Chair, the Chair-elect shall assume the position of Chair for the remainder of the unexpired term, and shall then serve a full one-year term as Chair.
2. In the event of a vacancy in the office of the Chair-elect, the Board of Directors shall appoint a Director-at-Large to assume the duties, but not the office, of Chair-elect for the remainder of the unexpired term. At the next Annual Meeting of the House of Delegates, both a Chair and a Chair-elect shall be elected in accordance with the provisions in Section B of this Article.
3. In the event of a vacancy in the office of the Treasurer, the Board of Directors shall elect one of the Directors-at-Large to serve as Treasurer, with one vote on the Board of Directors and one vote on the Executive Committee, until the next year's Annual Meeting of the House of Delegates, at which time a Treasurer shall be elected.

## ARTICLE IV. BOARD OF DIRECTORS

### SECTION A. MEMBERSHIP AND TERMS

1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, the Immediate Past Chair, nine Directors-at-Large and two Associate Members. At least two members of the Board, who are not Associate Members, shall be non-physicians, at least one of whom shall be a public/consumer member.
2. NOMINATION OF ASSOCIATE MEMBERS: Nominations for Associate Member positions shall be accepted from Member Boards, the Board of Directors and Administrators in Medicine (AIM). Associate Members shall be elected by the Board of Directors in staggered terms in accordance with policies and procedures established by the Board of Directors.
3. TERMS: Directors-at-Large shall each serve for a term of three years and shall be eligible to be reelected to one additional term. A partial term totaling one-and-a-half years or more shall count as a full term. Associate Members shall each serve for a term of two years. Associate Members shall not be eligible to serve consecutive terms.

### SECTION B. NOMINATIONS

1. The Nominating Committee shall submit a slate of one or more nominees for each of the offices and positions to be filled by election at the Annual Meeting of the House of Delegates.
2. The Nominating Committee shall mail its slate of candidates to Member Boards not fewer than 60 days prior to the Annual Meeting of the House of Delegates.

### SECTION C. ELECTIONS

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. 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 undesignated seats remaining to be filled. These candidates shall be those who received the most votes short of majority on the first ballot. The same procedure shall be used for any required subsequent runoff elections.

3. Directors shall assume office upon final adjournment of the Annual Meeting of the House of Delegates at which they were elected.
4. Only an individual who is a Fellow at the time of the individual's election shall be eligible for election as a Director of the FSMB.

**SECTION D. DUTIES OF THE BOARD OF DIRECTORS**

1. The control and administration of the FSMB is vested in the Board of Directors and it shall act for the FSMB between Annual Meetings.
2. The Board of Directors shall carry out the mandates of the FSMB as established by the House of Delegates, and it shall have full and complete power and authority to perform all acts and to transact all business for and on behalf of the FSMB.
3. The Board of Directors shall conduct and manage all property, affairs, work and activities of the FSMB, subject only to the provisions of the Articles of Incorporation and these Bylaws and to resolutions and enactments of the House of Delegates.
4. The Board of Directors shall be the fiscal agent of the FSMB.
5. The Board of Directors shall establish rules for its operations and meetings.
6. The FSMB may indemnify Directors, Officers and other individuals acting on behalf of the FSMB. Such indemnification shall be subject to the approval of the Board of Directors and shall be in accordance with the laws of the State of Nebraska and the operational policies and procedures of the Board of Directors, as adopted. The Board shall report to the membership of the FSMB at the Annual Meeting of the House of Delegates.
7. The Board of Directors shall establish a strategic plan for the FSMB that states the FSMB mission and objectives and shall submit that plan to the House of Delegates for ratification, modification or rejection. The Board shall review the current strategic plan annually and propose any amendments to the Annual Meeting of the House of Delegates for ratification, modification or rejection. The President shall report to the Annual Meeting of the House of Delegates on the extent to which the FSMB's stated objectives have been accomplished in the preceding year.

**SECTION E. REMOVAL FROM OFFICE**

1. REMOVAL: Any officer or member of the Board of Directors may be removed for any cause deemed sufficient by an affirmative vote of two-thirds of the total members of the Board of Directors entitled to vote and who are not subject to removal from office.
2. PROCEDURE: The procedure for removal shall be as follows:

a. The Board shall file with the Secretary of the Board and deliver a written statement of the cause for removal to the officer or board member in sufficient detail as to state the grounds for the removal. Delivery to the officer or member shall be by certified mail, return receipt requested, to the last address known to the Board and is effective upon mailing.

b. The officer or board member shall deliver a sworn written response to the Board no later than thirty calendar days after the written statement is filed with the Secretary of the Board. Delivery to the Board shall be by certified mail, return receipt requested, directed to the Secretary of the Board at the FSMB corporate office. Delivery is effective upon mailing.

c. At the next Board meeting, the Board shall determine whether or not to proceed with removal. Notice of the Board's action shall be delivered to the officer or Board member by certified mail, return receipt requested. If the officer or board member did not file a written response the Board shall proceed with a determination. Delivery is effective upon mailing.

d. If the Board votes to proceed with removal of the officer or Board member, at a Board meeting held no less than thirty days after delivery of the notice, the Board member shall be afforded the opportunity to address the Board on the merits of the allegations and produce any relevant information to the Board after which the Board shall make a determination.

3. APPEAL: Any officer or member of the Board of Directors removed by the Board of Directors may appeal to the House of Delegates at its next business meeting. The officer or member may be reinstated by a two-thirds vote of the House of Delegates.

**SECTION F. VACANCY**

In the event of a vacancy in the membership of the Directors-at-Large, the Board of Directors may appoint a Fellow who meets the qualifications for the position to serve until the next Annual Meeting of the House of Delegates, at which time an individual shall be nominated and, if elected, shall serve for the remainder of the unexpired term. In the event a Director-at-Large is elected to the office of Treasurer or Chair-elect, that vacancy shall be filled by an election at the same Annual Meeting of the House of Delegates.

**SECTION G. EXECUTIVE COMMITTEE OF THE BOARD**

1. MEMBERSHIP: The Board of Directors shall establish an Executive Committee of the Board, which shall consist of the Chair as Chair, Chair-elect, Treasurer, Immediate Past Chair and two Directors-at-Large. The Directors-at-Large shall be elected for a one-year term by majority vote of the Directors-at-Large and the Associate Members of the Board of Directors at the first regular meeting of the Board following the Annual Meeting of the House of Delegates. In the event of a vacancy in a Director-at-Large position, the Directors-at-Large and the Associate Members of the Board, by majority vote, shall choose another Director-at-Large to serve the remainder of the one-year term. In the event of vacancy in the position of Immediate Past Chair, this position shall remain vacant until the next Annual Meeting of the House of Delegates.

2. DUTIES: In intervals between Board meetings, the Executive Committee shall act for and on behalf of the Board in any matters that require prompt attention. It shall not modify actions previously taken by the Board.
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 slate of candidates is distributed to the Member Boards, the Boards will be informed that a Fellow who is qualified for nomination, but not otherwise nominated by the Nominating Committee, may seek to run for a position on the Board of Directors as an Officer or Director-at-Large, or for a position on the Nominating Committee.
2. In order to be placed on the ballot, the Fellow seeking nomination is required to present a petition to Administrative Staff that is signed by at least one Fellow from at least four Member Boards as well as a fellow from the Board of the member seeking nomination.
3. The deadline to submit petitions to the Administrative Staff is 21 days prior to the Annual Meeting.

### SECTION B. VALIDATION AND PLACEMENT ON BALLOT

1. The Administrative Staff shall verify that all signatures on the petition are valid. "Valid" is defined as the person who is seeking nomination and the persons who signed the petition are Fellows as defined in the FSMB Bylaws.
2. Once verified, the petitions are deemed valid and the candidate is placed on the ballot.
3. The names of those seeking to run by petition whose petitions are deemed valid shall be distributed to the Voting Delegates not fewer than 14 days prior to the Annual Meeting.

4. Once a candidate seeking to run by petition is added to the ballot, the candidate shall be afforded the same privileges and be bound by the same rules in the campaign process as candidates who were nominated by the Nominating Committee.

## ARTICLE VI. PRESIDENT

The Board of Directors may, by a two-thirds majority vote of the full Board, appoint a President of the FSMB, who shall be a physician, to serve without term. The President shall administer the affairs of the FSMB and shall have such duties and responsibilities as the Board of Directors and the FSMB shall direct. The President shall serve as Secretary of the FSMB and shall be an ex-officio member, without vote, of the Board of Directors.

## ARTICLE VII. MEETINGS

### SECTION A. ANNUAL MEETING OF THE HOUSE OF DELEGATES

The annual meeting of the House of Delegates of the FSMB, which shall be called the House of Delegates, shall be held at such time and place as may be fixed by the Board of Directors. Written notice of the time and place of the meeting shall be given to all Member Medical Boards by mail not fewer than 90 days prior to the date of the meeting.

### SECTION B. SPECIAL MEETINGS OF THE HOUSE OF DELEGATES

Special meetings of the House of Delegates may be called at any time by the Chair, on the written request of ten Member Medical Boards or by action of the Board of Directors. Written notice of the time and place of such meetings shall be given to all Member Medical Boards by mail not fewer than 30 days prior to the date of the meeting.

### SECTION C. RIGHT TO VOTE

1. The right to vote at meetings of the House of Delegates is vested in, and restricted to, Member Medical Boards. Each Member Medical Board is entitled to one vote, said vote to be cast by the delegate of the Member Board. The delegate shall be the president of the Member Medical Board or the President's designated alternate. In order for a delegate to be permitted to vote, the delegate shall present a letter of appointment to the Secretary of the Board of Directors.
2. All classes of membership shall have the right of the floor at meetings of the House upon request of a delegate and approval of the presiding officer; however, the right to introduce resolutions is restricted to Member Medical Boards and the Board of Directors and the procedure for submission of such resolutions shall be in accordance with FSMB Policy.

### SECTION D. QUORUM

A majority of Member Medical Boards shall constitute a quorum at any meeting of the House of Delegates. A majority of the voting members of the Board of Directors or any committee or other constituted group shall constitute a quorum of the Board, committee or group.

### SECTION E. RULES OF ORDER

Meetings of the House of Delegates, Board of Directors and all committees shall be conducted in accordance with the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure*, current edition, except when in conflict with the Articles of Incorporation or these Bylaws, in which case the Articles of Incorporation or these Bylaws shall prevail.

## ARTICLE VIII. STANDING AND SPECIAL COMMITTEES

### SECTION A. STANDING COMMITTEES

1. The Standing Committees of the FSMB shall be:
   a. Audit Committee
   b. Bylaws Committee
   c. Editorial Committee
   d. Education Committee
   e. Ethics and Professionalism Committee
   f. Finance Committee
   g. Nominating Committee
2. ADDITIONAL STANDING COMMITTEES. Additional standing committees may be created by resolution of the FSMB and/or amendment to the Bylaws. Chairs and members of all standing committees, with the exception of the Nominating Committee, shall be appointed by the Chair, with the approval of the Board of Directors, for a term of one year, unless otherwise provided for in these Bylaws. Reappointment, unless specifically prohibited, is permissible.
3. MEMBERSHIP. Honorary Fellows, Associate Members and Courtesy Members may be appointed by the Chair to serve on a standing committee in addition to the number of committee members called for in the following sections of this chapter. No more than one Honorary Fellow, Associate or Courtesy Member or non-member subject matter expert may be appointed by the Chair to serve in such a capacity on any standing committee unless otherwise provided for in these Bylaws. All committee members shall serve with vote. Honorary Fellows, Associate or Courtesy Members, and non-members appointed to standing committees by the Chair shall serve for a term concurrent with the term of the Chair. No individual shall serve on more than one standing committee except as specified in the Bylaws. With the exception of the Nominating Committee and the Editorial Committee, the Chair and the Chair-elect shall serve, ex-officio, on all committees.
4. VACANCIES. In the event a vacancy occurs in an elected position on a standing committee, the Chair, with the approval of the Board of Directors, shall appoint a Fellow to serve on the committee until the next meeting of the House of Delegates, at which time an election will be held to fill the vacant position for the remainder of the unexpired term. In the event a vacancy occurs in an appointed position on a standing committee, the Chair, with the approval of the Board of Directors, shall appoint a Fellow to serve on the committee for the remainder of the unexpired term. In the event the Chairmanship of the Nominating Committee becomes vacant, the FSMB Chair, with the approval of

the FSMB Board of Directors, shall appoint a Past Chair of the FSMB Board of Directors to serve in that capacity for the remainder of the unexpired term.

**SECTION B. AUDIT COMMITTEE**

The Audit Committee shall:

1. Be composed of five Fellows, three of whom shall be members of the Board of Directors. The Treasurer of the FSMB shall serve ex-officio without vote. The Chair of the FSMB shall appoint the Chair of the Audit Committee from one of the three sitting Board Members.
2. Ensure that an annual audit of the financial accounts and records of the FSMB is performed by an independent Certified Public Accounting firm.
3. Recommend to the Board of Directors the appointment, retention or termination of an independent auditor or auditors and develop a schedule for periodic solicitation of audit firms consistent with Board policies and best practices.
4. Oversee the independent auditors. The independent auditors shall report directly to the Committee.
5. Review the audit of the FSMB. Submit such audit and Committee's report to the Board of Directors.
6. Report any suggestions to the Board of Directors on fiscal policy to ensure the continuing financial strength of the FSMB.
7. When the finalized committee report to the Board of Directors is made, suggestions and feedback will be forwarded to the Finance Committee.

**SECTION C. BYLAWS COMMITTEE**

The Bylaws Committee, composed of five Fellows, shall continually assess the Articles of Incorporation and the Bylaws and shall receive all proposals for amendments thereto. It shall, from time to time, make recommendations to the House of Delegates for changes, deletions, modifications and interpretations thereto.

**SECTION D. EDITORIAL COMMITTEE**

1. An Editorial Committee, not to exceed twelve Fellows and three non-member subject matter experts, shall advise the Editor-in-Chief on editorial policy for the FSMB's official publication, and shall serve as the editorial board of that publication and otherwise assist the Editor-in-Chief in the performance of duties as appropriate and necessary. No officer or member of the Board of Directors shall serve on this Committee.
2. Service on the Editorial Committee is by nomination and appointment by the FSMB Chair, subject to approval of the Board of Directors, immediately following the Annual Meeting of the House of Delegates. Candidates are allowed to express their interest in serving on the Committee through self-nomination. Committee members shall serve staggered three-year terms and shall be limited to two full terms.
3. The Editor-in-Chief shall be elected by the Editorial Committee to a three-year term beginning on the date of the annual Editorial Committee meeting, with the Editor-in-Chief's term on the Editorial

Committee being automatically extended to allow the Editor-in-chief to serve for three years. A member of the Editorial Committee whose term is expiring shall continue to serve until the member's replacement meets at the next annual Editorial Committee meeting.

4. The Editorial Committee will elect its Chair, who will serve as the Editor-in-Chief of the *Journal of Medical Regulation.* The Editor-in-Chief will serve without compensation and will coordinate decisions on the *Journal* content, among other duties to be determined by the Bylaws Committee.

**SECTION E. EDUCATION COMMITTEE**

The Education Committee shall be composed of eight Fellows, to include the Chair as chair, the Immediate Past Chair and the Chair-elect. The Committee shall be responsible for assisting in the development of educational programs for the FSMB.

**SECTION F. ETHICS AND PROFESSIONALISM COMMITTEE**

The Ethics and Professionalism Committee shall be composed of up to five Fellows and up to two subject matter experts. The Ethics and Professionalism Committee shall address ethical and professional issues pertinent to medical regulation.

**SECTION G. FINANCE COMMITTEE**

The Finance Committee shall be composed of five Fellows, to include the Treasurer as Chair. The Finance Committee shall review the financial condition of the FSMB, review and evaluate the costs of the activities and programs to be undertaken in the forthcoming year, present a budget for the FSMB to the Board of Directors for its recommendation to the House of Delegates at the Annual Meeting and perform such other duties as are assigned to it by the Board of Directors. Except for the Treasurer, no Fellow shall serve on both the Audit and Finance Committees.

**SECTION H. NOMINATING COMMITTEE; PROCESS FOR ELECTION**

1. The Nominating Committee shall be composed of seven individuals, six Fellows and the Immediate Past Chair, who shall chair the Committee and serve without vote except in the event of a tie. At least 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. A member of the Nominating Committee may not serve consecutive terms. At least one elected member of the Nominating Committee shall be a non-physician. With the exception of the Immediate Past Chair, no two Committee members shall be from the same member board and no officer or member of the Board of Directors shall serve on the Committee. Members of the Nominating Committee are not eligible for nomination by the Committee.

2. Only an individual who is a Fellow at the time of the individual's election shall be eligible for election as a member of the Nominating Committee.

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

### SECTION D. REINSTATEMENT

In the event a member is suspended or expelled from the FSMB, the member may apply to the President for reinstatement after one year following final action on expulsion. The President shall review the application and the reason for the suspension or expulsion and forward a report to the Board. The Board may accept application for reinstatement under such terms and conditions as it may deem appropriate, reject the application or request further information from the President. The Board's decision to accept or reject an application is final.

## ARTICLE XIII. CORPORATE SEAL

The Board of Directors shall adopt a corporate seal that meets the requirements of the state in which the FSMB is incorporated.

## ARTICLE XIV. ADOPTION AND AMENDMENT OF BYLAWS, EFFECTIVE DATE

### SECTION A. AMENDMENT

These Bylaws may be amended at any annual meeting of the House of Delegates by two-thirds of those present and voting. Bylaws changes may be proposed only by the Board of Directors, Member Medical Boards or the Bylaws Committee. All such proposals must be submitted in writing to the Bylaws Committee, in care of the Secretary of the FSMB. The Bylaws Committee shall inform the Member Medical Boards of its meeting dates not fewer than 60 days in advance of the meeting. The recommendations of the Bylaws Committee and the full texts of all proposed amendments recommended to the Committee shall be sent to each Member Medical Board not fewer than 60 days prior to the Annual Meeting of the House of Delegates at which they are to be considered.

### SECTION B. EFFECTIVE DATE

These Bylaws and any other subsequent amendments thereto, shall become effective upon their adoption, except as otherwise provided herein.

Bylaws last amended in April 2014

# REPORT OF THE BOARD OF DIRECTORS

**Subject:** **Report of the Special Committee on Strategic Positioning: *FSMB 2015-2020 Strategic Plan***

**Referred to:** **Reference Committee A**

---

The Special Committee on Strategic Positioning was convened in August 2014 by FSMB Chair Donald H. Polk, DO to evaluate the continued relevance of the FSMB's 2010-2015 Strategic Plan, which includes the organization's Vision, Mission, Values 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 2015 for approval.

In completing its charge, the Special Committee met in person on August 20-21 and December 8, 2014. During its deliberations, the Committee considered key facts about the FSMB and its Member Medical Boards including their structure and function; major trends impacting the medical regulatory environment nationally and internationally; challenges and opportunities affecting key stakeholders; and information on the changing national healthcare policy landscape. The Committee considered the short-term and long-term needs of the state medical regulatory community and discussed a variety of leadership, policy and advocacy strategies that could help the FSMB meet the healthcare regulatory changes and challenges over the next five to ten years.

The result of the Special Committee's work are recommendations for a revised Strategic Plan that emphasizes the supportive role of the FSMB to its member boards and will guide the organization in reaching its goals through 2020 **(Attachment 1)**.

The draft report of the Special Committee on Strategic Positioning was distributed to FSMB member boards in February and March 2015 for comment. No comments were received. The Board of Directors has approved the Special Committee's report and recommends that the proposed *FSMB 2015-2020 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 proposed *FSMB 2015-2020 Strategic Plan* contained in the Report of the Special Committee on Strategic Positioning and the remainder of the report be filed.**

# Attachment 1

# SPECIAL COMMITTEE ON STRATEGIC POSITIONING

## Report on FSMB Strategic Plan Recommendations
## 2015-2020

**COMMITTEE MEMBERS**

J. Daniel Gifford, MD, Chair, FSMB Chair-elect

Boyd R. Buser, DO

Margaret B. Hansen, PA-C

R. David Henderson, JD

Stephen E. Heretick, JD

John K. Iglehart

Peter J. Katsufrakis, MD, MBA

Jerry G. Landau, JD

Padmini D. Ranasinghe, MD, MPH

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

Steven J. Stack, MD

Lance A. Talmage, MD

Jon V. Thomas, MD, MBA

Jacqueline A. Watson, DO, MBA

Michael D. Zanolli, MD

**EX OFFICIO**

Donald H. Polk, DO, FSMB Chair

Humayun J. Chaudhry, DO, FSMB CEO

**FACILITATOR**

Paul Larson, Paul Larson Communications

**MANAGEMENT**

Lisa A. Robin, MLA, FSMB CAO

Jonathan B. Jagoda, MPP, Director

Patricia C. McCarty, MM, Director

# FEDERATION OF STATE MEDICAL BOARDS
# SPECIAL COMMITTEE ON STRATEGIC POSITIONING

## Report on FSMB Strategic Plan Recommendations
## 2015-2020

### Introduction

The Federation of State Medical Boards' (FSMB) Special Committee on Strategic Positioning was convened in August 2014 and charged with reviewing the FSMB's current strategic plan and developing the strategic direction of the FSMB over the next 5 years. The Committee was asked to identify possible areas of modification of the current strategic plan and to develop new strategic planning recommendations, taking into account emerging trends and changes in the environment for medical regulation over the last 5 years.

During the course of its work, including two face-to-face meetings in Washington, D.C., the committee discussed the current medical regulatory environment in the United States and internationally, highlighted key trends, and identified challenges and opportunities for the FSMB in this environment. The group closely examined the FSMB's current Strategic Plan and major initiatives and operational priorities and discussed potential adjustments to the plan, given key trends and developments of the last five years.

Included in this report are summaries of key observations made during the committee's strategic planning sessions, a list of suggested strategic priorities that emerged during discussions, and draft-language recommendations for an updated 2015-2020 Strategic Plan.

### Environmental Trends

During discussions, participants identified a list of emerging trends in medical regulation -- and the health care environment in general – that the FSMB should consider as it updates its Strategic Plan. While many factors of significance were identified, several emerged as particularly noteworthy. These included:

- **Rapid change in the practice of medicine and the health care delivery system overall** – ranging from workforce and demographic shifts to the growth of telemedicine to ramifications of the Affordable Care Act. The fluidity of the current environment is a reality that will continue for the foreseeable future and will require flexibility and responsiveness in strategic outlook.

- **A new, coalition-and-partnership oriented environment for policy making and advocacy**. The importance of developing partnerships, alliances, and co-branding opportunities continues to grow, and the FSMB should be proactively engaged with other organizations as it pursues its agenda.

- **The importance of FSMB's role in advocating for state-based regulation and in serving and supporting state medical boards**. In the current policy-making environment, which includes new questions about the role and authority of federal vs. state agencies in regulatory matters, the FSMB has a vital role to play in articulating the value of state-based regulation. As state medical boards continue to face budget cuts and access to resources, the FSMB's role in providing education, data and other support services is more important than ever.

- **The growth of internationalism and the global interconnection of regulatory agencies**. Health care issues and policies increasingly cross national borders; international aspects of health care delivery, including the licensing of International Medical Graduates, can impact state medical boards directly. In this new environment, the FSMB should place stronger emphasis on working with international partners and should adopt an international view in its advocacy for best practices.

- **The increasing volume of health-care-related data and new technology platforms for the improved use of data**. "Big Data" has emerged as a powerful factor across sectors, as technology improves our ability to gather and analyze information. The FSMB's data and research capabilities have increased significantly in recent years and it is operating in an environment in which both are considered highly valuable assets. The FSMB should seek opportunities to leverage its data and expand its research parameters in pursuit of its mission and goals.

Other environmental factors identified by the committee that can impact medical regulation and should be taken into account as strategic goals are established included:

- The growing focus on **team-based care in medicine** and changes in traditional **scope-of-practice boundaries** in health care overall.

- An increasingly **polarized political environment** in Washington, D.C. and in state governments.

- The rise of more **empowered health care consumers**, who have higher expectations for their medical care and play a larger role in health care decision making.

- The nation's **opioid prescribing crisis**.

**Challenges and Opportunities**

The committee identified several challenges and opportunities that impact the FSMB's future, including:

***Challenges***

- An increased push by special interest groups for some form of national licensure, including support for proposed legislation in Congress.

- The growing focus on team-based health care, which is shaking up traditional scope of practice boundaries and introducing new questions about regulatory authority. (Note: team-based care was also identified as bringing potential opportunities – see below).

- Recent adverse court actions and actions by federal agencies, which have the potential to dilute state regulatory authority.

- Continuing economic pressure faced by states, which in turn threatens budgets and the operating effectiveness of state medical boards.

***Opportunities***

- The growing focus on team-based health care, which opens doors to new relationships with peer organizations in other sectors and the creation of new synergies to ensure patient safety and competent delivery of care.

- Health plans' interest in working in new ways with organizations such as the FSMB as the Affordable Care Act brings new mandates for them.

- The emergence of other new potential partners in health care, interested in working with the FSMB as the policy environment becomes more complex.

- The FSMB's growth in recent years as a major health care stakeholder, highlighted by its expanded advocacy role in Washington, D.C. ; the unique national "bully pulpit" it occupies as the voice of state medical boards.

- The FSMB's new data capabilities, which can open doors to assist federal agencies in addressing targeted issues such as opioid pill mills and fraud and abuse in health care.

- A growing level of interest and support in the new Interstate Compact for Medical Licensure, which offers a national infrastructure for sharing data about physician licensure and discipline while retaining state-based regulation.

- The willingness of international regulatory agencies to begin working more closely together and to coordinate activities in ways that benefit U.S. patient safety and medical competence.

**Key Trends among State Medical Boards**

The committee also identified environmental trends of particular importance in the state medical board community, including:

- State board budgetary pressures and staffing levels.

- A growing shift by state boards towards the use of remedial programs for physicians as an alternative to traditional forms of discipline.

- A more "policy-proactive" stance by state boards, which are increasingly attempting to identify emerging issues of importance to physicians and patients and to address these issues earlier, with innovative policy solutions.
- The increase of Continuing Medical Education (CME) offerings from state boards.
- Growth in the use of electronic communications and online processes for medical regulation.
- Increasing transparency by boards in their use of data, providing consumers more detailed information about the backgrounds of their licensees.
- The increase in collection of demographic data by state boards.

Several public policy issues were identified as having a high impact on state medical boards. These include:

- Opioid abuse
- Telemedicine/license portability
- Reporting issues/sharing and use of physician data

**FSMB Strategic Positioning Survey Findings**

Observations from the Committee's discussions closely tracked results from the FSMB's Strategic Positioning Survey, sent to staff and elected representatives of state medical boards earlier in 2014 in an effort to identify the short-term and long-term needs of the state medical regulatory community.

Key findings of the survey indicated that:

- Boards frequently use the FSMB as a source of information.
- Boards increasingly deal with and are challenged by a politically charged and legislatively complex environment.
- Boards consider emerging technologies (i.e., telemedicine) to be an important topic that will impact their future.
- Boards identify education and providing information as important services from the FSMB.

**Committee Recommendations**

In assessing the current FSMB Strategic Plan's focus, relevance and effectiveness in view of these factors, the committee agreed that in general, the overall structure and focus of the plan remains essentially on target, with a moderate degree of revision needed. The committee did not advise major shifts in strategy. New strategic directions and imperatives – adopted in response to a changing medical regulatory environment -- should be included as appropriate, along with changes in wording and adjustments to the tone and degree of emphasis placed on various elements.

To better align the plan with emerging trends and developments, and to more effectively position the FSMB for success between 2015 and 2020, the committee made these overarching recommendations:

- **Continue to articulate <u>general</u> goals, which in turn can guide the FSMB's more detailed yearly tactical action plan**. Retain the Strategic Plan's basic structure, focusing on a few carefully selected strategic goals and keeping the wording of these goals general enough to allow for flexibility in tactics as the environment changes from year to year.

- **Introduce several new key areas of strategic focus to reflect the changing health care environment**. These include a new emphasis on education, internationalism, research, and the development and use of data.

- **Place a stronger emphasis on several components of the current plan to indicate their new importance**. These include placing a stronger emphasis on partnerships and coalition building, and on providing resources and support for state medical boards.

- **Expand the language of the strategic goals for clarity, strengthening the use of active vs. passive voice and creating a more dynamic statement of the FSMB's strategic vision**.

- **Eliminate or modify the current graphic representation of the strategic goals**, which displays the goals in six linked grey circles, to create a more effective and reader-friendly presentation.

- **Remove "Values" as a formal component of the Strategic Plan and incorporate these instead as a tool to be used for internal purposes** – that is, to help guide FSMB staff and elected leadership as it carries on the work of the organization.

- **Create more distinction between the vision and mission statements**. The committee recommended making adjustments to the vision and mission statements, creating a stronger sense of envisioned future for the vision statement and slightly expanding the mission statement.

- **Strive for simplicity of language overall**. The committee discussed the importance of avoiding unneeded language and keeping the vision, mission and strategic goals as concise as possible to ensure they are clear and understandable by all audiences.

## RECOMMENDED STRATEGIC PLAN REVISIONS

### VISION Recommendations

The Committee recommends making slight adjustments to the Vision Statement in order to create more of a visionary tone and sense of path forward, emphasize leadership, and include references to patient safety and health care quality.

***Proposed Revised 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 Recommendations

The Committee recommends broadening the mission statement to more accurately reflect what the FSMB does; adding "voice of state medical boards," "education, assessment, research and advocacy," "services and initiatives," "regulatory best practices," and "patient safety." The Committee also recommends changing the term "excellence in medical practice" to "quality health care," as this is a more accurate representation of the scope of the FSMB's work.

***Proposed Revised 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.*

## VALUES Recommendations

The Committee recommends removing "Values" as a formal component of the Strategic Plan and incorporating it instead as a tool to be used for internal purposes – that is, to help guide FSMB staff and elected leadership as they carry on the work of the organization.

## STRATEGIC GOALS Recommendations

The Committee recommends retaining most of the current goals, but making adjustments of wording and emphasis, including simplifying headings, editing for consistency, and using active voice vs. passive voice. The Committee also recommends:

- Strengthening the language of the goals to indicate the FSMB's commitment to serving state medical boards
- Expanding the current "Information Resource" goal to include the terms "data and research"
- Strengthening references to patient safety and quality care
- Adding other new terms of emphasis into the language of the goals in keeping with overarching recommendations made earlier in this report

***Proposed Revised 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.*

## Addition of an "About the FSMB" section

The Committee recommends adding a preamble to the Strategic Plan, titled "About the FSMB," which will help clarify for public audiences the FSMB's structure and scope of its work.

***Proposed Preamble to the Strategic Plan***

*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.*

For comparison, the current 2010-2015 Strategic Plan and the proposed 2015-2020 Strategic Plan can be found under **Attachments A and B**, respectively.

## Attachment A: Current 2010-2015 Strategic Plan

### Vision

The Federation of State Medical Boards is the leader in medical regulation, serving as an innovative catalyst for effective policy and standards.

### Mission

The FSMB leads by promoting excellence in medical practice, licensure, and regulation as the national resource and voice on behalf of state medical boards in their protection of the public.

### Values

The FSMB, an organization of state medical boards, embraces these equally important values:

- Public Protection: Promotes public health, safety and welfare through its Member Boards.
- Leadership: Demonstrates innovation, cooperation and responsiveness.
- Integrity: Incorporates honesty, ethical behavior, reliability and transparency in all its operations and services.
- Excellence: Promotes and maintains high standards of performance and a commitment to continuous improvement, efficiency and effectiveness.
- Commitment to Service: Provides support and high quality service to its Member Boards.

### Strategic Goals:

- **Advocacy and Policy Leader:** Strive to enhance the role of state medical and osteopathic boards in an evolving health care environment.
- **Consistent Standards**: Effectively lead, assist and support state medical and osteopathic boards to develop and use standards, language, definitions and tools.
- **Information Resource**: Be recognized by the public and policymakers as a valued informational and educational resource for medical licensure and regulation.
- **Organizational Improvement**: Enhance our organizational vitality and nimbleness, broaden our financial resources, and provide a technology platform adequate for the evolving needs of FSMB.
- **Partnerships**: Engender greater participation and engagement among our member boards and more effective relationships with national and international organizations as a trusted and reliable partner.
- **Support for State Medical Boards**: Offer relevant policy, programs, education and services to state medical and osteopathic boards that result in improved quality and safety of patient care through effective and fair medical regulation and discipline.

## Attachment B: Proposed 2015-2020 Strategic Plan

### 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.

# REPORT OF THE BOARD OF DIRECTORS

**Subject:** **Report on Resolution 13-2; Higher Standards for Unrestricted Medical Licensure**

**Referred to:** **Reference Committee A**

---

In January 2013, the Michigan Board of Medicine approved and submitted a resolution to the Federation of State Medical Boards' (FSMB) House of Delegates calling for higher standards for licensure. The Michigan board's original resolution called for FSMB to evaluate the potential benefits and negative consequences of requiring successful completion of a program of graduate medical education accredited by the Accreditation Council for Graduate Medical Education (ACMGE) as a condition for an unrestricted medical license.

The Reference Committee hearing testimony on this resolution prior to the FSMB House of Delegates (HoD) meeting recommended a substitute resolution which was subsequently adopted by the HoD:

> *Resolved*, that the FSMB, in collaboration with other stakeholders, examine the benefits as well as the potential harms and unintended consequences that could occur as a result of requiring applicants for licensure to have completed 36 months of progressive medical training.

## Background: FSMB Policy Work

In examining the potential impact of the uniform adoption of 36 months of progressive graduate medical education (GME) as a condition for a full, unrestricted medical license, the FSMB board of directors weighed the considerable FSMB policy work that exists on the subject.

Dating back to its first policy document, the *Essentials of a Modern Medical Practice Act*, the FSMB considered GME a relevant consideration for setting the minimum standard for medical practice in all jurisdictions. The first edition of the *Essentials* document, in 1956, encouraged state medical boards to require a one-year internship in a post-graduate program recognized by the board as part of their requirements for initial licensure. This recommendation remained in place for more than thirty years before it was increased in the 6th edition of the *Essentials*, in 1991, to 24 months of "progressive" graduate medical training. The impetus for this increase stemmed, in part, from concerns about disparity in recommended requirements for US and international graduates.[1] Note: The 1985 edition of the *Essentials* recommended IMGs complete "*more* than 12 months and up to 36 months."(italics added)

The interest of state medical boards inGME was further explored and considered by the FSMB in the 1990s through a series of special committees and policy recommendations. In 1996, the FSMB adopted policy recommending that state medical boards develop mechanisms to bring resident physicians under the jurisdiction of the medical board. In 1998, the FSMB issued a policy

recommendation that all applicants for licensure should have satisfactorily completed a minimum of three years of GME in an ACGME- or AOA-approved program, including completion of PGY3 level training prior to full and unrestricted licensure.

**Current Environment Among State Medical Boards**

Like all FSMB policies, those related to GME serve only as recommendations for state medical boards to consider. As the FSMB possesses no directive authority over state medical boards, it is not uncommon for there to be variation, sometimes substantial, in the utilization and adoption of these policy recommendations.

In some instances, such as the adoption of the recommendation that state boards bring resident physicians under their jurisdiction through the issuance of resident or training licenses, there has been widespread adoption of the policy. As of 2008, 47 state medical and osteopathic boards issue some sort of permit or limited license for residents in accredited GME programs.

The policy recommendation for 36 months of progressive GME training, however, has gained relatively little traction among state medical boards. At this time only two states maintain such a requirement: Nevada (both medical and osteopathic boards) and South Dakota. (Note: the latter board requires completion of an ACGME- or AOA-accredited program for full licensure eligibility, which for specialties such as neurosurgery requires five years of training.) The overwhelming majority of state medical boards today require only 1-2 years of GME as a condition for a full, unrestricted license by US/Canadian medical graduates. However, 2-3 years of GME is the common requirement among most states for international medical graduates (IMGs). Thus, even though successful completion of a GME program has become a *de facto* requirement for a physician to be fully integrated into the U.S. health care system and most GME programs routinely require 3 or more years of training for completion and specialty certification, the standard for a full, unrestricted license in most jurisdictions and for most physicians remains well below three years of progressive training.

The results of an FSMB survey of state medical boards indicate that their GME requirement for licensure has not been a primary discussion point recently nor is it envisioned as such in the near future. Only 1/3 of medical boards identified ‘revisiting the length of their GME requirement’ as a subject they had discussed within the past two years. For those boards that have not discussed

this subject within the last two years, only two (2) identified this as a subject likely to be revisited within the next twelve months.[2]

**Current Environment in Graduate Medical Education (GME)**

The original FSMB policy recommendation for 36 months of progressive GME was intended to mirror the realities of program lengths in ACGME- and AOA-accredited GME programs and to assure best practices for patient safety. While a few residency program fields exist today that call for less than 3 years of training, the recommendation for 36 months of progressive training appears to remain aligned with the realities of GME program lengths today. A review of the length of training for ACGME- and AOA-accredited programs shows that only two ACGME programs (Medical Genetics; Preventive Medicine) and two AOA programs (Aerospace Medicine; Public Health & Preventive Medicine) require less than 36 months.

One major recent development unfolding in GME today is the gradual transition to a unified accreditation system. Previously, the ACGME and the AOA maintained separate systems for accrediting GME programs. In 2014, the ACGME, AOA and the American Association of Colleges of Osteopathic Medicine (AACOM) signed a memorandum of understanding to begin transitioning to a single system of accreditation for all GME programs in the United States. The goals behind this move are to foster greater accountability for patient outcomes, optimize GME resources and maximize opportunities for all medical students.[3] State medical boards and the FSMB should continue monitoring this transition to ensure applicable state statutes or board rules/regulations reflect this single accreditation system for GME.

One of the more important developments within the GME environment over the past fifteen years has been the adoption of a set of *core competencies* expected of all training physicians. Following the adoption in 1996 of a physician competency framework by the Royal College of Physicians and Surgeons of Canada, six core competencies for physicians were jointly identified by the American Board of Medical Specialties and the ACGME, arising from the latter's Outcomes Project in 1999.[4] These competencies are Medical Knowledge; Patient Care; Interpersonal and communication skills; Professionalism; Practice-based learning and improvement; and Systems-based practice. These competencies mirror similar work within the US osteopathic education community (i.e., AOA's seven competencies). This competencies schema has also gained support from a wide array of organizations as evidenced by its endorsement by the Coalition for Physician Accountability.[*]

[*] Association of American Medical Colleges (AAMC); American Board of Medical Specialties (ABMS), Accreditation Council for Continuing Medical Education (ACCME), Accreditation Council for Graduate Medical Education (ACGME), American Medical Association (AMA), American Osteopathic Association (AOA), Education Commission for Foreign Medical Graduates (ECFMG), Federation of State Medical Boards (FSMB), Liaison Committee on Medical Education (LCME), National Board of Medical Examiners (NBME), National Board of Osteopathic Medical Examiners (NBOME).

In alignment with this identification of core competencies, a major focus of activity within the GME community has been identifying "milestones" marking the stages of a physician's development in specific competencies and even more recently "entrustable professional activities"(EPAs) [5] that serve as descriptors of work toward meeting the milestones and demonstrating acquisition of knowledge/skills within each competency. These developments led ACGME to fundamental changes in its accrediting processes such that the overall system has now been renamed the Next Accreditation System (NAS). With all ACGME programs now participating, the NAS places an emphasis on "trainee assessment based on observable behaviors," i.e., the EPAs.[6]

There is a fundamental point that state medical boards should discern from these marked changes in GME. The competencies schema that is now accepted by the GME community carries an inherent assumption that *time* is no longer an acceptable surrogate for competency—that a linear, time-based curriculum and training model is not a good substitute for demonstrating proficiency in the medical knowledge and skills designated as appropriate for all physicians (i.e., core competencies) and those specific to one's training within a particular GME program. This fundamental shift away from time-based measures may eventually lead to GME training programs whose terminus is defined not by a traditional or arbitrary length of training but by successful demonstration of proficiency in identified areas through established markers, e.g., milestones, EPAs. While such a shift is speculative and may be years from implementation, the overall shift in this direction seems clear. The traditional delineations and distinctions of first-year residents, second-year residents, etc. may become anachronistic in the not-too-distant future as demonstrated proficiency replaces the time-based surrogate for competency. This is important to acknowledge as many state medical boards remain wedded at this time to GME requirements for licensure that are almost wholly time-based (e.g., completion of 1 year GME) and directed toward a specific point within a physician's GME training. Results from a recent FSMB survey of state medical boards show that only 11 of 33 responding boards agreed with the statement that GME requirement for unrestricted licensure should be based on competency rather than the a time-specific period for GME.

Not only is a competencies schema featuring milestones and EPAs bringing transformative change, it appears that such work signals an emerging era of innovation and re-envisioning within the GME community. One example comes from the field of Family Medicine and work specifically done by the American Board of Family Medicine and the Association of Family Medicine Residency Directors entitled *Preparing the Personal Physician for Practice* (P4). One of the themes emerging from this work was the desire to replace "national rigidity with local flexibility" as evidenced by a series of pilot programs involving more than a dozen programs examining "length of training"—specifically, experiments with the three-year Family Medicine program that establish a four year curriculum that begins in medical school.[7] Similar work is underway in other fields as evidenced by the Pediatrics Redesign Project, a pilot involving five

medical schools with students' exposure to Pediatrics in the second year of medical school and continuing into GME with differing rates of progression for each trainee. The intent is to meet one of the Carnegie Report's recommendations to standardize outcomes while retaining flexibility in how the individual student/physicians achieves them.[8]

In considering the implications of the current state requirements for a full, unrestricted medical license, it is difficult to overlook the long-term persistence of "moonlighting" as a common experience among many resident physicians. Because many states require only 1 year of GME, it remains possible for resident physicians to secure a full, unrestricted license and then supplement their income by working outside of their residency program (often in an Emergency Department or urgent care setting) while still engaged in their training program. This moonlighting activity may occur within their program's institution/hospital or it may occur in a setting wholly separate from the program. Despite the introduction of duty hour restrictions for residents in 2003 (i.e., a maximum average of 80 hours per week averaged over four weeks), this long-standing practice continues among a significant portion of physicians engaged in GME. A 1998 position paper by the Federation of State Medical Boards cited AMA surveys asserting that 23-37% of resident physicians moonlighted at some point during the GME experience. A more recent national survey published in the *Journal of Medical Regulation* cited the figure at 42% among nearly 3,000 respondents; and approximately one-third of the respondents indicated they secured their full license specifically so that they may be able to supplement their income by moonlighting. It should be noted, however, that the number of hours moonlighting by these resident physician residents was fairly limited, with 42% working four hours or less per week and another 30% moonlighting 5-8 hours weekly.[9] With the historic and continued persistence of moonlighting as a common experience shared among generations of physicians, it is likely that state and national organizations representing physician interests will give careful scrutiny to any proposed alterations in the minimum GME requirements for licensure in their respective jurisdictions.

If recent experience in Missouri is indicative, resident moonlighting directly impacts access to health care, particularly in underserved regions. In 2013, the Missouri Board of Healing Arts solicited input on a proposed change in their minimum GME requirement from one to three years. It bears noting that feedback from physician groups and the University of Missouri-Columbia School of Medicine was consistent in opposing raising the GME minimum to three years. In several instances, the feedback cited anecdotal evidence that moonlighting residents served a positive function extending health care to underserved areas; as well as national data that patient population in Health Professional Shortage Areas (HPSAs) might be placed at risk if residents' moonlighting were so curtailed that it impaired rural hospitals' ability to staff emergency departments.[10] It was also noted that most of the states bordering Missouri required only 1 year of GME for licensure; thus, some respondents to the board expressed concern that raising the minimum GME requirement in Missouri might make the state a less attractive option for prospective resident physicians. Internal data from the Missouri board would seem to indicate

that the state's licensure applicants are accustomed to the 1 year requirement as roughly half of all licensure applicants in 2011 were only one year removed from graduation.

On a similar note, the recent Institute of Medicine (IOM) report *Graduate Medical Education that Meets the Nation's Health Needs* touched upon the GME requirements of states for medical licensure. While the bulk of the IOM report centered upon the governance and funding aspects of GME, it did address the broader workforce context within which GME operates. The report identified GME capacity as a "limiting factor" in the nation's supply of physicians, based upon the requirement that all states mandate at least one year of GME for an unrestricted license.[11] While the report does not explicitly address the question of whether patients would be better served by a higher minimum GME requirement, one can draw inferences from the IOM report's discussion of how well prepared residents are under the current requirements. The report cites multiple studies that "new physicians often lack training and experience in care coordination, team-based care, costs of care, cultural competence and quality improvement."[12] This assessment of the preparedness of new physicians raises reasonable questions about the sufficiency of GME requirements that are well below completion of a GME program.

In addition, despite the IOM report's assertion that GME represents a potentially "limiting factor" in the pipeline supplying this nation's physicians, this does not appear to have been the case over the past several decades. For example, the Balanced Budget Act of 1997 placed a cap on Medicare- funded GME positions. Despite this cap and its accompanying restrictions, the number of first-year GME residency positions has increased steadily over the past decade.[13]

As many workforce analysts have noted, matriculates into U.S. allopathic and osteopathic medical education programs increased by nearly 30% from 2002 to the anticipated 2016-2017 matriculating classes. This figure exceeds the expansion in GME positions, which grew at a slower pace, e.g., 0.9% annually between 2001 and 2010.[14] However, the IOM report asserts that concerns that the number of U.S. medical graduates will "soon exceed" the number of available GME positions are not supported by the data. In the 2014 residency match there were 7,000 more first-year GME slots than U.S. applicants.[15] Additional demands on overall GME system capacity arise from the desire of many international medical graduates (IMGs) to train in the United States. Approximately 12,500 IMGs (including both U.S. citizen and foreign graduates) apply for entry into GME each year. Many are successful as evidenced by the National Residency Match Program's 2014 'match' which saw 3600 US-citizen IMGs and 2700 non-US-citizen IMGs secure GME position in the U.S.

Perceptions of the adequacy of the current GME system capacity have recently resulted in pushback by some national physician organizations. For example, in July 2014 the American Osteopathic Association's House of Delegates adopted a resolution calling for federal legislation that would allow U.S. medical school graduates to "lay first claim" to GME positions in the

United States.[16] That this resolution came from the New York State Osteopathic Medical Society is not surprising as New York has long been a preferred site for international schools based in the Caribbean to place their 3rd and 4th year students in clinical clerkships. This practice came under greater scrutiny after the announcement in 2008 of a 10 year, $100 million contract signed by St. Georges University (Grenada) with the New York City Health and Hospital Corporation, securing hundreds of clerkship positions for the school's students.[17]

Several recent commentaries have reflected on the extent to which medical education, including GME, is shaped by its past rather than an explicit vision of the present and future needs. A commentary piece in *Academic Medicine* observed that practices in medical education are shaped more often by "*tradition*, ritual, culture and history" than explicitly designed theoretical or conceptual frameworks. Similarly, the *New England Journal of Medicine* observed that "the current duration, settings and organization of GME are more than product of *tradition* than of evidence."[18] (Italics added) One might argue that the same characterization may also be true of the current GME requirements of state medical boards. These requirements are well below the recommended 3 years progressive GME but are also in danger of becoming obsolete as GME moves away from uniform chronology-based standards to integrate milestones and EPAs as markers assuring competence.

**Broader trends outside of GME**

In considering the broader trends within the U.S. health care environment, there are a number of factors that may be working against more widespread adoption of a 36 months progressive GME requirement for medical licensure.

One major consideration is undoubtedly the growing awareness and concern for workforce and demographic trends that might actually encourage movement in the opposite direction, i.e., shortening the length of undergraduate medical education programs and GME training. In considering the U.S. healthcare workforce, multiple factors are at work: the "aging" of the population as the baby boom generation moves into retirement; the expansion of healthcare delivery under the Affordable Care Act; delivery of healthcare to traditionally underserved and/or rural areas; shifts in scope of practice for allied health practitioners in response to increased demands for primary care services; etc.

In recent years, the Federation of State Medical Boards has attempted to provide a more complete demographic profile of the nation's actively licensed physicians. The latest physician census in 2012 identified more than 878,000 physicians with an active medical license. Approximately 45% of these licensees are below the age of 50; approximately 30% are female.[19] These attributes are important considerations as there is strong evidence that the priorities of younger physicians differ from those of older physicians. Specifically, younger physicians of

both gender increasingly place greater emphasis on a work-life balance that features working fewer hours than prior generations. Anecdotal evidence from medical educators and surveys of medical students and residents consistently reflect a generational shift in attitude. A 2011 survey of residents nearing the end of training is reflective of this shift as 48% identified the availability of free time as their single greatest concern, outranking all other issues (e.g., dealing with payers, educational debt, malpractice, income generation, etc.[20] This attitudinal shift carries implications for the physician workforce as one might reasonably infer that a generation of physicians has entered the workforce that has prioritized lifestyle and family over additional work hours—thus, limiting the potential for physicians collectively to address anticipated healthcare shortages, especially in primary care. [21]

Another of the factors limiting a broader adoption of the 36 month progressive GME recommendation is the continued reality of medically underserved areas. The persistence of this problem has led some legislators to adopt unique approaches to address medically underserved areas in their state. A recent example is from Missouri where, in mid-August 2014, a state law goes into effect establishing practice guidelines for "assistant physicians." These medical school graduates, who have completed only the first two components of USMLE or COMLEX and have not completed a GME program, will be allowed to provide primary care services through a "collaborative practice agreement" with a collaborating fully licensed Missouri physician. This legislation underscores the severity of the access to care problem experienced by many states and the extent to which legislators may prioritize increasing access over policy recommendations (e.g., 36 months progressive GME) that may be viewed as delaying physician entry into the workforce. From the perspective of the state medical board community, this represents the introduction of a new licensing category (Assistant Physician) that has not been previously seen in the United States. It is unclear whether this new category will remain an anomaly limited to the state of Missouri or gain traction in other states, or the extent to which it may address access to care issues without adversely impacting patient safety.

## Findings

In considering the information contained in this report, the FSMB board of directors finds:

1. Existing FSMB policy recommending state medical boards ~~to~~ bring residents under their purview through the issuance of resident/training licenses has been widely adopted by most boards.

2. There is an emerging trend within the graduate medical education community of focusing on competency-based training. However, as this evolution is in its early phases and very few boards have yet to move to three years progressive GME for all their licensure candidates,

the Board believes it premature to recommend completion of an ACGME- or AOA-accredited program as a minimum requirement for medical licensure.

**ITEM FOR ACTION:**

**For information.**

ENDNOTES

[1] Rassekh H. The Foreign Medical Graduate: A Personal Perspective. *Federation Bulletin* 1991;78(10): 303-304.

[2] Internal data derived from an August 2014 FSMB survey of state medical and osteopathic boards.

[3] "Allopathic and Osteopathic Medical Communities Commit to a Single Graduate Medical Education Accreditation System," Press release by ACGME, AOA and AACOM. February 26, 2014

[4] Swing SR. The ACGME Outcome Project: Retrospective and Prospective. *Medical Teacher* 2007; 29:648-654.

[5] Cate OT. Nuts and Bolts of Entrustable Professional Activities. *Journal of Graduate Medical Education* March 2013; 157-158.

[6] Carter WA. Milestone Myths and Misperceptions. *Journal of Graduate Medical Education* 2014; 6(1s): 18-20.

[7] Green LA, Jones SM, Fetter G, Pugno PA. Preparing the Personal Physician for Practice: Changing Family Medicine Residency Training to Enable New Model Practice. *Academic Medicine* 2007; 82(12): 1220-27.

[8] Powell DE, Carraccio C, Aschenbrenner CA. Pediatrics Redesign Project: A Pilot Implementing Competency-based Education Across the Continuum *Acad Med* 2011; 86: 13.

[9] Raymond MR, Mee J, Haist SA, et. al. Expectations for Physician Licensure: A National Survey of Practice. *Journal of Medical Regulation* 2014; 100(1):15-23.

[10] Bennett KJ, Baxley E, Probst JC. The impact of resident physician coverage on emergency department visits in South Carolina. *Southern Medical Journal* . December 2003; 96(12):1195-1202.

[11] Eden J, Berwick D, Wilensky G. *Graduate Medical Education that Meets the Nation's Health Needs*. National Institutes of Medicine (Washington DC: National Academies Press, 2014), 2-2

[12] Ibid., 2-11.

[13] Ibid.

[14] Iglehart JK. The Residency Mismatch. *New England Journal of Medicine* 2013; 369:297-299.

[15] *Graduate Medical Education Nation's Health Needs*, 2-3

[16] Raymond R. House Supports Offering Residency Positions to US Medical School Graduates First. *The DO*. Accessed at http://thedo.osteopathic.org on August 5, 2014.

[17] Hartocollis Anemona. "New York Hospitals Create Outcry in Foreign Deal," *New York Times* August 5, 2008

[18] Hodges BD. A *Tea-Steeping* or *i-Doc* Model for Medical Educaiton? *Acad Med* 2010;85: S534-544; Asch DA, Weinstein DF. Innovation in Medical Education. *NEJM* 2014;371(9): 794-795.

[19] Young A, Chaudhry HJ, Thomas JV, Dugan M. A Census of Actively Licensed Physicians in the United States, 2012. *Journal of Medical Regulation* 2012;99(2): 11-24.

[20] Elliott VS. Residents' desire for hospital employment poses recruiting challenge for practices. *AmedNews* October 24, 2011. Accessed at http://www.amednews.com/article/20111024/business/310249968/1/ on July 21, 2014; Glicksman E, Wanting it All: A New Generation of Doctors Places Higher Value on Work-Life Balance. *AAMC Reporter* May 2013. Accessed at https://www.aamc.org/newsroom/reporter/336402/work-life.html on July 21, 2014.

[21] Schumann JH. The Doctor Is Out: Young Talent Is Turning Away From Primary Care. *The Atlantic* March 14, 2012. Accessed on July 21, 2014 at http://www.theatlantic.com/health/archive/2012/03/the-doctor-is-out-young-talent-is-turning-away-from-primary-care/254221/

**Appendix I**

| Specialty | Length (ACGME) | Length (AOA) |
|---|---|---|
| | | |
| Aerospace medicine | NA | 2 years |
| Anesthesiology | 4 years | 4 years |
| Dermatology | 3 years | 3 years |
| Diagnostic Radiology | 4 years | 4 years |
| Emergency medicine | 3 years | 4 years |
| Family medicine | 3 years | 3 years |
| Internal medicine | 3 years | 3 years |
| Medical genetics | 2 years | |
| Neurological surgery | | |
| Neurology | 3 years | 4 years |
| Nuclear medicine | 3 years | |
| Neurological surgery | 7 years | |
| Neuromusculoskeletal medicine* | NA | 3 years |
| OB/GYN | 4 years | 4 years |
| Occupational & Environmental medicine* | NA | 3 years |
| Ophthalmology | 3 years | 3 years |
| | | |
| Orthopedic surgery | 5 years | 5 years |
| Otolaryngology | 5 years | 5 years |
| Pathology | 4 years | 4 years |
| Pediatrics | 3 years | 3 years |
| Physical medicine & rehabilitation | 3 years | 3 years |
| Plastic surgery | 3 years | 5 years |
| Preventive medicine | 2 years | |
| Proctology | NA | 3 years |
| Psychiatry | 4 years | 4 years |
| Public Health & preventive medicine | NA | 2 years |
| Radiology | 4 years | 4 years |
| General surgery | 5 years | 5 years |
| Thoracic surgery | 6 years | NA |
| Urology | 4 years | NA |

Note: Programs shown above with an asterisk (*) require a preliminary year and/or internship year which has been included as part of the total length of the program.

**Appendix II**

Below is an excerpt of selected questions (with responses) from an August 2014 survey of state medical boards by the FSMB.

Question 7
Has your board revisited the length of its GME requirement within the past 2 years?

Yes--11
No --22
Unsure—1

Question 8
If not, do you plan to revisit the length of GME requirement within the next 12 months?

Yes--2
No--13
Unsure—7

Question 15
Should the issuance of a full, unrestricted license should be based upon competency, not the number of years spent in GME?

| | |
|---|---|
| Strongly agree | 2 |
| Agree | 9 |
| Neutral | 12 |
| Disagree | 6 |
| Strongly disagree | 4 |

# REPORT OF THE BOARD OF DIRECTORS

**Subject:** **Report on Resolution 13-3; Shortening Undergraduate Medical Education**

**Referred to:** **Reference Committee A**

---

In February 2013, the Federation of State Medical Boards Board of Directors approved and submitted a resolution to the Federation of State Medical Boards' (FSMB) House of Delegates (HoD) calling for the FSMB to study the value of shortening the duration of undergraduate medical education (UME) from four years to three years and its impact on a number of relevant factors in collaboration with entities that are already involved in medical school curricular innovations.

The Reference Committee hearing testimony on this resolution prior to the FSMB HoD meeting recommended a substitute resolution which was subsequently adopted by the HoD:

> *Resolved,* that the FSMB work in collaboration with the AAMC, AACOM, AMA and the AOA to study the value of shortening the duration of undergraduate medical education from four years to three years and its impact collectively on access to care, patient outcomes, patient safety and medical student indebtedness.

The remainder of this report outlines the innovations currently underway and under consideration as related to UME. It is well established that the landscape of health care in the United States is rapidly changing and physician education and training may need to adapt to new circumstances. As a result, medical school curricula are beginning to be remodeled to support a competency-based assessment over time duration models in order to enable some or all of their medical students to progress at their own rates of achievement of knowledge, skills and attitudes.

State medical and osteopathic board statutes, rules and regulations generally are not drafted with education duration requirements. Nearly all state medical boards instead require "completion" or "graduation" from an accredited program, with no reference to the duration of the program. According to a survey conducted by the FSMB, UME requirements for state medical licensure have not been a primary discussion point recently among state medical boards, nor are there plans for such discussions in the near future. However, the survey results also reveal that state medical boards are not opposed to innovations in UME.

Considering the broader trends already occurring within the U.S. medical education environment, coupled with the access to care concerns stemming from implementation of the Affordable Care Act, it appears likely that shifting from time- to competency-based curricula

may shorten the duration of UME within allopathic and osteopathic medical schools. It is expected that this will positively impact physician shortage concerns, reduce the costs of educating physicians, and partially alleviate the medical student debt burden, without any negative impact on patient outcomes or patient safety.

This report is for information only and does not offer specific recommendations.

## Current Landscape of Undergraduate Medical Education (UME)

A traditional medical education in the United States, whether beginning in an allopathic or osteopathic medical school, usually entails a journey spanning up to 18 years after high school that requires a four-year undergraduate degree, four years of medical school, and three to six years of residency training plus one or more years or subspecialty fellowship training, depending on the specialty. The *Flexner Report* of 1910 is credited with helping promote the four-year medical school model that is in place today whereby medical students spend two years studying and training the preclinical sciences (e.g., anatomy, pharmacology, physiology) in classrooms, by and large, and then spend two years in various clinical training clerkships (e.g., medicine, surgery, pediatrics) in a hospital or other health care setting.[1]

With unprecedented changes in health care access and delivery occurring in recent years, how physicians are educated and trained may need to adapt to new circumstances. Some analysts have suggested that the average duration of medical training may be safely reduced without a negative impact on educational outcomes, such as by eliminating half a year each of preclinical and clinical training,[2] consistent with a growing movement in UME curricula toward competency-based education and milestones. Undergraduate medical education programs that are competency-based typically emphasize individualized instruction focused on skills development and progression of learning by an individual, promoting greater learner-centeredness, thereby allowing greater flexibility in the time required for training.

In fact, some medical schools have already adjusted their curricula to support a competency-based assessment model, away from strict time duration models, enabling some or all of their medical students to progress at their own rates of achievement of knowledge and skills. For example, since 1997, the University of Pennsylvania's School of Medicine has required only a year and a half of preclinical science training while Harvard Medical School requires students to complete only 15 months of clinical rotations.[3] Duke University School of Medicine has reconfigured UME to allow students to spend the first two years focusing on basic sciences and core clerkships and the second two years on clinical and bench research activities and in electives.[4] Additionally, a number of allopathic medical schools in the United States have offered selected students the option of obtaining a medical degree in three years: Texas Tech University Health Sciences Center School of Medicine, Mercer University School of Medicine (Georgia), and the New York University School of Medicine.[5] Similarly, two Canadian medical schools-

McMaster University's Michael G. DeGroote School of Medicine (Ontario) and the University of Calgary's Faculty of Medicine- offer a three year UME program, as well.[6]

a. Association of American Medical Colleges

The Association of American Medical Colleges (AAMC) has studied innovations in UME, with a particular emphasis on competencies. In June 2014, AAMC released a new set of guidelines to "help bridge the gap between patient care activities that new physicians should be able to perform on day one of residency training, and those they feel ready to perform without direct supervision."[7] With the goal of improving patient care and safety, the guidelines offer a formal outline of the activities and requisite competencies and behaviors that every graduating medical student should be able to perform upon entering residency.

AAMC's new guidelines, Core Entrustable Professional Activities (EPAs) for Entering Residency, were created in response to feedback from residency training program directors about the clinical preparedness of entering residents, and from emerging literature documenting a performance gap that often exists at the transition point between medical school and residency training. The EPAs include 13 activities that all medical students should be able to perform, regardless of specialty, to help standardize the expectations for both learners and teachers and better prepare medical students for their future roles as clinicians. The core EPAs—which include activities such as gathering a patient history, prioritizing differential diagnoses, and recommending tests—were chosen as the framework for the guide because they offer a promising approach for assessing the real-world impact of a resident physician's education on patient care. The guidelines describe expected behaviors and provide clinical vignettes demonstrating how new residents ready to be entrusted for performance without direct supervision would handle each of the specific EPAs. This summer, the AAMC will engage several allopathic medical schools to launch a multi-year pilot and develop a learning community to share ideas about how the EPAs can be broadly implemented.[i]

The American Osteopathic Association (AOA) and the American Association of Colleges of Osteopathic Medicine (AACOM) are also in the process of studying innovation within UME for osteopathic medical students. In 2011, the two organizations established an independent commission, the Blue Ribbon Commission for the Advancement of Osteopathic Medicine (BRC), to identify unique opportunities for the osteopathic profession to offer leadership in medical education to help improve the health of the U.S. population in the 21st century. Their

[i] It should also be noted that entrustable professional activities (EPAs) are gaining traction across the globe as a practical way to teach and assess competencies in the clinical setting. Full-scale implementation, though, has only taken place in obstetrics-gynecology in the Netherlands and in psychiatry in Australia and New Zealand. Academic Medicine, "From Theory to Practice: Making Entrustable Professional Activities Come to Life in the Context of Milestones".: Englander, Robert MD, MPH; Carraccio, Carol MD, Med (head-of-print online: http://journals.lww.com/academicmedicine/Abstract/publishahead/From_Theory_to_Practice__Making_Entrustable.99063.aspx).

recommendations included a shift in the focus of osteopathic medical school education from duration in time to competencies. In November 2013, the BRC released its final report, which was referenced in *Health Affairs*[8] and introduced a new model of osteopathic education built on a competency-based curriculum that was centered on the biomedical, behavioral, and clinical science foundations of osteopathic primary care medical practice.[9]

The BRC's model educational pathway ensures that the competency of the graduate is paramount, whether it takes five years or eight years to complete the program. The BRC's model establishes a continuous, longitudinal educational experience from medical school through residency,[ii] with a competency-based curriculum centered on the biomedical, behavioral, and clinical science foundations of osteopathic primary care medical practice and patient-centered care. Outcomes specific to medical education would be established to assess graduates' readiness for professional practice at multiple points in the physician education continuum. The colleges of osteopathic medicine and their residency training partners will jointly administer these programs, and the BRC opines that this innovative system should enhance the efficiency of the educational experience, eliminate redundancies, and reduce the time to completion and ultimately costs for many students.[10]

b. American Medical Association

The American Medical Association (AMA) is formally studying many of the innovations underway in UME. In 2013, the AMA launched its "Accelerating Change in Medical Education" initiative, an $11 million competitive grant endeavor designed to jumpstart the promotion of innovation within medical school education.[11] The AMA initiative's stated aims are to develop and study new methods for measuring and assessing key competencies for physicians at all training levels to create more flexible, individualized learning plans and to promote exemplary methods to achieve patient safety, performance improvement and patient-centered team care.[12] The AMA's initiative is, in fact, a five-year grant program that has already provided funds to 11 participating medical schools: Indiana University School of Medicine, Mayo Medical School (Minnesota), New York University School of Medicine, Oregon Health & Science University School of Medicine, Pennsylvania State University College of Medicine, The Brody School of Medicine at East Carolina University (North Carolina), The Warren Alpert Medical School of Brown University (Rhode Island), University of California Davis School of Medicine; University of California San Francisco School of Medicine, University of Michigan Medical School, and Vanderbilt University School of Medicine (Tennessee).[13]

These eleven participating schools will work to assess competency throughout a physician's learning continuum, from medical school to practice. A few schools participating in the initiative are specifically investigating three-year programs that use competency-based education to assess

[ii] Clinical experiences would begin in students' first year of medical education and would continue with increasing levels of responsibility throughout the duration of their training.

student progress and readiness for residency. For example, New York University School of Medicine offers a three-year pathway by providing an accelerated track for eligible students by utilizing an electronic patient portfolio and a panel of virtual patients in addition to core clinical work with actual patients to teach and track skills within specific competency domains.[14] Similarly, Vanderbilt University School of Medicine offers "Curriculum 2.0" to better prepare students to function as doctors. The program is based on competency assessments and built on the idea that an inflexible, classroom- and clerkship-based curriculum should be replaced by one that focuses instead on lifelong learning.[15]

The AMA continues to monitor and engage with each of the grant recipients. Last fall (October 2013), the AMA gathered nearly 200 medical education professionals, including the consortium of 11 participating medical schools, in Chicago for the first AMA Accelerating Change in Medical Education Conference. The grant recipients met again in April 2014 to further define and advance shared goals, and it will continue to convene regularly and work with the AMA to develop prototypes and disseminate innovative programs and ideas among the grant recipient schools and beyond.[16]

**State Medical Board Perspective**

State medical and osteopathic board statutes, rules and regulations generally do not specify that an applicant for full and unrestricted medical licensure complete four years of undergraduate medical education. Nearly all state medical boards instead require "completion" or "graduation" from an accredited program, with no reference to the duration of the program. Only a small minority of state medical boards make reference to the number of weeks and/or hours of undergraduate medical education that is required, typically in relation to the licensure of international medical graduates (IMGs). For instance, the Florida Board of Medicine specifies that in order to determine the extent of reasonable comparability of programs of medical education in schools other than those accredited by the Liaison Committee on Medical Education (LCME), "[t]he program of medical education leading to the M.D. degree or its equivalent must include at least 130 weeks of instruction, in basic and clinical medical sciences, preferably scheduled over at least four calendar years."[17]

The results of a recent FSMB survey of state medical boards, completed to support the analysis contained in this report, by and large indicate that UME requirements for state medical licensure have not been a primary discussion point recently among state medical boards, nor are there plans for such discussions in the near future. Less than a quarter of state medical boards identified "revisiting the length of their UME requirement" as a subject they had discussed internally within the past two years, with even fewer planning to discuss the subject in the next year. However, the survey results also reveal that state medical boards are not opposed to innovations in UME. When asked whether full, unrestricted medical licensure should be based on competencies and not the number of years spent in undergraduate medical education, fifty-

two percent (52%) of the 42 responding medical boards responded favorably, either agreeing or strongly agreeing with the statement.[18]

Moreover, some medical boards have endorsed competency-based UME outright. For example, the Medical Board of California has supported legislation to allow students enrolled in accredited medical school programs in California, such as the UC-Davis School of Medicine's pilot program, to become physicians in less than four years.[19] The new law will go into effect in January 2015 and is intended in part to ensure physicians have less student debt and to help address the state's access to care and physician shortage concerns.[20]

## Discussion

Considering the broader trends already occurring within the U.S. medical education environment, coupled with the access to care concerns stemming from implementation of the Affordable Care Act, it appears likely that shortening the duration of UME within allopathic and osteopathic medical schools will positively impact physician shortage concerns and medical school indebtedness without any negative impact on patient outcomes or patient safety.

It is well established that the changing landscape of health care in the United States has resulted in a shortage of physicians, especially in primary care. The World Health Organization projects fifteen percent (15%) more doctors will be needed worldwide,[21] while the American Association of Medical Colleges estimates the current deficit in the United States alone at almost 60,000 and forecasts for a shortfall of 130,600 doctors by 2025.[22] Allowing more physicians to practice in less time, particularly those who have demonstrated competency-based achievement in knowledge and skills, may ease workforce shortages by increasing the supply of physicians.

Shortening the duration of medical school may also reduce the costs of educating a physician and the medical student debt burden. According to the AAMC, in 2013, the mean medical school debt for indebted graduates was $169,901, with 79% of medical students carrying a debt of $100,000 or more.[23] It has been argued that the traditional undergraduate medical education system has inefficiencies and that the years of training that have been added over the last century in the education and training of U.S. physicians are not necessarily supported by overwhelming evidence that they enhance clinical skills or the quality of care.[24] This potential waste can add to the financial burden of young physicians and increase health care costs.[25] Reducing UME duration not only reduces debt by decreasing the number of years that tuition is paid, it may also result in an additional year of earnings by enabling physicians to enter the healthcare workforce earlier. Moreover, student debt burdens may serve as a financial barrier; potentially introducing a class bias into the physician population and reducing the diversity of the physician workforce by driving physicians to more specialized areas of medicine.[26]

Shifting from time- to competency-based curricula is not without its challenges, however. Assessing student competencies requires valid and reliable assessment tools, and educators must

consistently interpret their observations and evaluations of learners, requiring an increased investment in time and faculty development. Competencies can also be necessarily complex, requiring an assessment of learners throughout the physician continuum.[27]

Given the evolving role of the physician within health care teams and the growing complexity of medicine, some analysts argue that it may be counterproductive to shorten UME curricula. Physicians may in fact need more advanced education, particularly in nontraditional areas like health policy, systems-based practice and population health, in order to lead collaborative health teams and to best work in an evolving industry. Additionally, competency-based education does not necessarily guarantee shortened medical education and more time may be needed to achieve competence for all the skills required of an effective primary care physician. While there may be exceptional students capable of accelerated learning and small programs that create unusual opportunities for such students, it may be more typical for students seeking a medical degree to take four full years (or more) to do so.[28]

There are also examples of past attempts to shorten training by combining baccalaureate and medical education (B.A.–M.D.), into a six or seven-year program, an approach that has not become prevalent in UME in the United States.[29] In the last quarter of the twentieth century the number of schools reducing the duration of the medical school component has declined dramatically with 33 medical schools offering a three-year pathway in 1974 and only a handful offering this option today.[30] Analysts attribute the pressures experienced by both students and faculty to be a contributing factor in the failure of these compressed programs to flourish. Students who were able to complete the program in the abbreviated time were said to feel "exhausted"[31] and there was substantial faculty dissatisfaction with the adequacy of the curriculum.[32]

It may also be argued that shortening the duration of UME may have unintended consequences and compromise clinical education. For example, it is sometimes suggested that UME programs be shortened by simply eliminating the fourth year across the board, regardless of competencies achieved. The fourth year is generally valued by medical students, however, as it presents opportunities to participate in inpatient electives that offer them not only broad experience but also exposure to fields that they are considering for a career and to hospitals where they are considering pursuing their residency.[33] The wholesale elimination of the fourth year would require these activities to occur during the third year, taking time away from necessary clinical clerkships, or would have to be abandoned altogether- which may ultimately negatively impact decisions regarding postgraduate medical training or the matching of a suitable medical student to an appropriate specialty career choice.[34]

**Observations**

1. As access to health care and health care delivery models are evolving, so too is undergraduate medical education. Medical schools are already innovating their curricula

to support a competency-based assessment model, changing how physicians are educated and trained to progress at their own rates of achievement of knowledge and skills.

2. State medical and osteopathic boards are considering these new approaches to competency-based undergraduate medical education.
3. State medical and osteopathic boards are poised to accept competency-based assessment models and many will not have to amend their respective statutes, rules and regulations to accommodate such innovations.

This report is for information only by the House of Delegates. This report has been reviewed by FSMB staff and the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), American Medical Association (AMA) and the American Osteopathic Association (AOA).

**ITEM FOR ACTION:**

**For information.**

ENDNOTES

[1] Irby DM, Cooke M, O'Brien BC. Calls for reform of medical education by the Carnegie Foundation for the Advancement of Teaching: 1910 and 2010. Ac Med 2010;85:220-7.

[2] Shortening Medical Training by 30%, Ezekiel J. Emanuel, MD, PhD; Victor R. Fuchs, PhD, JAMA. 2012;307(11):1143-1144. doi:10.1001/jama.2012.292.

[3] Shortening Medical Training by 30%, Ezekiel J. Emanuel, MD, PhD; Victor R. Fuchs, PhD, JAMA. 2012;307(11):1143-1144. doi:10.1001/jama.2012.292.

[4] Shortening Medical Training by 30%, Ezekiel J. Emanuel, MD, PhD; Victor R. Fuchs, PhD, JAMA. 2012;307(11):1143-1144. doi:10.1001/jama.2012.292.

[5] A 3-Year M.D. — Accelerating Careers, Diminishing Debt
Steven B. Abramson, M.D., Dianna Jacob, R.P.A., M.B.A., Melvin Rosenfeld, Ph.D., Lynn Buckvar-Keltz, M.D., Victoria Harnik, Ph.D., Fritz Francois, M.D., Rafael Rivera, M.D., Mary Ann Hopkins, M.D., Marc Triola, M.D., and Robert I. Grossman, M.D, n engl j med 369;12 nejm.org september 19, 2013, pg/ 1085-87.

[6] A 3-Year M.D. — Accelerating Careers, Diminishing Debt
Steven B. Abramson, M.D., Dianna Jacob, R.P.A., M.B.A., Melvin Rosenfeld, Ph.D., Lynn Buckvar-Keltz, M.D., Victoria Harnik, Ph.D., Fritz Francois, M.D., Rafael Rivera, M.D., Mary Ann Hopkins, M.D., Marc Triola, M.D., and Robert I. Grossman, M.D, n engl j med 369;12 nejm.org september 19, 2013, pg/ 1085-87.

[7] https://www.aamc.org/newsroom/newsreleases/381260/06102014.html

[8] "A New Pathway For Medical Education," Stephen C. Shannon, Boyd R. Buser, Marc B. Hahn, John B. Crosby, Tyler Cymet, Joshua S. Mintz, and Karen J. Nichols, *Health Aff* (November 2013) 32:111899-1905; doi:10.1377/hlthaff.2013.0533.

[9] http://blueribboncommission.org/building-the-future-full-report/summary/

[10] http://blueribboncommission.org/building-the-future-full-report/summary/

[11] American Medical Association Council on Medical Education Report

[12] American Medical Association Council on Medical Education Report 3 file://svr-netdrives/sahronovich$/FSMB%20Shiri/13-3/AMA%20Competency%20Based%20Medical%20Education%20defined.pdf

[13] http://www.ama-assn.org/ama/pub/about-ama/strategic-focus/accelerating-change-in-medical-education.page

[14] http://school.med.nyu.edu/student-resources/medical-education/md-curriculum/three-year-md-degree; http://www.ama-assn.org/ama/pub/about-ama/strategic-focus/accelerating-change-in-medical-education.page.

[15] https://medschool.vanderbilt.edu/ume/curriculum-20

[16] http://www.ama-assn.org/ama/pub/about-ama/strategic-focus/accelerating-change-in-medical-education.page

[17] Fla. Admin. Code Ann. r. 64B8-15.007; *See Also* N.Y. Comp. Codes R. & Regs. tit. 8, § 60.10.

[18] Internal data derived from an August 2014 FSMB survey of state medical and osteopathic boards.

[19] *Sacramento Business Journal* reports (Robertson, *Sacramento Business Journal*, 7/18)

[20] http://www.californiahealthline.org/articles/2014/7/21/brown-signs-accelerated-degree-bill-to-address-doctor-shortage

[21] World Health Organization. Working Together for Health: World Health Report 2006. Geneva, Switzerland; 2006

[22] https://www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf

[23] https://www.aamc.org/download/152968/data/debtfactcard.pdf

[24] Shortening Medical Training by 30%, Ezekiel J. Emanuel, MD, PhD; Victor R. Fuchs, PhD, JAMA. 2012;307(11):1143-1144. doi:10.1001/jama.2012.292.

[25] Shortening Medical Training by 30%, Ezekiel J. Emanuel, MD, PhD; Victor R. Fuchs, PhD, JAMA. 2012;307(11):1143-1144. doi:10.1001/jama.2012.292.

[26] Greysen SR, Chen C, Mullan F. A history of medical student debt: observations and implications for the future of medical education. Acad Med 2011; 86:840-5.

[27] The 3-Year Medical School — Change or Shortchange?, Stanley Goldfarb, M.D., and Gail Morrison, M.D.,N Engl J Med 2013; 369:1087-1089September 19, 2013DOI: 10.1056/NEJMp1306457.

[28] The 3-Year Medical School — Change or Shortchange?, Stanley Goldfarb, M.D., and Gail Morrison, M.D.,N Engl J Med 2013; 369:1087-1089September 19, 2013DOI: 10.1056/NEJMp1306457.

[29] The proportion of schools that compressed their curriculum into 6 years dropped from 23% in 1990 to 7% in 2011, and the proportion requiring 7 years fell from 32% to 13%. Lyss-Lerman P, Teherani A, Aagaard E, Loeser H, Cooke M, Harper GM. What training is needed in the fourth year of medical school? Views of residency program directors. Acad Med 2009;84:823-9.

[30] The 3-Year Medical School — Change or Shortchange?, Stanley Goldfarb, M.D., and Gail Morrison, M.D.,N Engl J Med 2013; 369:1087-1089September 19, 2013DOI: 10.1056/NEJMp1306457.

[31] Kettel LJ, Dinham SM, Drach GW, Barbee RA. Arizona's three-year medical curriculum: a postmortem. J Med Educ 1979;54:210-6.

[32] The 3-Year Medical School — Change or Shortchange?, Stanley Goldfarb, M.D., and Gail Morrison, M.D.,N Engl J Med 2013; 369:1087-1089September 19, 2013DOI: 10.1056/NEJMp1306457.

[33] Kettel LJ, Dinham SM, Drach GW, Barbee RA. Arizona's three-year medical curriculum: a postmortem. J Med Educ 1979;54:210-6.

[34] The 3-Year Medical School — Change or Shortchange?, Stanley Goldfarb, M.D., and Gail Morrison, M.D.,N Engl J Med 2013; 369:1087-1089September 19, 2013DOI: 10.1056/NEJMp1306457.

**Appendix I:**

Below is the survey conducted by the FSMB in August 2014 in preparation of this report:

Welcome to the survey on undergraduate and graduate medical education requirements for licensure. Please click the arrow to begin the survey.

1. Please select your state medical board from the list below. [LIST]

2. What is your current position at the state medical board?
    a. Executive director
    b. Board member
    c. Other (specify)

3. How many years of undergraduate medical education must physicians attending a LCME accredited or AOA-accredited school complete to be granted a full, unrestricted license by your board?
    a. 3
    b. 4
    c. More than 4
    d. Other (specify)

4. During the past two years, has your board revisited the length of undergraduate medical education required for a physician to obtain a full unrestricted license?
    a. Yes
    b. No
    c. Unsure

5. [If "no" or "unsure" on Q4] Does your board plan to revisit this topic in the next 12 months?
    a. Yes
    b. No
    c. Unsure

6. All applicants for full, unrestricted licensure should be required to complete 4 full years of undergraduate medical education?
    [Strongly agree – Strongly disagree]

7. Please indicate your level of agreement with the following statements about decreasing the required length of undergraduate medical education from 4 years to 3 years.
    [Strongly agree – Strongly disagree]

a. It would threaten patient safety.
b. It would help alleviate physician shortages in underserved areas.

8. Full, unrestricted licensure should be based on competency, not the number of years spent in undergraduate medical education.
   [Strongly agree – Strongly disagree]

9. Use the space below to share any additional comments about the potential benefits or harms of decreasing the required length of undergraduate medical education from 4 years to 3 years for physicians attending a LCME accredited or AOA-accredited school.

The remaining questions are about graduate medical education (GME) and licensure. Please click the right arrow to continue.

10. How many years of GME must a U.S. medical school graduate complete to be granted a full, unrestricted license by your board?
    a. 1
    b. 2
    c. 3
    d. 4 or more
    e. Other (specify)

11. [If 2 or more on Q10] Are the years of GME required to be progressive (i.e. consecutive, uninterrupted and advancing)?
    a. Yes
    b. No
    c. Unsure

12. How many years of GME must an international medical school graduate complete to be granted a full, unrestricted license by your board?
    a. 1
    b. 2
    c. 3
    d. 4 or more
    e. Other (specify)

13. [If 2 or more on Q12] Are the years of GME required to be progressive (i.e. consecutive, uninterrupted and advancing)?
    a. Yes
    b. No
    c. Unsure

14. During the past two years, has your board revisited the length of GME required for a physician to obtain a full unrestricted license?
    a. Yes
    b. No
    c. Unsure

15. [If "no" or "unsure" on Q14] Does your board plan to revisit this topic in the next 12 months?
    a. Yes
    b. No
    c. Unsure

16. Please indicate your level of agreement with the following statements:
    [Strongly agree – Strongly disagree]

    Requiring U.S. medical school graduates to complete 3 years of graduate medical education…

    a. Should be required to obtain a full unrestricted license
    b. Would improve patient safety
    c. Would exacerbate physician shortages in underserved areas

17. Please indicate your level of agreement with the following statements:
    [Strongly agree – Strongly disagree]

    Requiring international medical school graduates to complete 3 years of graduate medical education…

    a. Should be required to obtain a full unrestricted license
    b. Would improve patient safety
    c. Would exacerbate physician shortages in underserved areas

18. Full, unrestricted licensure should be based on competency, not the number of years spent in GME.
    [Strongly agree – Strongly disagree]

19. Use the space below to share any additional comments about the potential benefits or harms of requiring physicians to complete 3 years of GME to obtain a full unrestricted license.

**Appendix II**

Below is an excerpt of selected questions (with responses) from an August 2014 survey of state medical boards by the FSMB.

Question: Has your board revisited the length of its UME requirement within the past 2 years?

| | |
|---|---|
| Yes: | 4 |
| No: | 37 |
| Unsure: | 1 |

Question: Do you plan to revisit the length of UME requirement within the next 12 months?

| | |
|---|---|
| Yes: | 1 |
| No: | 30 |
| Unsure: | 7 |

Question: Should the issuance of a full, unrestricted license should be based upon competency, not the number of years spent in UME?

| | |
|---|---|
| Strongly agree: | 5 |
| Agree: | 17 |
| Neutral: | 12 |
| Disagree: | 7 |
| Strongly disagree: | 1 |

**Resolution 15-3**

**Federation of State Medical Boards**
**House of Delegates Meeting**
**April 25, 2015**

Subject: Developing Model Language in Board Actions and Coordinating with ABMS on the Effects of Board Actions on Specialty Board Certification

Introduced by: Washington State Medical Quality Assurance Commission

Approved: January 2015

---

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

***Whereas,*** State medical boards are in the best position to determine the appropriate action necessary to protect the public under the facts of each case; and

***Whereas,*** State medical boards are in the best position to determine if a physician can practice with reasonable skill and safety while under the monitoring of a state medical board; and

***Whereas,*** State medical board action can result in the loss of specialty board certification, significantly impacting a physician's ability to practice and reducing access to care; and

***Whereas,*** State medical boards do not have a good understanding of what types of board actions or language will result in the loss of specialty board certification, creating uncertainty in imposing discipline and affecting decision-making; and

***Whereas,*** There are two reasons for the uncertainty:
(1) Specialty boards do not have consistent standards to determine whether state medical board action should result in a loss of board certification, and (2) state medical boards do not use consistent language in its board actions; and

***Whereas,*** The American Board of Medical Specialties (ABMS) is currently working on a consistency project to develop standard terminology in all aspects of its business, one of which is the evaluation of state medical board actions; and

***Whereas,*** State medical boards will benefit from undertaking a similar project to develop consistent language in its board actions; and

***Whereas,*** Having consistent terminology and coordination between ABMS boards and state medical boards will help state medical boards better understand what types of action will affect a physician's board certification status, improve decision-making, promote consistent outcomes, and better protect the public;

Therefore, be it hereby

***Resolved,*** That the Federation of State Medical Boards will establish a workgroup to develop model language in board actions and to coordinate with the American Board of Medical Specialties to better understand the types of actions and language that will affect board certification and to promote consistent outcomes among the state medical boards and the ABMS.

**Resolution 15-4**

**Federation of State Medical Boards**
**House of Delegates Meeting**
**April 25, 2015**

Subject: Revision of FSMB Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain

Introduced by: Washington State Medical Quality Assurance Commission

Approved: January 2015

---

***Whereas,*** The FSMB adopted a Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain in 2013; and

***Whereas,*** Recent studies have provided important new information on the use of opioids for pain, necessitating a revision to the Model Policy to make it aligned with the current science, as follows:

1. New studies do not support a "no ceiling on dose" principle. Language in the Model Policy suggesting otherwise should be removed:
   a. "Physicians will not be sanctioned solely for prescribing opioid analgesics or the dose (mg/mcg) prescribed for legitimate medical purposes;" and
   b. "The Board will judge the validity of the physician's treatment of a patient on the basis of available documentation, rather than solely on the quantity and duration of medication administered;" and

2. A recent study by the Agency for Healthcare Quality and Research finds a lack of long-term data on the effectiveness of opioids for chronic pain; and

3. Recent studies demonstrate the impact of escalating doses, the relationship of higher doses with overdose events, and that escalating doses do not have an impact on improving health outcomes; and

4. A study published in the New England Journal of Medicine in January 2015 found a national decrease in abuse of prescription opioid medications between 2011 and 2013 and called for further changes in public health policy; and

5. The Model Policy should be expanded to address how opioids are used for acute and sub-acute pain episodes to prevent chronic use that is not evidence-based. There is new evidence that the use of opioids in the acute and sub-acute pain period may be associated with adverse impact, particularly on the initiation and potentiation of disability, particularly in working-age people; and

6. The Model Policy emphasizes the importance of co-morbid substance abuse and mental health disorders, but needs stronger warnings on the increased risk of overdose and addiction. This is particularly true for the synergistic effect of respiratory depression regarding concomitant use of benzodiazepines and sedative-hypnotics. For example, benzodiazepines were involved in 31% of opioid analgesic poisoning deaths in 2011; and

7. The Model Policy needs greater guidance and specificity on tapering opioids. New data suggest that opioids are frequently continued in patients who have experienced an overdose event, and these patients may experience a subsequent overdose event or death; and

8. The Model Policy should give more attention to addiction. Current evidence suggests that addiction may be more common than previously appreciated. In addition, the current definitions of substance abuse disorder may be very different for persons prescribed opioids for chronic pain than it is for street users; and

9. The Centers for Disease Control and Prevention will be producing updated guidelines for opioid use in 2015. This guidance should be included in the updated FSMB Model Policy; and

10. In 2014, the latest edition of *Safe and Responsible Opioid Prescribing* by Dr. Scott Fishman was issued. The Model Policy should reflect the latest guidance for safe and effective opioid prescribing provided by Dr. Fishman (2014 edition); and

11. Language in the Model Policy is not consistent with language of at least six state medical boards who have revised their policies or rules in the last two years;

Therefore, be it hereby

***Resolved,*** That the Federation of State Medical Boards will establish a workgroup to review the current science and revise the Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain.

## TAB H: Report of Reference Committee B

### MANAGEMENT NOTE:

The following resolutions and reports will be submitted to Reference Committee B:

1. BRD RPT 15-3: *Elements of a State Medical and Osteopathic Board – 5th Edition*
2. BRD RPT 15-4: *Essentials of a State Medical and Osteopathic Practice Act – 14th Edition*
3. Resolution 15-1: Consistency in the Format of EMRs to Enhance Readability and Usability (TX)
4. Resolution 15-2: Task Force to Study Access by Regulatory Boards to Electronic Medical Records (MN)
5. Resolution 15-5: Best Practices in the Use of Social Media by Medical and Osteopathic Boards (NC)

# REPORT OF THE BOARD OF DIRECTORS

**Subject:** *Elements of a State Medical and Osteopathic Board – 5th Edition*

**Referred to: Reference Committee B**

---

The *Elements of a Modern State Medical and Osteopathic Board* was first drafted in 1988 with the primary focus being to develop a blueprint of the structure and function of a state medical or osteopathic board. The document details powers, duties and protections basic to a state board's structure and function. The *Elements* was revised and adopted as policy by the House of Delegates in 1998 and was designed to establish a closer and more functional relationship with the *Essentials of a Modern Medical and Osteopathic Practice Act*, as well as reflect a style more consistent with other FSMB documents. Revisions proposed this year will result in the publication of the Fifth Edition of the *Elements* (**Attachment 1)**.

The Advisory Council of Board Executives was asked to provide guidance in reviewing and revising the *Elements*. The Advisory Council met on September 10, 2014 and worked over the next several months to recommend revisions. A draft document was submitted to the FSMB Board of Directors in February 2015. Members of the Advisory Council include Kevin Bohnenblust, JD, CMBE, Margaret Hansen, PA-C, CMBE, Lyle Kelsey, MBA, CMBE, Kimberly Kirchmeyer, Robert Knittle MS, Kathleen Selzler-Lippert, JD, CMBE, Mari Robinson, JD, and Jacqueline Watson, DO, MBA.

During its review, the Advisory Council determined a number of the provisions to be overly prescriptive and therefore, the proposed revisions are designed to provide greater flexibility while maintaining key elements of board structure and administration. The proposed revisions include:

1) Amend Section II to define "Telemedicine" as contained in the policy, *Model Policy for the Use of Telemedicine Technologies in Medical Practice* (HoD 2014);
2) Amend the qualifications for public members (III.D.2b);
3) Expand the number of consecutive terms a board member may serve from two to three (III.D.3);
4) Delete "coordinate Board activities" as a duty of Board officers (III.E.2);
5) Provide greater flexibility in regards to board committees, frequency of committee meetings and the use of teleconferences (III.G);
6) Delete language regarding the bonding of staff members charged with the handling of funds (III.I); and
7) Expand the duties and authority of the board to impose "conditions" on the medical license (III.K and L).
8)

A copy of the Elements was distributed for comment to member boards on February 10, 2015. One board suggested modifications based, in part, on the recent Supreme Court decision in the matter of the *North Carolina State Board of Dental Examiners vs. Federal*

*Trade Commission*. However, upon review by the Advisory Council of Board Executives and the Board of Directors, the changes were not incorporated but will be included in a broader review and analysis of the Court decision on the structure and operation of state boards of medicine. Accordingly, additional revisions could be forthcoming to the House of Delegates for consideration in 2016.

**RECOMMENDATIONS:**

**The Board of Directors recommends that:**

**The 5th Edition of the *Elements of a State Medical and Osteopathic Board* be adopted as policy.**

# Attachment 1

# Elements of a State Medical and Osteopathic Board

**Approved by the House of Delegates of the Federation of State Medical Boards of the United States, Inc., as policy**

**April 2015**

## Preface

In early 1988, the Division of Medicine of the Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services, requested proposals for the development of a document on a medical board's structure and function. This document would incorporate the same concepts and principles used in the Federation's *A Guide to the Essentials of a Modern Medical Practice Act*. The Federation's knowledge, experience, and resources offered the most responsible and informed effort. The Federation's proposal was accepted, and the Health Resources and Services Administration contract was awarded to the Federation to develop the document and make it available for consideration by the public, state medical boards, medical organizations and other relevant groups.

A special Federation work panel met throughout the year and drafted the *Elements of a Modern State Medical Board: A Proposal*. The *Elements'* primary focus was to develop a blueprint of the structure and function of a modern state medical board. It detailed the powers, duties and protections that are basic to a state medical board's structure and function. In that context, it reflected the study, concepts, opinions, knowledge and experience of the individuals comprising the work panel including members, attorneys and staff of state medical boards. The *Elements* presented a blueprint that is consistent with the principles expressed in the Federation's policy document, *A Guide to the Essentials of a Modern Medical Practice Act*. It was offered as a stimulus for discussion of a number of issues vital to improving the regulation of the medical profession in the United States. The *Elements* and the *Essentials* are companion documents created with the intent to provide state medical boards a blueprint of a functional and modern state medical board.

In preparing this document, the work panel, chaired by Melvin E. Sigel, MD, carefully studied the basic structural and functional outlines of 65 medical boards, contacted 56 boards in telephone surveys on several specific issues, reviewed in detail the medical statutes of 38 states and analyzed the potential impact of the *Elements* if implemented in 18 widely differing state settings. While developing the document, the work panel benefited greatly from the advice, insight and counsel of 26 state medical board members, 18 of whom were board presidents, and 23 state medical board executives.

In May 1997, then-Federation President Susan Spaulding appointed a special committee to review the *Elements*

*of a Modern State Medical Board: A Proposal*. Chaired by Lee E. Smith, MD, the committee was charged with revising and updating the *Elements* to establish a closer, more functional relationship with the Federation's eighth edition of *A Guide to the Essentials of a Modern Medical Practice Act* and to reflect a style more consistent with other Federation documents. Through a series of meetings, the committee developed new language based on research conducted by Federation staff. The committee presented the revised edition of the *Elements* to the House of Delegates at the Federation's Annual Meeting in May 1998, where it was adopted as Federation policy.

## Introduction

The structure and function of each of the 70 medical regulatory boards (allopathic, osteopathic and composite) within the United States and its territories are determined by a unique state statute, usually referred to as a medical practice act. The differences among these statutes are related to the general administrative structure of each jurisdiction and to the needs of the public as they are perceived by each responsible legislative body.

The *Elements of a State Medical and Osteopathic Board* is not intended to encourage movement toward total uniformity among these statutes. Given the diversity of administrative structures and the variations in perceived needs, that would be a futile exercise. The existing differences do have a positive creative value, allowing the evolution and testing of a range of new approaches in a number of jurisdictions concurrently. In light of the concepts and principles it offers for consideration, the *Elements* is intended to nurture that creativity by encouraging the public, state legislators, medical boards, medical societies and others who have an interest in the regulation of the medical profession to reexamine existing practice acts as they relate to the composition, structure, functions, responsibilities, powers and funding of medical boards. In doing this, however, the *Elements* does not address issues relating to standards for licensure, grounds for disciplinary action, or rules and regulations. It is not an effort to provide a template for a complete medical practice act. It includes only those portions of an act the authors believe focus most directly on the medical board itself.

State medical boards—without a doubt—can effectively discharge their important responsibilities to society only if they are properly organized and effectively empowered. The project that resulted in development of the *Elements* was conceived because of the growing realization that some medical practice acts remain inadequate to enable boards to respond to diverse public needs. The Federation of State Medical Boards encouraged and facilitated the improvement of the various state medical practice acts through its official publication, *A Guide to the Essentials of a Modern Medical and Osteopathic Practice Act.* Revised every three years, the *Essentials* serve as a highly effective stimulus to medical boards and state legislatures for periodic review and revision of their statutes. *The Elements of a Modern State Medical and Osteopathic Board* builds on the foundation of the *Essentials* and is, in effect, an explanation of the chapters of that publication. Unlike the broad recommendations of *A Guide to the Essentials of a Modern Medical and Osteopathic Practice Act*, the *Elements* document is presented in language and detail readily adaptable to statutory formats.

The *Elements* reflects not only relevant characteristics of effective current practice acts, but also a number of innovative concepts not yet widely implemented. The result is a document worthy of consideration for adaptation to the requirements of any jurisdiction. Although it could hardly be expected that any one jurisdiction would accept the *Elements* in every particular—the principles of responsibility, empowerment and accountability that the proposal clearly affirms—it should lead each jurisdiction to assess its present board structure and function to determine if it provides maximum potential for public protection. Does the status

quo provide maximum potential for protection of the public interest? Though presented for consideration as an integrated whole, the *Elements* offers significant approaches to a variety of issues that concern many boards. Issues involving funding and budgeting, confidentiality, board authority, personnel and staffing, administration, emergency powers, training of board members, immunity and indemnity, standards of evidence and the public's right to know are valid concerns.

In some states, responsibility for licensing and disciplinary functions is divided between two separate boards. In others, boards are subject to supervision or, in some cases, complete control by larger administrative or umbrella agencies. In a few, the board is simply an advisory body. In most states, the board regulates both allopathic and osteopathic physicians; in others, separate boards exist. And in some states, narrow constitutional restrictions inhibit effective board funding. Clearly, the *Elements* proposes a true working board with real and effective power and support, a proposal some states are much better prepared to implement than others. But it is also a reflection of those principles the authors consider to be basic to the operation of any accountable medical board, regardless of the administrative structure of the state, the size or distribution of the physician population being regulated, the form of legislation required for funding, or the title of the body to which responsibility and power for regulation have been entrusted. It may be drawn upon by both allopathic and osteopathic boards, making appropriate adaptations in the area of board membership. Larger administrative agencies can use it to better assess their own structures and functions and to explore the broader roles their medical boards might play in meeting public expectations. The *Elements* includes significant material on a wide range of issues, much of which has the potential to benefit any administrative structure.

Recognizing the differences among jurisdictions, the authors have designed the *Elements* with the flexibility to accommodate as many of those differences as possible while maintaining the integrity of the overall concept. In addition, some sections empower a board to adopt alternatives of its choice, provided they are in accord with other state statutes. Finally, some sections, such as those relating to board committees, are phrased loosely to allow board-needed discretionary authority. The *Elements* may be seen not as one proposal, but as various proposals. Each is applicable, in one form or another, to a diversity of settings, and all are aimed at increasing or refining the ability of state medical boards to protect the health, safety and welfare of the public.

—*The Federation Project Work Panel*

Revised by:

Special Committee to Review the *Elements of a Modern State Medical Board*: A Proposal 1998

The Advisory Council of Board Executives: 2006

The Advisory Council of Board Executives: 2009

The Advisory Council of Board Executives: 2012

The Advisory Council of Board Executives: 2015

1 **Table of Contents**

## I. Legislative Findings and Declaration

As a matter of public policy, the practice of medicine is a privilege granted by the people of the State acting through their elected representatives by their adoption of the Medical Practice Act. It is not a natural right of individuals. Therefore, in the interests of public health, safety and welfare, and to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine, it is necessary to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine and to ensure, as much as possible, that only qualified and fit persons hold that privilege. The Board's primary responsibility and obligation is to protect the public, and any license, certificate or other practice authorization issued pursuant to this statute shall be a revocable privilege and no holder of such a privilege shall acquire thereby any irrevocable right.

## II. Definitions

Dyscompetence: Failing to maintain acceptable standards in one or more areas of professional physician practice, as defined in Report of the Special Committee on Quality of Care and Maintenance of Physician Competence. (HOD 1999)

License: any license, certificate or other practice authorization granted by the State Medical or Osteopathic Board pursuant to this or any other applicable statute.

Licensee: the holder of any license, certificate or other practice authorization granted by the State Medical or Osteopathic Board.

Statute: this statute or any other statute applicable to the State Medical or Osteopathic Board.

Telemedicine: the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient. (HOD 2014)

All other relevant definitions are provided in the Federation's *Essentials of a State Medical and Osteopathic Practice Act*.

## III. State Medical Board

### A. Board Created

There is hereby created the State Medical Board (hereafter referred to as the Board) to protect the public from unlawful, incompetent, unqualified, impaired or unprofessional practitioners of medicine through licensure, regulation and rehabilitation of the profession in this state.

### B. Duty

The Board shall determine a physician's initial and continuing qualification and fitness for the practice of medicine, shall initiate proceeding against the unprofessional, improper, incompetent, unlawful, fraudulent, deceptive or unlicensed practice of medicine, and shall enforce this statute. The Board shall discharge this duty in accord with this statute and other governing laws.

### C. Interpretation of Powers

It is necessary that the powers conferred on the Board by this statute be liberally construed to protect the health, safety and welfare of the people of the State.

### D. Board Membership

1. Number

The Board shall consist of enough members to appropriately discharge the duties of the Board at least 25% of whom should be public members. (The Board should consider several factors when determining the appropriate size and composition of a Medical Board, including the size of a state's physician population, the composition and functions of Board committees, adequate separation of prosecutorial and judicial powers and the other work of the Board envisioned throughout this document. The Board should be of sufficient size to allow for recusals due to conflicts of interest and other occasional member absences without concentrating final decisions in the hands of too few members or loss of quorum.

2. Qualifications

a. The membership of the Board shall be drawn from as many different regions of the State, as many different specialties as possible and should reflect the licensee population.
b. Public members must reside in the State and be persons of recognized ability and integrity, are not licensed physicians or providers of health care or a retired physician or health care provider, have no past or current substantial personal or financial interests in the practice of medicine or with any organization regulated by the Board (except as a patient or care giver of a patient), and have no immediate familial relationships with individuals involved in the practice of medicine or any organization regulated by the Board, unless otherwise required by law.
c. Physician members must reside in the State and be persons of recognized professional ability, and integrity who actively practice medicine, if appropriate, hold a full and unrestricted medical license in the jurisdiction and have practiced a sufficient time to be knowledgeable with laws, policies and practice in the State (e.g., five years).
d. Members must be citizens of the United States who have attained the age of majority as defined in the statutes of the State.
e. Sex, race, national or ethnic origin, creed, religion, disability or age above majority shall not be used as the sole reason for making an individual eligible or ineligible to serve on the Board
f. No member shall be a registered lobbyist representing any health care interest or association.
g. No member shall be an officer, board member or employee of a statewide or

national organization established for advocating the interests of individuals involved in the practice of medicine or any organization regulated by the Board.

3. Terms

The term of Board service shall be four years. A person shall not serve as a member of the Board for more than two three consecutive full terms, but may be reappointed two years after completion of such service. A person who serves more than two years of an un-expired term shall be considered to have served a full term. Terms of service shall be staggered, one fourth of the Board's membership being appointed each year. For Boards with up to four public members, the term of no more than one public member shall expire in any one year. For Boards with more than four public members, the terms of no more than two public members shall expire in any one year.

4. Requirements
   a. Before assuming the duties of office, each member of the Board shall take the constitutional oath or affirmation of office and shall swear or affirm that he or she is qualified to serve under all applicable statutes.
   b. Before assuming the duties of office, the Board shall require each member to sign a statement agreeing that he/she will disclose any potential conflicts of interest that may arise for that member in the conduct of Board business.
   c. Before assuming duties of office, the Board shall require each member to sign a confidentiality and ethics statement agreeing to maintain the confidentiality of confidential board business and patient identification and uphold high ethical standards in discharging board duties.
   d. The Board shall conduct and new members shall attend a training program designed to familiarize new members with their duties. The Board shall hold an annual training program for new members.
5. Appointment of Members
   a. The members of the Board shall be appointed by the Governor, who shall make each appointment at least 30 calendar days prior to the beginning of the Board term being filled. The Governor shall fill an unexpired term within 30 calendar days of the vacancy's occurrence. The incumbent shall serve until the Governor names a replacement. Should the Governor not act as required by this paragraph, the Board, by majority vote, shall select a qualified person to serve in the interim until the Governor acts.
   b. Any individual, organization or group may suggest potential Board appointees to the Governor.
6. Removal of Board Members

A Board member shall be automatically removed from the Board should he or she:

   a. ceases to be qualified;
   b. on deathdie;
   c. on submit written resignation submitted to the board Chair or to the governor;
   d. beon absentce from the state for a period of more than six months;

e. be found guilty of a felony or an unlawful act involving moral turpitude by a court of competent jurisdiction;
f. be found guilty of malfeasance, misfeasance or nonfeasance in relation to his or her Board duties by a court of competent jurisdiction;
g. be found mentally incompetent by a court of competent jurisdiction;
h. fail to attend three successive Board meetings without just cause as determined by the Board, or, if a new member, fail to attend the new members' training program without just cause as determined by the Board;
i. be found in violation of the medical practice act; or
j. be found in violation of the conflict of interest/ethics law.

7. Board Compensation/Reimbursement
   a. Compensation: Service on the Board should not present an undue economic hardship. Board members shall therefore receive compensation in an amount sufficient to allow full participation and not preclude qualified individuals from serving.
   b. Expenses: Each Board member's travel and expenses necessarily and properly incurred for active Board service shall be paid at the State's current approved rate.
   c. Education/Training: Travel, expenses and daily compensation shall also be paid for each Board member's attendance, in or out of State, for education or training purposes approved by the Board and directly related to Board duties.

## E. Board Structure

1. Officers

The Board shall elect annually from its members a president/chair, a vice president/vice- chair, a secretary-treasurer and those other officers it determines are necessary to conduct its business. The officers shall serve for a one-year term.

2. Duties of Officers
   a. The president/chair shall approve Board meeting agendas, preside at Board meetings, appoint Board committees and their chairs, coordinate Board activities and perform those other duties assigned by the Board and this statute.
   b. The vice president/vice-chair shall assist the president/chair in all duties as requested by the president/chair and shall perform the duties of the president/chair in that officer's absence.
   c. The secretary-treasurer shall ensure the maintenance of the minutes of all meetings of the Board and that the expenditure of funds complies with State law.

3. Committees

To effectively facilitate its work, fulfill its duties and exercise its powers, the Board may establish standing committees, including, but not limited to, licensing, investigation, finance, administration, personnel, rules, legislative communications and public information committees. The chair may name ad hoc committees as required. The president/chair shall appoint members and chair of committees, who shall serve one-year terms and may reappoint members. In the absence of regular committee members and when necessary to provide a quorum for the conduct of committee business, the president/chair may appoint from the Board temporary members to a

committee. Changes in membership shall not be deemed to affect or hinder the continuing business or activity of any committee. If established, committees of the Board shall conform to the following:

a.A licensing committee shall be responsible for reviewing or directing the review of the qualifications of applicants for licensure in accord with this statute and Board policy and rules. It shall recommend to the Board the issuance or denial of licenses to applicants. A licensing committee may also be responsible for recommending or preparing for the Board's consideration and approval those examinations to be used in meeting the examination requirements set by this statute for medical licensure and for other evaluative purposes. It may also administer or direct administration of all examinations in keeping with this statute and Board policy and rules.

b. An investigation committee shall be comprised of at least three members of the Board, but less than a quorum or in such number as to deprive the Board of a quorum when the committee members recuse themselves, one of whom must be a public member. An investigation committee shall be responsible for reviewing any complaint or charge referred to it in accord with written Board policy, for conducting an investigation to determine if there is a reasonable basis for the complaint or charge, for determining if a hearing is required and for referring the matter to the appropriate prosecuting authority for presentation to the Board or, if directed to do so by the Board, to a Board-designated hearing officer or State required hearing officer. In performing its duties, it shall have all the powers granted the Board in this statute to compel cooperation and the provision of information by individuals and institutions. The Board shall act in the capacity of the adjudicatory body, and no member of an investigation committee shall sit with the Board to hear or adjudicate a matter considered by his or her investigation committee nor shall he or she be counted as part of the Board in determining a quorum for the conduct of business during such a hearing or adjudication. Should the volume of complaints and charges require it, more than one investigation committee may be named at the Board's discretion.

c. A finance committee shall be comprised of the secretary-treasurer, acting as chairperson, the president/chair and vice president/vice-chair, and one public member of the Board without constituting a quorum of the Board. It shall be responsible for recommending a budget to the Board for its consideration. It shall also assure a periodic audit of the Board's accounts by the authority charged by law for auditing State accounts. It shall also coordinate and assist a State mandated audit by the authority charged by law with primary responsibility for auditing the State's accounts. A report of the audit shall be sent to the Board and the Legislature. Budgets shall be prepared and adopted sufficiently in advance of the fiscal year to allow reasonable notice for increases or decreases in the fees and charges set by the Board.

Other committees created by the Board shall have those responsibilities, consistent with this statute, delegated to them by the Board.

4. Advisory Committees

To assist the Board in the performance of its duty relating to the regulation of health care professionals other than M.D.'s and D.O.'s, the president/chair, with the advice and approval of the Board, shall appoint a separate Advisory Committee for each of the health care fields for which the Board has responsibility under this statute. Each Advisory Committee shall include two Board members, one of whom shall serve as Committee chair, the other to serve as vice chair. The Committee shall also include three or four non-Board members. Each of these non- Board members shall meet the same requirements and be subject to the same limitations and causes for removal as a physician member of the Board, with the requirement for medical licensure being replaced by that for full and unrestricted authorization to practice in the

particular health care field of the Advisory Committee to which he or she is appointed. Terms and limitations of service on an Advisory Committee shall be the same as for the Board. The non-Board members of an Advisory Committee may be compensated at an appropriate and reasonable level as determined by the Board and shall be reimbursed for meeting-related travel and expenses at the State's current approved rate. Advisory Committees shall meet at least once each year to review the regulation of their health care fields and to advise the Board on policy and rules relating to that regulation. The Board may also consult them or their members for advice on particular issues or disciplinary matters. The Board shall determine the specific functions of the Advisory Committees in keeping with this statute.

## F. Funding

1. Revenues

The Board shall be fully supported by the revenues generated from its activities, including fees, charges and recovered costs. The Board shall hold all such revenues, with the exception of fines, in a fund for its use, which is hereby established and which shall receive all interest earned on the deposit of such revenues. Such funds are appropriated continuously and shall be used by the Board only for administration and enforcement of this statute. All fines levied by the Board shall be deposited in the State General Fund, unless otherwise allowed by law. In the event the legislature imposes additional responsibilities on the Board beyond the Board's statutory responsibilities for licensure and discipline, the legislature shall appropriate additional funds to the Board sufficient to carry out such additional responsibilities.

2. Budget

The Board shall develop and adopt its own budget reflecting revenues, including the interest thereon, and costs associated with each health care field regulated. Revenues and interest thereon, from each health care field regulated shall fully support Board regulation of that field. The budget shall include allocations for establishment and maintenance of a reasonable reserve fund.

3. Setting Fees and Charges

All Board fees and charges shall be set by the Board pursuant to its proposed budget needs. The Board shall provide reasonable notice to the regulated healthcare professional and the public of all increases or decreases in fees and charges.

4. Fiscal Year

The Board shall operate on the same fiscal year as the State.

## G. Board and Committee Meetings

1. Location

The Board and its several committees shall meet in the Board's offices or other appropriate facilities in the same city as those offices. At their discretion, however, they may meet from time to time in other areas of the State to facilitate their work or to enhance communication with the public and members of the regulated professions.

2. Frequency, Duration

The Board shall meet at least bimonthly for a period sufficient to complete the work before it at that time. One meeting per quarter may be sufficient for states with small physician populations. Committees shall meet as directed by the Board. However, each standing committee shall meet at least once per year to review its area of responsibility and to prepare a formal annual report for presentation to the Board.

3. Special Meetings, Conferences
    a. Emergency meetings of the Board may be called at any time by the president/chair or at the request of an officer and two Board members if required to enforce this statute. The Board may establish procedures by which its committees may call emergency meetings in accordance with the State's open meeting laws.
    b. Informal conferences of an investigation committee may be called by the chair of the committee for the purpose of holding discussions with licensees, accused or otherwise, who seek or agree to such conferences. Any disciplinary action taken as a result of such a conference and agreed to in writing by the Board and licensee shall be binding and a matter of public record. The holding of an informal conference shall be at an investigation committee's discretion and shall not preclude formal disciplinary investigation, proceedings or action.
    c. A telephone or other telecommunication conference shall be an acceptable form of Board meeting for the purpose of taking emergency action to enforce the medical practice act if the president/chair alone or another officer and two Board members believe the situation precludes another form of meeting. the Board's business can be properly conducted by teleconference. The Board shall be authorized to establish procedures by which its committees may meet by telephone or other telecommunication conference system. to take emergency action.
4. Notice
    a. The Board shall establish a system for giving all Board and committee members reasonable advance notice of all Board and committee meetings.
    b. The Board shall comply with the State's open meeting laws.
5. Quorum
    a. A majority of members shall constitute a quorum for the transaction of business by the Board or any committee of the Board.
    b. Notwithstanding any provision of law to the contrary, tThe business of the Board

and its committees shall be conducted in accord with this statute and with rules of parliamentary procedure adopted by the Board.

6. Conflict of Interest

No member of the Board, acting in that capacity or as a member of any Board committee, shall participate in the deliberation, making of any decision or the taking of any action affecting his or her own personal, professional or pecuniary interest, or that of a known relative or of a business or professional associate. With advice of legal counsel, the Board shall adopt and annually review a conflict of interest policy to enforce this section.

7. Minutes

Minutes of all Board and committee meetings and proceedings, and other Board and committee materials, shall be prepared and kept in accord with the Board's adopted rules of parliamentary procedure and other applicable State laws.

8. Open Meetings, Confidentiality

a. All meetings of the Board and its committees shall be open to the public in accordance with the State's Open Meeting laws, with the following exceptions:
    1. meetings or portions of meetings of the Board, acting in its capacity as a hearing or adjudicatory body, held to receive testimony or evidence the public disclosure of which the Board determines would constitute an unreasonable invasion of personal privacy, to consult with legal counsel, to deliberate issues and to arrive at disciplinary judgments;
    2. meetings or portions of meetings regarding investigations;
    3. meetings or portions of meetings regarding license applications; and
    4. meetings or portions of meetings regarding personnel actions.

b. The Board shall ratify all recommendations or decisions made in nonpublic meetings in public, which shall be matters of public record.

c. The minutes and all records of nonpublic meetings are privileged and confidential and shall not be disclosed except to the Board or its designees for the enforcement of this statute, except that all licensing decisions made by the Board and all disciplinary orders, with the associated findings of fact and conclusions of law and order, issued by the Board shall be matters of public record.

d. The following shall be privileged and confidential:
    1. application and renewal forms and any evidence submitted in proof or support of an application to practice, except that the following items of information about each applicant or licensee included on such forms shall be matters of public record:
        a. full name,
        b. date and place of birth,
        c. name(s) and location(s) of professional schools attended,
        d. school awarding professional degree, date of award, and designation of degree,
        e. site(s) and date(s) of graduate certification(s) held and date(s) granted,

f. specialty certifications,
g. year of initial licensure in the State,
h. other states in which licensed to practice, and
i. current office address and telephone number.

2. all investigations and records of investigations;
3. any report from any source concerning the fitness of any person to receive or hold a license;
4. any communication between or among the Board and/or its committees, staff, advisors, attorneys, employees, hearing officers, consultants, experts, investigators and panels occurring outside public meetings; and
5. a complaint and the identity of that an individual or entity filing an initial complaint with the Board.

e. Notwithstanding the foregoing provisions, the Board may cooperate with and provide documentation to other boards, agencies or law enforcement bodies of the State, other states, other jurisdictions or the United States upon written official request by such entity(s). The Board should share investigative information at the early stages of a complaint investigation in order to reduce the likelihood that a licensee may become licensed in one state while under investigation in another state.

f. Nothing herein shall be construed as prohibiting a respondent or his or her legal counsel from exercising the respondent's right of due process under the law.

## H. Offices, Administration

1. Offices

The Board shall maintain offices it determines are adequate in size, staff and equipment to effectively carry out the provisions of this statute. At its discretion, it may establish branch offices, staffed and equipped as it finds necessary, in as many areas of the State as it believes require such branch offices to facilitate the work of the Board.

2. Administration

The Board shall set out the function, operation and administration structure of its offices.

## I. Staff, Special Personnel

1. Board Authority

The Board is hereby empowered to determine its staff needs and to employ, fix compensation for, evaluate and remove its own full-time, part-time and temporary staff in accord with the statutory requirements of the State. It The Board shall define the duties of and qualifications for staff positions. and shall bond those members of staff charged with the handling of funds. Staff benefits shall be provided in accord with the statutes of the State.

2. Staff Positions

The Board's staff may include, but need not be limited to, the following:

a. an executive director, who, among administrative and other delegated

responsibilities, may assist, at the Board's discretion, in the discharge of the duties of the secretary-treasurer and if one exists, the licensing committee, the investigation committee and any other standing or ad hoc committee;

b. one or more assistant executive directors;

c. one or more medical consultants, who shall be licensed to practice medicine in the State without restriction;

d. office and clerical staff;

e. one or more attorneys, who may be full-time employees of the Board, contractors of the Board, or assigned from the Office of the State Attorney General by agreement between the Board and that office, or in private practice;

f. one or more investigators, who shall be trained in and knowledgeable about the investigation of medical and related health care practice; and/or

g. experts and consultants.

3. Special Support Personnel

The Board may enlist, at its discretion, the services of experts, advisors, consultants and others who are not part of its staff to assist it in more effectively enforcing this statute. Such persons may serve voluntarily, be reimbursed for expenses in accord with State law and policy, or be compensated at a level commensurate with services rendered in accord with state law and policy. When acting for or on behalf of the Board, such persons shall benefit from the same immunity and indemnification protections afforded by this statute to the members and staff of the Board.

## J. Immunity, Indemnity, Protected Communication

1. Immunity

There shall be no liability, monetary or otherwise, on the part of, and no cause of action for damages shall arise against, any current or former member, officer, administrator, staff member, committee member, examiner, representative, agent, employee, consultant, witness or any other person serving or having served the Board, either as a part of the Board's operation or as an individual, as a result of any act, omission, proceeding, conduct or decision related to his or her duties undertaken or performed in good faith and within the scope of the function of the Board.

2. Qualified Immunity and Indemnity

If a current or former member, officer, administrator, staff member, committee member, examiner, representative, agent employee, consultant or any other person serving or having served the Board requests the State to defend him or her against any claim or action arising out of any act, omission, proceeding, conduct or decision related to his or her duties undertaken or performed in good faith in furtherance of the purposes of this chapter and within the scope of the function of the Board, and if such a request is made in writing at a reasonable time before trial, and if the person requesting defense cooperates in good faith in the defense of the claim or action, the State shall provide and pay for such defense and shall pay any resulting judgment, compromise, or settlement.

3. Protected Communication

a. Every communication made by or on behalf of any person, institution, agency or

organization to the Board or to any person(s) designated by the Board relating to an investigation or the initiation of an investigation, whether by way of report, complaint or statement, shall be privileged. No action or proceeding, civil or criminal, shall be permitted against any such person, institution, agency or organization by whom or on whose behalf such a communication was made in good faith.

b. The protections afforded in this provision shall not be construed as prohibiting a respondent or his or her legal counsel from exercising the respondent's constitutional right of due process under the law.

**K. Duties of the Board**

In addition to any other duties placed on the Board by this statute, the Board, acting in accord with this statute, shall:

1. enforce the provisions of this statute;
2. adopt and enforce rules and regulations to effect the provisions of this statute and to fulfill its duties there under;
3. adopt policies and guidelines related to medical practice, other health care professions and regulation;
4. develop and use applications and other necessary forms and related procedures it finds appropriate for purposes of this statute;
5. prepare or select, conduct or direct the conduct of, set passing requirements for, and assure security of licensing and other required examinations;
6. acquire information about and evaluate the professional education and training of applicants;
7. issue, condition, or deny licenses;
8. process applications for license renewal;
9. review and investigate complaints and adverse information about licensees;
10. establish a mechanism, which at the Board's discretion, may involve cooperation with and/or participation by one or more Board-approved professional organizations, for the identification and monitored treatment of licensees who are dependent on or abuse alcohol or other addictive substances which have the potential to impair;
11. establish a mechanism by which licensees who believe they abuse or may be dependent on or addicted to alcohol or other addictive substances which have the potential to impair, and who have not been identified by the Board through other sources of information, will be encouraged to report themselves voluntarily to the Board and/or, at the Board's discretion, to a professional organization approved by the Board to seek assistance and monitored treatment;
12. develop and implement methods to identify dyscompetent physicians and physicians who fail to meet acceptable standards of care. The Board should also be authorized to develop and implement methods to assess and improve physician practice;
13. develop and implement methods to ensure the ongoing competence of licensees;
14. conduct hearings in accord with this statute;
15. adjudicate those matters that come before it for judgment under this statute and issue final decisions on such matters;

16. discipline licensees;
17. report all final disciplinary actions, non-administrative license withdrawals as defined by the board, license denials and voluntary license limitations or surrenders related to physicians, with any accompanying license limitations or surrenders related to physicians, with any accompanying Board orders, findings of fact and conclusions of law, to the Federation Physician Data Center of the Federation of State Medical Boards of the United States and to any other data repository required by law, and report all such actions, denials and limitations or surrenders related to other licensees, with the same supporting documentation, to the appropriate national practitioner data repositories recognized by the Board or required by law;
18. act to halt the unlicensed or illegal practice of medicine and to seek penalties against those engaged in such practice;
19. institute proceedings in courts of competent jurisdiction to enforce its orders and the provisions of this statute;
20. establish appropriate fees and charges to ensure active and effective pursuit of its responsibilities;
21. employ, direct, reimburse, evaluate and dismiss staff in accord with State procedures;
22. establish policies for Board operations;
23. maintain secure and complete records on individual licensees, including, but not limited to license application, verified credentials, disciplinary information, and malpractice history;
24. recommend to the Legislature those changes in or amendments to this statute that it determines would benefit the health, safety and welfare of the public; and
25. acknowledge receipt of complaints or other adverse information to persons or entities reporting to the Board and inform them of the final disposition of the matters reported.

**L. Powers of the Board**

In addition to any other powers provided the Board herein, the Board, when acting in accord with this statute, shall have those powers necessary to fulfill its duties under this statute. Those powers shall include, but not be limited to, the following:

1. to employ or contract with one or more organizations or agencies known to provide acceptable examinations for the preparation and scoring of required examinations; employ or contract with one or more organizations or agencies known to provide acceptable examination services for the administration of required examinations;
2. to impose conditions (e.g., time or attempt limits) for successful completion of the examination sequenceto prescribe the time, place, method, manner, scope and subjects of examination;
3. to impose conditions, sanctions, deny licensure, levy fines, seek appropriate civil and/or criminal penalties, or any combination of these, against those who violate or attempt to violate examination security, those who obtain or attempt to obtain licensure by fraud or deception, and those who knowingly assist in such activities;
4. to determine which professional schools, colleges, universities, training institutions and educational programs are acceptable in connection with licensure under this statute and to accept the approval of such facilities and programs by Board-recognized accrediting bodies in

the United States and Canada;

5. to require supporting documentation or other acceptable verifying evidence of any information provided the Board by an applicant or licensee;
6. to require information on an applicant's or a licensee's fitness, qualification and previous professional record and performance from recognized data sources, including, but not limited to, the Federation of State Medical Boards' Federation Physician Data Center, other national data repositories, licensing and disciplinary authorities of other jurisdictions, professional education and training institutions, liability insurers, health care institutions and law enforcement agencies;
7. to require the self-reporting by applicants or licensees of any information the Board determines may indicate possible deficiencies in practice, performance, fitness or qualification. This self-reporting requirement is intended to include, but not be limited to, all pertinent areas outlined in the Federation's *Essentials of a State Medical and Osteopathic Practice Act*;
8. to require all licensees, healthcare professional, healthcare facilities and medical societies and organizations to report to the Board information that appears to show another licensee is or may be professionally incompetent, guilty of unprofessional conduct or mentally or physically unable to engage safely in licensed practice, and to report to the Board and/or to an agency designated by the Board a licensee's possible dependence on alcohol or other addictive substances which have the potential to impair, and require licensees, malpractice insurance companies, attorneys and healthcare facilities to report any payments on a demand, claim, settlement, arbitration award or judgment by or on behalf of a licensee;
9. when deemed appropriate by the Board to do so, to require professional competency, physical, mental or chemical dependency examination, and evaluations of any applicant or licensee, including withdrawal and laboratory examination of bodily fluids;
10. in establishing mechanisms for dealing with licensees who abuse or are dependent on or addicted to alcohol or other addictive substances, to conclude agreements, at its discretion, with professional organizations, whose relevant procedures and techniques it has evaluated and proved, for their cooperation and/or participation;
11. to issue cease and desist orders and to obtain court orders and injunctions to halt unlicensed practice, violation of this statute or the rules of the Board;
12. to act on its own motion in disciplinary matters, administer oaths, issue notices, issue subpoenas in the name of the State, including subpoenas for patient records, hold hearings, institute court proceedings for contempt to compel testimony or obedience to its orders and subpoenas, take evidentiary depositions, and perform such other acts as are reasonably necessary under law to carry out its duties;
13. to use preponderance of the evidence as the standard of proof and to issue final decisions;
14. to present to the proper authorities information it believes indicates an applicant or licensee may be subject to criminal prosecution;
15. to issue conditionalconditioned, restricted or otherwise circumscribed licenses as it determines necessary;
16. to take the following actions, in accord with applicable State statutes; alone or in combination, against those found in violation of this statute:

a. revoke, suspend, condition, restrict and/or otherwise limit the license,
b. place the licensee on probation with conditions,
c. levy fines and/or assess the costs of proceedings against the licensee,
d. censure, reprimand and/or otherwise admonish the licensee,
e. require the licensee to provide monetary redress to another party, and/or provide a period of free public or community service,
f. require the licensee to satisfactorily complete an educational, training, and/or treatment program or programs and
g. require the licensee to successfully complete an examination, examinations or evaluations designated by the Board; and

17. to summarily suspend a license if it has cause to believe such action is required to protect public health and safety prior to hearing and final adjudication;
18. to enforce final disciplinary action against a licensee as deemed necessary to protect public health and safety;
19. to determine and direct the Board's operating, administrative, personnel and budget policies and procedures in accord with applicable State statutes;
20. to acquire real property or other capital for the administration and operation of the Board;
21. to set necessary fees and charges, employ and evaluate the Board's executive director;
22. to develop and recommend standards governing the profession;
23. to engage in a full exchange of information with the licensing and disciplinary boards and medical associations of other states and jurisdictions of the United States and foreign countries;
24. to direct the preparation and circulation of educational material, policies and guidelines the Board determines is helpful and proper for licensees;
25. to develop and adopt rules regarding the regulation and the qualifications of physicians,
26. to issue subpoenas in the course of an investigation to compel production of documents or testimony to any party or entity that may possess relevant information regarding the subject of the investigation; and
27. to delegate to the executive director the board's authority to discharge its duties as deemed appropriate by the Board. The Board shall adopt policy statements for each duty delegated to the executive director.

**M. Board Reports**

1. Annual Report

The Board shall present to the Governor, the Legislature and the public, at the end of each fiscal year, a formal report summarizing its licensing and disciplinary activity for that year. The report shall include, but not limited to, the following information about each of the Board's regulated professions:

a. the total number of persons fully licensed by the State and the number of those licensees currently practicing in the State;
b. the number of licensees holding each form of limited license authorized by this statute;

c. the number of persons granted a full license by the State for the first time in the past year, the number of those licensees currently practicing in the State, and the number of full licenses denied in the past year;

d. the number of licensees currently practicing in-state about whom a complaint, a charge or an adverse item of information required by law was received in the past year;

e. the number and the source, by category, of complaints, charges and adverse items of information required by law received about licensees practicing in-state in the past year and the number of these found not to warrant action under this statute and the rules of the Board;

f. the number of disciplinary investigations conducted by the Board or its representatives concerning licensees practicing in-state in the past year;

g. the number of disciplinary actions, by category, taken by the Board in the past year against all licensees;

h. a ranking, by frequency, of primary causes for disciplinary action against all licensees in the past year;

i. the efforts of the Board to halt the unlawful practice of medicine in the past year;

j. a review of disciplinary activity related to holders of limited forms of license in the past year;

k. a review of the operations of the Board's current mechanisms for dealing with a licensee dependent on or addicted to alcohol or other addictive substances which have the potential to impair;

l. a schedule of all current fees and charges;

m. a revenue and expenditure statement for the past year indicating the percentage of revenue from and expenditures for each regulated profession;

n. a summary of other Board activities and a schedule of days met by the Board and each of its committees during the year;

o. a summary of administrative and legislative activity in the past year;

p. a summary of the goals and objectives established by the Board for the coming fiscal year; and

q. a copy of the Board's strategic plan.

2. Public Record, Action Reports

Each of the Board's non-administrative license application withdrawals, license denials and final disciplinary orders, including any associated findings of fact and conclusions of law, shall be matters of public record. Voluntary surrenders of or limitations on licenses shall also be matters of public record. The Board shall promptly report all denials, orders, surrenders and limitations to the public, all health care institutions in the State, appropriate State and federal agencies, related professional societies or associations in the State and any data repository. The Board shall make the information readily accessible to the public via the physician's profile. The Board shall update the profile at least annually and offer the licensee an opportunity to correct erroneous information. A licensee's profile shall contain, but not limited to:

a. Demographic Information

1. name and license number;

2. gender;
3. business or practice address; and
4. birth date.

b. Medical Education

1. medical school(s)' name, address, year of graduation and degree; and
2. post-graduate training program(s)' name, address, years attended and year completed.

c. License and Board Certification Information

1. license status;
2. license type;
3. original license date;
4. license renewal date;
5. specialty and type of practice; and
6. board certification by a certifying authority recognized by the Board.

d. Criminal Convictions

A description of any conviction of a felony or a misdemeanor involving moral turpitude within the last five years, including cases with a deferred adjudication or expungement.

e. Malpractice History

1. the number of awards or judgments within the past 10 years;
2. when the number exceeds 3, the number of demands, claims, and/or settlements paid by the licensee or on behalf of the licensee in the past 5 years; and
3. a statement that malpractice payments do not necessarily demonstrate the quality of care provided by a physician, and that the Board independently investigates all reports of payment in malpractice cases, which will appear in the licensee's disciplinary history if the Board completed the investigation and took disciplinary action.

f. Disciplinary History

1. all disciplinary actions taken by the Board;
2. a brief description of the reason for a disciplinary action;
3. all disciplinary actions taken by other state medical/osteopathic boards and a brief description of the reason for discipline if available;
4. all disciplinary actions taken by hospitals;
5. an explanation of the types of discipline the Board takes and its effects on the licensee's ability to practice; and
6. a statement that hospitals may take disciplinary actions for reasons that do not violate the governing statutes.

**FSMB Advisory Council of Board Executives**

2014-2015 Members

Kimberly Kirchmeyer, Medical Board of California

Robert C. Knittle, MS, West Virginia Board of Medicine

Mari Robinson, JD, Texas Medical Board

Kathleen Selzler Lippert, JD, Kansas State Board of Healing Arts

Ex Officio Members:

Margaret B. Hansen, PA-C, President, Administrators in Medicine

Kevin D. Bohnenblust, JD, Vice President, Administrators in Medicine

Lyle R. Kelsey, MBA, FSMB BOD, Oklahoma Board of Medical Licensure and Supervision

Jacqueline A. Watson, DO, MBA, FSMB BOD, District of Columbia Board of Medicine

Staff Support:

Lisa A. Robin, MLA

Shiri A. Hickman, JD

# REPORT OF THE BOARD OF DIRECTORS

**Subject:** *Essentials of a State Medical and Osteopathic Practice Act – 14th Edition*

**Referred to: Reference Committee B**

---

The FSMB first published *A Guide to the Essentials of a Modern Medical and Osteopathic Practice Act* in 1956 to (1) serve as a guide to those states that may adopt new medical practice acts or may amend existing laws, and (2) encourage the development and use of consistent standards, language, definitions and tools by state medical boards. The *Essentials* is revised every three (3) years to reflect changes in medical regulation, practice, and policy. Revisions proposed this year will result in the publication of the Fourteenth Edition of the *Essentials* **(Attachment 1).**

For the past several years, the Advisory Council of Board Executives has provided guidance in reviewing and suggesting revisions to the Essentials. The Advisory Council met via teleconference on September 23, 2014 and worked over the next several months to complete the recommended revisions to the policy. A draft was submitted to the FSMB Board of Directors in February 2015. Members of the Advisory Council include Kevin Bohnenblust, JD, CMBE, Margaret Hansen, PA-C, CMBE, Lyle Kelsey, MBA, CMBE, Kimberly Kirchmeyer, Robert Knittle MS, Kathleen Selzler-Lippert, JD, CMBE, Mari Robinson, JD, and Jacqueline Watson, DO, MBA.

Many of the revisions suggested by the Advisory Council are not substantive but are organizational in nature or designed to improve readability. Proposed revisions are indicated by underline and strikeout and include:

1) Amend Section II.A to include "where the patient is located" in the definition of the "Practice of Medicine;"
2) Amend Section II.B to except team physicians from the application of the medical practice act in accordance with the recommendations in the policy, *Innovations in State Based Licensure* (HoD 2014);
3) Revise Examinations (IV) to reflect current practices and procedures;
4) Specify approved graduate medical education be accredited by the Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) (V.D, VI.F);
5) Specify approved licensing examinations as USMLE, COMLEX-USA or their predecessor examinations (V.E);
6) Amend Section VII.D to reflect the recommendation contained in the policy, *Innovations in State Based Licensure* (HoD 2014);
7) Expand the list of laboratory bodily fluid examinations that the board may require to evaluate chemical dependency to include the examination of "tissues, hair, or nails" (IX.C);
8) Delete Section X.B regarding the separation of a Board's investigative and judicial functions;

9) Amend Sections XI.B and XII.D to authorize the Board to “place conditions on" a license as a disciplinary option related to impaired, dyscompetent or incompetent physicians;
10) Expand the list of those required to report possible violations of the medical practice act (XIII.B); and,
11) Revise Section XII regarding the regulation of physician assistants to bring current with current practice.

A draft of the revised *Essentials* was distributed to FSMB’s member boards for comment on February 10, 2015. Only one board suggested changes which were based, in part, on the recent Supreme Court ruling in the matter of the *North Carolina State Board of Dental Examiners vs. Federal Trade Commission*. The Advisory Council considered the suggested modifications but recommended additional time for analysis of the Court’s ruling on the structure and operation of health professional licensing boards. Accordingly, additional revisions to the *Essentials* could be brought forth for consideration by the House of Delegates in 2016.

**RECOMMENDATIONS:**

**The Board of Directors recommends that;**

**The 14th Edition of the *Essentials of a State Medical and Osteopathic Practice Act* be adopted as policy.**

# Attachment 1

# Essentials of a State Medical and Osteopathic Practice Act

**Approved by the House of Delegates of the Federation of State Medical Boards of the United States, Inc., as policy**

**April 2015**

## Introduction

As early as 1914, the Federation of State Medical Boards of the United States and its member boards recognized the need for what was to become *A Guide to the Essentials of a Modern Medical Practice Act*. First published in 1956, the stated purposes of the document have always been the same:

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

Changes in medical education, in the practice of medicine and in the diverse responsibilities that face medical boards necessitate regular revision of medical practice acts. The *Essentials* has undergone numerous revisions in order to respond to these changes and to provide assistance to member boards in the evaluation and revision of their medical practice acts. The Federation urges member boards to consider including any recommendation contained in the *Essentials* in its medical practice act or under its rules.

The *Essentials* applies equally to practice acts that govern physicians who have acquired the M.D. or D.O. degree in the same statute or in separate statutes. The terms used herein should be interpreted throughout with this understanding.

## Preamble

An essential is that element, quality or property that is indispensable in making a body, character or structure what it is. It constitutes the essence. The Federation of State Medical Boards of the United States believes that each of the 19 sections of this document express an essential of a modern medical practice act and that the recommendations in each section are basic to the realization of that essential.

**Table of Contents**

## Section I: Statement of Purpose

The medical practice act should be introduced by a statement of policy specifying the purpose of the act. This statement should include language expressing the following concepts:

A. The practice of medicine is a privilege granted by the people acting through their elected representatives.
B. In the interests of public health, safety and welfare, and to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine, it is necessary for the government to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine.
C. The primary responsibility and obligation of the state medical board is to act in the sovereign interests of the government by protecting the public through licensing, regulation and education as directed by the state government.

## Section II: Definitions

A. Definitions: As used in this Act, the following terms shall have the following meanings:

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

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

"Dyscompetence" means failing to maintain acceptable standards of one or more areas of professional physician practice.

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

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

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

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

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

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

medical practice act should provide definitions of the practice of medicine as governed by the act as well as exceptions to the act. These provisions of the act should implement or be consistent with the following:

"Practice of medicine" means:

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

"Remediation" means the process whereby deficiencies in physician performance identified through an examination or assessment program are corrected, resulting in an acceptable state of physician competence.

"Supervising physician" means a licensed physician in good standing in the same jurisdiction as the physician assistant who the Board approved to supervise the services of a physician assistant, and who has in writing formally accepted the responsibility for such supervision.

B. The medical practice act shall not apply to:

1. students while engaged in training in a medical school approved or recognized by the state medical board, unless the Board licenses the student;
2. those providing service in cases of emergency where no fee or other consideration is contemplated, charged or received by the physician or anyone on behalf of the physician;
3. commissioned medical officers of the armed forces of the United States and medical officers of the United States Public Health Service or the Veterans Administration of the United States in the discharge of their official duties and/or within federally controlled facilities, provided that such persons who hold medical licenses in the jurisdiction should be subject to the provisions of the act and provided that all such persons should be fully licensed to practice medicine in one or more jurisdictions of the United States, further the military physician should be subject to the Military Health System Clinical Quality Assurance (CQA)

Program 10 U.S.C.A. § 1094; Regulation DOD 6025.13-R;

4. those practicing dentistry, nursing, optometry, podiatry, psychology or any other of the healing arts in accord with and as provided by the laws of the jurisdiction;
5. those practicing the tenets of a religion or ministering religious based medical procedures or ministering to the sick or suffering by mental or spiritual means in accord with such tenets;
6. a person administering a lawful domestic or family remedy to a member of his or her own family;
7. those fully licensed to practice medicine in another jurisdiction of the United States who briefly render emergency medical treatment or briefly provide critical medical service at the specific lawful direction of a medical institution or federal agency that assumes full responsibility for that treatment or service and is approved by the state medical board.; and

7.8. a physician licensed in another state, territory or jurisdiction of the United States is exempted from the licensure requirements in (state) if the physician is employed or formally designated as the team physician by an athletic team visiting (state) for a specific sporting event and the physician limits the practice of medicine in (state) to medical treatment of the members, coaches and staff of the sports entity that employs (or has designated) the physician.

C. For the purpose of the medical practice act, the practice of medicine is determined to occur where the patient is located in order that the full resources of the state are available for the protection of that patient.

## Section III: The State Medical Board

The medical practice act should provide for a separate state medical board, acting as a governmental agency, (referred to hereafter as the Board) to regulate the practice of medicine, including the licensure and discipline of physicians, in the jurisdiction. These provisions of the act should implement or be consistent with the following:

A. Whatever the professional regulatory structure established by the government of the jurisdiction, physicians should bear the primary responsibility for licensing and regulating the medical profession for the protection of the public, without abusing physicians in the discharge of that duty. Every Board should include both physician and public members. All Board members shall act to further the interest of the state, and not their personal interests.

B. Whatever the professional regulatory structure established by the government of the jurisdiction, the Board, within the context of the act and the requirements of due process, should have, at a minimum, the following powers and responsibilities:

1. Promulgate rules and regulations;
2. Select and/or administer licensing examination(s);
3. Develop and adopt policies and guidelines related to medical practice, other health care professions and regulation;
4. Evaluate medical education and training of applicants;
5. Evaluate or verify certification of medical and training programs to determine if these programs are appropriately preparing physicians for the practice of medicine;
6. Evaluate previous professional performance of applicants;
7. Issue or deny initial or endorsement licenses;

8. Maintain secure and complete records on individual licensees;
9. Provide the public with a profile of all licensed physicians;
10. Approve or deny applications for license renewal;
11. Develop and implement methods to identify physicians who are in violation of the medical practice act;
12. Develop and implement methods to identify and rehabilitate, if appropriate, physicians with an alcohol, drug and/or psychiatric illness;
13. Receive, review and investigate complaints including sua sponte complaints;
14. Review and investigate reports received from entities having information pertinent to the professional performance of licensees;
15. Review, investigate, and take appropriate action to enjoin reports received concerning the unlicensed practice of medicine;
16. Share investigative information at the early stages of a complaint investigation with other Boards;
17. Issue subpoenas, subpoenas duces tecum, administer oaths, receive testimony and conduct hearings;
18. Discipline licensees found in violation of the medical practice act;
19. Develop policies for disciplining or rehabilitating physicians that demonstrate inappropriate sexual behavior with patients or other professional boundaries violations;
20. Institute actions in its own name and enjoin violators of the medical practice act;
21. Acknowledge receipt of complaints or other adverse information to persons or entities reporting to the Board and to the physician, and inform them of the final disposition of the matters reported;
22. Develop and implement methods to identify dyscompetent physicians and physicians who fail to meet acceptable standards of care;
23. Develop or identify and implement methods to assess and improve physician practice;
24. Develop or identify and implement methods to ensure the ongoing competence of licensees;
25. Establish appropriate fees and charges to ensure active and effective pursuit of its legal responsibilities;
26. Develop and adopt its budget;
27. Develop educational programs to facilitate licensee awareness of provisions contained in the medical practice act and to facilitate public awareness of the role and function of state medical boards; and
28. Acquire real property or other capital for the administration and operation of the Board.

C. Members of the Board, whether appointed or elected, should serve staggered terms to ensure continuity. All appointments and elections should be confirmed through the legislative branch of the jurisdiction.

D. The length of terms on the Board should be set to permit development of effective skill and experience by members (e.g., three or four years). However, a limit should be set on consecutive terms of service (e.g., two or three).

E. Members of the Board should receive appropriate compensation for services and reimbursement for expenses at the State's current approved rate.

F. A member of the Board should be subject to removal only when he or she

1. ceases to be qualified;

2. is found guilty of a felony or an unlawful act involving moral turpitude by a court of competent jurisdiction;
3. is found guilty of malfeasance, misfeasance or nonfeasance in relation to his or her Board duties by a court of competent jurisdiction;
4. is found mentally incompetent by a court of competent jurisdiction;
5. fails to attend three successive Board meetings without just cause as determined by the Board or, if a new member, fails to attend a new members' training program without just cause as determined by the Board;
6. is disciplined for violations of the medical practice act; or
7. is found in violation of the conflict of interest/ethics law.

G. All physician members of the Board should hold full and unrestricted medical licenses in the jurisdiction, should be persons of recognized professional ability and integrity, and should have resided, practiced in the jurisdiction long enough to have become familiar with policies and practice in the jurisdiction (e.g., five years).

H. The Board should include public members who:
1. are not licensed physicians or providers of health care;
2. have no substantial personal or financial interests in the practice of medicine or with any organization regulated by the Board;
3. have no immediate familial relationships with individuals involved in the practice of medicine or any organization regulated by the Board;
4. are residents of the State; and
5. are individuals of recognized ability and integrity.

I. The Board should be authorized to appoint committees from its membership. To effectively perform its duties under the Act, the Board should also be authorized to hire, discipline and terminate staff, including an executive secretary or director. It should also be assigned adequate legal counsel by the office of the attorney general and/or be authorized to employ private counsel or its own full-time attorney.

J. The Board should conduct and new members should attend a training program designed to familiarize new members with their duties and the ethics of public service.

K. Travel, expenses and daily compensation should be paid for each Board member's attendance, in or out of state, for education or training purposes approved by the Board and directly related to Board duties.

L. Telephone or other telecommunication conference should be an acceptable form of Board meeting for the purpose of taking emergency action to enforce the medical practice act if the president/chair alone or another officer and two Board members (if allowed by open meeting laws) believe the situation precludes another form of meetingthe Board's business can be properly conducted by teleconference. The Board should shall be authorized to establish procedures by which its committees may meet by telephone or other telecommunication conference system. to take emergency action.

## Section IV: Examinations

The medical practice act should provide for the Board's authority to approve an examination(s) of medical knowledge satisfactory to inform the Board's decision to issue a full, unrestricted license to practice medicine and surgery in the jurisdiction.

A. In order to ensure a high quality, valid and reliable examination of physician preparedness to practice medicine, the Board may delegate the responsibilities for examination development, administration, scoring and security to a third party or nationally recognized testing entity. Such an examination should be consistent with recognized national standards for professional testing such as those reflected in Standards for Educational and Psychological Testing.

B. No person should receive a license to practice medicine in the jurisdiction unless he or she has successfully completed all components of an examination(s) identified as satisfactory to the Board.

1. The currently administered USMLE Steps 1,2,3 or COMLEX-USA Levels 1,2,3; or
2. previously administered examinations such as the FLEX, NBME Parts or NBOME Parts; or
3. a combination of these examinations identified as acceptable by the Board.

C. The examination(s) approved by the Board shall be in the English language and designed to ascertain an individual's fitness for an unrestricted license to practice medicine and surgery.

D. The Board may stipulate the numeric score or performance level required for passing the examination(s) or accept the recommended minimum passing score as determined by the developers of the examination.

E. The Board should be authorized to limit the number of times an examination may be taken, to require applicants to pass all examinations within a specified period, and to specify further medical education required for applicants unable to do so.

B.F. In order to support periodic or mandated reviews of its approved examination(s), the Board should be provided with reasonable access by the third party or testing entity in order to review the examination design, format and content as well as performance data and relevant procedures for test administration, security, and scoring.

A. Medical Licensing Examination(s)

1. No person should receive a license to practice medicine in the jurisdiction unless he or she has passed an examination or examinations satisfactory to the Board.

2. The Board should approve the preparation and administration of an examination or examinations, in English, that it deems must be satisfactorily passed as part of its procedure for deter-mining an applicant's qualification for the practice of medicine.

3. Examinations should be scored in a way to ensure the anonymity of applicants.

4. The Board should stipulate the score required for passing the examination(s). The required passing score should be set before the administration of the examination(s).

5. The Board should be authorized to limit the number of times an examination may be taken, to require applicants to pass all examinations within a specified period, and to specify further medical education required for applicants unable to do so.

6. An applicant should pay all examination fees prior to the examination being administered and no later than a date set by the Board.

7. The Board may delegate to its agent or a third party examination agent the responsibilities of examination development and administration, including eliminating the need for the Board to sponsor or authorize an applicant for examination eligibility.

B. Examination Application

To apply for examination(s), an applicant should provide the Board or its agent and attest to the following information and documentation no later than a date set by the Board:

1. his or her full name and all aliases or other names ever used, current address, Social Security Number and date and place of birth;

2. a recent signed photograph and/or other documentation of identity;

3. name and location of medical school of graduation, degree earned and date of graduation or the medical school now being attended and current matriculated status;

4. a history of graduate medical education, including name and address of all programs and hospitals;

5. original of all documents and credentials or notarized photocopies or other verification of such documents and credentials acceptable to the Board or its agent and

6. any other information or documentation the Board or its agent determines necessary. C. Examination Security

1. Any individual found by the Board or its agent to have engaged in conduct that subverts or attempts to subvert the medical licensing examination process or the specialty board certification/recertification process, should, at the discretion of the Board, have his or her scores on the licensing examination withheld and/or declared invalid, be disqualified from the practice of medicine and/or be subject to the imposition of other appropriate sanctions. The Federation of State Medical Boards of the United States should be informed of all such actions.

2. Conduct that subverts or attempts to subvert the medical licensing examination process should include, but not be limited to:

a. conduct that violates the security of the examination materials, such as removing from the examination room any of the examination materials; reproducing or reconstructing any portion of the licensing examination; aiding by any means in the reproduction or reconstruction of any portion of the licensing examination; selling, distributing, buying, receiving or having unauthorized possession of any portion of a future, current or previously administered licensing examination; "hacking" or attempting to "hack" the electronic version of any examination or the files of the developing or administering entity through unauthorized access or entry;

b. conduct that violates the standard of test administration, such as communicating with any other examinee during the administration of the licensing examination; copying answers from another examinee or permitting one's answers to be copied by another examinee during the administration of the licensing examination; having in one's possession during the administration of the licensing examination any books, notes, written or printed materials or data of any kind, other than the examination distributed and/or

c. conduct that violates the credentialing process, such as falsifying or misrepresenting educational credentials or other information required for admission to the licensing examination, impersonating an examinee or having an impersonator take the licensing examination on one's behalf.

3. The Board or its agent should provide written notification to all applicants for medical licensure of the prohibitions on conduct that subverts or attempts to subvert the licensing examination process and of the sanctions imposed for such conduct. A copy of such notification attesting that he or she has read and understood the notification should be signed by the applicant and filed with his or her application.

## Section V: Requirements for Full Licensure

The medical practice act should provide minimum requirements for full licensure for the independent practice of medicine that bear a reasonable relationship to the qualifications and fitness necessary for such practice. These provisions of the act should implement or be consistent with the following:

A. The applicant should provide the Board, or its agent, and attest to, or provide the means to obtain and verify the following information and documentation in a manner required by the Board:
   1. his or her full name and all aliases or other names ever used, current address, Social Security number and date and place of birth;
   2. a signed photograph not more than two (2) years old and, at the board's discretion, other documentation of identity;
   3. originals of all documents and credentials required by the Board, notarized photocopies or other verification acceptable to the Board of such documents and credentials;
   4. a list of all jurisdictions, United States or foreign, in which the applicant is licensed or has ever applied for licensure to practice medicine or is authorized or has ever applied for authorization to practice medicine, including all jurisdictions in which any license application or authorization has been withdrawn;
   5. a list of all jurisdictions, United States or foreign, in which the applicant has been denied licensure or authorization to practice medicine or as any other health care professional or has voluntarily surrendered a license or an authorization to practice medicine or as any other health care professional;
   6. a list of all sanctions, judgments, awards, settlements or convictions against the applicant in any jurisdiction, United States or foreign, that would constitute grounds for disciplinary action under the medical practice act or the Board's rules and regulations;
   7. a detailed educational history, including places, institutions, dates and program descriptions of all his or her education including all college, pre-professional, professional and professional postgraduate education;
   8. a detailed chronological life history, including places and dates of residence, employment and military service (United States or foreign) including periods of absence from the active practice of medicine;
   9. all Web sites associated with the applicant's practice and professional activities;
   10. a list and current status of all specialty certifications and the name of certifying organization; and
   11. any other information or documentation the Board determines necessary.

B. The applicant should possess the degree of Doctor of Medicine or Doctor of Osteopathic Medicine/Doctor of Osteopathy from a medical college or school located in the United States, its territories or possessions or Canada that was approved by the Board or by a private nonprofit accrediting body approved by the Board at the time the degree was conferred. No person who graduated from a medical school that was not approved at the time of graduation should be examined

for licensure or be licensed in the jurisdiction based on credentials or documentation from that school nor should such a person be licensed by endorsement.

C. Should the applicant graduate from a medical school in a foreign country, other than Canada, the applicant should meet all the requirements established by the Board to determine the applicant's fitness to practice medicine.

D. The applicant should have satisfactorily completed at least thirty-six (36) months of progressive postgraduate medical training approved accredited by the Board, the Accreditation Council for Graduate Medical Education (ACGME), or the American Osteopathic Association (AOA). or by a private nonprofit accrediting body approved by the Board in an institution in the United States, its territories or possessions or Canada, which has been approved by the Board or by a private nonprofit accrediting body approved by the Board.

E. The applicant should have passed the USMLE Steps 1, 2, 3 or COMLEX Levels 1, 2, 3 or a predecessor examination (FLEX, NBME Parts, NBOME Parts) or a combination of these examinations identified as accredited by the Board. The applicant should have passed medical licensing examination(s) satisfactory to the Board.

F. The applicant should have demonstrated a familiarity with the statutes and regulations of the jurisdiction relating to the practice of medicine and the appropriate use of controlled or dangerous substances.

G. The applicant should be physically, mentally and professionally capable of practicing medicine in a manner acceptable to the Board and should be required to submit to a physical, mental, professional competency or chemical dependency examination(s) or evaluation(s) if deemed necessary by the Board.

H. The applicant should not have been found guilty by a competent authority, United States or foreign, of any conduct that would constitute grounds for disciplinary action under the regulations of the Board or the act. The Board may be authorized, at its discretion, to modify this restriction for cause, but it should be directed to use such discretionary authority in a consistent manner.

I. If the applicant's license is denied or in accordance with Board policy, the applicant should be allowed a personal appearance before the Board or a representative thereof for interview, examination or review of credentials. At the discretion of the Board, the applicant should be required to present his or her original medical education credentials for inspection at the time of personal appearance.

J. The applicant should be held responsible for verifying to the satisfaction of the Board the validity of all credentials required for his or her medical licensure. The Board or its agent should verify medical licensure credentials directly from primary sources, and utilize recognized national physician information services (e.g., the Federation of State Medical Boards' Board Action Data Bank and Credentials Verification Service, the files of the American Medical Association and the American Osteopathic Association, and other national data banks and information resources.)

K. The applicant should have paid all fees and have completed and attested to the accuracy of all application and information forms required by the Board before the Board's verification process begins. The Board should require the applicant to authorize the Board to investigate and/or verify any information provided to it on the licensure application.

L. Applicants should have satisfactorily passed a criminal background check.

## Section VI: Graduates of Foreign Medical Schools

The medical practice act should provide minimum requirements, in addition to those otherwise established, for full licensure of applicants who are graduates of schools located outside the United States, its

territories or possessions, or Canada. These provisions of the act should implement or be consistent with the following:

A. Such applicants should possess the degree of Doctor of Medicine, Bachelor of Medicine or a Board-approved equivalent based on satisfactory completion of educational programs acceptable to the Board.
B. Such applicants should be eligible by virtue of their medical education, training and examination for unrestricted licensure or authorization to practice medicine in the country in which they received that education and training.
C. Such applicants should have passed an examination acceptable to the Board that adequately assesses the applicants' medical knowledge.
D. Such applicants should be certified by the Educational Commission for Foreign Medical Graduates or its Board-approved successor(s), or by an equivalent Board-approved entity.
E. Such applicants should have a demonstrated command of the English language satisfactory to the Board.
F. Such applicants should have satisfactorily completed at least thirty-six (36) months of progressive post-graduate medical training approved accredited by the Board, the Accreditation Council for Graduate Medical Education (ACGME), or the American Osteopathic Association (AOA). or by a private nonprofit accrediting body approved by the Board in an institution in the United States, its territories or possessions or Canada approved by the Board or by a private nonprofit accrediting body approved by the Board.
G. All credentials, diplomas and other required documentation in a foreign language submitted to the Board by or on behalf of such applicants should be accompanied by certified English translations acceptable to the Board.
H. Such applicants should have satisfied all of the applicable requirements of the United States Immigration and Naturalization Service.

## Section VII: Licensure by Endorsement, Expedited Licensure by Endorsement, and Temporary and Special Licensure

The medical practice act should provide for licensure by endorsement, expedited licensure by endorsement, and in certain clearly defined cases, for temporary and special licensure. These provisions of the act should implement or be consistent with the following:

A. Endorsement for Licensed Applicants:

The Board should be authorized, at its discretion, to issue a license by endorsement to an applicant who:

1. has complied with all current medical licensing requirements save that for examination administered by the Board;
2. has passed a medical licensing examination given in English by another state, the District of Columbia, a territory or possession of the United States or Canada, provided the Board determines that examination was equivalent to its own current examination, or an independent testing agent designated by the Board; and
3. has a valid current medical license in another state, the District of Columbia, a territory or

possession of the United States or Canada.

B. Expedited Licensure by Endorsement:

The Board should be authorized, at its discretion, to issue an expedited license by endorsement to an applicant who provides documentation of:

1. identity as required by the Board;
2. all jurisdictions in which the applicant holds a full and unrestricted license;
3. graduation from an approved medical school;
   a. Liaison Committee on Medical Education (LCME) or American Osteopathic Association (AOA) approved medical school;
   b. Fifth Pathway certificate; or
   c. Educational Commission for Foreign Medical Graduates (ECFMG) certificate
4. passing one or more of the following examinations acceptable for initial licensure within three attempts per step/level;
   a. United States Medical Licensing Examination (USMLE) Steps 1-3 or its predecessor examinations (National Board of Medical Examiners (NBME) I-III or the Federation Licensing Examination (FLEX).
   b. Examinations offered by the National Board of Osteopathic Medical Examiners (COMLEX-USA) Levels 1-3 or its predecessor examination(s).
   c. Medical Council of Canada Qualifying Examinations (MCCQE) or its predecessor examination(s) offered by the Licentiate Medical Council of Canada.
5. successful completion of the total examination sequence within seven (7) years, except when in combination with a Ph.D. program;
6. successful completion of three (3) years of progressive postgraduate training in a program accredited by the Accreditation Council on Graduate Medical Education (ACGME) or the AOA; and/or
7. certification or recertification by a medical specialty board recognized by the American Board of Medical Specialties (ABMS) or the AOA within the previous ten (10) years. Lifetime certificate holders who have not passed a written specialty recertification examination must demonstrate successful completion of the Special Purpose Examination (SPEX), Comprehensive Osteopathic Medical Variable Purpose Examination (COMVEX) or applicable recertification examination.

Boards should obtain supplemental documentation including, but not limited to:

1. Criminal background check;
2. Absence of current/pending investigations in any jurisdiction where licensed;
3. Verification of specialty board certification; and
4. Professional experience.

Physicians desiring an expedited process for licensure must utilize the Federation Credentials Verification Service (FCVS), or credentials verification meeting equivalent standards for verification of core credentials, including:

1. medical school diploma,

2. medical school transcript,
3. dean's certificate,
4. examination history,
5. disciplinary history,
6. identity (photograph and certified birth certificate or original passport),
7. ECFMG certificate, if applicable,
8. Fifth Pathway certificate, if applicable, and postgraduate training verification.

C. Temporary Licensure:

The Board should be authorized to establish regulations for issuance of a temporary medical license for the intervals between Board meetings. Such a license should:

1. be granted only to an applicant demonstrably qualified for a full and unrestricted medical license under the requirements set by the medical practice act and the regulations of the Board and
2. automatically terminate within a period specified by the Board.

D. Special Licensure:

The Board should be authorized to issue conditional, restricted, probationary, limited or otherwise circumscribed licenses as it determines necessary. This provision should include the ability to issue a special purpose license to practice medicine across state lines. It is to the discretion of the state medical board to set the criteria for issuing special purpose licenses. This provision should include, but not be limited to, the ability to issue a special license for the following purposes:

1. to practice medicine across state lines;
2. to provide medical services to a traveling sports team, coaches and staff for the duration of the sports event;
3. to provide volunteer medical services to under-insured/uninsured patients;
4. to provide medical services to youth camp enrollees, counselors and staff for the duration of the youth camp; and
5. to engage in the limited practice of medicine in an institutional setting by a physician who is licensed in another jurisdiction in the United States.

## Section VIII: Limited Licensure for Physicians in Postgraduate Training

The medical practice act should provide that all physicians in all postgraduate training in the state or jurisdiction who are not otherwise fully licensed to practice medicine should be licensed on a limited basis for educational purposes. These provisions of the act should implement or be consistent with the following:

A. To be eligible for limited licensure, the applicant should have completed all the requirements for full and unrestricted medical licensure except postgraduate training or specific examination requirements.
B. Issuance of a limited license specifically for postgraduate training shall occur only after the applicant demonstrates that he or she is accepted in a residency program. The application for limited licensure should be made directly to the Board in the jurisdiction where the applicant's postgraduate training is to take place.
C. The Board should establish by regulation restrictions for the limited license to assure that the holder

will practice only under appropriate supervision and within the confines of the program within which the resident is enrolled.

D. The limited license should be renewable annually and upon the written recommendation of the supervising institution, including a written evaluation of performance, until the Board regulations require the achievement of full and unrestricted medical licensure.

E. Program directors responsible for postgraduate training should be required annually to provide the Board a written report on the status of program participants having a limited license.

1. The report should inform the Board about program participants who have successfully completed the program, have departed from the program, have had unusual absences from the program, or have had problematic occurrences during the course of the program.
2. The report should include an explanation of any disciplinary action taken against a limited licensee for performance or behavioral reasons which, in the judgment of the program director, could be a threat to public health, safety and welfare; unapproved or unexplained absences from the program; resignations from the program or nonrenewal of the program contract; dismissals from the program for performance or behavioral reasons; and referrals to substance abuse pro-grams not approved by the Board.
3. Failure to submit the annual program director's report shall be considered a violation of the mandatory reporting provisions of the Medical Practice Act and shall be grounds to initiate such disciplinary action as the Board deems appropriate, including fines levied against the supervising institution and suspension of the program director's medical license.

F. The disciplinary provisions of the medical practice act should apply to the holders of the limited and postgraduate training license as if they held full and unrestricted medical licensure.

G. The issuance of a limited license should not be construed to imply that a full and unrestricted medical license would be issued at any future date.

## Section IX: Disciplinary Action against Licensees

The medical practice act should provide for disciplinary and/or remedial action against licensees and the grounds on which such action may be taken. These provisions of the act should implement or be consistent with the following:

A. Range of Actions: A range of progressive disciplinary and remedial actions should be made available to the Board. These should include, but not be limited to, the following:

1. revocation of the medical license;
2. suspension of the medical license;
3. probation;
4. stipulations, limitations, restrictions, probation, and conditions relating to practice;
5. censure (including specific redress, if appropriate);
6. reprimand;
7. chastisement, letters of concern and advisory letters;
8. monetary redress to another party;
9. a period of free public or charity service, either medical or non-medical;
10. satisfactory completion of an educational, training and/or treatment program(s), or professional developmental plan;
11. levy fine; and

12. payment of administrative and disciplinary costs.

The Board should be authorized, at its discretion, to take disciplinary, non-disciplinary, public or non-public actions singly or in combination as the nature of the violation requires and to promote public protection.

B. Letter of Concern or Advisory Letter: The Board should be authorized to issue a confidential (if allowed by state law), non-reportable, non-disciplinary letter of concern or advisory letter to a licensee when evidence does not warrant formal discipline, but the Board has noted indications of possible errant conduct by the licensee that could lead to serious consequences and formal action if the conduct were to continue. In its letter of concern or advisory letter, the Board should also be authorized, at its discretion, to request clarifying information from the licensee.

C. Examination/Evaluation: The Board should be authorized, at its discretion, to require professional competency, physical, mental or chemical dependency examination(s) or evaluation(s) of any applicant or licensee, including withdrawal and laboratory examination of bodily fluids, tissues, hair, or nails.

D. Grounds for Action: The Board should be authorized to take disciplinary action for unprofessional or dishonorable conduct, which should be defined to mean, but not be limited to, the following:

1. fraud or misrepresentation in applying for or procuring a medical license or in connection with applying for or procuring periodic renewal of a medical license;
2. cheating on or attempting to subvert the medical licensing examination(s);
3. the commission or conviction or the entry of a guilty, nolo contendere plea, or deferred adjudication (without expungement) of:
    a. a misdemeanor whether or not related to the practice of medicine and any crime involving moral turpitude;
    b. or a felony, whether or not related to the practice of medicine. The Board shall revoke a licensee's license following conviction of a felony, unless a 2/3 majority vote of the board members present and voting determined by clear and convincing evidence that such licensee will not pose a threat to the public in such person's capacity as a licensee and that such person has been sufficiently rehabilitated to warrant the public trust;
4. conduct likely to deceive, defraud or harm the public;
5. disruptive behavior and/or interaction with physicians, hospital personnel, patients, family members or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient;
6. making a false or misleading statement regarding his or her skill or the efficacy or value of the medicine, treatment or remedy prescribed by him or her or at his or her direction in the treatment of any disease or other condition of the body or mind;
7. representing to a patient that an incurable condition, sickness, disease or injury can be cured;
8. willfully or negligently violating the confidentiality between physician and patient except as required by law;
9. professional incompetency as one or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes gross negligence, as determined by the board;

professional incompetency by repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board;

10. being found mentally incompetent or of unsound mind by any court of competent jurisdiction;
11. being physically or mentally unable to engage in the practice of medicine with reasonable skill and safety;
12. practice or other behavior that demonstrates an incapacity or incompetence to practice medicine;
13. the use of any false, fraudulent or deceptive statement in any document connected with the practice of medicine;
14. giving false, fraudulent, or deceptive testimony while serving as an expert witness;
15. practicing medicine under a false or assumed name;
16. aiding or abetting the practice of medicine by an unlicensed, incompetent or impaired person;
17. allowing another person or organization to use his or her license to practice medicine;
18. commission of any act of sexual misconduct, including sexual contact with patient surrogates or key third parties, which exploits the physician-patient relationship in a sexual way;
19. habitual or excessive use or abuse of drugs, alcohol or other substances that impair ability;
20. failing or refusing to submit to an body fluid examination or any other examination that may detect the presence of alcohol or drugs upon Board order or any other form of impairment;
21. prescribing, selling, administering, distributing, diverting, ordering or giving any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug for other than medically accepted therapeutic purposes;
22. knowingly prescribing, selling, administering, distributing, ordering or giving to a habitual user or addict or any person previously drug dependent, any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug, except as otherwise permitted by law or in compliance with rules, regulations or guidelines for use of controlled substances and the management of pain as promulgated by the Board;
23. prescribing, selling, administering, distributing, ordering or giving any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug to a family member or to himself or herself;
24. violating any state or federal law or regulation relating to controlled substances;
25. signing a blank, undated or predated prescription form;
26. obtaining any fee by fraud, deceit or misrepresentation;
27. employing abusive, illegal, deceptive or fraudulent billing practices;
28. directly or indirectly giving or receiving any fee, commission, rebate or other compensation for professional services not actually and personally rendered, though this prohibition should not preclude the legal functioning of lawful professional partnerships, corporations or associations;
29. disciplinary action of another state or federal jurisdiction against a license or other authorization to practice medicine or participate in a federal program (payment or treatment)

based upon acts or conduct by the licensee similar to acts or conduct that would constitute grounds for action as defined in this section, a certified copy of the record of the action taken by the other state or jurisdiction being conclusive evidence thereof;

30. failure to report to the Board any adverse action taken against oneself by another licensing jurisdiction (United States or foreign), by any peer review body, by any health care institution, by any professional or medical society or association, by any governmental agency, by any law enforcement agency or by any court for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
31. failure to report or cause a report to be made to the Board any physician upon whom a physician has evidence or information that appears to show that the physician is incompetent, guilty of negligence, guilty of a violation of this act, engaging in inappropriate relationships with patients, is mentally or physically unable to practice safely or has an alcohol or drug abuse problem;
32. failure of physician who is the chief executive officer, medical officer or medical staff to report to the Board any adverse action taken by a health care institution or peer review body, in addition to the reporting requirement in 31. (note: a report under 32 31 may need to wait until the peer review and due process procedures are completed, but the report under 31 30 must be reported immediately without waiting for the final action of the health care institution and applies to all physicians not just staff physicians);
33. failure to report to the Board surrender of a license limitation or other authorization to practice medicine in another state or jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society has surrendered the authority to utilize controlled substances issued by any state or federal agency, or has agreed to a limitation to or restriction of privileges at any medical care facility while under investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
34. any adverse judgment, award or settlement against the licensee resulting from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
35. failure to report to the Board any adverse judgment, settlement or award arising from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
36. failure to provide pertinent and necessary medical records to another physician or patient in a timely fashion when legally requested to do so by the subject patient or by a legally designated representative of the subject patient regardless of whether the patient owes a fee for services;
37. improper management of medical records, including failure to maintain timely, legible, accurate, and complete medical records and to comply with the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Part 160 and 164, of the Health Insurance Portability and Accountability Act of 1996.
38. failure to furnish the Board, its investigators or representatives, information legally requested by the Board or to fail to comply with a Board subpoena or order;
39. failure to cooperate with a lawful investigation conducted by the Board;
40. violation of any provision(s) of the medical practice act or the rules and regulations of

the Board or of an action, stipulation or agreement of the Board;

41. engaging in conduct calculated to or having the effect of bringing the medical profession into disrepute, including but not limited to, violation of any provision of a national code of ethics acknowledged by the Board;
42. failure to follow generally accepted infection control procedures;
43. failure to comply with any state statute or board regulation regarding a licensee's reporting responsibility for HIV, HVB (hepatitis B virus), sero-positive status or any other reportable condition (including child abuse and vulnerable adult abuse) or disease;
44. practicing medicine in another state or jurisdiction without appropriate licensure;
45. conduct which violates patient trust, exploits the physician-patient relationship or violates professional boundaries;
46. failure to offer appropriate procedures/studies, failure to protest inappropriate managed care denials, failure to provide necessary service or failure to refer to an appropriate provider within such actions are taken for the sole purpose of positively influencing the physician's or the plan's financial well- being;
47. providing treatment or consultation recommendations, including issuing a prescription via electronic or other means, unless the physician has obtained a history and physical evaluation of the patient adequate to establish diagnosis and identify underlying conditions and/or contraindications to the treatment recommended/provided;
48. violating a Board formal order, condition of probation, consent agreement or stipulation;
49. representing, claiming or causing the appearance that the physician possesses a particular medical specialty certification by a Board recognized certifying organization (ABMS, AOA) if not true;
50. failing to obtain adequate patient informed consent;
51. using experimental treatments without appropriate patient consent and adhering to all necessary and required guidelines and constraints;
52. any conduct that may be harmful to the patient or the public;
53. failing to divulge to the Board upon legal demand the means, method, procedure, modality or medicine used in the treatment of an ailment, condition or disease;
54. conduct likely to deceive, defraud or harm the public;
55. the use of any false, fraudulent or deceptive statement in any document connected with the practice of the healing arts including intentional falsifying or fraudulent altering of a patient or medical care facility record;
56. failure to keep written medical records which accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination results and test results;
57. delegating professional responsibilities to a person when the licensee knows or has reason to know that such person is not qualified by training, experience, or license to perform them;
58. using experimental forms of therapy without proper informed patient consent, without conforming to generally accepted criteria or standard protocols, without keeping detailed legible records or without having periodic analysis of the study and results reviewed by a committee or peers; and
59. failing to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

## Section X: Procedures for Enforcement and Disciplinary Action

The medical practice act should provide for procedures that will permit the Board to take appropriate enforcement and disciplinary action when and as required, while assuring fairness and due process to licensees. These provisions of the act should implement or be consistent with the following:

A. Board Authority: The Board should be empowered to commence legal action to enforce the provisions of the medical practice act and to exercise full discretion and authority with respect to disciplinary actions. In the course of an investigation, the Board's authority should include the ability to issue subpoenas to licensees, health care organizations, complainants, patients and witnesses to produce documents or appear before the Board or staff to answer questions or be deposed. The Board should have the power to enforce its subpoenas, including disciplining a non-compliant licensee, and it is incumbent upon the subpoenaed party to seek a motion to quash the subpoena.

B. Separation of Functions: In the exercise of its power, the Board's investigative and judicial functions should be separated to assure fairness and the Board should be required to act in a consistent manner in the application of disciplinary and/or remedial sanction.

C.B. Administrative Procedures: The existing administrative procedures act or similar statute, in whole or in part, should either be applicable to or serve as the basis of the procedural provisions of the medical practice act. The procedural provisions should provide for Board investigation of complaints; notice of formal or informal charges or allegations to the licensee; a fair and impartial hearing for the licensee before the Board, an examining committee or hearing officer; an opportunity for representation of the licensee by counsel; the presentation of testimony, evidence and arguments; subpoena power and attendance of witnesses; a record of the proceedings; and judicial review by the courts in accordance with the standards established by the jurisdiction for such review. The Board should have subpoena authority to conduct comprehensive reviews of a licensee's patient and office records and administrative authority to access otherwise protected peer review records. The Board should not need the patients' consent to obtain copies of medical records, nor shall health care institutions' peer-review privilege bar the Board from obtaining copies of peer review information. Once in the Board's possession, the patient records and peer review records should have the same legal protection from disclosure as they have when in the possession of the licensee, the patient or the peer-review organization.

D.C. Standard of Proof: The Board should be authorized to use preponderance of the evidence as the standard of proof in its role as trier of fact for all levels of discipline.

E.D. Informal Conference: Should there be an open meeting law, an exemption to it should be authorized to permit the Board, at its discretion, to meet in informal conference with a licensee who seeks or agrees to such a conference. Disciplinary action taken against a licensee because of such an informal conference and agreed to in writing by the Board and the licensee should be binding and a matter of public record. However, license revocation and suspension should be held in open formal hearing, unless executive session is permitted by the State's open meetings law. The holding of an informal conference should not preclude an open formal hearing if the Board determines such is necessary.

F.E. Summary Suspension: The Board should be authorized to summarily suspend or restrict a license prior to a formal hearing when it believes such action is required to protect the public from an imminent threat to public health and safety. The Board should be permitted to summarily suspend or restrict a license by means of a vote con-ducted by telephone conference call or other electronic means if appropriate Board officials believe such prompt action is required. Proceedings for a formal

hearing should be instituted simultaneously with the summary suspension. The hearing should be set within a reasonable time of the date of the summary suspension. No court should be empowered to lift or otherwise interfere with such suspension while the Board proceeds in a timely fashion.

G.F. Cease and Desist Orders/Injunctions: The Board should be authorized to issue a cease-and-desist order and/or obtain an injunction to restrain any person or any corporation or association and its officers and directors from violating any provision of the medical practice act. Violation of an injunction should be punishable as contempt of court. No proof of actual damage to any person should be required for issuance of a cease-and-desist order and/or an injunction, nor should issuance of an injunction relieve those enjoined from criminal prosecution, civil action or administrative process for violation of the medical practice act.

H.G. Board Action Reports: All the Board's final disciplinary actions, non-administrative license withdrawals, and license denials, including related findings of fact and conclusions of law, should be matters of public record. The Board should report such actions and denials to the Board Action Data Bank of the Federation of State Medical Boards of the United States within 30 days of the action being taken, to any other data repository required by law and to the media. Voluntary surrender of and voluntary limitation(s) on the medical license of any person should also be matters of public record and should also be reported to the Federation of State Medical Boards of the United States and to any other data repository by law. The Board should have the authority to keep confidential practice limitations and restrictions due to physical impairment when the licensee has not violated any provision in the medical practice act.

I.H. Tolling Periods of License Suspension or Restriction: The Board should provide, in cases of license suspension or restriction, that any time during which the disciplined licensee practices in another jurisdiction without comparable restriction shall not be credited as part of the period of suspension or restriction.

J.I. The Board should have the authority, at its discretion, to share investigative and adjudicatory files with other state and territorial medical boards at any time during the investigational or adjudicative process.

## Section XI: Impaired Physicians

The medical practice act should provide for the limitation, restriction, conditioning, suspension or revocation of the medical license of any licensee whose mental or physical ability to practice medicine with reasonable skill and safety is impaired.

The Board should have available to it a confidential impaired physician program approved by the Board and charged with the evaluation and treatment of licensees who are in need of rehabilitation. The Board may directly provide such programs or through a formalized contractual relationship with an independent entity whose program meets standards set by the Board. The Board shall have authority over such program and the ability to monitor or audit the program to ensure the program meets the requirements of the Board.

The Board should be authorized, at its discretion, to require a licensee or applicant to submit to a mental or physical examination, body fluid, nail, or hair follicle test, or a chemical addiction, abuse or dependency evaluation conducted by an independent evaluator designated or approved in advance by the Board. The results of the examination or evaluation should be admissible in any hearing before the Board or hearing officer, despite any claim of privilege under a contrary rule or statute. Every person who receives a license to practice medicine or who files an application for a license to practice medicine should be deemed to have given

consent to submit to mental or physical examination or a chemical addition, abuse or dependency evaluation, and to have waived all objections to the admissibility of the results in any hearing before the Board. If a licensee or applicant fails to submit to an examination or evaluation when properly directed to do so by the Board, the Board should be permitted to enter a final order upon proper notice, hearing and proof of refusal.

If the Board finds, after an evaluation, examination or hearing, that a licensee is mentally, psychologically, physically or chemically impaired, it should be authorized to take one or more of the following actions:

A. direct the licensee to submit to therapy, medical care, counseling or treatment acceptable to the Board and comply with monitoring to ensure compliance;
B. suspend, limit or, restrict or place conditions on the licensee's medical license for the duration of the impairment and monitoring or treatment; and/or
A.C. revoke the licensee's medical license.

Any licensee or applicant who is prohibited from practicing medicine under this provision should be afforded at reasonable intervals an opportunity to demonstrate to the satisfaction of the Board that he or she can resume or begin the practice of medicine with reasonable skill and safety. A license should not be reinstated, however, without the payment of all applicable fees and the fulfillment of all requirements as if the applicant had not been prohibited from practicing medicine.

While all impaired licensees should be reported to the Board in accord with the mandatory reporting requirements of the medical practice act, unidentified and unreported impaired licensees should be encouraged to seek treatment. To this end, the Board should be authorized, at its discretion, to establish rules and regulations for the review and approval of a medically directed Physician Health Program (PHP). Those conducting a Board-approved PHP should be exempt from the mandatory reporting requirements relating to an impaired licensee who is participating satisfactorily in the program, or the Board should hold its report in confidence and without action, unless or until the impaired licensee ceases to participate satisfactorily in the program. The Board should require a PHP to report any impaired licensee whose participation is unsatisfactory to the Board as soon as that determination is made. Participation in an approved PHP should not protect an impaired licensee from Board action resulting from a report of his or her impairment from another source. The Board should be the final authority for approval of a PHP, should conduct a review of its approved program(s) on a regular basis and should be permitted to withdraw or deny its approval at its discretion. The PHP should be required to report to the Board information regarding any violation of the medical practice act by a PHP participant, other than the impairment, even if the violation is unrelated to the licensee's impairment.

## Section XII: Dyscompetent and Incompetent Licensees

The medical practice act should provide for the restriction, conditioning, suspension, revocation or denial of the medical license of any licensee who the Board determines to be dyscompetent or incompetent. These provisions of the act should implement or be consistent with the following:

A. The Board should be authorized to develop and implement methods to identify dyscompetent or incompetent licensees and licensees who fail to provide the appropriate quality of care. The Board should also be authorized to develop and implement methods to assess and improve licensee practices.
B. The Board should have access to a Board-approved assessment program charged with assessing

licensees' clinical competency.

C. The Board should be authorized, at its discretion, to require a licensee or an applicant for licensure to undergo a physician competency evaluation conducted by a Board-designated independent evaluator at licensee's own expense. The results of the assessment should be admissible in any hearing before the Board or hearing officer, despite any claim of privilege under a contrary rule or statute. Every person who receives a license to practice medicine or who files an application for a license to practice medicine should be deemed to have given consent to submit to a physician competency evaluation, and to have waived all objections to the admissibility of the results in any hearing before the Board or hearing officer. If a licensee or applicant fails to submit to a competency assessment when properly directed to do so by the Board, the Board should be permitted to enter a final order upon proper notice, hearing and proof of refusal to submit to such an evaluation.

D. If the Board finds, after evaluation by the assessment program, that a licensee or applicant for licensure is unable to competently practice medicine, it should be authorized to take one or more of the following actions:

    1. suspend, revoke or deny the licensee's medical license or application;
    2. restrict or limit the licensee's practice to those areas of demonstrated competence and comply with monitoring to ensure compliance, and/or;
    3. place conditions on the licensee's license; and/or,
    4. 3. direct the licensee to submit to a Board approved remediation program and comply with monitoring to ensure compliance to resolve any identified deficits in medical knowledge or clinical skills acceptable to the Board.

E. Any licensee or applicant for licensure who is prohibited from practicing medicine, or who has had restrictions or conditions placed upon his license, under the pro- vision referenced in paragraphSubsection D of this section should be afforded, at reasonable intervals, an opportunity to demonstrate to the satisfaction of the Board that he or she can resume or begin the practice of medicine, or can practice without the restrictions or conditions, with reasonable skill and safety. A license should not be reinstated, however, without the payment of all applicable fees and the fulfillment of all requirements as if the applicant had not been previously prohibited.

F. The Board should be authorized to require the assessment program to provide to the Board a written report of the results of the assessment with recommendations for remediation of the identified deficiencies.

G. The Board should have access to Board approved remedial medical education programs for referral of licensees in need of remediation. Such programs shall incorporate and comply with standards set by the Board. During remediation, the program shall provide, at Board determined intervals, written reports to the Board on the licensee's progress. Upon completion of the remediation program, the program shall provide a written report to the Board addressing the remediation of the previously identified areas of deficiency. The Board should be authorized to mandate that the licensee undergo post-remediation assessment to identify areas of continued deficit. The licensee shall be responsible for all expenses incurred as part of the assessment and the remediation.

## Section XIII: Compulsory Reporting and Investigation

The medical practice act should provide that certain persons and entities report to the Board any possible violation of the act or of the Board's rules and regulations by a licensee. These provisions of the act should implement or be consistent with the following:

A. Any person should be permitted to report to the Board in a manner prescribed by the Board, any information he or she believes indicates a medical licensee is or may be medically incompetentdyscompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine.

B. The following should be required to report to the Board promptly and in writing any information that indicates a licensee is or may be medically incompetentdyscompetent, guilty of unprofessional conduct or mentally or physically unable to engage safely in the practice of medicine; and any restriction, limitation, loss or denial of a licensees staff privileges or membership that involves patient care:

1. all licensees licensed under the act,
2. all licensed health care providers,
3. the state medical associations and its components,
4. all hospitals and other health care organizations in the state, to include hospitals, medical centers, nursing homes, long term care facilities, managed care organizations, ambulatory surgi-centers surgery centers, clinics, group practices, coroners, etc.,
5. all chiefs of staff, medical directors, department administrators, service directors, attending physicians, residency directors, etc.,
6. all liability insurance organizations,
7. all local medical/osteopathic societies,

5.8. all local professional societies,

6.9. all state agencies,

7.10. all law enforcement agencies in the state,

8.11. all courts in the state,

9.12. all federal agencies (e.g., DEA, FDA, and CMS),

10.13. all peer review bodies in the state, and

11.14. resident training program directors.

C. A licensee's voluntary resignation from the staff of a health care organization or voluntary limitation of his or her staff privileges at such an organization should be promptly reported to the Board by the organization if that action occurs while the licensee is under formal or informal investigation by the organization or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct or mental, physical, alcohol or drug impairment.

D. Malpractice insurance carriers, the licensee's attorney, a hospital, a group practice and the affected licensees should be required to file with the Board a report of each final judgment, settlement, arbitration award, or any form of payment by the licensee or on the licensee's behalf by any source upon any demand, claim or case alleging medical malpractice, battery, dyscompetence, incompetence or failure of informed consent. Licensees not covered by malpractice insurance carriers should be required to file the same information with the Board regarding themselves. All such reports should be made to the Board promptly (e.g., within 30 days).

E. The Board should be permitted to investigate any evidence that appears to show a licensee is or may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine.

F. Any person, institution, agency or organization who reports in good faith and not made in bad faith, a licensee pursuant to subsections (A) or (B) of this section should not be subject to civil damages or criminal prosecution for so reporting. A bad faith report is grounds for disciplinary action under the

medical practice act. There should be no monetary liability on the part of, and no cause of action for damages should arise against any person, institution, agency or organization for reporting in good faith.

G. To assure compliance with compulsory reporting requirements, specific civil penalties should be established for demonstrated failure to report (e.g., up to $10,000 per instance).

H. The Board should promptly acknowledge all reports received under this section. The Board should promptly notify persons or entities reporting under this section of the Board's final disposition of the matters reported.

## Section XIV: Protected Action and Communication

The medical practice act should provide legal protection for the members of the Board and its staff and for those providing information to the Board in good faith. These provisions of the act should implement or be consistent with the following:

A. Qualified Immunity

1. There shall be no liability on the part of and no action for damages against any member of the board, or its agents or employees, or any member of an examining committee of physicians appointed or designated by the board, for any action undertaken or performed by such person within the scope of the duties, powers, and functions of the board or such examining committee as provided for in this Part when such person is acting in good faith and in the reasonable belief that the action taken by him is warranted.
2. No person, committee, association, organization, firm, or corporation providing information to the board in good faith and in the reasonable belief that such information is accurate and, whether as a witness or otherwise, shall be held, by reason of having provided such information, to be liable in damages under the law of the state or any political subdivision thereof.
3. In any suit brought against the board, its employees or agents, any member of an examining committee appointed by the board or any person, firm, or other entity providing information to the board, when any such defendant substantially prevails in such suit, the court shall, at the conclusion of the action, award to any such substantially prevailing party defendant against any such claimant the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the claim was frivolous, unreasonable, without foundation, or in bad faith. For the purposes of this Section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.
4. There shall be no liability on the part of and no action for damages against any nonprofit corporation, foundation, or organization that enters into any agreement with the board related to the operation of any committee or program to identify, investigate, counsel, monitor, or assist any licensed physician who suffers or may suffer from alcohol or substance abuse or a physical or mental condition which could compromise such physician's fitness and ability to practice medicine with reasonable skill and safety to patients, for any investigation, action, report, recommendation, decision, or opinion undertaken, performed, or made in connection with or on behalf of such committee or program, in good faith and in the reasonable belief that such investigation, action, report, recommendation, decision, or opinion was warranted.

5. There shall be no liability on the part of and no action for damages against any person who serves as a director, trustee, officer, employee, consultant, or attorney for or who otherwise works for or is associated with any nonprofit corporation, foundation, or organization that enters into any agreement with the board related to the operation of any committee or program to identify, investigate, counsel, monitor, or assist any licensed physician who suffers or may suffer from alcohol or substance abuse or a physical or mental condition which could compromise such physician's fitness and ability to practice medicine with reasonable skill and safety to patients, for any investigation, action, report, recommendation, decision, or opinion undertaken, performed, or made in connection with or on behalf of such committee or program, in good faith and in the reasonable belief that such investigation, action, report, recommendation, decision, or opinion was warranted.
6. In any suit brought against any nonprofit corporation, foundation, organization, or person described in Subsection D4 or E5 of this Section, when any such defendant substantially prevails in the suit, the court shall, at the conclusion of the action, award to any substantially prevailing party defendant against any claimant the cost of the suit attributable to such claim, including reasonable attorney fees, if the claim was frivolous or brought without a reasonable good faith basis. For purposes of this Subsection, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains a judgment for damages, permanent injunction, or declaratory relief.

B. Indemnity and Defense

The state should defend a current or former member, officer, administrator, staff member, committee member, examiner, representative, agent, employee, consultant, witness, contractor or any other person serving or having served the Board against any claim or action arising out of the act, omission, proceeding, conduct or decision related to his or her duties undertaken or performed in good faith and within the scope of the function of the Board. The State should provide and pay for such defense and should pay any resulting judgment, compromise or settlement.

C. Protected Communication

1. Every communication made by or on behalf of any person, institution, agency or organization to the Board or to any person(s) designated by the Board relating to an investigation or the initiation of an investigation, whether by way of report, complaint or statement, should be privileged. No action or proceeding, civil or criminal, should be permitted against any person, institution, agency or organization that made such a communication in good faith.
2. The protections afforded in this provision should not be construed as prohibiting a respondent or his or her legal counsel from exercising the respondent's constitutional right of due process under the law.

## Section XV: Unlawful Practice of Medicine: Violations and Penalties

The medical practice act should provide a definition of the unlawful practice of medicine and penalties for such unlawful practice. These provisions of the act should implement or be consistent with the following:

A. It should be unlawful for any person, corporation or association to perform any act constituting the practice of medicine as defined in the medical practice act without first obtaining a

medical license in accord with that act and the rules and regulations of the Board. Other licensed health care professionals may provide medical services within the scope of their authorizing license.

B. The Board should be authorized to issue a cease-and-desist order and/or obtain injunctive relief against the unlawful practice of medicine by any person, corporation or association.

C. It should be a felony crime for any person, corporation or association that performs any act constituting the practice of medicine as defined in the medical practice act, or causing or aiding and abetting such actions.

D. A physician located in another state practicing within the state by electronic or other means without a license (full, special purpose or otherwise) issued by the Board should be deemed guilty of a felonious offense.

## Section XVI: Periodic Renewal

The medical practice act should provide for the periodic renewal of medical licenses to permit the Board to review the qualifications of licensees on a regular basis. These provisions of the act should implement or be consistent with the following:

A. At the time of periodic renewal, the Board should require the licensee to demonstrate to its satisfaction his or her continuing qualification for medical licensure. The Board should design the application for licensure renewal to require the licensee to update and/or add to the information in the Board's file relating to the licensee and his or her professional activity. It should also require the licensee to report to the Board the following information:

1. Any action taken for acts or conduct similar to acts or conduct described in the medical practice act as grounds for disciplinary action against a licensee by:
    a. any jurisdiction or authority (United States or foreign) that licenses or authorizes the practice of medicine or participation in a payment or practice program;
    b. any peer review body;
    c. any specialty certification board;
    d. any health care organization;
    e. any professional medical society or association;
    f. any law enforcement agency;
    g. any health insurance company;
    h. any malpractice insurance company;
    i. any court; and
    j. any governmental agency.
2. Any adverse judgment, settlement or award against the licensee or payment by or on behalf of the licensee arising from a professional liability demand, claim or case.
3. The licensee's voluntary surrender of or voluntary limitation on any license or authorization to practice medicine in any jurisdiction, including military, public health and foreign.
4. Any denial to the licensee of a license or authorization to practice medicine by any jurisdiction, including military, public health and foreign.
5. The licensee's voluntary resignation from the medical staff of any health care

organization or voluntary limitation of his or her staff privileges at such an organization if that action occurred while the licensee was under formal or informal investigation by the organization or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct or mental, physical, alcohol or drug impairment.

6. The licensee's voluntary resignation or withdrawal from a national, state or county medical society, association or organization if that action occurred while the licensee was under formal or informal investigation or review by that body for any reason related to possible medical incompetence, unprofessional conduct mental, physical, alcohol or drug impairment.
7. Whether the licensee has abused or has been addicted to or treated for addiction to alcohol or any chemical substance.
8. Whether the licensee has had any physical injury, impairment, condition, disease or mental or psychological illness that adversely affected or interrupted his or her practice of medicine.
9. The licensee's completion of continuing medical education or other forms of professional maintenance and/or evaluation, including specialty board certification or recertification, within the renewal period.

B. The Board should be authorized, at its discretion, to require continuing medical education for license renewal and to require documentation of that education. The Board should have the authority to audit, randomly or specifically, licensees for compliance.

C. The Board should require the licensee to apply for license renewal in a manner prescribed by the board and attest to the accuracy and truthfulness of the information submitted.

D. The Board should be directed to establish an effective system for reviewing renewal forms. It should also be authorized to initiate investigations and/or disciplinary proceedings based on information submitted by licensees for license renewal.

E. Failure to report fully and correctly should be grounds for disciplinary action by the Board.

## Section XVII: Physician Assistants

The medical practice act should provide for the Board to license and regulate physician assistants. These provisions of the act should implement or be consistent with the following:

A. Administration: The Board should administer and enforce these provisions of the medical practice act with the advice and assistance of the Physician Assistant Council.

B. Physician Assistant Licensing

1. No person should perform or attempt to perform practice as a physician assistant without first obtaining a license from the Board and having a supervising physician.
2. An applicant for licensure as a physician assistant should complete all Board application forms and pay a nonrefundable fee. The forms should request the applicant provide their name and address and such additional information as the Board deems necessary. The Board may issue a license to a physician assistant applicant who fulfills all board requirements for licensure. However, a licensed physician assistant is prohibited from practicing until they have an agreement with a supervising physician(s).
3. Each licensed physician assistant should renew their license and file updated documentation stating their name and current address and any additional information as required by the Board. A fee set by the Board should accompany each renewal and filing of updated

documentation.

4. The Board may require written notification by the supervising physician and the physician assistant if the relationship is changed or severed for any a reason that would have an adverse effect for patient care. The notification should include a detailed explanation of when and why the relationship changed and/or ended.
5. Persons not licensed by the Board who hold themselves out as physician assistants should be subject to penalties applicable to the unlicensed practice of medicine.

C. Rules and Regulations: The Board should be empowered to adopt and enforce rules and regulations for:

1. setting qualifications of education, skill and experience for the licensing of a person as a physician assistant and providing forms and procedures for licensure and for renewal; and
2. evaluating applicants for licensure as physician assistants as to their skill, knowledge and experience in the field of medical care.

D. Disciplinary Actions: The Board should be empowered to deny, revoke or suspend any license, to limit or restrict the location of practice, to issue reprimands, to remove the authorization of a supervising physician and to limit or restrict the practice of a physician assistant upon grounds and according to procedures similar to those for such disciplinary actions against licensed physicians. Such actions should be reported to the Federation of State Medical Boards.

E. Duties and Scope of Practice: A physician assistant should be permitted to provide those medical services delegated to them by the supervising physician that are within their training and experience, form a usual component of the supervising physician's scope of practice, and are provided pursuant to the supervising physician's instructions.

F. Responsibility of Supervising Physician: Every physician supervising or employing a physician assistant should practice in the medical areas in which the physician assistant is to perform and should be legally responsible for the delegation of health care tasks, the performance and the acts and omissions of the physician assistant. Nothing in these provisions, however, should be construed to relieve the physician assistant of any responsibility for any of their own acts and omissions. No physician should have under their supervision more staff, physician assistant or otherwise than the physician can adequately supervise. In the event the supervising physician is absent, he or she must provide for appropriate supervision of the physician assistant by another licensed physician. Each and every relationship should adhere to all statutory requirements for licensure.

G. The Board should be authorized, at its discretion, to require evidence of satisfactory completion of continuing medical education for license renewal.

## Section XVIII: Rules and Regulations

The medical practice act should authorize the Board to promulgate rules and regulations to facilitate the enforcement of the act. These provisions of the act should implement or be consistent with the following:

A. The Board should be authorized to adopt and enforce rules and regulations to carry out the provisions of the medical practice act and to fulfill its duties under the act.

B. The Board should adopt rules and regulations in accord with administrative procedures established in the jurisdiction.

## Section XIX: Funding and Fees

The medical practice act should provide that Board fees be adequate to fund the Board's effective regulation of the practice of medicine under the act and that those fees paid by licensees be used only for purposes related to licensee licensure, discipline and Board administration. These provisions of the act should implement or be consistent with the following:

A. The Board should be fully supported by the revenues generated from its activities, including fees, charges and reimbursed costs, which the Board should deposit in an appropriate account, and the Board should also receive all interest earned on the deposit of such revenues. Such funds should be appropriated continuously. All fines levied by the Board may be deposited in the State General Fund, unless otherwise allowed by law. All administrative, investigative and adjudicatory costs recoupment should be deposited in the Board's account.
B. The Board should develop and adopt its own budget reflecting revenues, including the interest thereon, and costs associated with each health care field regulated. Revenues and interest thereon, from each health care field regulated should fully support Board regulation of that field. The budget should include allocations for establishment and maintenance of a reasonable reserve fund.
C. The Board should be authorized to set fees and charges pursuant to its proposed budget needs. Reasonable notice should be provided for all increases or decreases in fees and charges.
D. The Board should operate on the same fiscal year as the State.
E. A designated officer of the Board or employee, at the direction of the Board, should oversee the collection and disbursement of funds.
F. The State Auditor's Office (or the equivalent State office) should routinely audit the financial records of the Board and report to the Board and the Legislature.

**FSMB Advisory Council of Board Executives**

2014-2015 Members

Kimberly Kirchmeyer, Medical Board of California

Robert C. Knittle, MS, West Virginia Board of Medicine

Mari Robinson, JD, Texas Medical Board

Kathleen Selzler Lippert, JD, Kansas State Board of Healing Arts

Ex Officio Members:

Margaret B. Hansen, PA-C, President, Administrators in Medicine

Kevin D. Bohnenblust, JD, Vice President, Administrators in Medicine

Lyle R. Kelsey, MBA, FSMB BOD, Oklahoma Board of Medical Licensure and Supervision

Jacqueline A. Watson, DO, MBA, FSMB BOD, District of Columbia Board of Medicine

Staff Support:

Lisa A. Robin, MLA

Shiri A. Hickman, JD

**Resolution 15-2**

**Federation of State Medical Boards**
**House of Delegates Meeting**
**April 25, 2015**

Subject: Task Force to Study Access by Regulatory Boards to Electronic Medical Records

Introduced by: Minnesota Board of Medical Practice

Approved: January 2015

---

***Whereas,*** An increasing number of health care systems and individual providers maintain patient medical records in an electronic format; and

***Whereas,*** Regulatory boards require access to patient medical records as part of investigative and enforcement processes; and

***Whereas,*** Completeness and coherence of a medical record produced from an electronic format may be inconsistent;

Therefore, be it hereby

***Resolved,*** That the Federation of State Medical Boards (FSMB) will establish a task force to review the format of an electronic medical record; and be it further

***Resolved,*** That the FSMB task force will evaluate how information is entered into an electronic record and how information is compiled and released from an electronic format; and be it further

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

**Resolution 15-5**

**Federation of State Medical Boards**
**House of Delegates Meeting**
**April 25, 2015**

Subject: Best Practices in the Use of Social Media by Medical and Osteopathic Boards

Introduced by: North Carolina Medical Board

Approved: February 2015

---

***Whereas,*** The North Carolina Medical Board (the "NCMB") is committed to disseminating information to its constituents, which include the public, Board licensees, the media and others. Outreach and transparency are key features of the Strategic Plan which the Board adopted in 2014; and

***Whereas,*** The NCMB uses different forms of social media to communicate news and information, including public disciplinary actions taken by the NCMB, and has noted the rapid growth in the use of social media by government and other public agencies; and

***Whereas,*** Posting on social media has augmented the NCMB's more traditional forms of communicating, which include printed and online publications and RSS feeds; and

***Whereas,*** Concerns have been raised about the use of social media to communicate public disciplinary actions taken by the NCMB; some characterize social media as an informal and inappropriate means of such communication that undermines the integrity of the NCMB's disciplinary process; and

***Whereas,*** During its January meeting, the NCMB had a vigorous debate on the appropriate use of social media. On one hand, the NCMB's work should be transparent and its communications should be effective and modern. On the other hand, the NCMB should be fair to licensees and should communicate about licensees with respect and decorum;

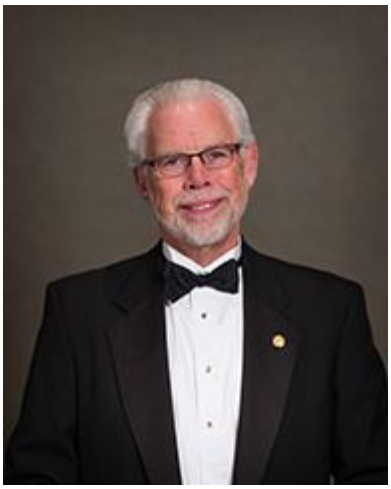
Therefore, be it hereby

***Resolved,*** That at its 2016 Annual Meeting, the Federation of State Medical Boards shall present information on current uses of social media by regulatory agencies and recommend guidelines on best practices for regulatory agencies to follow in using social media and other forms of communication to publicize Board news and information, including public disciplinary actions.

FEDERATION OF STATE MEDICAL BOARDS (FSMB)
**Candidates for the FSMB Leadership 2015-2016**

**CHAIR—ELECT**
Arthur S. Hengerer, MD - New York PMC
**TREASURER**
Ralph C. Loomis, MD - North Carolina
**BOARD OF DIRECTORS**
Claudette E. Dalton, MD - Virginia
Mark A. Eggen, MD - Minnesota
Stephen E. Heretick, JD - Virginia
Jerry G. Landau, JD - Arizona Osteopathic
Sharon L. Levine, MD - California Medical
Louis J. Prues, DMin, MBA - Michigan Medical
Gregory B. Snyder, MD - Minnesota
Sridhar V. Vasudevan, MD - Wisconsin
**NOMINATING COMMITTEE**
Mohammed A. Arsiwala, MD - Michigan Medical
James F. Griffin, DO - Rhode Island
Kelli M. Johnson, MBA - Minnesota

## Arthur S. Hengerer, MD - New York PMC
**Candidate for Chair-elect**



- **FSMB: Board of Directors 2011-2014, 2014-present; Ethics & Professionalism Committee (Chair) 2014-2015; Executive Committee 2013-2014**
- **FSMB Foundation Board of Directors 2013-2016**
- **FSMB Representative to the NBME Advisory Board 2014-2018**
- **Attended FSMB Annual Meetings 2005-present; my service on multiple FSMB committees since 2007 has provided valuable experience to assume the Board leadership position**
- **Chair, New York State Office of Professional Medical Conduct 2012-present**
- **Board Member, New York State Office of Professional Medical Conduct 2002-present**
- **Clinical practice experience in private and academic settings for 30+ years**
- **Tenured appointment for 20+ years as Department Chair of Otolaryngology with four years as Acting Chair of General Surgery at University of Rochester**

**PERSONAL STATEMENT** I have made the decision to submit my application to be a candidate for Chair-elect of the FSMB Board of Directors. I have been a practicing physician in Otolaryngology since 1974, first in private practice for six years then Chair of Otolaryngology at the University of Rochester for 27 years. It was during this period of time that I was first impacted by physician behavior and professionalism.

Initially I served on committees at our county medical society and NYS Medical Society including the board of censure. In 2002 I was appointed to the Board of Professional Medical Conduct and made the Chair 2 ½ years ago by the governor. This Board lead to my attending FSMB Annual Meetings starting in 2005 with resulting appointments to the: Planning Committee, Nominating Committee, Audit Committee (Chair), Long-Range Planning Committee, Awards Committee, Governance Committee, and presently Chair of the Ethics & Professionalism Committee. I am currently serving as a Member of the Board of Directors for my second three-year term. Recently I was also elected to the Board of the FSMB Foundation and as the FSMB representative to the Advisory Board of the NBME. I also attended the past two IAMRA meetings in Ottawa and London as a member of the FSMB delegation. This past year I represented the FSMB at the NCSBN, the AMA Committee on Ethics & Judicial Affairs, the Medical Council of Ireland, and the MSSNY CME Advisory Providers.

As an academic otolaryngologist, I was a member of the Academy of Otolaryngology and all the senior leadership sub-specialty and administrative societies. I served on various committees and task forces over my career.

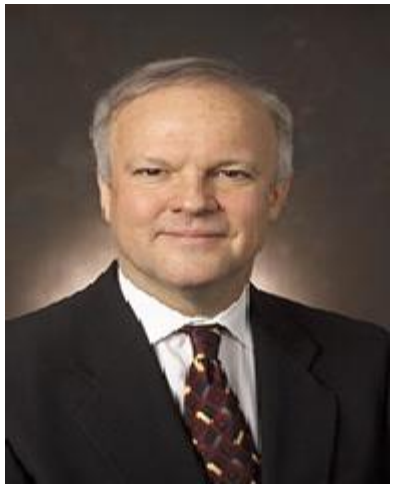
In the past five years I began to change my focus to the area of regulation and discipline. The opportunity to serve on the FSMB Board these past four years allowed me to expand my knowledge and offer input and guidance in many new areas and organizations. It has energized me to want to continue these efforts and make a difference during these rapidly changing times in health care. I continue to remain involved in part time clinical practice so I am connected to the changes affecting our physician members and the medical and osteopathic boards. This affords me the time required to serve the FSMB, committee activities, and other organization appointments. It is the network of activities that continue to expand making the service to this Board and as its Chair-elect so compelling and satisfying.

I am a father of three children and eight grandchildren and a widower. They are another important focus of my life and are included in many of my free time activities and travels. When time permits I also enjoy the Arts and the creation of stained glass windows, as a hobby.

In seeking this position of Chair-elect, I assure you I have the experience in the areas of licensure, discipline, regulation, leadership, and protecting the public that are instrumental in filling the role for which I ask your support and vote. I have demonstrated this over the past four years with total commitment to the mission and vision of the FSMB.

- Letter of Nomination
- Candidate Form
- Signatory Page
- Curriculum Vitae

**Ralph C. Loomis, MD - North Carolina**
**Candidate for Treasurer**



- **FSMB: Board of Directors 2013-2016; Audit Committee (Chair) 2014-2015; Bylaws Committee 2010-2014 (Chair 2010-2013 completing major Bylaws overhaul 2011); Executive Committee 2014-2015; Governance Committee 2013-2014**
- **FSMB Foundation Board of Directors 2014-2016**
- **President, North Carolina Medical Board 2011-2012**
- **Member, North Carolina Medical Board 2005-2008, 2009-2012**
- **30 years of community neurosurgery practice and continuous Level II trauma call**

**PERSONAL STATEMENT** Serving on the FSMB Board of Directors these past two years has directed my focus to the Board's strong financial base, which lies at the heart of the FSMB mission. As Chair of the FSMB Audit Committee, I traveled on site visits with our Chief Financial Officer and, in the process, learned a great deal about FSMB finances and budgeting.

By serving on the 2014 Investment committee, I participated in the review and selection of new options aimed to improve the financial strength of the FSMB. In serving on the 2014 Compensation committee, I took part in decisions impacting the selection and retention of the top level executives we require in our mission. I explored cost savings alternatives in many identified areas of our business.

Attending the 2014 IAMRA Conference I learned from those around the world about delivering risk-based regulation with decreasing resources.

As Treasurer, I hope to apply this experience and knowledge to: (1) expand and support new and existing revenue options and products, and (2) further our continuing goal of maintaining strong internal controls over our organization's finances.

- Letter of Nomination
- Candidate Form
- Signatory Page
- Curriculum Vitae
- CV Summary / Bio

**Claudette E. Dalton, MD - Virginia**
**Candidate for Board of Directors**

- **MOL: FSMB Advisory Committee on MOL; Past Chair, AMA Council on Medical Education's MOC/MOL Task Force; Past Chair, Virginia Board of Medicine's Competency Committee mmittee on Reentry; Chair, FSMB Special Committee on Reentry for the Clinically Inactive Physician**
- **FSMB Annual Meetings: 2007 Panel Moderator, "Strengthening Enforcement Performance"; 2009 Speaker, "The Changing Landscape of Competency"; 2010 Panel Speaker, "Telemedicine and Licensure: A State Medical Board Perspective"; 2012 HOD Voting Delegate (VA BOM); 2013 Panel Chair, "MOL for the Clinically Inactive Physician"**
- **Virginia Board of Medicine: Finance Committee 2005-2006; Credentials Committee 2006-2010 (Chair 2008-2010); Legislative Committee 2007-2011 (Chair 2010-2011); Joint Board of Nursing and Medicine 2011-2013; Chair, ad hoc Committee on Competency 2009-2013; Executive Committee (2008-2013); Vice-President 2010-2011; President 2011-2012**
- **Telemedicine: Involved early in my practice by championing a critical implementation of telemedicine for an underserved area of Virginia's Appalachia; Chairing several Medical Society of Virginia committees on telemedicine, provided testimony to a VA BOM's committee charged with implementing new regulations on telemedicine in the 1990's**
- **Private Practice: Clinical OR work ended 2010; career as consultant for the Joint Commission Resources ended July 2014; I continue to serve as a board member for the National Commission on Certification of Physician Assistants, and am proud to be an advocate for PA's who serve as partners on the care teams under the supervision of physicians**

**PERSONAL STATEMENT** I would be honored to serve on the FSMB Board of Directors. As an anesthesiologist, administrator and educator, I have worked to uphold the ethical standards of medical practice and to inculcate those standards in my colleagues and my students.

Interactions with the Virginia Board of Medicine began in 1999 when I testified to the Board's ad hoc Committee on Telemedicine and in 2003-2005, I served as a public member of the ad hoc Committee on Promulgation of Regulations on Ethics. Both opportunities broadened my perspectives on Board matters.

In 2005, I was appointed to the Board as its first ever academic member. Since that appointment, I have served on the Finance Committee; the Credentials committee from 2006-2010 (Chair 2008-2010); Legislative

Committee from 2007-2013 (Chair 2010-2011); Chair of the ad hoc Committee on Competency since its inception in 2009 until 2013 when my second term ended after 8 years and 4 extra months. I served on the executive committee starting in 2008 and served as Vice-President and then President of the Board in 2011-2012. My Board of Medicine tenure has given me experience with all types of licensure and disciplinary matters.

I also served on the AMA's Council on Medical Education. I was Chair in 2008-2009 and on the executive committee from 2006-2010. I also served on and chaired the Continuing Medical Education Sub-committee and was Chair of the MOC, MOL and Reentry Task Force from 2006-2010 when I had reached maximum tenure. I was a liaison to the AAP and the CPE on reentry matters and served six years on the NBME Medical School Advisory Committee. I was appointed to the ACCME's Board of Directors and was Vice-Chair at the time of my 2009 resignation. I am currently on the NCCPA Board of Directors. These appointments and offices allowed me to forge positive relationships with many stakeholders and to see the whole spectrum of competency assessment.

I have participated in five annual FSMB meetings: I moderated a panel on in 2007, spoke on "The Changing Landscape of Competency" in 2009 and in 2010 on "Telemedicine and Licensure: A State Board Perspective." I was a delegate in 2012 and served on the 2010 Advisory Committee on MOL and on the Special Committee on Reentry. I chaired the Committee on Reentry for Non-clinical Physicians and led a panel on its report at the 2013 meeting.

My interests and background in the MOL and Reentry issues led me to consider running for the FSMB Board of Directors. I hope to encourage important partnerships that will help meet the FSMB objectives in these areas and others. I feel that my service on the Virginia Board of Medicine and on other national bodies will be an asset to the FSMB and enable me to make collaborative and informed decisions on matters that protect patients and increase the delivery of safe and competent care to the public.

- Letter of Nomination
- Candidate Form
- Signatory Page
- Curriculum Vitae
- CV Summary / Bio

**Mark A. Eggen, MD - Minnesota**
**Candidate for Board of Directors**

- **FSMB: Finance Committee 2011-2012; Nominating Committee 2012-2014; Minimum Data Set Advisory Group (Chair) 2013-2014; Workgroup to Define a Minimal Data Set 2011-2013 (Chair 2012-2013); Workgroup on Telemedicine Consultations *(previously known as the State Medical Boards' Appropriate Regulation of Telemedicine "SMART" Workgroup)* 2014-2015**
- **FSMB Associate Member, American Board of Medical Specialties (ABMS) Health & Public Policy Committee 2010-present**
- **Minnesota Board of Medical Practice: Board Member 2009-present; President 2015; Vice President 2014; Complaint Review Committee (Chair) 2014; Complaint Review Committee 2011-2013; Licensure Committee 2009-2010**

**PERSONAL STATEMENT** It would be an honor and privilege to serve the FSMB as a member of the Board of Directors. As an FSMB fellow, I have developed a broad, national perspective on medical regulation. My FSMB activities include: 1) State Medical Boards' Appropriate Regulation of Telemedicine (SMART)

Workgroup; 2) Nominating Committee; 3) Minimal Data Set (MDS) Workgroup; 4) Finance Committee; and 5) FSMB Associate Member to the American Board of Medical Specialties (ABMS) Health & Public Policy Committee since 2010.

As a member of the Minnesota Board of Medical Practice for the past six years, I have served on the Board's Licensure and Complaint Review Committees, and as Vice President of the Board. I served as the former Chair of the Complaint Review Committee and I currently serve as President of the Minnesota Board. I have traveled Minnesota giving seminars on application of the FSMB guidelines for managing chronic pain patients with opioids. I was also actively involved in writing rules to allow ABMS MOC and AOA-BOS ACC to be used in lieu of CME to satisfy maintenance of licensure requirements for Minnesota physicians.

As a businessman, I have been employed as President of Health Billing Systems, LLP, a corporation that provides billing, management and consulting services to the anesthesia community, nationally. I also own a business, Analytical Instrument Brokers, LLC, which provides scientific instrumentation and support to the biomedical research community.

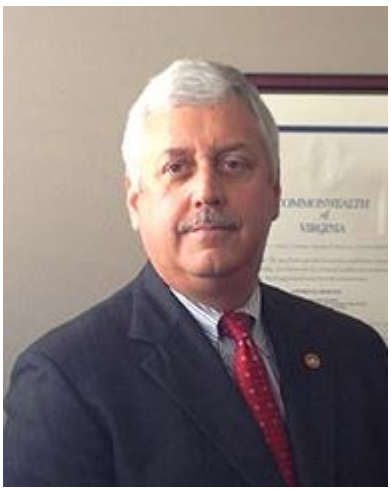
As a clinician, I was a partner in a physician anesthesiologist private practice, for 20 years, from 1994 to 2014. In order to serve further in the medical regulatory community, I retired from private practice and joined the University of Minnesota Medical School. I work part time clinically as a professor of anesthesiology.

A seat on the FSMB Board of Directors would give me an opportunity to further the mission, vision and values of the FSMB.

I would appreciate your support.

- Letter of Nomination
- Candidate Form
- Signatory Page
- Curriculum Vitae
- CV Summary / Bio

**Stephen E. Heretick, JD - Virginia**
**Candidate for Board of Directors**



- **Member, Virginia Board of Medicine 2003-2014; President 2007-2009**
- **Director, FSMB Foundation 2009-present; President 2011-2013; Coordinated FSMB Foundation's Public Member Initiative; Coordinated Rights and Distribution of *Responsible Opioid Prescribing, 2nd Edition, A Clinician's Guide*; Faculty, FSMB Annual Meeting 2010, 2011; Speaker, 2012 Tri-regulators Conference**
- **Director, FSMB 2012-present; Executive Committee; Governance Committee; Investment Committee;Compensation Committee;Special Committee on Strategic Positioning**
- **Member, National Board of Medical Examiners Committee on Individualized Review 2014-present**
- **Portsmouth (Virginia) City Council 2004-2012**
- **Bachelor of Arts (A.B.), The College of William & Mary 1982**
- **Juris Doctor (J.D.), Villanova University Law School 1988**
- **Doctor of Philosophy (Ph.D./ABD), Hahnemann Medical School**
- **Admitted to the Practice of Law Before the Supreme Court of the Commonwealth of Pennsylvania (1988) and the Supreme Court of the Commonwealth of Virginia (1989)**
- **Admitted to Practice Before the United States Courts of Appeals for the Third and Fourth Circuits (1988, 1989)**

- **Admitted to Practice Before the United States District Courts for the Eastern and Western Districts of Virginia, and the Eastern and Middle Districts of Pennsylvania**

**PERSONAL STATEMENT** Three years of service on the FSMB's Board of Directors comes and goes pretty fast. For that matter, so does 11 years on the Virginia Board of Medicine. I've been privileged to serve in a variety of leadership roles in health care regulation since my initial appointment to the Virginia Board as a public member in 2003, including my appointment as a Director of the FSMB Foundation, and more recently with my election in 2012 by the House of Delegates as a Director of the FSMB. I'm proud to have had these opportunities, and to have served among committed professionals who dedicate their time, energy, and creativity to making our system of healthcare delivery the safest and best in the world. It's been challenging. I'd like the opportunity to continue to serve a little longer, if possible.

When I joined the Virginia Board of Medicine back in 2003, I brought with me a somewhat unusual educational background. Having trained in a dual doctoral program sponsored jointly by

Hahnemann Medical School and Villanova Law School , I brought with me academic, clinical, and research experience in addition to a solid grounding in legal, legislative, and regulatory processes. As a former Justice Department attorney, and then as corporate litigation counsel, I also brought solid experience in litigation and dispute resolution. As a practicing attorney and public member, I was more than proud when my physician colleagues on the Virginia Board of Medicine elected me as their President, the first non-physician in the Board's 125+ year history elected to serve in that capacity.

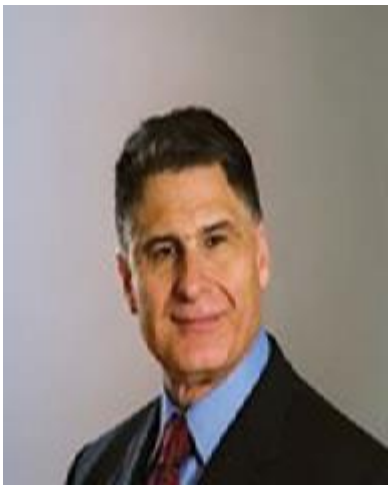
In 2009, I was selected as a Director of the FSMB Foundation. In 2010 I became the FSMB Foundation's President, and for almost three years I worked to develop educational and research opportunities to help make opiate prescribing safer and more consistent, our boards safer, and our public members more integral to healthcare regulation, among other things. At the same time, I helped to develop the team that, today, makes the FSMB Foundation a more robust and proactive resource for the FSMB and our member boards.

Since my election to the FSMB Board of Directors in 2012, I have worn a variety of hats, serving on the Executive, Governance and Investment Committees, as well as the Special Committee on Strategic Positioning, among others, all of which enhance the FSMB's work as an advocate, resource, and partner with each of our member boards. Since then, I've visited and learned from colleagues in medical regulation around the nation, and around the world. I enjoy the challenges that come with this position, and I hope that I've earned my keep since joining this Board.

Service as a Director of the FSMB is a lot of things: It's healthcare regulation. It's corporate governance. It's vision. It's a combination of teamwork and leadership. And it's a lot more besides. Mostly, though, it's just plain hard work. I have sincerely enjoyed the privilege of working with so many friends and colleagues to tackle these challenges, and I would be delighted to continue to serve among them.

- Letter of Nomination
- Candidate Form
- Signatory Page
- Curriculum Vitae
- CV Summary / Bio

**Jerry G. Landau, JD - Arizona Osteopathic**
**Candidate for Board of Directors**



- **FSMB: Special Committee on Strategic Positioning 2014-present; Nominating Committee 2012-2014; Bylaws Committee 2011-2012; Rules Committee for 2011 Annual Meeting; two task forces**
- **Participated in the significant re-write of the FSMB Bylaws by serving as the drafter**
- **Currently serving my 5th year as a member of the Arizona Board of Osteopathic Examiners in Medicine & Surgery, Chair Statutes & Rules Committee**
- **Past Chair, National Safety Council Committee on Alcohol & Other Drugs; Chair, Legal Factors Committee**
- **Conduct judicial training in Arizona; conducted nationwide prosecutor and law enforcement training**
- **Married with 20 year old son, junior in college**

**PERSONAL STATEMENT** After serving on the FSMB Nominating Committee and other FSMB committees and task forces as well as the four and a half years on the Arizona Osteopathic Board, I am ready for and looking forward to taking the next leap - to the FSMB Board of Directors. Therefore, I am a candidate for the FSMB Board.

I sit as a public member on the Arizona Osteopathic Board where I also chair the Statute and Rules Committee. Professionally, I am an attorney and the Government Affairs Director of the Arizona Supreme Court, interacting on a regular basis with the Arizona State Legislature, Governor's office, other government agencies, trade associations and the private sector. I also sit as a Judge Pro-Tempore.

Throughout my career I strive to emphasize professional responsibility, involvement and contribution. In 2010, I was appointed by Arizona's Governor to serve on Osteopathic Board, which led me to active involvement in the FSMB. I was fortunate to be selected to serve as a delegate to two conventions, elected to the Nominating Committee and appointed to the By-Laws and the Special Committee on Strategic Positioning, two task forces and a convention Rules Committee. On the By-Laws Committee I took on the responsibility of drafting proposed modifications to be presented to the 2012 delegates.

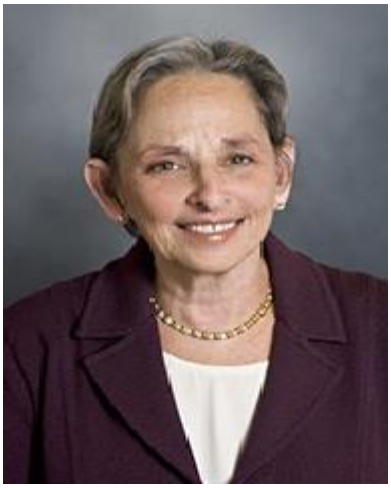
I commit to maintaining the high standards and professionalism of the FSMB and strongly support strong role of medical boards in medical regulation, licensure, discipline and protection of the public. The FSMB does not exist without the Boards. The FSMB Board is in place to support our Boards. We are entering exciting times. I just mention two projects. A contemporary strategic plan is being presented to the Board and Delegates. It is one which I was honored to participate in developing. An interstate compact is written and in the process of being presented to legislatures throughout the country, a project in which I will be involved in Arizona.

In my prior service as a prosecutor my specialty was vehicular crimes, concentrating on the prosecution of traffic fatalities, mostly caused by DUI drivers. An understanding of toxicology and the effects of drugs on the body was essential. In 1991, I was elected to membership of the National Safety Council, Committee on Alcohol and Other Drugs (now the Division of Alcohol, Drugs and Impairment) and subsequently was elected chair of the committee. Therefore, my interaction with the medical community pre-dates my appointment to the Osteopathic Board. This background helps my understanding a public member.

I interact with the highest levels of state government and with people influential on a national level, experience and skills important to the FSMB Board and its strategic plan and goals. During my career I have been fortunate to serve in leadership roles on various councils, organizations and committees, working as part of a group and interacting with others. I possess a global vision, so important to success and look forward to continuing utilization my skills for the betterment of the Federation and our boards.

- Letter of Nomination
- Candidate Form
- Signatory Page
- Curriculum Vitae
- CV Summary / Bio

**Sharon L. Levine, MD - California Medical**
**Candidate for Board of Directors**



- **FSMB participation: Voting delegate 2013, 2014; member, PLAS Program Committee 2014-present**
- **Medical Board of California participation: Six years of service on the Medical Board of California (MBC); two years as President (2012-2014); member of multiple committees (Licensure, Enforcement, Physician Health & Education, Executive Committee, Editorial Review Committee) during my tenure**
- **Professional experience: 37 years practicing with The Permanente Medical Group, Kaiser Permanente and 23 years in an executive leadership role in the medical group, with multiple responsibilities including the portfolio of professionalism for the 8300 physician group**
- **Accolades/Recognition: Recipient of the 2013 Womens Health Care Executives "Woman of the Year" Award; recipient of the California Medical Association "Gary Krieger MD Speakers Award" for contributions to organized medicine and the profession; Professional Business Women Conference award for outstanding leadership in health care**

**PERSONAL STATEMENT** I am a candidate for election to the FSMB Board of Directors. A pediatrician by training, I have practiced with The Permanente Medical Group in Northern California for the last 37 years and have served on the executive leadership team of the Medical Group for the last 23 years. In my leadership role I have had responsibility for all aspects of the professionalism agenda, including physician well-being, physician health and wellness, CME (including MOC and CMOC), GME and UME, professional development, physician HR support and conflict-of-interest issues. I am also responsible for our 8300 physician organization's involvement in public policy and health policy, and state legislative and regulatory efforts. My professional experiences include service on non-profit Boards (Public Health Institute of California; ITUP (Insure the Uninsured Project); Women's Foundation of California) and leadership roles in professional associations (CMA, CAPG at the state level, AMA). At a national level I served as a founding Board member of the Reagan Udall Foundation, and am currently a member of the Board of Governors of the federal Patient Centered Outcomes Research Institute, established in 2010, and a member of the Committee on Evidence-based Benefit Design of the National Business Group on Health.

I have been involved with IMAP (Institute for Medicine as a Profession) at Columbia University for a number of years, and am part of the steering committee for an IMAP task force convening in 2015 to look at the implications for medical professionalism of the growing number of physicians working as employees of institutions, rather than as self-employed practitioners.

In March 2009 I was a gubernatorial appointee to the Medical Board of California (MBC), and have served on the Board since that time and as President of the Board from July 2012 through June 2014. My committee assignments have included the Executive, Licensing, Enforcement, Editorial and Education/Health and Wellness Committees, which have given me a broad and deep exposure to the many facets of the consumer protection functions the Boards play through their licensing, discipline and professional support functions.

Serving on the MBC has been an extraordinary privilege, and has prompted me to put myself forward as a candidate for the FSMB Board of Directors. Through my attendance to two FSMB National Meetings, I have come to appreciate the value and importance of the work the FSMB does on behalf of the states, and also the importance of State Medical Board participation in the work of the FSMB. I believe that my experience as a clinician, a leader in a large professional medical group, and an active member of our State Medical Board have prepared me well for service on the FSMB Board, and I am at the point in my career in which I have the time, energy and commitment to the mission of public protection and patient-centeredness to enable me to carry out the responsibilities of a Board member. I would consider it a privilege to do so.

- Letter of Nomination
- Candidate Form
- Signatory Page
- Curriculum Vitae
- CV Summary / Bio

**Louis J. Prues, DMin, MBA - Michigan Medical**
Candidate for Board of Directors

- **FSMB Awards Committee 2013-2014**
- **Attendee, FSMB Annual Meeting, Boston, MA 2013**
- **Attendee, FSMB Special Meeting on Licensure and Telemedicine, Dallas, TX 2013**
- **Public Member, Michigan Board of Medicine 2012-present**
- **2008 Recipient, Herbert Manning Award for "Distinguished Service to the Church and the World"**
- **Retired COO of $175M, 2600+ employee faith-based social service agency**
- **Married 42 years with two of the cutest grandchildren ever**

**PERSONAL STATEMENT** I am honored and humbled to submit my name for election to the Board of Directors of the FSMB as a Public Member. I am a third year member of the State Medical Board of Michigan, serving as the co-chair of the Investigations and Allegations subcommittee. I attended the 2013 Annual meeting of the FSMB in Boston; attended the special meeting in Dallas on licensure and telemedicine; and was appointed by Dr. Jon Thomas to the 2013 Awards Committee. I previously served for almost six years as a Public Member of the State Board of Nursing. In that capacity I ultimately ended up chairing the Disciplinary sub-committee. I am challenged by, and enjoy being involved in, volunteering at this level. Appointed by two Governors to serve the residents of Michigan is a responsibility I do not take lightly.

I fully support the work and the direction of the Board of Directors, under the excellent leadership of CEO Dr. Chaudhry, and endorse all of the Board's endeavors. Through its Licensure, Policy and Education and Credentialing divisions, the FSMB has become the premier organization in protecting the public through licensure and regulation. Having read the responsibilities of the Board of Directors, I believe I would bring a unique perspective and a strong set of skill sets to the position:

- I bring advanced degrees in business (MBA) and Psychology (DMin/PhD equivalent)
- I have been in the nonprofit arena most of my working life
- I understand issues around health care reimbursement
- I have written and led for profit and not for profit organizations through numerous strategic plans
- I have the time and energy to serve at the Board level
- I'm a consensus builder but yet not afraid to speak my position
- I am a person of integrity

In my professional life I balance running a $175 million dollar faith-based social service agency with over 2600 employees, with the struggles and challenges of being on the Pastoral staff of an inner-city Detroit

church. To both I bring a strong commitment to the care and nurture of the people we serve, the need to balance "mission" with "margin" and the value of short and long range strategic planning.

I would be my honor to have your vote for a position on the FSMB Board of Directors.

- Letter of Nomination
- Letter of Support
- Candidate Form
- Signatory Page
- Curriculum Vitae
- CV Summary / Bio

**Gregory B. Snyder, MD - Minnesota**
**Candidate for Board of Directors**

- **FSMB: Board of Directors 2012-2015; Governance Committee (Chair) 2014; Planning Committee 2013; Audit Committee 2012; PLAS Governing Committee 2013-2016; Nominating Committee 2009-2011; Workgroup on Intl Collaboration (Chair) 2014-2015; Board of Directors Task Force on the Board Liaison Program (Chair) 2014; Telemedicine Workgroup 2010-2012; State Board Advisory Panel to USMLE 2013-2014; State Medical Boards Appropriate Regulation of Telemedicine (SMART) Workgroup; Attendee, USMLE 7th Annual Item Writing Workshop 2012**
- **FSMB Liaison Director to NV-M, CT, MA, MI-M, MN and WI state medical boards**
- **FSMB Delegate: FSMB/NABP/NCSBN Tri-regulator Meeting 2012, 2014; FMRAC 2014; IAMRA 2014**
- **FSMB Liaison: ACEP 2012-2015; ABMS (Alternate) 2013-2014**
- **Minnesota Board of Medical Practice: Member, 2006-2014; President 2013-2014; Vice President 2012-2013; Complaint Review Committee Chair 2010-2013; Licensing Committee 2006-2010; Voting Delegate, FSMB HOD Meeting 2011**
- **Moderator & Meeting Faculty: Panelist, "Future of Patient Centered Health Care" FSMB Annual Meeting 2014; Master of Ceremony, FSMB Annual Investiture of Chair and Delegates 2013; Moderator, Regional Board Meeting 2013, 2014; Moderator, National Symposium on Telemedicine 2012**

**PERSONAL STATEMENT** I am grateful for the potential opportunity to continue my service to the Federation. Over the past 8 years I have strived to become as active as possible within our organization both because I find it very engaging and also to prepare myself to be effective in a leadership role. Over the past three years on the Board of Directors I feel that I have developed the requisite skills and institutional knowledge to serve as a powerful communicator of the Federations message and a strong representative of our work products.

Unequivocally my involvement with the Federation has been the highlight of my medical career. Service on my state medical board has taught me the vital role that medical boards play in ensuring patient safety and the competence of state practitioners. Bringing my interest to the national level has allowed me a unique vantage point through the Federation to try to promote best practices criteria and work products that assist each of our state boards in their missions and advance a common message of the paramount importance of patient safety using the tools of regulation and discipline.

Although each state is unique in board composition, staffing, due process and physician expectations, we ALL share the common bond of responsibility to the public for their safety. The Federation was conceptualized and developed to promote our common interests and to serve as a resource to allow states to seek

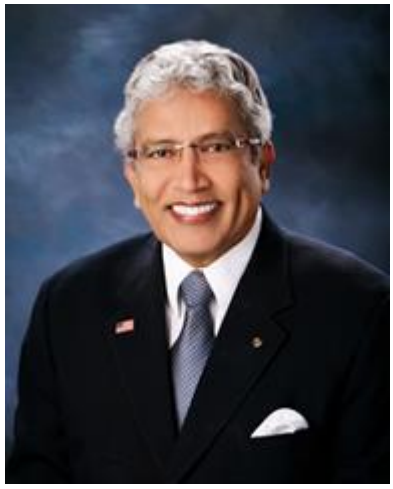
consensus opinions on key issues of regulation and to track discipline issues as less competent or unfit physicians may attempt to use interstate travel to avoid consequences from previous bad actions and outcomes.
We are unpaid volunteers and my personal reward for this time commitment is the vitality and excitement of being able to sit at the table and contribute to the conversation as national items are discussed and a course of action is agreed upon. In this venue, we have the opportunity to make a real difference, to support our individual states by supporting all states & territories and to attempt to shape the future of medicine with patient needs and safety at the center.

My time on the board has been phenomenal and I am prepared and dedicated to continue my active involvement if allowed to do so by this committee and the House of Delegates.

With this in mind, I respectfully submit my application for re-appointment to the Board of Directors.

- Letter of Nomination
- Candidate Form
- Signatory Page
- Curriculum Vitae

**Sridhar V. Vasudevan, MD - Wisconsin**
**Candidate for Board of Directors**



- **FSMB: Member, Education Committee 2014-2015; Attended and participated actively in Annual Meetings in Boston (2013) and Denver (2014)**
- **WISCONSIN MEDICAL EXAMINING BOARD: Member, February 2012-July 2016; Liaison to monitoring program and alternate to PAP (Physician Assistance Program) 2013-2014, 2014-2015; Member, Legislative Liaison Committee 2014-2015; Secretary 2014-2015**
- **CLINICAL ACTIVITIES: Board Certified and practicing Physical Medicine and Rehabilitation, Pain Medicine and Electro-diagnostic Medicine in Wisconsin since 1977**
- **PERSONAL QUALITIES: I am passionate, energetic and dedicated in all my clinical and volunteer leadership activities. I am affable, approachable and, if elected, will work in a collaborative team approach in meeting my roles and responsibilities as an active member of the FSMB Board of Directors to meet its vision and mission**

**PERSONAL STATEMENT** I am a candidate for the FSMB Board of Directors. 41 years ago after successfully completing medical school in India, I came to the United States in 1973. After one year of surgical training in Honolulu, HI, I finished my Residency in Physical Medicine and Rehabilitation (PM&R/Physiatrist) at the Medical College of WI (MCW) in Milwaukee, WI from 1974-1977. Since then I have practiced Pain Medicine/Pain Rehabilitation in academic, group practice and solo settings. I am currently practicing at the MCW clinics in Menomonee Falls, WI. Since 1975, I have been active in providing volunteer activities with local hospitals, county, state, national and international medical organizations. I have been an active member, serving on numerous committees, being chair of several committees and serving on their BOD.

I have been elected and served as President of Midwest Pain Society, American Academy of Pain Medicine, WI Society of PM&R, American College of Pain Medicine and Waukesha County Medical Society. I have served on the Board of Directors of Midwest Pain Society, WI Society of PMR, American Pain Society, American Academy of Pain Medicine, American Academy of PM&R, Waukesha County Medical Society, WI Medical Society (WMS), WMS Political Action Committee, and the WMS Foundation. I also have always given

back to the community by participating as member of Rotary Clubs since 1983-present (being Charter President of two Rotary Clubs) and am currently on the local YMCA Board.

Since being appointed to the Medical Examing Board (MEB) of WI in 2012, I realize the important work MEB's and the FSMB perform in safeguarding the public. I am liaison to our state MEB monitoring program, alternate to credentialing and liaison to WI Medical Society in developing opioid treatment guidelines. I attended the special meeting of the FSMB on License Portability in Dallas, TX; the annual meetings in Boston, MA in 2013 and Denver, CO in 2014. I am currently a member of the 2014-2015 FSMB Education Committee.

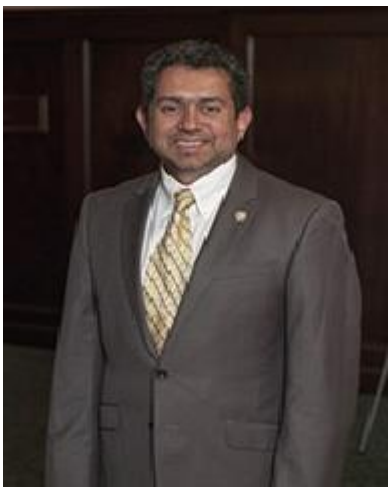
The FSMB will be facing very important challenges in the next few years which include: Interstate compacts, Telehealth, License Portability, Maintenance of Licensure, Electronic Health Records including mobile EHR-TYOD (take your own device), social media and implementation of Affordable Care Act. The FSMB needs to be active with state MEBS and other state holders in meeting its mission, vision, values and strategies goals in the face of these changes. I will supportive of the initiatives' of the FSMB.

I bring a broad national and local perspective and have the back ground, experience, time and commitment to serve on the FSMB Board, and fulfill my responsibilities of the office outlined in the call for nominations, I bring diversity, both geographic and specialty. In addition to the experience in leadership, academic and clinical background to be elected to and effectively serve on the FSMB Board in meeting its vision and mission. I enjoy what I do and look forward to contributing to the FSMB in several ways to the best of my abilities.

If nominated and elected, I will serve the FSMB with the same energy, passion and diligence that I bring to all my activities, and assist in the mission of the FSMB which is focused on licensure, discipline and protection of the public.

- Letter of Nomination
- Letter of Support (1)
- Letter of Support (2)
- Candidate Form
- Signatory Page
- Curriculum Vitae
- CV Summary / Bio

**Mohammed A. Arsiwala, MD - Michigan Medical**
**Candidate for Nominating Committee**



- **LEADERSHIP: Member, Michigan Board of Medicine and Disciplinary Subcommittee for the state of Michigan; Member, FSMB Editorial Committee**
- **SOCIAL ISSUES: support educational activities of under-served children to pursue higher education via HELP Foundation**
- **MENTORING: over a decade to high school kids via career internship program to encourage them to pursue the field of medicine**
- **SERVICE: continuous volunteer work in Africa, Afghanistan, India and Haiti by providing health care to the people**
- **ENTREPRENEURSHIP: built the largest urgent care company in the state of Michigan providing clinical care to nearly 120,000 patients every year in five counties**

**PERSONAL STATEMENT** I am a candidate for the FSMB Nominating Committee. For 16 years I have practiced in my community as an urgent care physician.

To me the Doctor/Patient relationship is the most sacred relationship. As a Doctor, I have done my best to better the lives of my patients. Also as a physician leader I have demonstrated my entrepreneurship by expanding one urgent care network to 10 urgent care centers in six counties in Michigan.

I have volunteered for over 10 years at St. Vincent DePaul Health Center, HUDA clinic taking care if indigent patients and for the last three years have done multiple medical mission trips to Haiti, India, Afghanistan and Africa. I am in the process of building a 100 bed hospital in Afghanistan in the most dangerous war torn area to provide much needed healthcare services to reduce infant/child mortality and perinatal death in women. The hospital will service the entire geographic area. In Uganda, Africa, I have created a sustainable agricultural solution and empowered over 100 farmers by tilling their farm lands to decrease poverty and increase self-sustenance.

Currently I serve on the FSMB Editorial Committee being appointed in 2013 by then Chair-elect Dr. Donald Polk.

I am willing to work hard for the FSMB with dedication and to the best of my ability; serve with honor, integrity and mutual respect for my colleagues.

Thank you for considering me as a candidate for Nominating Committee.

- Letter of Nomination
- Letter of Support
- Candidate Form
- Signatory Page
- Curriculum Vitae
- CV Summary / Bio

**James F. Griffin, DO**
**Candidate for Nominating Committee**

- **Member, FSMB Ethics & Professionalism Committee 2014-present**
- **Member, FSMB Finance Committee 2005-2006, 2006-2007**
- **Voting Delegate, FSMB House of Delegates 2000, 2003, 2014**
- **Appointed for a 3rd term on the Rhode Island Board of Medical Licensure and Discipline**
- **President, Rhode Island Society of Osteopathic Physicians and Surgeons 2012-present**

**PERSONAL STATEMENT** Since my initial appointment to the Rhode Island Board of Medical Licensure and Discipline, I have had a special interest in matters relating to medical licensure, certification, and regulation. This stems, in large part, to the circuitous path I have taken en route to my current practice of anesthesiology. I attended chiropractic and osteopathic colleges, trained in osteopathic and allopathic programs, certified with three specialty boards, and practiced Internal Medicine and Anesthesiology. Consequently, I have personally experienced “being on both sides of the fence” when considering matters such as medical education standards, board certification and scope of practice issues.

The expanded frame of reference garnered from this process has served me well in both my clinical practice and in my three terms on the Rhode Island Board of Medical Licensure & Discipline. It is this broad perspective, along with experience derived from leadership positions and participation on a variety of

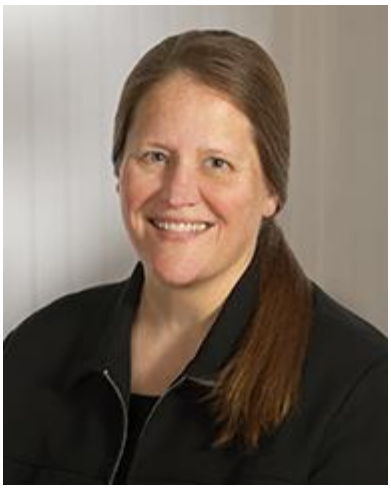
committees (such as ethics, finance, educational program planning, legislative affairs, board examinations, and credentialing) that I would bring to the Nominating Committee. These assets would be instrumental in the process of identification, recruitment, and selection of exemplary candidates possessing the requisite skill sets, vision, and commitment to serve most effectively.

The ability of the Federation to meet the myriad challenges of the future depends directly, as it has in the past, on it having the "best and brightest" leadership. Our medical boards and the public they protect deserve no less.

I would be honored to have the opportunity to help ensure that this continues to be the case.
Thank you for your consideration.

- Letter of Nomination
- Candidate Form
- Signatory Page
- Curriculum Vitae
- CV Summary/Bio

**Kelli M. Johnson, MBA - Minnesota**
**Candidate for Nominating Committee**



- **Minnesota Board of Medical Practice: Public member for eight years; Complaint Review Committee, experience on Licensure Committee, and one term as Board Secretary; enthusiastic, engaged and dedicated to supporting the Board's role in protecting the public**
- **Non-profit board experience: 10+ years service on non-profit boards for supportive housing for the long-term homeless population plus safe and healthy housing for low-income families; four years chairing boards, extensive experience with executive director searches, serving on various committees and in other leadership roles**
- **Nominating Committee experience: Two terms as appointed community member of the Nominating Committee for ClearWay Minnesota, a non-profit effort to reduce tobacco's harm in MN, gaining experience recruiting candidates, screening applications, conducting interviews, assessing conflicts of interest, and deliberating with the Committee to agree on slate of candidates for board approval**
- **Professionalism & Education: 25 years in public health, health policy, and organizational leadership; MN Dept of Health, University of Minnesota, and MN House of Representatives; expertise in collaborative decision-making, leadership, staff recruitment; University of MN doctoral candidate, Organizational Leadership, Policy, & Development focused on Evaluation Studies**

**PERSONAL STATEMENT** I am a candidate for the FSMB Nominating Committee. My service as a public member of the Minnesota Board of Medical Practice began with my initial appointment in 2004. I have found my time on the board energizing, educational, and meaningful and have been fortunate to be able to serve on the licensure and complaint review committees, learning the scope of board responsibilities in regulation, licensure, and discipline.

In addition, in serving as the board representative on the Program Committee of the Health Professional Services Program (HPSP) I developed an appreciation for the important work of the board and its partners in

promoting early intervention, treatment, monitoring, and accountability for licensees with illness, addiction, substance abuse, and mental health disorders.

Since 2004, I have been on board of directors for several non-profit organizations and have served in the role of Secretary, Treasurer, and Chair, and have served multiple terms as a member of the Finance Committee, the Human Resources Committee, the Nominating Committee, the Executive Director Search Committee (four times), and countless ad hoc committees.

I want to serve because I respect and rely on the Federation's innovative leadership, national perspective, and technical and regulatory expertise. I would appreciate the opportunity to be of service to the organization; and I believe that this is a unique opportunity to bring to the service of the FSMB my range of skills and experience – namely the competencies developed during my medical board service, my perspective as a public member, my professional expertise in collaborative decision-making and staff recruitment/selection, and my substantial experience with non-profit board governance, committee processes and procedures. In addition, I know how much energy and perseverance this type of committee work requires, and I am able to commit the time required to meet the demands of service on the Nominating Committee.

FSMB's work to promote excellence in medical practice, licensure, and regulation is invaluable to state boards and to me as an individual board member. I appreciate the work of the FSMB in providing technical expertise and direction to help us act at the state-level with a clearer understanding of the national context. If elected to the Nominating Committee, I would be honored at the opportunity to contribute to the ongoing strength and vibrancy of the FSMB as a leader and catalyst for effective policy and standards.

- Letter of Nomination
- Candidate Form
- Signatory Page
- Curriculum Vitae
- CV Summary / Bio