House of Delegates

Saturday, May 1

CHANGES TO VOTING DELEGATES

CHANGES TO DESIGNATED VOTING DELEGATES MUST BE MADE NO LATER THAN MIDNIGHT "CENTRAL" TIME ON APRIL 23, 2021. THIS WILL ALLOW TIME FOR THE NECESSARY TRAINING OF THE DELEGATE(S)

PLEASE NOTIFY MAGGIE QUINN AT MQUINN@FSMB.ORG IF A CHANGE IN THE DESIGNATION OF VOTING DELEGATE IS REQUIRED

FSMB STRATEGIC PLAN
(Approved May 2, 2020)

About the FSMB

The Federation of State Medical Boards represents the 71 state medical and osteopathic regulatory boards – commonly referred to as state medical boards – within the United States, its territories and the District of Columbia. It supports its member boards as they fulfill their mandate of protecting the public's health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and, in most jurisdictions, other health care professionals.

Vision

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

Mission Statement

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

Strategic Goals

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

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

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

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

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

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

FSMB 2021

Annual Meeting

Education, networking and resources for medical regulators

Member State Medical and Osteopathic Boards

Alabama Board of Medical Examiners

Medical Licensure Commission of Alabama

Alaska State Medical Board

Arizona Board of Osteopathic Examiners in Medicine and Surgery

Arizona Medical Board

Arkansas State Medical Board*

Medical Board of California

Osteopathic Medical Board of California

Colorado Medical Board

Connecticut Medical Examining Board

Delaware Board of Medical Licensure and Discipline

District of Columbia Board of Medicine

Florida Board of Medicine

Florida Board of Osteopathic Medicine

Georgia Composite Medical Board

Guam Board of Medical Examiners

Hawaii Medical Board

Idaho Board of Medicine

Illinois Department of Financial and Professional Regulation: Division of Professional Regulation*

Medical Licensing Board of Indiana

Iowa Board of Medicine

Kansas State Board of Healing Arts

Kentucky Board of Medical Licensure

Louisiana State Board of Medical Examiners*

Maine Board of Licensure in Medicine

Maine Board of Osteopathic Licensure

Maryland Board of Physicians*

Massachusetts Board of Registration in Medicine*

Michigan Board of Medicine*

Michigan Board of Osteopathic Medicine and Surgery

Minnesota Board of Medical Practice*

Mississippi State Board of Medical Licensure

Missouri Board of Registration for the Healing Arts

Montana Board of Medical Examiners*

Nebraska Board of Medicine and Surgery

Nevada State Board of Medical Examiners

Nevada State Board of Osteopathic Medicine

New Hampshire Board of Medicine

New Jersey State Board of Medical Examiners*

New Mexico Medical Board

New Mexico Board of Osteopathic Medical Examiners

New York State Board for Medicine*

New York State Office of Professional Medical Conduct

North Carolina Medical Board

North Dakota Board of Medicine

Commonwealth of the Northern Mariana Islands Health Care Professions Licensing Board

State Medical Board of Ohio*

Oklahoma Board of Medical Licensure and Supervision*

Oklahoma State Board of Osteopathic Examiners

Oregon Medical Board*

Pennsylvania State Board of Medicine*

Pennsylvania State Board of Osteopathic Medicine

Puerto Rico Board of Medical Licensure and Discipline

Rhode Island Board of Medical Licensure and Discipline*

South Carolina Board of Medical Examiners*

South Dakota Board of Medical and Osteopathic Examiners

Tennessee Board of Medical Examiners

Tennessee Board of Osteopathic Examination

Texas Medical Board

Utah Physicians and Surgeons Licensing Board*

Utah Osteopathic Physicians and Surgeons Licensing Board

Vermont Board of Medical Practice*

Vermont Board of Osteopathic Physicians and Surgeons

Virgin Islands Board of Medical Examiners

Virginia Board of Medicine*

Washington Medical Commission

Washington Board of Osteopathic Medicine and Surgery

West Virginia Board of Medicine

West Virginia Board of Osteopathic Medicine

Wisconsin Medical Examining Board*

Wyoming Board of Medicine

**Original 1912 charter member board of the FSMB*

FSMB 2021

Annual Meeting

Education, networking and resources for medical regulators

2020-21 Board of Directors

Chair	**Cheryl L. Walker-McGill, MD, MBA** North Carolina Medical Board
Chair-elect	**Kenneth B. Simons, MD** Wisconsin Medical Examining Board
Treasurer	**Jerry G. Landau, JD** Arizona Board of Osteopathic Examiners in Medicine and Surgery
Secretary	**Humayun J. Chaudhry, DO, MACP** FSMB President and CEO
Immediate Past Chair	**Scott A. Steingard, DO** Arizona Board of Osteopathic Examiners in Medicine and Surgery
Directors	**Mohammed A. Arsiwala, MD** Michigan Board of Medicine
	Jeffrey D. Carter, MD Missouri Board of Registration for the Healing Arts
	Melanie C. de Leon, JD, MPA Washington Medical Commission
	Jone C. Geimer-Flanders, DO Hawaii Medical Board
	Anna Z. Hayden, DO Florida Board of Osteopathic Medicine
	Frank B. Meyers, JD District of Columbia Board of Medicine
	Shawn P. Parker, JD, MPA North Carolina Medical Board
	Katie L. Templeton, JD Oklahoma State Board of Osteopathic Examiners
	Sarvam P. TerKonda, MD Florida Board of Medicine
	Barbara E. Walker, DO North Carolina Medical Board
	Joseph R. Willett, DO Minnesota Board of Medical Practice

FSMB 2021

Annual Meeting

Education, networking and resources for medical regulators

Welcome New Fellows

Board Member Fellows

Alaska State Medical Board
Sarah Bigelow Hood, PA-C
David Boswell
Larry Daugherty, MD
Maria Freeman, MD
Christopher Gay, MD
Lydia Mielke
Steve Parker, MD
Richard Wein, MD

Arizona Medical Board
Shiva Kumar Yadav Gosi, MD, MPH, FAAFP
Eileen M. Oswald, MPH

Arkansas State Medical Board
Elizabeth Anderson
Edward K. Gardner, MD
Betty Guhman

Medical Board of California
Alejandra Campoverdi
Richard E. Thorp, MD
Cinthia Tirado, MD

Colorado Medical Board
Hien Ly
Kian Modanlou, MD
Saughar Samali, DO

Delaware Board of Medical Licensure & Discipline
Joseph Rubacky, DO

Florida Board of Medicine
Eleonor Pimentel, MD

Georgia Composite Medical Board
William K. Bostock, DO
Shawn M. Hanley

Guam Board of Medical Examiners
Annette David, MD

Illinois Division of Professional Regulation - Medical Disciplinary Board
Aja Carr-Favors, JD
Caroline Moellering

Iowa Board of Medicine
Trudy Caviness
Patricia Fasbender, DO

Kansas Board of Healing Arts
Richard Bradbury, DPM
Camille Heeb, MD
Jennifer Koontz, MD
Stephanie Suber, DO

Kentucky Board of Medical Licensure
William C. Thornbury, Jr., MD

Louisiana State Board of Medical Examiners
Lolie C. Yu, MD

Maine Board of Licensure In Medicine
Renee Fay-LeBlanc, MD
Noel Genova, PA
Noah Nesin, MD

Maine Board of Osteopathic Licensure
Peter Michaud
Christine Munroe, DO

Maryland Board of Physicians
Chikaodili Iloanusi Logie, MD
Carol E. Ritter, MD
Ifeyinwa Arah Stitt, MD
Matthew Tristan Wallace, MD

Massachusetts Board of Registration In Medicine
Deborah Levine, MD
Lisa O'Connor
Holly Oh, MD

Michigan Board of Osteopathic Medicine & Surgery
Samantha Danek, PA-C
John Everett, DO
Ayanna Neal

Minnesota Board of Medical Practice
Pamela Gigi Chawla, MD, MHA
Anjali Gupta, MBBS, MPH
Shaunequa B. James, MSW, LGSW
Jennifer Y. Kendall Thomas, DO
Cherie Zachary, MD

Montana Board of Medical Examiners
Bruce Robertson, MD

Nebraska Board of Medicine & Surgery
Adam B. Kuenning, JD, LLM

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

New Hampshire Board of Medicine
Richard Kardell, DO

New Jersey State Board of Medical Examiners
Thomas J. Kirn, MD, PhD
Louis Zinterhofer, MD

New York State Office of Professional Medical Conduct
Eileen Pasquini

North Carolina Medical Board
William Brawley
Anuradha Rao-Patel, MD

North Dakota Board of Medicine
Rajendra Potluri, MD

State Medical Board of Ohio
Yeshwant P. Reddy, MD

Oklahoma Board of Medical Licensure & Supervision
Steven Katsis, MD

Oregon Medical Board
Alexandria N. Mageehon, PhD
Jill Shaw, DO

Pennsylvania State Board of Medicine
Gerard F. Dillon, PhD
Walter Eisenhauer, PA-C
Nazanin Silver, MD
Donald M. Yealy, MD

Pennsylvania State Board of Osteopathic Medicine
Kalonji Johnson, JD

FSMB 2021

Annual Meeting

Education, networking and resources for medical regulators

Welcome New Fellows

Rhode Island Board of Medical Licensure & Discipline
Sabina Holland, MD

Texas Medical Board
James Distefano, DO
Tomeka M. Herod

Utah Physicians & Surgeons Licensing Board
Susan Wiet, MD
Brian K. Zehnder, MD

Virginia Board of Medicine
Amanda Barner, MD
Milly Rambhia, MD
Ryan Williams, MD
Khalique Zahir, MD

Washington State Board of Osteopathic Medicine & Surgery
Tania Hernandez, DO
Yuri Tsirulnikov, DO

West Virginia Board of Medicine
Quartel-Ayne Amjad, MD, MPH
Christopher J. Tipton, PA-C

Wisconsin Medical Examining Board
Diane M. Gerlach, DO
Michael A. Parish, MD
Rachel E. Sattler, JD
Lemuel G. Yerby, III, MD
Emily Yu, MD

Staff Fellows

Alabama Board of Medical Examiners
William M. Perkins

Alaska State Medical Board
Natalie Norberg

Medical Board of California
William J. Prasifka

Florida Board of Medicine
Paul Vazquez, JD, BA

Michigan Board of Medicine
Debra Gagliardi, JD

Michigan Board of Osteopathic Medicine and Surgery
Debra Gagliardi, JD

New Hampshire Board of Medicine
Christine L. Senko

New Jersey State Board of Medical Examiners
Terri Goldberg

North Dakota Board of Medicine
Sandra DePountis, JD

Oklahoma State Board of Osteopathic Examiners
Michael T. Leake, Jr., JD

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

HOUSE OF DELEGATES ANNUAL BUSINESS MEETING
INSTALLATION OF NEW OFFICERS AND DIRECTORS

MAY 1, 2021

Agenda Item	**Tab**
1. Call to Order, *1:00 p.m. CDT* *Cheryl Walker-McGill, MD, MBA, Chair*	
2. Roll Call of Member Boards *Humayun J. Chaudhry, DO, MACP, President/CEO*	
3. Approval of Agenda *Cheryl Walker-McGill, MD, MBA, Chair* ►***For Action***	
4. Introduction of Parliamentarian and Tellers *Cheryl Walker-McGill, MD, MBA, Chair*	
5. Welcome New Fellows *Humayun J. Chaudhry, DO, MACP, President/CEO*	
6. Report of the Rules Committee *Kenneth B. Simons, MD, Chair-elect* ►***For Action***	A
7. Consent Agenda *Cheryl Walker-McGill, MD, MBA, Chair* ►***For Action***	B
8. Approval of Minutes of April 2020 Business Meeting *Cheryl Walker-McGill, MD, MBA, Chair* ►***For Action***	C
9. Chair's Report of the Board of Directors *Cheryl Walker-McGill, MD, MBA, Chair*	D
10. Report of the President-CEO *Humayun J. Chaudhry, DO, MACP, President/CEO*	E

11. Report on the FSMB Strategic Plan F
Humayun J. Chaudhry, DO, MACP, President/CEO

12. Treasurer's Report G
Jerry G. Landau, JD, Treasurer

13. Report of the Reference Committee H
Jorge A. Alsip, MD, MBA
►***For Action***

14. Report of the Nominating Committee I
Scott A. Steingard, DO, Immediate Past Chair

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

16. Installation of New Chair, Chair-elect, Treasurer and Directors
Cheryl Walker-McGill, MD, MBA, Chair

17. Remarks by the New Chair
Kenneth B. Simons, MD, FY 2022 Chair

18. Adjournment, *4:00 p.m. CDT*

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

FEDERATION OF STATE MEDICAL BOARDS
2021 ANNUAL HOUSE OF DELEGATES MEETING

Report of the Rules Committee

Presented by: Kenneth B. Simons, M.D., Chair
Saturday, May 1, 2021

Members Present:
Kenneth B. Simons, M.D., Chair
Kristina Lawson, J.D.
Michael Rodman

Member Excused:
Stephen R. Bell, DO, DPh

Others Present:
Humayun J. Chaudhry, D.O., President and CEO
Eric Fish, J.D., Chief Legal Officer
Linda Gage-White, M.D., Parliamentarian
Sandra McAllister, Executive Administrative Associate, recorder

Madame Chair, Members of the Federation of State Medical Boards:

Your Committee on Rules recommends the following:

I. House Security:

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

II. Credentials:

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

III. Order of Business:

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

IV. Privilege of the Floor:

All classes of membership shall have the right of the floor at meetings of the House upon request of a delegate and approval of the presiding officer. The presiding officer shall have

the discretion to structure and limit discussion, as needed for the orderly conduct of the meeting.

V. Procedures of the Annual Business Meeting:

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

The presiding officer shall appoint a parliamentarian to advise on all procedural questions using the Federation Bylaws and *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* (last revised 2012) may not participate in the general discussion but only advise on procedural issues when there is a dispute or question.

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

VI. Nominations:

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

VII. Elections:

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

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

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

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

When it is necessary to meet the minimum Bylaws requirement for election of a non-physician director, election of a non-physician director from the field of non-physicians shall

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

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

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

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

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

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

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

Proxies - In accordance with *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* (last revised 2012), no proxies shall be accepted in the voting process.

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

I want to thank the committee participants.

Respectfully submitted,

Kenneth B. Simons, M.D.
Chair

Tab B: Consent Agenda

MANAGEMENT NOTE:

The following items are included on the Consent Agenda:

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

ITEM FOR ACTION:

APPROVE the Consent Agenda for the May 1, 2021 House of Delegates meeting.

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

MANAGEMENT NOTE:

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

Attachment 1 contains an overview of ABMS activities since its last report to the FSMB House of Delegates in May 2020.

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

ITEM FOR ACTION:

No action required; report is for information only.

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

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

American Board of Medical Specialties
Report to the FSMB Board
March 2021

Achieving the Vision

Two years ago, after studying certification and gathering input from boards, participating clinicians, and users of board certification, The Continuing Board Certification: Vision for the Future Commission ("Commission") delivered its Final Report to the American Board of Medical Specialties (ABMS) Board of Directors. The report recommendations were endorsed by the ABMS Board of Directors and task forces were established in collaboration with certifying board stakeholders to help develop new, draft standards for continuing board certification that reflect the recommendations of the Commission.

The Commission's recommendations were grounded in two principles: next generation continuing certification must deliver learning value to participating diplomates while ensuring that it continues to deliver a meaningful credential for users of the certificate; and the boards must work collaboratively with their stakeholders. In implementing new standards, the boards were directed to create a more coherent system of assessment, learning, and improvement.

Although new Draft Standards for Continuing Board Certification were developed by December 2020, the public Call for Comments was delayed to April 2021out of concern for the clinical obligations of constituents as the COVID-19 pandemic surged. Depending on the state of the COVID-19 surge and hospital caseloads in April, ABMS will move forward with the Call for Comments with ample time to permit broad stakeholder input.

Symposium on Improving Health and Health Care

On December 11, 2020, the ABMS convened national thought leaders on quality improvement for a virtual Symposium entitled *The Next Generation of Board Certification: Improving Health and Health Care (IHHC)* to discuss the role of improvement in continuing certification. Featured were Paul Batalden, MD, Emeritus Professor of the Dartmouth Institute at the Dartmouth Geisel School of Medicine, and Carolyn Clancy, MD, Deputy Undersecretary for Discovery, Education, and Affiliate Networks at the Veterans Health Administration. Participants included

the ABMS Board of Directors, Member Board leaders, staff and board governance representatives, ABMS Certification Committee members, Continuing Board Certification: Vision for the Future Commission Task Force members, representatives from ABMS Associate Members, Medical Specialty Society leaders, and representatives from the ABMS Portfolio Program Sponsor community. The ABMS Portfolio Program is represented by 92 sponsor organizations who have the capacity to align their quality work with18 Member Boards' continuing certification programs.

The overall goal of the Symposium was to begin to establish a learning community that advances diplomate engagement with meaningful improvement opportunities through certification programs. Specifically, the Symposium examined methods to develop a collaborative quality agenda to guide improvement within each specialty and to engage diplomates in improvement work throughout their careers.

Call for Continuing Professional Development and Remediation Programs and Resources

ABMS Remediation Task Force, a collaborative task force comprised of national thought leaders on physician remediation and specialty board certification, established to implement a key recommendation of the Commission, has issued a call for programs and resources for inclusion in the ABMS Continuing Certification Directory. The Task Force seeks to:

- Support diplomates to address a performance or participation deficit prior to a change in certification status
- Offer a collection of remediation resources and programs for the ABMS Member Boards and their diplomates.

To learn more about the ABMS Call for Remediation Programs and Resources, please visit the ABMS website.

Opportunities for Strategic Engagement with FSMB

The events of the last year and the policy initiatives under way at ABMS suggest several strategic opportunities for collaboration with FSMB:

- ***Data exchange to support verification of license status.*** Alongside the development of new standards for continuing certification, ABMS is revising its professionalism policies, which are anchored by information about state licensure. There may be opportunities to improve the exchange and analysis of disciplinary and other data to enhance the ability of the Member Boards to improve the judgments they make about licensure actions.

- ***Data enhancements regarding race, ethnicity, and location.*** ABMS boards differ in the extent of their access to standardized data on race and ethnicity, and the boards may not have up-to-date location data for non-time-limited certificate holders. Shared data would be helpful to support research on racial diversity and equity.

- ***Initiatives to promote positive professionalism.*** ABMS boards have defined professionalism as a "belief system about how medical care should be organized and delivered." The values embodied in that belief system are vital to improving patient outcomes and clinician well-being. A Professionalism Task Force established as part of the effort to implement recommendations from the Vision Initiative Commission has been exploring how ABMS boards can enhance their professionalism policies, support formative assessment, learning and improvement of behaviors and skills associated with professionalism, and support programmatic efforts to provide a safe, supportive environment for addressing professionalism issues.

###

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

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

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

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

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

The standards for certification are specialty-specific, going beyond those required for state licensure. They provide a foundation for the board certification process and incorporate core competencies integral to quality patient care. These are: practice-based learning and improvement, patient care and procedural skills, systems-based practice, medical knowledge, interpersonal and communication skills, and professionalism. Physicians meet the Standards for Initial Certification to become board certified. Additional continuing certification standards (Standards for the ABMS Program for MOC) guide the process of ongoing assessment and learning over the course of a physician's career. The standards are designed to help physicians maintain up-to-date knowledge, enhance quality clinical outcomes and promote patient safety. They also help the ABMS Member Boards create assessment and evaluation systems, select learning programs and improvement activities, and pioneer new pathways for physicians to learn the latest innovations in their specialty.

In 2019, ABMS announced plans to implement recommendations from the Continuing Board Certification: Vision for the Future Commission's final report. New Draft Standards for Continuing Board Certification were developed by ABMS by December 2020. However, the public Call for Comments was delayed to April 2021 out of concern for the clinical obligations of constituents as the COVID-19 pandemic surged.

ABMS maintains a website (www.certificationmatters.org) for consumers to find out whether their physician is Board Certified.

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

ABMS is located at: 353 North Clark Street, Suite 1400, Chicago, IL, 60654
Phone: (312) 436-2600
Website: www.abms.org
President and CEO: Richard E. Hawkins, MD

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

MANAGEMENT NOTE:

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

Attachment 1 contains the report on the ACCME. **Attachment 2** provides an overview of the ACCME and its relationship with the FSMB.

ITEM FOR ACTION:

No action required; report is for information only.

FSMB HOUSE OF DELEGATES

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

APRIL 2021

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

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

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

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

Linda Gage-White, MD, PhD, MBA, and Michael D. Zanolli, MD, have served as FSMB representatives to the Accreditation Council for Continuing Medical Education (ACCME). Dr. Gage-White has served her final term and reached maximum tenure in December 2020. Dr. Zanolli, who served as Chair of the ACCME from December 2019 to December 2020, is serving his final term on the Board and will reach maximum tenure in December 2021. Dr Jone Geimer-Flanders was elected to the ACCME Board of Directors and is serving the first year of her three-year term (December 2020 – December 2023.)

ACCME's most notable highlights since April 2020 include the following:

- In February 2021, the ACCME announced it will be launching a new and improved Program and Activity Reporting System (PARS) by this summer. The new version of PARS will feature a modernized, user-friendly, streamlined interface for activity and learner reporting.

- In December 2020, the ACCME announced its new Standards for Integrity and Independence in Accredited Continuing Education. Providers in the ACCME system will be expected to implement the new Standards by **January 1, 2022.**
- In December 2020, the ACCME updated its *COVID-19 – Learn to Vaccinate: Clinician Resources* resource page to include a searchable list of accredited CE activities related to administering the COVID-19 vaccines. Resources and materials from the vaccine manufacturers is also provided.
- In September 2020, the ACCME released a 2020 update on Opioid REMS – Compliant Accredited CE Activities. From March 1, 2020 through August 15, 2020, 24 accredited providers reported 213 OA REMS-compliant CE activities. Of those, 166 activities had been held or released, and 44 were planned for the future. The activities were offered in a variety of formats; the most common format was live courses. For those activities that had been held or released, accredited providers reported 111,358 learners.
- In July 2020, the ACCME released its *ACCME Data Report: Steady Growth in Accredited Continuing Medical Education.* According to this report, more than 1,700 accredited CME providers offered nearly 190,000 educational activities in 2019. These activities comprised of approximately 1.3 million hours of instruction with approximately 37 million interactions with healthcare professionals.
- In January 2020, the ACCME invited stakeholders to participate in a call for comment about the proposed revisions to the rules that protect the independence and integrity of accredited CME. FSMB provided comments in support of many of the revisions and offered feedback and suggestions for improving some of the proposed revisions. Once the ACCME Board of Directors reviews and adopts the revised standards, the ACCME will release a transition plan for the accredited continuing education community.

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

Accreditation Council for Continuing Medical Education (ACCME)

(may serve two 3-year terms)

Jone Geimer-Flanders, DO	Hawaii, 1st term, Exp. 12/23
Michael D. Zanolli, MD	Tennessee-Medical, 3rd term, Exp.12/21

ACCME Accreditation Review Committee (ARC)

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

Bruce Brod, MD (PA State Board of Medicine)	2nd term, Exp. 12/21 – ARC Chair
Crystal Gyiraszin	3rd term, Exp. 12/21
Hemesh Patel, DO, MS	1st term, Exp. 12/22

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

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

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

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

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

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

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

Last Updated February 3, 2021

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

MANAGEMENT NOTE:

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

Attachment 1 contains the report on the ACGME. **Attachment 2** provides an overview of the ACGME and its relationship with the FSMB.

ITEM FOR BOARD ACTION:

No action required; report is for information only.

FSMB HOUSE OF DELEGATES

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

MAY 2020

The following is a summary of the meetings I attended as the FSMB Representative to the ACGME.

June 2020

The ACGME Board of Directors convened its spring meeting in June 2020; however, due to the continued spread of COVID-19 and the unrest in our country over the senseless murder of George Floyd, the Plenary Session that was originally scheduled in conjunction with the ACGME Board meeting was cancelled and replaced with a virtual Educational Symposium on Diversity, Equity and Inclusion. The Symposium, which took place via Zoom on Monday, June 13 from 9:30 am to 12:00 pm Central Time, was an opportunity for the ACGME Board of Directors, member representatives and partners to collectively share their perspectives on how institutional systemic racism affects the health care provided in this country.

Prior to the meeting, registrants were asked to review a collection of prework materials to help enrich and form the foundation for small group discussions and to prompt meaningful self-reflection on how those of us with a nexus to health care can take on the challenging work required to address deep rooted societal problems that manifest in the devaluation of human life and disparity of medical care given, which can lead to loss of life.

The pre-meeting materials included such items as a highly rated presentation by Dr. Owen Garrick, President and COO of Bridge Clinical Research and a speaker at the ACGME's 2020 Annual Educational Conference, who discussed racial congruity in physician-patient relationships and its impact on health care outcomes; and also a video by Robin D'Angelo on her New York Times Best Seller book, *White Fragility: Why It's So Hard for White People to Talk About Racism*. There were also papers and other supplementary publications provided that discussed the incivility and lack of inclusion in our nation's surgical training programs.

The Symposium began with an overview on institutional systemic racism by ACGME Chief Diversity and Inclusion Officer William McDade, MD, PhD, after which attendees were divided into eight small workgroups to discuss the obstacles preventing the breakdown of systemic racism. The small groups were subsequently paired together into four larger groups and asked to report on three obstacles that would be the most challenging to address and three that would be the easiest. There were a variety of opinions, all of which set the stage for future discussions on how the

ACGME as an organization can help rid the overt discrimination exhibited in our educational and clinical learning environments and, instead, promote equity and fairness and demand justice in all its forms, especially in the provision of health care to all who require it.

In the words of Dr. Thomas Nasca, ACGME President and CEO, "The work of the ACGME has always been to bring people together to build better systems of education and training for the improvement of the health and well-being of the public…Only when racism, implicit bias, and other forms of discrimination are rooted out of our society, and when our health care system provides its benefits to all in need, can we rest."

September 2020

The ACGME Plenary Session was held virtually on Sunday, September 27th from 8:00-11:35 a.m. Central. The first hour-and-a-half consisted of sharing lessons learned during the era of COVID-19 by the ACGME, its member organizations, as well as the FSMB and National Resident Matching Program (NRMP). A great deal of discussion revolved around 1) the movement towards competency rather than simply time in training; 2) telemedicine and the need for increasing diversity/anti-racism in medical education; and 3) the need to address the digital divide for rural and underserved populations.

The Veterans Health Administration (VA) noted that next year it would be celebrating the 75th anniversary of the VA's graduate medical education (GME) program. The VA is responsible for $1 billion in direct medical education training and $1 billion in indirect costs, of which eighty percent (80%) goes to GME. There are approximately 45,000 residents supported by VA funding. Additionally, the VA is providing 66 scholarships to students attending Historically Black Colleges and Universities (HBCU), but which have a payback provision. It should be noted that the VA is seeking to allow trainees to practice telehealth from their own homes across state lines.

Reports were provided by the ACGME standing committees including, Executive, Awards, Audit, Education, Journal Oversight, Monitoring and Policy. The reports largely consisted of referring to committee meeting agendas without providing details, as was true for the report from the Council of Public Members. The Requirements Committee proposed changes to program requirements for Nuclear Medicine, Brain Injury, Diagnostic Radiology, Interventional Radiology, Neuro-Radiology and Osteopathic Recognition. These changes were unanimously approved by the ACGME Board of Directors. The Requirements Committee also asked for changes to the "Background and Intent for Tele-Supervision" (Common Program Requirement VI.A.2.c).(1).(b): The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.(Core)). This, too, was unanimously approved by the ACGME board. The Council of Review Committee Residents (CRCR) noted its priorities were the physical and mental health of trainees including childcare, competency-based graduation assessment and board

certification issues. The CRCR also spoke of its desire to form a diversity, equity and inclusion subcommittee and a CRCR alumni network, and elaborated on its current qualitative research on the Committee's initial Back to Bedside efforts.

The Council of Review Committee Chairs reported on their 2020-21 priorities including 1) addressing/reviewing program requirements in relation to financial realities; 2) having diversity, equity and inclusion as a standing agenda item; and 3) reviewing accreditation requirements while considering board requirements in light of the impact of COVID-19 on achieving these, e.g., case numbers.

The outgoing board members were acknowledged, and the meeting was adjourned.

February 2021

The ACGME Board of Directors winter meeting was held virtually on Sunday, February 7, from 8:00 am-12:00 pm CST.

The meeting began with the ACGME Member Organizations and invited guests (ECFMG, FSMB and NRMP) discussing the impact of COVID-19 on their organizations, the changes in operations or strategies enacted by the organizations that will remain post pandemic, racial discrimination and systemic racism and how the organizations are approaching solutions, and reactions to the incoming administration and any potential opportunities it presents for medical education and GME in particular.

Following the discussion, the minutes of the September 27, 2020 Plenary Session were approved, and the meeting continued with reports from HRSA, VHA and the ACGME Committees.

HRSA reported upon the Teaching Health Centers Program noting 883 residents were supported, 286 graduates with 66% going into a primary care setting and 55% working in underserved or rural areas. The Children's Hospitals GME program is in 59 institutions and supported 50% of all general pediatrics residents in the US. The rural residency program supports tracks in Family Medicine, Internal Medicine, Preventive Medicine, Psychiatry, General Surgery and Obstetrics-Gynecology. There are 37 grantees, 10 with ACGME accreditation and 6 with matriculants.

VHA reported that this is the 75th anniversary of VHA medical education programs, which includes 1 billion in direct funding for GME (and some for nursing); that 1 million vaccine doses had been given; and that there was a 5% increase in GME trainees. VA noted that through regulations, it was expanding telehealth such that trainees would be allowed to do this under direct supervision. The regulation applies to nursing, but there are issues with nursing licensure that will need to be addressed prior to implementation. VA has expanded the number of trainees in rural

areas and there are 100 slots left for rural and mental health trainees. Cerner implementation has had issues.

The ACGME Finance Committee noted a $4 million positive margin as a result of ODI increased revenue from new applications and cost savings from decreased travel and staff hiring. The investment subcommittee reported that upon review of their advisor for the past 5 years, they interviewed two additional firms and elected to change advisors to TIF. The transition began in September and is on-going due to private equity investments. The prior firm had a 6.4% average return but there were communication issues.

The ACGME Awards Committee will be expanding the number of Diversity and Inclusion awards in 2022. The new name will be the Barbara Ross-Lee Diversity, Equity and Inclusion awards. The ACGME agreed to have the ACGME-I Board of Directors manage the ACGME-I awards. A subcommittee was formed to look at diversifying who gets awards and determined that no sitting Board Member is eligible or may be nominated for awards.

The ACGME Audit Committee reported that a plan will be presented at the June meeting. Insurance premiums increased by 20% due to hardening in the marketplace. A cyber attack of ACGME systems was attempted in December 2020 but there was no compromise because of the mitigation strategies employed.

The ACGME Committee on Requirements brought forth 8 revisions (6 focused revisions, 1 major revision and 1 new specialty). These were approved by the ACGME Board of Directors. Two subcommittees were approved to address the issue of dedicated administrative time: a template subcommittee and a toolkit subcommittee.

The ACGME Education Committee noted that the Annual Education Conference (AEC) would be held virtually in three weeks.

The ACGME Journal Oversight Committee noted it was moving to all open access articles, that they had changed publishers and that website changes had been made. Increased submissions have been seen and three special editions are planned (Milestones 2.0, Diversity, Equity and Inclusion, and Covid-19).

The ACGME Monitoring Committee reported it had reviewed the Cardio-Thoracic and Obstetrics-Gynecology Review Committees.

The ACGME Policy Committee reported it had discussed the Diversity, Equity and Inclusion policy, the role of allied health professionals in GME and commitment to IPE.

The ACGME Council of Review Committee Residents reported on the Back to Bedside grant funding initiative, having a pre-conference at the upcoming AEC and the launch of an alumni network from this group.

The ACGME Council of Review Committee Chairs reported on its mentorship program.

The ACGME Council of Public Members reported on its development of a guidebook for new members.

ACGME CEO Dr. Tom Nasca advised the group that beyond the pandemic, the ACGME was continuing its efforts with NAM on the opioid crisis and the burnout, depression, & suicide crisis. He advised that each of us needs to consider diversity, equity and inclusion as a core value.

Finally, the meeting concluded with ACGME Board Chair Dr. Karen Nichols noting the passing of a resolution recognizing women physicians, and that this was the 200th birthday of Elizabeth Blackwell, the first woman physician. In addition, she reminded the group that February is Black History Month and that this is the 40th anniversary of the ACGME in its current structure.

Respectfully submitted,
Kenneth B. Simons, M.D.

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

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

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

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

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

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

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

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

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

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

MANAGEMENT NOTE:

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

Attachment 1 contains the report on the NBME. **Attachment 2** provides an overview of the NBME and its relationship with the FSMB.

ITEM FOR BOARD ACTION:

No action required; report is for information only.

MARCH 2021 | AN ANNUAL UPDATE TO FSMB HOUSE OF DELEGATES

TRANSFORMING ASSESSMENT BY CREATING NEW SOLUTIONS

Several opportunities to transform assessment emerged in the past year. In this report, you can specifically learn how the joint partners of the United States Medical Licensing Examination® (USMLE®) program—NBME and the Federation of State Medical Boards (FSMB)—have continued to collaborate to transform the USMLE by adapting this licensure series to the changing needs of medical education and dynamism of health care.

DISCONTINUATION OF USMLE STEP 2 CLINICAL SKILLS (CS)

"NBME's commitment to performance-based assessment and clinical skills has accelerated. Our newest area of focus around competency-based assessment, and our exploration of novel assessments, will allow us to work with the medical education and regulatory communities to develop assessments of these essential skills and the optimal way to integrate these assessments into the education and licensure space.**"**

-Peter J. Katsufrakis, MD, MBA, President and CEO of NBME

- In January 2021, FSMB and NBME announced the discontinuation of work to relaunch a modified Step 2 CS. Although there are no plans to bring back Step 2 CS, USMLE intends to take this opportunity to focus on working with colleagues in medical education and at the state medical boards to determine innovative ways to assess clinical skills.
- You can listen to a March 4, 2021 podcast episode of *USMLE Connection,* in which David Johnson, MA, Chief Assessment Officer at FSMB, and Christopher Feddock, MD, MS, Executive Director for the Clinical Skills Evaluation Collaboration, discuss the discontinuation of Step 2 CS; the reasons behind the decision; and next steps.
- Earlier this month, the USMLE Composite Committee, the governing body of USMLE comprising medical educators, regulators and members of the public, met to determine how the discontinuation of Step 2 CS will impact certain USMLE policies including Step 3 eligibility requirements; the reporting of Step 2 CS results; and attempt limits. Learn more here.

FSMB and NBME look forward to continuing their conversations with medical regulators to gain a full understanding of the clinical skills that are most critical to measure in assessment.

RESPONDING TO THE COVID-19 PANDEMIC

Working together with colleagues and organizations enabled increased USMLE testing opportunities for many examinees during this public health crisis.

Expanding USMLE Testing

Pandemic-related public health guidelines monumentally disrupted testing. To address the needs of individuals whose testing windows were impacted, the medical education community and the USMLE program worked together to create new testing options for examinees. Below, you can learn more about testing expansion options offered in 2020 from the perspectives of NBME talent who helped confront challenges with innovative solutions.

NBME Staff Insight

In 2020 we had to conceptualize and then implement new exam delivery platforms for USMLE in response to the disruption in testing due to the COVID-19 pandemic, all the while keeping our stakeholders up-to-date on our progress through multiple communication channels. So many people across NBME and our external partners, in a relatively short period of time, helped deliver two solutions: regional testing and event testing. Testing went smoothly, and our examinees and stakeholders were pleased with our responsiveness. We are incredibly grateful to the medical education community in helping to create more testing opportunities for examinees.

SUZANNE MCELLHENNEY
Director, Program Management

AMY BUONO
Director, Program Management

Since testing was first disrupted, NBME and FSMB have strived to provide students with straightforward, up-to-date information. Communications have included USMLE weekly updates; a new COVID-19 resource portal; FAQs directly addressing student questions; engaging podcasts and webinars; social media posts; and targeted emails to the more than **35,000** students registered for USMLE in May and June 2020 alone.

Providing Examinees with Resources to Foster Learning and Support Study Plans

Those working with students and residents saw first-hand how the pandemic caused some of them to feel increased stress and uncertainty around USMLE testing. Along with a disruption to assessments, some study plans were upended, and students told us they needed more resources.

- This past summer, NBME launched a new video series, *Unlocking Assessment,* to support examinees by providing the opportunity to hear how their peers and faculty would approach answering NBME test questions. With **nearly 10,000** views so far, the series has been a well-received resource for educators and students alike. We encourage you to share this new video series, which can equally serve as a helpful teaching tool when adapting curricula to expanded virtual learning environments. You can view all episodes of this video series on NBME.org.

- Between Apr. 3 and Sept. 30, 2020, NBME was pleased to offer seven complimentary NBME® Self-Assessments. More than **400,000** free self-assessments were ordered during this time. Examinees who ordered complimentary self-assessments had until Dec. 31, 2020 to complete them.

DECISION TO MAKE USMLE STEP 1 PASS/FAIL

FSMB and NBME believe that changing Step 1 score reporting to pass/fail can help reduce some of the overemphasis on USMLE performance, while also retaining the ability of medical licensing authorities to use the exam for its primary purpose of medical licensure eligibility. The USMLE co-sponsors believe that moving to pass/fail reporting of Step 1 while retaining a scored Step 2 Clinical Knowledge (CK) represents a positive step toward system-wide change.

- The transition to Step 1 pass/fail score reporting is on track to be implemented in January 2022. Specific dates and information will be made available in advance of the implementation date. Information about the Step 1 pass/fail score reporting policy change can be found here.

STEP 1 & STEP 2 CK CONTENT DISTRIBUTION CHANGES

Content distribution changes to Step 1 and Step 2 CK took effect in October and November 2020, respectively. To support examinees, free practice materials were updated to align with these changes.

NBME's COMMITMENT TO DIVERSITY, EQUITY & INCLUSION (DEI)

NBME is firmly committed to demonstrating DEI values and practices in everything we do, including our work related to USMLE.

- A DEI approach to assessment creation is supported by the Test Development committees that rely on diversity of voice, experience and background to reflect the varied patient populations our examinees serve. Diverse representation—in geography, institution type, subspecialty, role, gender, race/ethnicity—of Test Development committee members has steadily increased over time. In 2011, **38%** of USMLE committee members were women, and those representing minority racial/ethnic groups made up **15%** of members. In 2020, **49%** of USMLE committee members were women, and minority racial/ethnic groups comprised nearly **24%** of membership.

- For several years, NBME's Test Development staff, Research and Measurement staff and committee members have incorporated DEI principles into their assessment creation and review processes. As of January 2021, the entire USMLE exam pool of content has been reviewed to identify and eliminate stereotyping and bias. We also support this work through Item Writing Workshops as well as with the newly revised NBME® Item Writing Guide.

ABOUT NBME

NBME offers a versatile selection of high-quality assessments and educational services for students, professionals, educators and institutions dedicated to the evolving needs of medical education and health care. To serve these communities, we collaborate with a comprehensive array of professionals including test developers, academic researchers, scoring experts, practicing physicians, medical educators, state medical board members and public representatives.

Together with the Federation of State Medical Boards, NBME develops and manages the United States Medical Licensing Examination®. In addition, we are committed to meeting the needs of educators and learners globally with assessment products and expert services such as Subject Examinations, Customized Assessment Services, Self-Assessments, the International Foundations of Medicine® and Item-Writing Workshops.

We also provide medical education funding and mentorship through the Latin America Grants Program, Stemmler Fund and Strategic Educators Enhancement Fund, which serve to advance assessment at educators' and health professionals' own institutions.

Learn more about NBME at NBME.org.

Thank you for reading. We hope this report finds you healthy and well.

If you have any questions about the content within this report, please e-mail Communications@NBME.org.

National Board of Medical Examiners (NBME)

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

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

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

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

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

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

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

MANAGEMENT NOTE:

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

Attachment 1 contains the report on the NCCPA. **Attachment 2** provides an organizational summary of the NCCPA.

ITEM FOR BOARD ACTION:

No action required; report is for information only.

Report of FSMB Representative to the
National Commission on Certification of Physician Assistants
Submitted March 2021

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

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

2020 - An Unprecedented Year for All

Soon after submitting the last annual report in March 2020, all NCCPA business operations quickly transitioned from on-site to remote format. NCCPA exam programs continued to be offered at PearsonVue centers throughout the country, although scheduling was challenged by mandated business closures and recurring site challenges due to health and safety concerns. Two full-time NCCPA staff members focused primarily on scheduling with PearsonVue centers allowing PAs across the U.S. the ability to continue to sit for PANCE with only moderate scheduling disruption. All stakeholder events and presentations as well as NCCPA test committee meetings were transitioned to the virtual environment; a condition which continues to date. More than 70% of PAs with 2020 deadlines to fulfill their certification maintenance requirements were able to do so, while also serving on the front lines of health care delivery in the U.S. Nevertheless, with Board support, management extended all maintenance of certification deadlines until March 31, 2021 to ease some of the personal and professional burdens borne by PAs due to the pandemic.

Alternative to PANRE Pilot Launch

As reported previously, the alternative to PANRE pilot successfully launched in January 2019 with 18,529 PAs participating. On December 18, 2020, scores were processed for 18,099 PAs (97.7%) who remained in the Pilot for the duration. The pass rate for the Pilot was 97.5%. The 461 PAs who did not pass were notified of their certification expiration extension to March 31, 2021 and the need to take and pass PANRE to fulfill their recertification requirement.

Pilot participants answered twenty-five core medical knowledge test questions each quarter, receiving immediate feedback on each question and additional educational information about the topic. This strategy enabled participants to continue to demonstrate current medical knowledge, utilizing any web accessible device. Participants provided feedback throughout the process. Findings suggest that the Pilot was an exceptionally successful initiative. Psychometrics data gathered over the past two years will be instrumental in consideration of future recertification processes. Additionally, management has contracted

with researchers who specialize in qualitative research to conduct the final focus groups with Pilot participants. Information from the qualitative initiative and data gathered throughout the two-year Pilot period will be examined throughout this year. Board action on the next steps is expected at the end of 2021.

2020 Annual Report from the NCCPA Review Committee

During the February Board Meeting, the Chair of the Review Committee provided an overview of the Review and Appeals process along with a comprehensive report of cases and conditions addressed by the NCCPA staff and the Review Committee. Throughout 2020, 902 cases for disciplinary action, requests for exception to policy, requests for re-establishment of eligibility for certification and complaints from Physician Assistants were reviewed by NCCPA staff; a 14% decrease over 2019. 187 of those were requests for exception to policy, unrelated to the COVID 19 pandemic and 9 were requests to reestablish eligibility. Per policy, the NCCPA Review Committee of the Board is seated annually to review cases presented on appeal by Physician Assistants, which totaled 6 in 2020.

Other Highlights

- NCCPA continues to **enforce its *Code of Conduct*** and to communicate with FSMB and with state licensing boards about disciplinary actions taken against PAs. In 2020, NCCPA issued 38 letters of censure, 43 non-permanent revocations and 1 permanent revocation. NCCPA also reviewed 9 requests to reestablish eligibility following non-permanent revocation. Five were granted.

- 2021 marks the first year that PAs holding a **Certificate of Added Qualifications (CAQs)** in one of seven CAQ granting disciplines, would be eligible to renew their CAQ. PAs who are maintaining their CAQs may choose the online exam option utilized in the Pilot Alternative to PANRE or take the maintenance exam at a PearsonVue test center during the standard spring and fall administrations. To date, ~30 CAQ holders have registered to renew their CAQ in 2021. In addition, work continues to examine requests from PA groups and organizations for CAQs in additional clinical disciplines.

- NCCPA continues to provide IT and psychometrics support for the Physician Assistant Education Association's (PAEA's) **End of Rotation (EOR) and End of Curriculum (EOC) exams,** which are offered to more than 260 PA programs nationwide.

- The social conditions unveiled in 2020, while battling a pandemic that evidenced overt health disparities and generalized economic failure, unleashed a racial reckoning throughout the country. Efforts continue to ensure that NCCPA's programs and processes reflect its commitment to **diversity, equity, and inclusion**. Toward that end, NCCPA is engaged in several internal (leadership and staff-led) initiatives as well as several externally facing efforts aimed to promote diversity, equity, and inclusion within the PA profession.

- The nccPA Health Foundation (www.nccpahealthfoundation.net) continues to pursue its mental and oral health initiatives and to integrate strategies to reduce health disparities within each of its program areas. In 2020, the Foundation increased the grant award amounts and awarded more than two-dozen grants to support PA-led health promotion and disease prevention efforts. In 2021, the foundation will also embark on a new educational effort to help promote principles of professional practice.

- NCCPA continues to house and support the PA History Society (www.pahx.org). The PAHx continues to promote its **Historian Toolkit and the Anniversary & Celebration Planner** to its Associates. In January, the staff began updating the Anniversary & Celebration Planner with 'virtual' event ideas and suggestions for celebrating significate milestones in a virtual setting. The **Educational Toolkit Modules** is part of the Society's effort and mission to make the history of the PA profession come to life, and to be meaningful and inspirational for future generations of PAs. This resource has been one of the Society's most popular benefits to PA programs. Work continues on the PA History Society's new book, ***PAs Do That: Social Innovators in Healthcare.***

Thank you for your attention to this information. It is an honor to serve in the FSMB seat on the NCCPA Board of Directors.

My eight-year (two terms) of service will conclude on December 31, 2021. During this period, I have witnessed tremendous growth of the PA profession and participated in engaging efforts to innovate and enhance PA certification and maintenance of certification. Thank you for the opportunity to serve my profession and the healthcare industry in this capacity. It has been a highlight of my PA career.

Please feel free to contact me (peggy.robinson@duke.edu) or NCCPA's President and CEO, Dawn Morton-Rias, Ed.D, PA-C (dmorton-rias@nccpa.net) with your comments or questions about anything contained in this report.

Respectfully submitted,

Peggy R. Robinson, MS, MHS, PA-C
March 2021

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

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

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

NCCPA's purpose is to provide certification programs that reflect standards for clinical knowledge, clinical reasoning and other medical skills and professional behaviors required upon entry into practice and throughout their careers as PAs. The NCCPA certification process requires formal collegiate education at an ARC-PA accredited PA educational program, examination (Physician Assistant National Certifying Examination - PANCE), and ongoing pursuit of continuing medical education (certification maintenance) as well as recertification by examination (Physician Assistant National Recertifying Examination - PANRE). Since its inception, NCCPA has certified more than 173,000 PAs. There were more than 148,500 certified PAs at the end of 2020.

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

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

On 12/10/2020, NCCPA concluded a two-year Pilot alternative to PANRE, a longitudinal assessment that enabled eligible PAs to answer core medical knowledge questions toward fulfillment of the PANRE requirement. 18,529 PAs (58% of the eligible pool) were enrolled at the launch in January 2019 and 18,099 (97.7%) remained for the duration. The pass rate for the Pilot was 97.5%. Outcomes from the PANRE Pilot will help inform the Board's decision making regarding PANRE for 2023 and beyond.

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

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

Leveraging its extensive database on certified PAs, NCCPA publishes a host of statistical reports on the profession available on NCCPA's website (**www.nccpa.net**) and engages with a broad range of stakeholders within the healthcare industry.

NCCPA is located at 12000 Findley Road, Suite 100, Johns Creek, GA, 30097-1409.
Phone: 678-417-8100 Fax: 678-417-8135 Email: **nccpa@nccpa.net** Website: **www.nccpa.net**

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

DRAFT

MINUTES
Saturday, May 2, 2020
Virtual Zoom Meeting

Call to Order

The virtual annual business meeting of the House of Delegates was called to order at 2:21 p.m. PT on Saturday, May 2, 2020 by FSMB chair Scott A. Steingard, D.O.

Dr. Steingard thanked everyone for their attendance at the virtual meeting and recognized the 2020 FSMB Award recipients. The recipients were:

> ***Editorial Awards for Excellence in Writing***: Christine Moutier, MD, Eleni Anagnostiadis, RPh and Sangeeta Chatterjee, PharmD.
> ***Award of Merit***: Scott Kirby, MD and Timothy Terranova
> ***John H. Clark, MD Leadership Award***: Randel Gibson, DO, Maroulla Gleaton, MD and Candace Lapidus Sloane, MD
> ***Distinguished Service Award***: Kathleen Haley, JD and Boyd Buser, DO, Thomas Nasca, MD and Stephen Shannon, DO, collectively

Roll Call

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

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

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

Agenda

The agenda of the May 2, 2020 House of Delegates virtual annual business meeting was reviewed. No corrections to the agenda were noted.

ACTION: **APPROVED the agenda of the May 2, 2020 House of Delegates virtual annual business meeting.**

Announcement of Parliamentarian and Tellers

Dr. Steingard announced Linda Gage White, MD as parliamentarian. Rita Mohsin and Dr. Aaron Young, FSMB staff, were appointed as tellers.

Welcome New Member Medical Board, Fellows, Affiliate Member and Courtesy Members

Dr. Chaudhry welcomed to the FSMB its newest Member Medical Board, the Medical Licensure Commission of Alabama. He also welcomed the new FSMB Fellows, Affiliate Member and Courtesy Members, all of whom became members in FY 2020 and were listed in the House of Delegates book.

Report of the Rules Committee

The House of Delegates was presented with the report of the Rules Committee, which met on Tuesday, March 31, 2020 and was chaired by Cheryl Walker-McGill, M.D., MBA. No changes were requested and the report was adopted as presented.

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

Consent Agenda

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

ACTION: **ACCEPTED the Consent Agenda.**

Minutes

Minutes of the April 27, 2019 House of Delegates annual business meeting were reviewed. No corrections to the minutes were noted.

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

Report of the FSMB Chair

Dr. Steingard presented his Chair's Report during which he praised the board of directors as well as the 70+ individuals on the FSMB committees and workgroups, and the staff supporting them, for the time and energy they invested over the year that culminated in the wealth of important

information to be acted on by the House of Delegates. He spoke about the increased scrutiny state-based medical regulation has been under, and he challenged the House and everyone involved in medical regulation to continue stressing to legislators the vital role that state medical boards play in protecting the public, which has never been more apparent than during the pandemic

Report of the President

Dr. Chaudhry presented his Report of the President. He began by acknowledging the hard work of the entire FSMB staff throughout the year, even as circumstances necessitated they work remotely. Dr. Chaudhry presented a timeline of activities in which the FSMB had been involved since the beginning of the pandemic to help the Member Medical Boards fulfill their responsibilities in keeping the public safe. He reported on 1) the FSMB's Ad Hoc Taskforce on Pandemic Response that was meeting every two weeks; 2) the resources posted on the FSMB's COVID-19 website, including a list of what each state/territory was doing to address the challenges caused by the pandemic; and 3) how the FSMB was responding to federal government/agency actions seeking emergency changes to state medical licensure requirements so that all changes would continue to safeguard the public and protect health care workers.

Report on the FSMB Strategic Plan

Dr. Chaudhry referred the House of Delegates to his written report on the FSMB 2015-2020 Strategic Plan provided in their meeting materials. He reported on the six overarching goals contained in the Strategic Plan and summarized the ways in which the FSMB accomplished those goals over the past year.

Treasurer's Report

Jerry G. Landau, JD, FSMB Treasurer, provided the Treasurer's Report highlighting the activities of the Investment, Finance and Audit Committees this past year. The proposed FY 2021 budget was also discussed. Mr. Landau also thanked members of the Finance, Audit, and Investment Committees along with the board of directors and management.

Report of the Reference Committee

Denise Pines, MBA, Chair of the Reference Committee, presented the Committee's report. The Committee met on Thursday, April 30, 2020 at 3 pm PT via videoconference and considered five items of business brought before the House of Delegates for action. Testimony was solicited and received from the board of directors and a Member Medical Board for the Committee to consider during its deliberations.

1. Report of the Bylaws Committee

The Bylaws Committee was charged with considering the current Bylaws, reviewing two proposed amendments and additional commentary submitted for consideration, and making recommendations for any necessary changes. In keeping with its charge, the Committee also discussed the FSMB Articles of Incorporation as they relate to the Bylaws.

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

PROPOSED BYLAWS AMENDMENT #1 is as follows:

> Amend **Article VIII. Section F. Ethics and Professionalism Committee** as follows:
>
> The Ethics and Professionalism Committee shall be composed of up to ~~**five**~~ **eight** Fellows and up to two subject matter experts. The Ethics and Professionalism Committee shall address ethical and professional issues pertinent to medical regulation.

The North Carolina Medical Board submitted a proposed amendment urging the Bylaws Committee to review the composition of the Ethics and Professionalism Committee and consider whether allowing for additional members would increase opportunities for Fellows to serve on this increasingly important committee. The Bylaws Committee aligned behind the rationale of the proposal and agreed that increasing Committee membership provided additional perspectives on challenging topics and allowed the Committee's membership greater ability to collaborate with the FSMB's other generative committees, such as the Education and Editorial Committees. Also, because the Ethics and Professionalism Committee meet through teleconference or other electronic platform, the Committee determined any cost to be minimal.

The Reference Committee considered testimony from the Board of Directors in support of the proposed amendment citing that increasing the number of Fellows on the Ethics and Professionalism Committee will result in broader representation of the Federation's membership and increased diversity of opinion, which will be essential as this Committee confronts the issues that lie ahead.

No other testimony was received and there was no further discussion.

PROPOSED BYLAWS AMENDMENT #2 is as follows:

> Amend **Article XIV. Section B. Effective Date** as follows:
>
> These Bylaws and any other subsequent amendments thereto, shall become effective upon their adoption, except as otherwise provided ~~**herein**~~ **in the amendment**.

Both the FSMB Board of Directors and the North Carolina Medical Board asked the Bylaws Committee to review the effective date of Bylaws approved by the FSMB House of Delegates and assess whether amendment would be proper. The North Carolina Medical Board suggested the adoption of language so that amendments become effective ". . . upon adjournment of the Annual Meeting of the House of Delegates at which they were adopted . . ..", citing that such a change would prevent Bylaws amendments from unduly impacting subsequent matters coming before the House of Delegates during that meeting. The FSMB Board of Directors had similar concerns about the immediate applicability of approved changes and referred to the Bylaws

Committee the issue of the House of Delegates election balloting and a possible change to the effective date of approved Bylaws amendments.

Inclusion of an effective date on amendments was identified by the Bylaws Committee as a more proper vehicle to address concerns about immediate applicability of amendments that would impact organizational structure or election process. A Bylaws change that alluded to the inclusion of an effective date on future amendments to the Bylaws would also allow reference committees to review the impact of the amendment and delay implementation of a desired change, if deemed necessary to maintain integrity of process.

The Reference Committee considered testimony from the Board of Directors in support of the proposed amendment citing that the amendment provided greater clarity of process for changes that may impact organizational structure, while also providing flexibility to make other changes immediate.

The Reference Committee agreed with the rationale provided in the proposition and support of the proposals and recommended that the House of Delegates adopt both amendments.

> **Action: As recommended by the Reference Committee, the proposed Bylaws Amendments #1 and #2 as contained in the Report of the Bylaws Committee were ADOPTED.**

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

The Special Committee on Strategic Planning was charged with evaluating the continued relevance of the FSMB's 2015-2020 Strategic Plan, which included the organization's Vision, Mission Statement and Strategic Goals that guide the FSMB's work in supporting 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 other health care professionals. The Committee presented a new and enhanced Strategic Plan to the 2020 House of Delegates for approval that was intended to respond to:

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

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

The Reference Committee considered testimony from the Board of Directors in support of the proposed Strategic Plan contained in BRD RPT 20-1 citing that although the 2015-2020 Strategic Plan remained fundamentally sound in that it continued to focus on core values and relevant strategic imperatives, the Committee's proposed changes aligned the plan more closely with emerging trends and new issues of importance to state medical boards.

No other testimony was received.

The Reference Committee agreed with the testimony provided and noted the prudence of proposing a Strategic Plan that is a fluid document with no expiration date. The Committee also noted that given the current situation with COVID-19 and the sustaining impact the pandemic may have on state medical regulation, the FSMB may consider revisiting its Strategic Plan accordingly.

Action: As recommended by the Reference Committee, the FSMB Strategic Plan as contained in the *Report of the Special Committee on Strategic Planning* was ADOPTED and the remainder of the report filed.

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

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

The goal of the Workgroup's report was to provide state medical boards with best practice recommendations for effectively addressing and preventing sexual misconduct with patients, surrogates and others by physicians, while highlighting key issues and existing approaches. The recommendations included specific requests of individual entities, as well as general ones that apply to multiple parties, including state medical boards, the FSMB and other relevant stakeholders. The Workgroup felt strongly that effectively addressing physician sexual misconduct required widespread cultural and systemic changes that can only be accomplished through shared efforts across the medical education and practice continuum.

The Reference Committee heard testimony from a representative of the FSMB Board of Directors in support of Board Report 20-2. It was stated that this report provided guidance to state medical boards for addressing some of the most dangerous and traumatic situations in which patients may find themselves. A minor amendment to the report was requested involving the deletion of lines 900-902 to improve document flow and avoid misinterpretation. With this amendment, the Board of Directors recommended that the recommendations be adopted and the remainder of the report filed.

Testimony was also received from the Medical Licensure Commission of Alabama suggesting a modification to the report at lines 1037-1038 to allow greater flexibility in the enforcement of reporting requirements, including levying of fines. The following substitute language was offered:

> **Institutions should be required by statute to report instances of egregious conduct to** ~~**S**~~**s**tate medical boards **and be subject to** ~~**should have the ability to levy**~~ fines **levied by the appropriate regulatory agency or the state attorney general** ~~**against institutions**~~ for failing to report ~~**instances of egregious conduct**~~.

The Reference Committee considered the testimony it received and accepted the amendment proposed by the Board of Directors to delete the sentence at lines 900-902.

The Reference Committee agreed with the rationale behind the substitute language proposed by the Medical Licensure Commission of Alabama but wanted to ensure that the recommendation was inclusive of those boards that have the ability to fine institutions as well as those that do not. As such, the Reference Committee recommended a qualification of the types of regulatory agencies mentioned with a specific mention of state medical boards. The language proposed by the Reference Committee was as follows:

> Institutions should be required by statute to report instances of egregious conduct to state medical boards and be subject to fines levied by the **state medical board, another** appropriate regulatory agency or the state attorney general for failing to report.
>
> **ACTION: As recommended by the Reference Committee, BRD RPT 20-2: Report of the FSMB Workgroup on Physician Sexual Misconduct was ADOPTED AS AMENDED::**

1) Delete lines 900-902 of the report as follows: ~~**This should include education about the prevalence of victimization and abuse in the general population and the fact that more than half of patients who are exploited sexually by physicians have been exploited before.**~~

2) Modify lines 1037-1038 of the report as follows: **Institutions should be required by statute to report instances of egregious conduct to** ~~**S**~~**s**tate medical boards **and be subject to** ~~**should have the ability to levy**~~ fines **levied by the state medical board, another appropriate regulatory agency or the state attorney general** ~~**against institutions**~~ for failing to report ~~**instances of egregious conduct**~~.

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

In April 2019, Resolution 19-1: Correlation Between Licensee USMLE or COMLEX Passage Attempt Rate and Reports of State Medical Board Discipline was submitted by the Minnesota Board of Medical Practice and called for the creation of a taskforce and recommendations. In lieu of Resolution 19-1, the 2019 House of Delegates adopted the following substitute resolution:

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

(1) Identify current licensing requirements specific to USMLE and COMLEX, including time and/or attempt limits on these examinations;
(2) Identify existing, or facilitate additional, research evaluating whether time and/or attempt limitations on USMLE and COMLEX correlate with external measures such as a decrease in future medical board disciplinary action and/or medical malpractice;
(3) Begin work toward a long-term goal of research exploring the correlation between performance on these licensing examinations and other measures of clinical aptitude or outcomes; and
(4) Share initial findings back to the FSMB House of Delegates in 2020 and with subsequent periodic reports as research becomes available.

BRD RPT 20-3 summarized the work completed to fulfill the charge of the resolution. The report was divided into two sections: 1) the first section summarized the licensing requirements specific to USMLE and COMLEX-USA, and 2) the second section addressed relevant research supportive of state medical boards' decisions to utilize attempt limits on their licensing examination. The report concluded that most medical licensing authorities (46:69 or 67%) have a time limit completion of the USMLE and/or COMLEX-USA examinations for licensure purposes. Additionally, most boards (47:69 or 68%) have an attempt limit for completion of all or parts of the USMLE and/or COMLEX-USA sequence for purposes of licensure. The report summarized research that currently exists or was in progress regarding performance on USMLE or COMLEX-USA and future medical board disciplinary action and/or medical malpractice

claims, and other measures of clinical aptitude. Future reports will provide updates on that and other research as available or requested.

No testimony was received on BRD RPT 20-3.

The Reference Committee received BRD RPT 20-3 as written.

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

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

In April 2019, Resolution 19-4: Emergency Licensure Following a Natural Disaster was submitted by the North Carolina Medical Board and called for the creation of a workgroup to develop model emergency licensure laws and rules. In lieu of Resolution 19-4, the 2019 House of Delegates adopted the following substitute resolution:

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

BRD RPT 20-4 summarized the work that has been completed to fulfill the charge of the resolution. The FSMB Board of Directors tasked the FSMB Advisory Council of Board Executives to complete the charge of Resolution 19-4 and report its findings and recommendations. The Advisory Council reviewed state and federal statutes, rules, and board policies currently in place regarding licensure following disasters and emergencies. Because of the varied approaches, statutorily and otherwise, the Advisory Council did not recommend the development and dissemination of model legislation but, rather, favored providing an informational report to include resources and examples for boards to use in determining an approach that best meets the needs of the residents and licensees in their respective states. The report was intended to provide boards with resources and examples to assist in their efforts in assessing and/or enhancing their disaster readiness. In keeping with the intent of Resolution 19-4, the FSMB will continue to collect and maintain information, including state and federal legislation, rules, policies and procedures pertinent to the deployment of health personnel in response to disasters, public health emergencies, and mass casualties. State medical and osteopathic boards are encouraged to proactively share their experiences and best practices with FSMB to facilitate the collection of state specific information.

No testimony was received on BRD RPT 20-4.

The Reference Committee received BRD RPT 20-4 as written.

ACTION: No action required; report was for Information Only

Report of the Nominating Committee

Patricia A. King, MD, PhD, FACP, presented the report of the Nominating Committee and read the slate of candidates.

Elections

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

Chair-elect:	**Kenneth B. Simons, MD (2020-2021)**
(by acclamation)	
Directors-at-Large:	**Jeffrey D. Carter, DO (2020-2023)**
	Katie L. Templeton, JD (2020-2023)
	Barbara E. Walker, DO (2020-2023)
Nominating Committee:	**Alexander S. Gross, MD (2020-2022)**
	John "Jake" M. Monahan, JD (2020-2022)
	J. Michael Wieting, DO (2020-2022)

Installation of New Chair and Board Members

Dr. Cheryl Walker-McGill was installed as the new Chair of the FSMB board of directors by Dr. Steingard. Dr. Walker-McGill then installed the new Chair-elect, Dr. Ken Simons, along with newly elected board members Dr. Jeffrey Carter, Ms. Katie Templeton and Dr. Barbara Walker, and the board's new Staff Fellow Melanie de Leon, JD.

FSMB Chair Remarks

Dr. Cheryl Walker-McGill provided an overview of her five areas of focus during her term as Chair of the board of directors. The areas of focus were 1) communication and collaboration; 2) data and collection; 3) board education; 4) key stakeholder relationships and 5) state medical board support.

Announcement of 2021 Annual Meeting Site

Dr. Steingard announced that the 2021 Annual Meeting will be held April 29-May 1 at the Hilton Minneapolis hotel in Minneapolis, MN.

Concluding Remarks

Dr. Steingard thanked everyone for their attendance at the first virtual FSMB House of Delegates annual business meeting.

Adjournment

There being no further business, the virtual annual business meeting of the House of Delegates was adjourned at 4:27 pm PT.

Sandy McAllister
Pat McCarty
Recorders

CHAIR'S REPORT
MAY 1, 2021
HOUSE OF DELEGATES

The past year will be remembered historically as one of the most challenging in our nation's history. From the COVID-19 pandemic to social and racial upheaval to extreme political polarization, America was faced with uncertainty and conflict – at virtually every level and sector of our society.

It was a daunting time to begin my tenure as FSMB Chair, but as I reflect on our organization's work over the last year, I am proud to report that the nation's 71 state and territorial medical boards have truly risen to the occasion. Despite the many hurdles and obstacles before them, our member boards have responded decisively and effectively during these trying months, with actions and policies that have ensured the safety of the public. It has been my honor and privilege to serve as FSMB Chair at a time when our member medical boards worked more closely and collaboratively than ever before.

The year required of us agility, commitment and vision, and the FSMB has responded with new programs and policies that – in addition to addressing our current national challenges – will provide exciting new directions for the future of medical regulation. In addition to managing the usual annual cycle of FSMB operational activities, our team of elected leaders, staff, dedicated state-board volunteers and partner organizations stepped forward admirably to meet the urgent needs and demands that were placed upon them during the pandemic.

This report to the House of Delegates summarizes key highlights of the FSMB's activities over the last year.

RESPONDING TO THE COVID-19 PANDEMIC

The demands the Covid-19 pandemic placed on physicians and physician assistants, on our member medical boards and on health care systems across the country have been extraordinary. When combined with government mandates that prohibited large-scale gatherings and restrictions on travel, these challenges have required us to very quickly re-configure our operations and processes.

As the pandemic swung into high gear last spring, I engaged in multiple weekly meetings with Dr. Chaudhry as we worked together to ensure the FSMB responded appropriately and in a timely manner during a time of growing crisis. As the pandemic continued to spread, our work was complicated by the unsettling events following the tragic killing of George Floyd – which brought new relevance to longstanding issues of health inequity and disparities.

Throughout the days, weeks and months of 2020-2021, we tried to create an environment that encouraged increased engagement between the FSMB, its member medical boards, other stakeholders and the public. Looking back, we are extremely grateful for the dedication and many sacrifices of time made by so many dedicated public servants in the medical regulatory community. Among the action steps we took in response to the pandemic during this challenging year:

FSMB Workgroup on Emergency Preparedness and Response

At the forefront of our efforts in mobilizing the regulatory community to address COVID-19 has been the Workgroup on Emergency Preparedness and Response, which was expanded from a task force to a full workgroup when I began my term in May. In my role as Chair of the workgroup, I have been inspired by the incredible commitment, collective input and creative solutions advanced by its members, who have met frequently over the course of the year to discuss pandemic strategies and best practices that could be utilized by state boards. All of us at the FSMB deeply appreciate the timely and much-needed efforts of the workgroup, which will present a full report during the House of Delegates meeting in May.

Special Meetings of FSMB Member Boards

The pandemic has brought out one of the FSMB's great strengths: its role as a forum and networking hub for the nation's regulatory community. Early on in the pandemic, on May 28, I chaired a special virtual meeting of the FSMB's member medical boards to discuss "Planning the Future of Medical Licensing Post-COVID-19 Pandemic," during which we discussed the impact of COVID-19 on the licensing process and how temporary licensure modifications and waivers will be managed once the pandemic subsides. Nearly 80 individuals representing 34 member boards participated in this extraordinary meeting, exploring lessons learned, best practices and what the future may hold in a post-pandemic world. On August 27, we hosted a second virtual meeting of the FSMB boards to discuss "The Impact of COVID-19 on Physician Well-being and Patient Safety," with nearly 50 individuals from 24 boards participating. The meeting included a panel addressing national initiatives on physician well-being, particularly in view of the pandemic, and state-based licensing strategies aimed at promoting licensee health and reducing stigma associated with seeking help and treatment.

Provider Bridge

One of the resources developed over the last year by the FSMB that will have lasting impact after the pandemic is Provider Bridge (ProviderBridge.org), which was launched in January. This robust new online platform, made possible by a grant from the Health Resources and Services Administration (HRSA), was developed during the pandemic in order to mobilize volunteer health care professionals to treat patients. It supports license portability by making it easier to connect volunteer health care professionals with state agencies and health care entities in order to quickly increase access to care for patients in rural and underserved communities – and establishes an important new resource for future large-scale emergencies impacting states and regions.

FSMB Virtual Education Program

Given travel restrictions in response to the pandemic, the FSMB had to quickly reconfigure its annual educational activities last spring. Our hardworking FSMB Education staff nimbly developed a completely new platform for offering robust, CME-eligible content for our member boards. With the 2020 Annual Meeting cancelled, the FSMB developed a plan for a multi-month series of webinars, which kicked off July 14 with a presentation by John Whyte, MD, MPH, Chief Medical Officer of WebMD about the empowered health care consumer. Other

webinars through the summer, fall and winter included a presentation by Cary Coglianese, PhD, who spoke about achieving regulatory excellence in a world of advanced technologies and complex risks; a panel discussion among regulators on state medical board efforts to address physician sexual misconduct; an update from the National Practitioner Data Bank on its new tools for medical regulators; a panel discussion on pandemic-related developments in telemedicine, a stimulating presentation by Bryant T. Marks, PhD, on overcoming implicit bias in medical regulation; and a special panel discussion by FDA staff, who explained the FDA's regulatory oversight of human cells, tissues, cellular and tissue-based products. To extend value, CME credit was extended for these programs, which continue to be available for viewing online.

FSMB Special Event with Dr. Michael Osterholm

On January 14, the FSMB hosted a special webinar with Michael Osterholm, PhD, MPH, a renowned epidemiologist and member of President Biden's COVID-19 Advisory Board. This unique opportunity provided regulators with the most up-to-date news about the pandemic at a key time in its progression.

IAMRA Webinars

The FSMB's role as Secretariat of the International Association of Medical Regulatory Authorities (IAMRA) has become increasingly important, and with the pandemic, IAMRA's presence has taken on new meaning for the world's medical regulators. As Secretariat, the FSMB has been pleased to provide support for a series of IAMRA webinars, which have helped bring global regulatory issues related to the pandemic to the forefront. The first of the webinars kicked off last May and have continued since – most recently touching on other issues of importance internationally, including health equity and new developments in graduate medical education.

ADDRESSING HEALTH EQUITY AND DISPARITIES

Just as the medical regulatory community has faced the impacts of the pandemic, the FSMB has also turned its attention, appropriately, to the nation's recent social and racial upheaval, asking: What role can state medical boards play in mitigating the impact of racism and implicit bias on health equity? The mission of our member boards is to protect the public. Health inequities are a matter of public safety. And racism contributes to health inequities. These factors make it important for the regulatory community to step forward as a part of the national effort to seek better, more equitable care.

FSMB Implicit Bias Webinar

We began exploration of these issues in earnest on December 16, with "Ensuring Fairness in Medical Regulation: Can Implicit Bias Be Overcome?" – a special webinar for state board members, featuring national expert Dr. Bryant T. Marks of Morehouse College – who highlighted unseen barriers to achieving justice.

FSMB Symposium on Health Equity and Medical Regulation

On January 26, we continued the discussion, with the first-ever FSMB symposium on the topic of "Health Equity and Medical Regulation: How Disparities are Impacting U.S. Health Care Quality and Delivery and Why it Matters." The virtual symposium, which was very well attended, included presentations by keynote speakers Marc Morial, JD, President and Chief Executive Officer of the National Urban League, and Mark McClellan, MD, PhD, Director of the Duke-Robert J. Margolis Center for Health Policy, followed by a moderated panel discussion featuring Leonard Weather, Jr., MD, RPh, a Past President of the National Medical Association and currently a member of the Louisiana State Board of Medical Examiners; Aletha Maybank, MD, MPH, Chief

Health Equity Officer of the American Medical Association; and Diana Currie, MD, a member of the Washington Medical Commission.

Task Force on Health Equity and Medical Regulation

Looking to the future, we have launched the Task Force on Health Equity and Medical Regulation, which I will chair, and which will evaluate education and training programs to assist state medical and osteopathic boards in identifying opportunities for understanding and addressing systemic racism, implicit bias and health inequity in medical regulation and patient care. In fulfilling its charge, the task force will review the literature on these issues in medical regulation; identify current state medical board implicit bias initiatives; direct efforts for the creation of a public facing platform to provide educational resources for addressing implicit bias in medical licensing, discipline, and regulation; and participate in and lead discussions on the topic of medical regulation and systemic racism, implicit bias and health equity.

SERVICE TO STATE MEDICAL BOARDS

The FSMB considers supporting the needs of state medical boards a strategic priority – a point that was strongly reflected in the work and recommendations of its strategic plan, adopted by the House of Delegates last year. The FSMB worked hard on behalf of its member boards in 2020-2021 and will continue to ensure all have access to the kinds of resources that will help them achieve their vital mission of public protection. We are here to serve our boards, via such services as the Federation Credentials Verification Service (FCVS), Physician Data Center (PDC), and DocInfo – our portal supplying essential physician-data to both boards and the public. FCVS, PDC, and DocInfo are all core services the FSMB provides to support the state boards and the public, operating under the leadership of Michael Dugan, MBA, FSMB Chief Operating Officer – and these programs continued to improve and grow over the last year, even in the midst of our pandemic difficulties.

Additional highlights from the last year include our new FSMB Clearinghouse, our ongoing efforts to serve member boards via our advocacy team in Washington, D.C., and the FSMB's ongoing multi-channel communications program.

The FSMB Clearinghouse

Over the last year, FSMB staff worked on a number of updates to our website and technology platform in an effort to improve communications with, and service for, our member medical boards. Of these, one of the most useful new resources is the FSMB Clearinghouse, which we have steadily populated with easily accessible new content intended to help state medical boards be more effective. At this new online resource, member boards are able to upload information regarding their activities and programs and to access valuable information from other boards. They also have access to key legislative and policy information from the FSMB. Plans are under way to expand, step-by-step, the Clearinghouse to facilitate communication even more between boards.

Washington, D.C. Advocacy

Our outstanding FSMB Advocacy Office, headquartered in Washington, D.C., and under the leadership of Chief Advocacy Officer Lisa Robin, has continued to play a critical role in advancing the interests of our member medical boards and the public with federal and state officials. From antitrust reform to promoting initiatives such as the Interstate Medical Licensure Compact, the team served as the voice of medical regulation, continuing to advance these key strategic imperatives in the midst of the pandemic's disruptions. They also worked tirelessly –

especially in the early days of the pandemic – with legislators and federal agencies as the FSMB provided leadership in helping to modify regulations to allow physicians to practice across state lines.

FSMB Hill Day

The advocacy team organized a very effective "Hill Day" on September 30, making it possible for state regulators to meet for one-on-one visits with elected leaders and staff despite the restrictions of the pandemic. Board members participated in 31 Hill Day visits and a group session focused on addressing pandemic-related health care workforce issues, which concluded the day.

FSMB Communications

I continue to believe that improving communications is a key strategic imperative for the FSMB, and our Communications staff, working in both Washington, D.C., and Euless, Texas, delivered great results. During the last year, we redesigned the Federation's bi-weekly publication, *Federation eNews*, and the *Journal of Medical Regulation* continued to increase its page count, offering new studies and data of interest to member medical boards. Other improvements to our communications capabilities included our new and improved *FSMB Roundtable* webinar series, which is now Zoom-based, as well a much wider deployment in general in the use of virtual, Zoom-based meetings for the activities of our many FSMB workgroups and committees.

USMLE STEP 2 CS DEVELOPMENTS

In a year of many challenges, the FSMB and the National Board of Medical Examiners (NBME) made the difficult decision to cancel permanently the Step 2 Clinical Skills (CS) exam – which had been put on hold early in the pandemic last year. For the last several years the FSMB has worked closely with the NBME and other stakeholder organizations, including the Educational Commission for Foreign Medical Graduates, to determine the best path forward with Step 2 (CS).

This challenging, but necessary, decision came after a lengthy process of soliciting input from a wide cross-section of stakeholders – ranging from students to policy makers. Our FSMB assessment staff, under the leadership of Chief Assessment Officer David Johnson, played an instrumental role in helping to guide this process forward. We are confident that our decision is in the best interests of medical regulation and look forward to our continued work with our partners at the NBME in ensuring the USMLE reflects best practices in assessment for future generations of physicians.

OTHER FSMB WORKGROUPS

In addition to the previously mentioned Health Equity and Medical Regulation Task Force and the Workgroup on Emergency Preparedness and Response, the efforts of the FSMB's special workgroups moved many initiatives forward this year. Among the highlights:

Workgroup on Board Action Content Evaluation (BACE)

The collection and analysis of data allows medical regulators to be well-informed and to identify best practices – both within states and across state lines. It is through periodic and consistent data analysis that we improve. Recognizing this, we launched the new Board Action Content Evaluation – or BACE – Workgroup in 2020. Chaired by FSMB Board of Directors member Melanie de Leon, JD, MPA, this workgroup will build upon the

earlier work of the BACE Task Force and will develop standards to ensure that board orders contain adequate information identifying actions and reasons for discipline, including examples on how to write narratives of complaint and action that can be shared with state attorneys general, board attorneys and related organizations. The workgroup will also support pilot projects to study best practices for collection and analysis of complaint data and will provide recommendations for automating the complaint collection and analysis process.

Workgroup on Physician Impairment

The Workgroup on Physician Impairment, chaired by Danny Takanishi, MD, a member of the Hawaii Medical Board, made excellent progress in its review of the FSMB's Policy on Physician Impairment, and, in collaboration with the Federation of State Physician Health Programs (FSPHP), is making recommendations to revise and expand the policy in light of new and emerging issues – ranging from the use of medication-assisted treatment to physician wellness and burnout. The workgroup's efforts will be highlighted during a special session at this year's FSMB Annual Meeting in April.

Workgroup to Study Risk and Support Factors Affecting Physician Performance

Under the leadership of FSMB Board of Directors member Mohammed A. Arsiwala, MD, the Workgroup to Study Risk and Support Factors Affecting Physician Performance is diligently pursuing its mandate to help the medical regulatory community better understand the drivers of physician performance and the ability to practice medicine safely, while identifying resources, strategies and best practices to help regulators as they assess mitigating impacts on performance. The significance of the efforts of both our physician impairment and physician performance workgroups have been amplified in light of the stresses brought on by the COVID-19 pandemic, and their work will be critical as we seek to better understand impacts of the pandemic going forward.

Workgroup on Board Education, Service and Training (BEST)

The BEST Workgroup, chaired by Thomas Mansfield, JD, Chief Legal Officer and Legislative Liaison for the North Carolina Medical Board, continued its effort to provide new learning resources for state medical board members. The workgroup's online educational series, "Understanding Medical Regulation in the United States," includes slide presentations on topics of interest to state medical board members. The workgroup posted its most recent online learning-module, "Understanding Physician Assistant Licensure," in February and will soon release "Understanding Discipline in Medical Regulation."

Artificial Intelligence Task Force

Under the leadership of FSMB Board of Directors member Sarvam P. TerKonda, MD, the Artificial Intelligence Task Force continued its work during the year, charting new directions for medical regulators as this topic becomes an increasing presence in our lives. The task force is exploring the complex challenges that the integration of artificial intelligence into health care presents, including studying the ability of artificial intelligence to support state medical boards with their regulatory responsibilities and adjudicatory functions.

FSMB FOUNDATION

The FSMB Foundation, the philanthropic arm of the FSMB, was an outstanding partner in the FSMB's efforts to provide pandemic-related service to both the regulatory community and the overall health system in the last year. Topping the list of its efforts is a new program, which has provided $100,000 in funding for COVID-19 state-response grants – aimed at studying state and health care entities' response to the pandemic and to identify ways

to better prepare for future emergencies. The long-term goal of the Foundation's grants program is to support the development and implementation of sustainable models and policies that can guide state preparedness and responses to similar emergencies in the future, as well as their capacity for recovery planning. The program also intends to promote health equity and reduce disparities in health care.

COLLABORATION WITH PARTNER ORGANIZATIONS

The FSMB's success is largely a result of strong and productive relationships with stakeholder organizations across the spectrum of health care. During the last year we worked closely with longstanding partners, ranging from the NBME to organizations such as the American Medical Association, the American Osteopathic Association and the Coalition for Physician Accountability. Among the highlights:

National Academy of Medicine (NAM)

The FSMB continues to partner with NAM on two key initiatives: the Collaborative on Clinician Well-Being and Resilience, and the Collaborative on Countering the U.S. Opioid Epidemic. In November I delivered a presentation for a "State Licensing Board Perspectives" session during a historic meeting on the opioid epidemic co-sponsored by the FSMB and NAM of representatives of the state licensing boards for eight health professions. Our efforts to address physician wellness and burnout with NAM also continue to progress forward, as more and more state boards begin to consider steps they can take proactively to ensure good mental health and well being among their physician populations.

Coalition for Physician Accountability

We worked in new ways with our colleagues in the Coalition for Physician Accountability (CPA) over 2020-2021. I co-chaired one of four workgroups of the CPA in April that was charged with pulling together helpful information that would provide guidance to a variety of stakeholders to help ensure that quality and standards are maintained when health care workers are deployed during the pandemic. This information, titled "Maintaining Quality and Safety Standards Amid COVID-19," was distributed publicly last May.

Tri-Regulator Collaborative

Our partners at the National Association of Boards of Pharmacy (NABP) and the National Council of State Boards of Nursing (NCSBN), who with the FSMB form the Tri-Regulator Collaborative, have been valuable collaborators during the pandemic – helping in our efforts to communicate key messages to the public about pandemic-related prescribing and other issues of patient safety. Planning is currently underway for the fifth Tri-Regulator Symposium for members and staff of state boards of medicine, nursing and pharmacy, to be held in 2022.

CONCLUSION

As we begin a second year of grappling with an acute international health crisis, I cannot help but reflect on this moment in the FSMB's history.

As medical regulators, we have faced many pressing questions: What can we do to increase state medical board awareness of current and future needs related to the pandemic? How can we increase communication with and between state medical boards regarding the many pandemic-related challenges they face? What can we do to

ensure we are effective in dealing with important ongoing operational priorities, which have now become even more complex as a result of COVID-19?

Each of us has been impacted personally as we strive to keep ourselves and our families healthy and safe from COVID-19 – and our personal challenges are compounded by all we are facing as representatives of the broader regulatory community. I know firsthand the pain of loss, as during this difficult year, I lost my husband and life's inspiration, Paul – without whom I never would have been able to take on the duties of serving as FSMB Chair.

I have been blessed by the wonderful friendships I have developed over my time serving the FSMB – and to each of you who have provided consolation and support during this year, I am eternally grateful. I'm so proud of our entire regulatory community, our FSMB Board, and our tireless FSMB staff, who have truly distinguished themselves during an extremely difficult year. Despite all we have been through, we have much to be thankful for and much to look forward to.

Serving as your Chair has been the opportunity of a lifetime. I thank you for putting your faith and trust in me as we have worked together to fulfill the FSMB's mission and protect the public.

REPORT OF THE PRESIDENT-CEO
May 1, 2021
HOUSE OF DELEGATES

FROM THE CEO'S DESK

As we gather for FSMB's second virtual Annual Meeting, I am reminded that we have just passed the one year anniversary of the declaration on March 11, 2020 by the World Health Organization (WHO) of a worldwide pandemic due to COVID-19, caused by the novel (new) SARS-CoV-2 coronavirus. That day changed forever how we all lived and worked.

We are still not out of the woods, of course, and there is a race going on to get as many eligible people vaccinated around the world as quickly as possible in order to stay ahead of variants of the virus that may be more infectious and worrisome. As I write this report, on March 31, 2021, the United States appears to be headed for a fourth surge of COVID-related infections, hospitalizations and deaths, even if the magnitude of this surge is smaller than the third surge because so many individuals have now received at least one dose of a COVID vaccine. We are encouraged by the words of CDC Director Rochelle Walensky, MD on March 30, 2021: "Our data from the CDC today suggest that vaccinated people do not carry the virus." Reflecting the dynamic nature of the pandemic and our approach to its management, we are also heartened to learn that at least one of the mRNA vaccines against COVID-19, produced by Pfizer-BioNTech, may be 100% effective in children ages 12-15. Clinical trials involving children are also being undertaken by Moderna and Johnson & Johnson, makers of the two other vaccines emergently authorized for COVID-19.

As I reflect on the year that has passed since our last Annual Meeting, I am grateful that the FSMB and its staff and governance have continued to be there to support our member boards and have pivoted very nimbly to find new and exciting ways to educate and inform our member boards and to continue to assist them as they protect the public. All our state and territorial medical boards have been challenged by the pandemic and have also pivoted nimbly to license and look out for healthcare workers as well as the public during this pandemic.

As of March 31, 2021, there have been 128,377,922 confirmed cases and over 2.8 million deaths due to COVID-19 worldwide. In the United States, there have now been 30, 394,810 confirmed cases and 551,005 deaths due to COVID-19, more than any country in the world by far. The U.S. Food and Drug Administration emergently authorized two novel mRNA vaccines – one produced by Pfizer/BioNTech and the other by Moderna – in December of 2020. On February 27, the FDA emergently authorized the one-dose COVID-19 vaccine developed by Johnson and Johnson. The United States has administered 147,600,000 vaccines as of March 30, 2021, with 16 percent of Americans now fully vaccinated and 28.7 percent having been given at least one shot. Worldwide, more than 564 million vaccine doses have been administered.

This past year has seen many firsts for the FSMB and for organizations around the world. As you may recall, our Annual Meeting moved from an in-person event to a virtual House of Delegates session in May 2020 with virtual education sessions then taking place throughout the rest of the

year and into 2021. Technology platforms like Zoom, WebEx, Microsoft Teams, BlueSky and others became ubiquitous and common as most of us transitioned to working from home, at the FSMB and at our member boards. Our unsung heroes and individuals deserving our support and appreciation throughout this pandemic have been our many healthcare workers, including emergency medical technicians, on the front-lines who have continued to take care of patients each day while doing their best to maintain their own health and mental well-being and that of their loved ones.

On January 21, 2021, the FSMB formally announced the launch of Provider Bridge, a new online platform that may be used by volunteer healthcare professionals and those who employ or need them during COVID or a future national public health emergency. Provider Bridge was developed by the FSMB and made possible through a grant provided by the Health Resources and Services Administration (HRSA), a division of the U.S. Department of Health and Human Services. The platform is designed to help connect volunteer health care providers (doctors, nurses and others) with health care entities/agencies so that individuals in underserved and rural areas may receive timely access to care in a public health emergency.

On January 26, 2021, shortly after the boards of directors of the FSMB and the National Board of Medical Examiners deliberated and voted separately on the matter, the USMLE program announced the discontinuance of the Step 2 CS component of the USMLE sequence of exams. The decision was not taken lightly, as there were many calls, meetings and discussions that took place in the weeks leading up to the decision. The Step 2 CS had been suspended due to the pandemic since March of 2020. In our messaging, we have been careful to note that while the clinical skills examination has been discontinued, we have not altered our commitment to many of the clinical skills (e.g., communications, clinical reasoning) that the Step 2 CS exam assessed. While this was a significant change, it will allow the USMLE program, of which the FSMB and NBME are co-owners, to collaborate with our member boards, the medical education community and other stakeholders to enhance the assessments remaining in Steps 1, 2 and 3.

While the COVID-19 pandemic and USMLE governance matters took up an extraordinary amount of time in recent months, the work of FSMB's many committees, workgroups, and advisory councils and boards continued without delay or much interruption. Cheryl Walker-McGill, MD, MBA, FSMB's Chair, worked very hard to directly and thoughtfully lead the FSMB's Workgroup on Emergency Preparedness and Response, which met more often (every three weeks, on average) throughout the past year than any FSMB committee or workgroup in the history of our organization. The FSMB's Governance Committee, under the leadership of Board Member Shawn Parker, JD, engaged in thoughtful discussions to improve governance and operational efficiencies of the FSMB during the pandemic. The Nominating Committee worked diligently on the nominations for FSMB elected offices, guided by the committee's chair, FSMB past Chair Scott Steingard, DO. Dr. Steingard also chaired the Awards Committee, and you will see a wonderful video presentation of our recipients during our virtual 2021 Annual Meeting. Other Committees and Workgroups that met during the past year include our Ethics and Professionalism Committee, chaired by Jeffrey Carter, MD; the Board Action and Content Evaluation (BACE) Workgroup, chaired by Melanie de Leon, JD. MPA; the Workgroup on Physician Impairment, chaired by Danny Takanishi, MD; the Workgroup on Risk and Support Factors, chaired by Mohammed Arsiwala, MD; the Task Force on Artificial Intelligence, chaired by Sarvam TerKonda, MD; and the Finance Committee, chaired by Jerry Landau, JD, FSMB's Treasurer. In addition, the Bylaws Committee, chaired by W. Reeves Johnson, Jr, MD, and the Planning Committee, chaired by

FSMB Chair-elect, Ken Simons, MD, also met during this past year, as did several advisory councils and ad hoc subcommittees created to address issues as they arose during the pandemic.

While the FSMB is long accustomed to creating committees and workgroups on various issues to offer insight and recommendations for the consideration of our member boards at their House of Delegates meetings, we also from time to time create ad hoc task forces when needed and necessary. This was the case last year, when Dr. Steingard created the ad hoc Task Force on Pandemic Preparedness, which I chaired, and which quickly transformed into the ad hoc Task Force on Pandemic Response when the COVID-19 pandemic was formally declared. This year, Dr. Walker-McGill announced the creation of a new ad hoc Task Force on Health Equity and Medical Regulation, which she is chairing. The task force met for its first call on March 30, 2021, to begin to discuss what role medical regulators may be able to play to help advance diversity, equity and inclusion as part of their mission to protect the public. Given all that has happened over the last several months with civil unrest across our nation and concerns about systemic racism persisting in health care, the task force is timely. The tragic and jarring events of January 6 at our U.S. Capitol, not far from FSMB's DC offices, remind us of the need to provide a thoughtful voice as we seek to better understand our nation as it continues its quest, as written in the Preamble to the U.S. Constitution in the summer of 1787, "to form a more perfect union."

On the home front, with respect to our Texas and D.C. offices, our Executive offices in Euless are currently being renovated. This renovation had been in the plans for some time and given the fact that employees were working remotely from home, this gave Todd Phillips, MBA, Chief Financial Officer, staff, and the construction crew time to move forward on those plans. While most of our staff continue to work from home, several of our executive team and support staff occasionally work from the office and have since been temporarily placed in empty offices and/or meeting rooms while the changes are being made. For the D.C. offices, we successfully negotiated a new lease for office space on part of the 8th floor of 2101 L Street NW.

I am extremely grateful for the extraordinary and dedicated leadership of our FSMB Chair, Dr. Walker-McGill, and to our outstanding staff at the FSMB who have made all our efforts on behalf of state and territorial medical and osteopathic boards this past year possible. In reviewing my notes, I learned that I had been in communication by e-mail or text with Dr. Walker-McGill on average of three times a day during the past year, to discuss matters large and small. Dr. Walker-McGill was always available and always ready to offer leadership and guidance to me and our staff. While none of us traveled and all our meetings and communications benefited from technology, it is not an exaggeration to note that we have been busier than ever this past year.

Dr. Walker-McGill's leadership of the FSMB and her active engagement during the pandemic have been extraordinary, especially given the unexpected passing of her dear husband, Paul McGill, DDS, who passed away at age 71 on November 12, 2020. A trailblazer like Cheryl, Paul became the first African-American orthodontist to ever serve Charlotte, North Carolina. A graduate of the University of North Carolina, he received his dental degree from Howard University. In 2017, he was honored by the Charlotte Medical Society of North Carolina for his dedication to the community. He will long be remembered by his many friends and colleagues in North Carolina, across the country, and at the FSMB for his smile, his passion, and his loyalty and support of our chair.

I would particularly like to recognize our senior staff in Euless and in Washington, DC for their continued hard work during this pandemic: Lisa Robin, M.A., our Chief Advocacy Officer; David Johnson, MA, our Chief Assessment Officer; Todd Philips, MBA, our Chief Financial Officer; Michael Dugan, MBA, our Chief Operating Officer; and Eric Fish, JD, our Chief Legal Officer. I am grateful to Sandy McAllister, my Executive Administrative Associate, for her diligent and consistent support behind the scenes of all my activities, domestic and international, and to Patricia McCarty, Director of Leadership Services, for her attentive and exceptional hard work for and on behalf of our board of directors.

Finally, I would like to take this opportunity to thank Scott Steingard, DO., who will complete his term as Immediate Past Chair of the FSMB with the conclusion of this Annual Meeting. Dr. Steingard will be long remembered for his very capable and strong leadership, which overlapped with the beginning of the COVID-19 pandemic. Dr. Steingard lead us through a challenging time at the beginning of the pandemic, especially as the FSMB transitioned to holding its first ever virtual meeting. His tireless support of our state and territorial board will long be remembered.

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

The following are highlights of the FSMB's many projects, activities, and services on behalf of the nation's state and territorial medical and osteopathic boards managed by the more than 160 full time employees in Euless, Texas and Washington, DC.

ADVOCACY AND POLICY

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

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

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

COVID-19 Response: In the wake of the COVID-19 Pandemic, the FSMB mobilized its data and advocacy resources to assist state medical boards and the public with staying informed on emergency regulatory changes and efforts to address workforce needs. Important information and resources, including a chart of state-by-state emergency declarations and licensing waivers, is updated daily on the FSMB's COVID-19 website. This resource has been referenced in various media outlets and included as a resource on the CMS/Assistant Secretary of Preparedness and Response online healthcare workforce and the US Health and Human Services online telehealth. The FSMB engages with federal and state authorities, individual state medical boards, and representatives of the medical regulatory community to ensure information regarding state medical licensure is timely and accurate.

Coronavirus License Portability Grant Program: In May 2020, the FSMB was awarded grant funding in the amount of $2.5 million through the Health Resources and Services Administration, Health and Human Services, and the 2020 Coronavirus Aid, Relief, and Economic Security Act (CARES Act). These funds were used to create and launch Provider Bridge, a technology platform designed to streamline the process for mobilizing health care professionals during the COVID-19 pandemic and future public health emergencies. The platform includes a directory of state and federal COVID-19 resources with a dedicated customer service hub to help clinicians navigate state emergency licensure waivers and other modifications. Provider Bridge also allows physicians, physician assistants and nurses to register and receive an official digital document verifying critical data points including name, medical school graduation, NPI, licensure, disciplinary actions, DEA registration and specialty certification. The platform allows hospitals and other health care entities to identify and obtain health care providers to fulfill workforce needs based on their medical profession and specialty.

Telehealth During COVID-19: The use of telehealth grew exponentially during the COVID-19 pandemic and as it became more widely used, interest in how it is regulated also became an area of focus for Congress. Federal proposals for changes to telehealth ranged from expanded reimbursement to licensure reciprocity during emergencies, creating many opportunities for the FSMB to engage with legislators on priority issues. The FSMB has focused its advocacy efforts on supporting bills that would study the use of telehealth during COVID-19 and collect data to inform any future policy changes. The FSMB supported the *Evaluating Disparities and Outcomes of Telehealth During the COVID-19 Emergency Act*, introduced by Rep. Robin Kelly (D-IL) and the *Knowing the Efficiency and Efficacy of Permanent "KEEP" Telehealth Options Act of 2020*, introduced by Reps. Cindy Axne (D-IA) and Troy Balderson (R-OH), each of which would require studies on the use of telehealth services during the pandemic.

Physician Wellness and Burnout: Congress took a serious interest in the implications of stress and burnout in the healthcare workforce during the 116th Congress, paying special attention to the impact on front line COVID-19 responders. There was a bipartisan call to recognize the problem and to begin addressing it through funding for resources and research on the issue. The FSMB supported bipartisan efforts through the *Dr. Lorna Breen Health Care Provider Protection Act* and the *Coronavirus Health Care Worker Wellness Act of 2020*, which would have created additional funding for programing, educational campaigns, and studies on health care worker wellness, particularly during COVID-19. The FSMB also continued to participate in the *National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience*.

Interstate Medical Licensure Compact: The FSMB continued to support state medical boards interested in implementing the Interstate Medical Licensure Compact (IMLC). As of March 2021, thirty (30) states, one territory, and the District of Columbia have enacted the compact, while the IMLC has been introduced during the 2021 legislative session in Missouri, New Jersey, New York, Ohio, Oregon, and Texas. FSMB staff has supported state legislative efforts by submitting written and oral testimony, assisting boards with testimony, and coordinating technical and legal assistance.

In May 2019, the FSMB was awarded a five-year grant of $250,000 annually from the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, to support the IMLC and further enhance license portability for physicians and physician assistants (PAs). The five-year HRSA funding was used to support enhancements to the IMLC technology platform and outreach to educate stakeholders on how to utilize the IMLC to improve access to care using telemedicine across state lines. The grant will also support new and existing IMLC member states in increasing efficiency in conducting required criminal background checks. The funds are being used to support a collaboration with the Council of State Governments, the American Academy of Physician Assistants, and the National Commission for the Certification of Physician Assistant to develop a licensure compact for PAs. Model legislation will be circulated for comment to member boards and other stakeholders in April 2021.

Congressional Activity: The DC Advocacy Office continued to be active on federal legislative and regulatory issues pertinent to state medical boards. In addition to addressing topics that came to the forefront of the national dialogue as a result of the COVID-19 pandemic, the FSMB continued its efforts to ensure robust reporting of adverse actions within the VA to state licensing boards. The FSMB also submitted a comment on *the Department of Veterans Affairs Interim Final Rule - Authority of VA Professionals to Practice Health Care (RIN 2009-AQ94),* highlighting the importance of ensuring that veterans receive the same level of quality care and appropriate regulatory oversight as the general public, through robust reporting standards and appropriate training and asking for clarification regarding the process that will be used to develop and "National Standards of Practice" for practitioners within the VA.

Additionally, the FSMB supported the introduction of legislation that would provide antitrust liability relief to state licensing boards. The *Occupational Licensing Board Antitrust Damages Relief Act of 2020* was introduced during the 116th Congress by Reps. Jamie Raskin (D-MD), David Cicilline (D-RI), and Michael Conaway (R-TX).

FSMB Advocacy Network News: This e-newsletter was distributed regularly to more than 400 recipients and provided updates on pertinent federal and state legislative and regulatory activity of interest to member boards. The newsletter also included a "call to action," requesting targeted advocacy efforts when necessary.

State Medical Board Reviews: At the request of the State Medical Board of Ohio, the FSMB conducted a review of the Board's operations, processes, and policies as it sought to address recommendations contained in the 2019 Report of Governor Mike DeWine's Working Group on Reviewing the Medical Board's Handling of the Investigation Involving Richard Strauss. The FSMB assembled a review team comprised of Dr. Patricia King, Kathleen Haley, JD, former Executive Director of the Oregon Medical Board and Brian Blankenship, JD, Deputy General Counsel, North Carolina Medical Board. Due to the COVID-19 pandemic, the review transitioned

to a virtual format for meetings and interviews with the Board's leadership and staff. A final report and recommendations were provided to the Board on June 30, 2020.

Nevada statutes require an audit of the Nevada State Board of Medical Examiners every eight years. The FSMB conducted previous audits in 2004 and 2012 and was awarded a contract with the State of Nevada to again conduct the required audit. The FSMB assembled a review team comprised of Dr. Art Hengerer, former FSMB Chair and former chair of the New York Board of Professional Medical Conduct, Kevin Bohnenblust, JD, Executive Director of the Wyoming Board of Medicine, Rob Law, public member, Georgia Composite Medical Board, and Elizabeth Huntley, JD, Deputy Executive Director, Minnesota Board of Medical Practice. Team meetings and interviews with Board leaders and staff were conducted virtually. A report of the audit was submitted to the Nevada Legislative Commission on November 30, 2020.

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

In 2020, the FSMB monitored more than 3,000 legislative bills, on issues such as COVID-19, including licensure requirement waivers and modified continuing medical education requirements; pain management, including prescription drug monitoring programs, opioid abuse and prevention, and controlled substances; state health-professional licensing/disciplinary boards, including occupational licensure reforms, board investigations, board composition and oversight, reporting requirements, and funding; physician scope of practice; continuing medical education; and telemedicine. The FSMB submitted official letters and testimony in response to legislation in Florida, Minnesota, New Jersey, and South Carolina.

Policy Documents and Legislative Summaries: The FSMB develops and maintains various documents setting forth the unique jurisdictional approaches espoused by the states and state medical boards with respect to key issues of importance to the state boards. These documents are available to the public on the FSMB website and are frequently circulated upon request to a variety of stakeholders. Legislative summaries that were updated during 2020 included: Continuing Medical, Pain Management, Prescription Drug Monitoring Programs, Telemedicine, COVID-19, Interstate Medical Licensure Compact (IMLC), License Portability, Occupational Licensure Reform, and Board Structure & Function. Board-by-Board Overview charts that were updated during 2020 included: Continuing Medical Education, Expert Witness, Marijuana, Pain Management, and Telemedicine.

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

COMMITTEES AND WORKGROUPS

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

Advisory Council of Board Executives: Charged with conducting a triennial review of *Guidelines for the Structure and Function of a State Medical and Osteopathic Board (2018)*, the Advisory Council discussed the *Guidelines* section by section and suggested revisions and language clarifications to bring the document in line with current best practices. The final document was completed and will be considered by the FSMB House of Delegates in May 2021.

The Ethics and Professionalism Committee: Chaired by Jeffrey D. Carter, MD, the Committee's charge for 2020-21 included 1) providing direction regarding the professional responsibility to wear a face covering during patient care to limit the spread of COVID-19, 2) developing a position statement on physician treatment of self, family members, and close personal relations, and 3) drafting guidance on key considerations for obtaining and working with expert reviewers in quality-of-care cases. The Committee's direction regarding face coverings was provided to the FSMB Board of Directors and informed a press release on the topic which was published in October of 2020. The Committee consulted with state medical boards on a draft position statement on the treatment of self, family members, and close personal relations in summer of 2020. A revised draft which incorporates member board feedback will be considered for adoption by the FSMB House of Delegates at its 2021 meeting. The House of Delegates will also consider an informational report on Board Practices Regarding Expert Reviews in Quality-of-Care Cases.

Workgroup on Board Education, Service and Training (BEST): The BEST Workgroup, chaired by Thomas Mansfield, JD, continues to play a coordinating role in the FSMB's effort to create new resources for state medical board members as they fulfill the roles and responsibilities associated with their board service.

Development of learning modules in the online educational series **"Understanding Medical Regulation in the United States"** has continued, with the most recent module, "Understanding Physician Assistant Licensure" recently completed and posted online.

Each module consists of a slide presentation with audio narration. In addition to the audio portion of each module, the narration is available in text form. Included in the various modules are concepts about medical regulation, including licensure, data collection, discipline, policy development, legal principles, and operational and governance matters.

With the continued growth of the PA workforce overall in the U.S., and its increasing role in delivering care to rural and underserved areas, the Workgroup made the decision to add "Understanding Physician Assistant Licensure" to its original line-up of educational resources.
The fourth module in the series, "Understanding Discipline in Medical Regulation," is now in development and will be posted online after review and approval by the Workgroup.

Other topics to follow Module 4 include:

- Common Problems that Lead to Discipline

- Roles and Responsibilities of State Medical Board Members
- Understanding Law, Policy and Administration
- The Importance of Information and Data in Medical Regulation
- Special Topics in Medical Regulation

Workgroup on Emergency Preparedness and Response: The Workgroup on Emergency Preparedness and Response, chaired by Dr. Cheryl Walker-McGill, began meeting in May 2020 and was charged with collecting and evaluating experiences and potential needs of state medical boards and other health regulatory boards related to licensure, regulation, and the U.S. healthcare workforce in response to the COVID-19 pandemic. The Workgroup continued the work of the *Ad Hoc Task Force on Pandemic Preparedness*, formed in February 2020 by FSMB Chair at the time Scott Steingard, DO, and chaired by FSMB CEO Humayun Chaudhry, DO, MS, MACP. The Workgroup has held 14 virtual meetings since May 2020, circulated a draft interim report with recommendations to member boards and external stakeholder organizations in January 2021, and submitted a final draft to the FSMB Board of Directors which will be considered for adoption by the House of Delegates at its 2021 meeting.

Workgroup on Physician Impairment: The Workgroup on Physician Impairment was appointed by Dr. Scott Steingard in 2019. Chaired by Dr. Danny Takanishi, MD, the Workgroup is responsible for revising and expanding the existing FSMB Policy on Physician Impairment in light of new and emerging issues. The Workgroup held several virtual meetings from 2019 to 2021, circulated a draft report to member boards and external stakeholder organizations in the fall of 2020, and submitted a final draft to the FSMB Board of Directors which will be considered for adoption by the House of Delegates at its 2021 meeting.

Workgroup to Study Risk and Support Factors Affecting Physician Performance: Chaired by Mohammed Arsiwala, MD, this Workgroup was charged with: 1) Collecting and evaluating data and research on factors affecting physician performance and ability to practice medicine safely, including but not limited to practice context (specialty, workload, solo/group, urban/rural), gender, time in practice, examination scores, and culture; 2) Convening stakeholder organizations and experts to engage in collaborative discussions about patient safety issues and ethical and professional responsibilities as they relate to physician performance, including the duty to report; 3) Identifying principles, strategies, resources and best practices for assessing and mitigating potential impacts on physician performance; and 4) Providing information to state medical boards about the risk and support factors affecting physician performance throughout their careers, how these can impact patient care, and what key principles should be applied to consideration of fair, equitable and transparent regulatory processes. The Workgroup drafted an informational report containing information about risk and support factors affecting physician performance, a summary of state medical board approaches to these factors and educational offerings for licensees, visual representations of risk and support factors categorized according to their relationship with health and wellness, experience and transitions, and the practice environment, and suggestions for furthering FSMB support of member board resources and practices.

COMMUNICATIONS AND PUBLIC AFFAIRS

FSMB is frequently contacted by the nation's news media to provide insight and national perspective on issues of relevance to the medical regulatory community. In the past year, FSMB granted interviews and provided statements to The New York Times, ABC News, the Associated Press, CBS News, the Washington Post, the Wall Street Journal, Politico, Medscape, the Atlantic, and many other medical and non-medical publications.

In the wake of the COVID-19 pandemic, the communications team worked with FSMB's IT team to quickly develop a COVID-19 page on FSMB's website. This page was used to provide multiple daily updates to state medical boards, the media, policymakers and the general public about changes to licensure waivers and policies across the country. The FSMB's COVID-19 webpage has been viewed more than 70,000 times and was frequently cited in media reports and linked to by state agencies and medical organizations.

The communications team worked closely with FSMB leadership and the FSMB Board of Directors to issue press releases and statements on a number of actions and developments related to medical regulation during the COVID-19 pandemic. These included the FSMB making PDC data free for health care entities for 30-days to aid in quickly verifying medical licenses, recommendations for facilitating license portability, and reminding licensees they have a duty to wear face coverings during patient care.

The FSMB also joined with the Tri-Regulator Collaborative and the Coalition for Physician Accountability to issue statements on proper prescribing practices during COVID-19 and guidance for health care workers on maintaining quality of care and safety.

As co-owners of the USMLE, the communications team is responsible for driving communications and social media efforts for the USMLE program. The COVID-19 pandemic caused substantial disruptions to test administrations and the communications team worked closely with colleagues at NBME to share critical updates with examinees via direct announcements and through social media. The decision to suspend and ultimately discontinue Step 2 CS was carefully communicated to state medical boards, medical educators and examinees. That announcement was well-received within the medical education community and the USMLE program received praise for its commitment to remain transparent and provide frequent updates as that decision was made.

Additionally, the team provided media relations assistance to medical boards for both state and national stories on a variety of issues, such as physician sexual misconduct, licensing application questions about mental health, and the opioid epidemic. medical boards through issuing press releases on a wide variety of topics. These topics included the success of the Interstate Medical Licensure Compact, the release of FSMB's latest regulatory trends and actions report, the efforts of FSMB Workgroups to support member boards and the development of additional free education modules for state medical board members, medical students and residents.

STATUS OF RESOLUTIONS TO THE HOUSE OF DELEGATES

Resolution 19-6; *Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office Policy (2013)*, submitted by the North Carolina Medical Board. In 2019, FSMB staff began reviewing and identifying areas of the *Model Policy* to update, as well as reached out to relevant stakeholder organizations to gather input. As part of the review, FSMB staff identified that it was

pertinent to include any newly or expected federal guidance. With the Special Registration for Telemedicine Act of 2018, which was part of the SUPPORT for Patients and Communities Act signed into law in late 2018, the Drug Enforcement Agency (DEA) had until October 24, 2019 to set the rules for providers with a special registration to prescribe controlled substances. The DEA published its interim final rules on November 2, 2020, with comments due on January 4, 2021. On January 14, 2021, the Trump Administration's HHS announced forthcoming Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder, but the Biden Administration paused the release of those guidelines. The Biden Administration has signaled support for broader access to medication-based treatment for opioid use disorder and is working to find ways to lift burdensome restrictions on medications for opioid use disorder treatment. As a result, FSMB staff continues to review the *Model Policy*. A draft of proposed amendments should be circulated to Member Boards in the second half of 2021.

Resolution 19-7; *Policy on Physician Impairment*, submitted by the North Carolina Medical Board was referred to the Workgroup on Physician Impairment. The Workgroup was charged with reviewing the FSMB Policy on Physician Impairment (HoD 2011) in cooperation with the Federation of Physician Health Programs (FSPHP), and making recommendations to revise the policy in light of new and emerging issues, including the management of licensees receiving Medications for Opioid Use Disorder (MOUD), implementation of the DSM-5, and revisions to the FSPHP's *Physician Health Program Guidelines*. The Workgroup has completed a draft report that includes an updated definition of physician impairment and guidance on the management of physicians receiving MOUD. The report also addresses the role of PHPs and state medical boards in supporting licensee wellness and combatting burnout and updates the description of the stigma associated with physician impairment, including barriers to reporting, treatment/rehabilitation, and re-entry to practice. The revised draft report was distributed to state medical boards for comment in the fall of 2020. After further revisions based on feedback received, the report was submitted to the House of Delegates and will be considered for adoption as FSMB policy in May of 2021.

Continuing Professional Development (CPD)

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

The FSMB has also engaged in conversations with international medical regulatory authorities and organizations responsible for the accreditation of CME to discuss the development of substantive equivalency standards. Such standards would guide the accreditation of CME globally and could be used to determine substantive equivalency between accrediting bodies from different jurisdictions, allowing a wider array of relevant and high-quality educational opportunities for practicing physicians.

Post-Licensure Assessment System (PLAS)

The Post-Licensure Assessment System (PLAS), a joint program of the FSMB and the National Board of Medical Examiners (NBME), provides diagnostic tools for evaluating the ongoing competence of currently or previously licensed physicians. The PLAS collaborates with assessment programs across the country to provide standardized and personalized assessments of physicians for whom there is a question regarding clinical competence. The assessment tools provided by PLAS complement the programs' other performance-based methods of assessment

and assist in evaluating a physician's medical knowledge, clinical judgment and patient management skills in his or her current or intended area of practice.

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

Special Purpose Examination (SPEX)

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

United States Medical Licensing Examination (USMLE)

The USMLE continues to draw upon the expertise and insight of the medical licensing community to inform ongoing enhancements (and their implementation) to the examination. In 2020, 25 individuals from 18 boards participated in a USMLE activity in some capacity. This recent activity reflects the long-standing tradition of medical board participation in the USMLE. Since the program's inception, 258 individuals from 61 medical and osteopathic boards have participated on a USMLE committee, panel, workgroup, etc.

One mechanism for tapping into the expertise of the licensing community is a sounding board group comprised of members and staff from state medical boards. Constituted in 2011 as an ongoing mechanism to provide feedback and guidance to the program, the State Board Advisory Panel to the USMLE convened twice in 2020 and once already in 2021; due to the COVID-19 pandemic, all meetings were held virtually. Current panel members include staff and board members from the Florida-Medical, Illinois, Maine-Medical, Minnesota, Nevada-Medical, New York-Licensure, North Carolina, Vermont-Medical, West Virginia-Medical and Wisconsin boards.

In 2020, 25 individuals with experience as members or staff of a medical board actively participated or served on a USMLE committee, task force, advisory or standard setting panel. These individuals came from 18 boards, including: Alaska, Arizona-Medical, Arizona-Osteo, District of Columbia, Florida-Medical, Hawaii, Illinois, Iowa, Maine-Medical, Minnesota, Montana, Nevada-Medical, New York-Licensure, North Carolina, Vermont-Medical, Virginia, West Virginia-Medical and Wisconsin. The members and executive directors of state medical boards serving on these committees provide the USMLE program with assistance in multiple areas, including setting program policy, approving examination blueprints, establishing the fees for each Step exam, rendering final determinations relative to allegations of examinee misconduct, etc. Physician members of state medical boards are also involved in the process of test item development for the USMLE.

FSMB actively works to increase state board participation in the USMLE program and hosts an annual orientation workshop for state board members and staff. The workshop normally takes

place at NBME's offices in Philadelphia, but due to the COVID-19 pandemic, the 2020 workshop was held virtually as a two-part webinar series in December 2020. A total of 73 individuals attended, including state board members and staff. For comparison, the total number of individuals attending an in-person orientation from 2007-2013 was 130 individuals, representing 52 medical and osteopathic boards. Since the webinar format allows for far greater attendance than an in-person meeting – especially by state board staff – USMLE program staff are considering how the program could be offered in the future to facilitate similar increased participation. To date, fifty-seven (57) past orientation participants (representing 35 boards) have served subsequently with the USMLE program. This includes participation on standard-setting and advisory panels, as well as serving on the USMLE Management Committee and item-writing committees for the program.

In February 2020, the USMLE announced three policy changes:

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

The latter policy change stemmed largely from the national dialogue commenced through the Invitational Conference on USMLE Scoring (InCUS) that FSMB hosted in March 2019 with co-sponsors NBME, ECFMG, American Medical Association and the Association of American Medical Colleges.

In March 2020, due to the COVID-19 pandemic, Prometric closed all testing centers for computer-based USMLE Step exams and the USMLE program suspended administration of the Step 2 CS exam. Subsequently, in May 2020, the USMLE program announced that it would be taking the next 12-18 months to bring back a modified Step 2 CS exam that was appreciably better than the prior assessment. However, in January 2021, after reviewing current and anticipated progress with the exam and in consideration of the rapidly evolving medical education, practice and technology landscapes, the FSMB and the NBME announced their decision – as the USMLE parents – to discontinue Step 2 CS. Although there are no plans to bring back Step 2 CS, the intent is to take this opportunity to focus on working with colleagues at the state medical boards and in medical education to determine innovative ways to assess clinical skills.

With the discontinuation of Step 2 CS, several policy changes were announced by USMLE. The Step 3 eligibility requirements are being revised to default to the pre-2004 requirement that did not include Step 2 CS. The program will continue to report a complete, full exam history for all candidates on the USMLE history, including the Step 2 CS outcomes. The following statement is being added to all USMLE transcripts stating, *"The USMLE Step 2 CS examination was suspended on March 16, 2020 and formally discontinued on January 26, 2021. Due to the exam's discontinuation, examinees with a failing Step 2 CS outcome may not have had an opportunity to retest and remediate their performance. The USMLE defines successful completion of its examination sequence as passing Step 1, Step 2 CK, and Step 3."*

Finally, the USMLE program issued a statement defining successful completion of the USMLE sequence as follows: "*With the discontinuation of Step 2 Clinical Skills (CS) on January 26,2021,*

the USMLE defines successful completion of its examination sequence as passing Step 1, Step 2 CK and Step 3."

In 2020, the FSMB and the USMLE program relied heavily on its communication avenues to keep USMLE examinees, state medical boards and the undergraduate and graduate medical education communities apprised of ongoing developments. This included regular updates and announcements via the USMLE website and social media accounts (Facebook, Twitter, and LinkedIn), as well as webinars and quarterly updates for state medical boards specifically. In March 2020, the FSMB issued its first quarterly update on USMLE as part of ongoing educational outreach efforts to state medical boards. Updates are distributed to state boards via email every quarter (March, June, September, December). USMLE program staff from the FSMB and the NBME hosted two webinars with state medical boards in 2020. The April 13 webinar focused on the February 2020 policy announcements issued by USMLE and the USMLE program's response to the COVID-19 pandemic. The July 16 webinar focused on the impact of the COVID-19 pandemic on USMLE testing and the impact of the pandemic and the Step 2 CS suspension on licensing.

Education Services

2021 FSMB Annual Meeting – April 29 – May 1, 2021: In late 2020, after weeks of discussion with the FSMB's Board of Directors, the FSMB's Education Committee, and senior staff, the FSMB decided to hold the 2021 FSMB Annual Meeting virtually. This was a difficult decision to make, but due to the surge in COVID-19 cases around the country, the organization felt it was the right decision for the health and safety of our attendees and staff. The 2021 FSMB Annual Meeting was originally scheduled to be held in Minneapolis, MN on April 29-May 1. Although we will not be able to meet in-person, we have worked hard to develop a robust virtual program that will build off of the success of the 2020 virtual House of Delegates business meeting and educational series. The 2021 program will feature keynote speakers and opportunities for networking and information-sharing on a wide range of issues related to medical regulation. This year's event will also feature new offerings, such as our first-ever Town Hall meeting, and favorites from the past, including our Spotlight Poster Hall.

We are pleased to announce **Ashish K. Jha, MD, MPH**, Dean of Brown University School of Public Health and globally recognized expert on pandemic preparedness, will deliver this year's *Dr. Herbert Platter Lecture* on Thursday, April 29. **Jeh Johnson, JD,** Former US Secretary of Homeland Security will deliver the *Dr. Bryant L. Galusha Lecture* on Friday, April 30.

After our two-day Annual Meeting, the FSMB will convene its annual House of Delegates Meeting on Saturday, May 1 – also to be held virtually.

FSMB's 2020 Virtual Education Program: Upon cancellation of the in-person 2020 Annual Meeting, the FSMB launched the virtual educational learning hub on July 14, 2020, with the first of six educational webinars. All six (6) live webinars were recorded as an on-demand internet activity and was accredited for *1.0 AMA PRA Category 1 Credit™*. The on-demand courses are still available on the learning hub at https://www.pathlms.com/fsmb. Overall, we are pleased with participation as the average number of learners per activity is 177. Outlined below is a summary of the sessions.

Activity Date	Title	Speakers	# of Live Attendees	# of On-Demand Attendees	Total Learners
July 14, 2020	*Where Will the Empowered Health Care Consumer Lead Us?*	John Whyte, MD Humayun Chaudhry, DO	89	73	162
July 30, 2020	*Achieving Regulatory Excellence in a World of Advanced Technologies & Complex Risks*	Cary Coglianese, JD, PhD Scott A. Steingard, DO	94	53	147
September 10, 2020	*Physician Sexual Misconduct: New Policies and Approaches*	Patricia A. King, MD, PhD Melanie de Leon, JD Mark Staz, MA Kerrie Webb, JD	236	61	297
November 12, 2020	*New Pandemic-Related Developments in Telemedicine*	Mei Wa Kwong, JD Jeremy Sherer, JD Sarvam TerKonda, MD	100	32	132
December 2, 2020	*National Practitioner Data Bank Update: New Tools for Regulators*	David Loewenstein Harnam Singh, PhD Lisa Robin	115	21	136
December 16, 2020	*Ensuring Fairness in Medical Regulation: Can Implicit Bias be Overcome?*	Bryant T. Marks, Sr., PhD Cheryl Walker-McGill, MD, MBA	165	24	189
		Totals:	**799**	**264**	**1063**

Additionally, as a part of the virtual education program, the FSMB and Administrators in Medicine (AIM) co-hosted a virtual version of the **Spotlight Poster Hall.** The 2020 Spotlight Poster Hall included 11 posters from 9 state medical boards and organizations and can be found at https://www.pathlms.com/fsmb/courses/21345.

Special Event with Michael Osterholm, PhD, MPH: On January 14, the FSMB hosted a special online event with renowned epidemiologist, Michael Osterholm, PhD, MPH**.** Dr. Osterholm, who was recently appointed to President Biden's 13-member transition COVID-19 Advisory Board, shared his perspective on the national response to the pandemic and what 2021 may have in store.

FSMB Virtual Symposium – January 26, 2021: On January 26, FSMB hosted a virtual symposium titled *Health Equity and Medical Regulation: How Disparities are Impacting U.S. Health Care Quality and Delivery – and Why It Matters*. During this 3-hour virtual event, guest speakers addressed the impact of racism and implicit bias on health disparities and the need for change to eliminate barriers to access to quality care for at-risk communities. The online symposium included presentations by keynote speakers Marc Morial, JD, President and Chief Executive Officer of the National Urban League, and Mark McClellan, MD, PhD, Director of the Duke-Robert J. Margolis Center for Health Policy, along with a moderated panel-discussion featuring leaders in health equity. Panelists included Diana Currie, MD, a member of the Washington Medical Commission; Aletha Maybank, MD, MPH, the American Medical Association's Chief Health Equity Officer; and Leonard Weather Jr., MD, RPh, a member of the Louisiana State Board of Medical Examiners and a Past President of the National Medical Association. Dr. Walker-McGill hosted the event, and the panel discussion was moderated by Dr. Chaudhry.

To assist with the delivery of the symposium, FSMB partnered with Solid Line Media who produced the "simulated live" sessions. The sessions consisted of pre-recorded presentations from the 2 keynote speakers with live Q&A. We saw many benefits to hosting the event with the simulive interaction style. It allowed speakers to pre-record their presentations at their convenience so that they did not have to be available to present at a given time slot. It also allowed them to perfect their presentation to their desires, and it gave us control over the content quality, improved technical quality and session interactions. The symposium was accredited for *2.5 AMA PRA Category 1 Credits™,* and two hundred and thirty-two (232) physicians and non-physicians joined in the event.

FSMB CME Program and Accreditation Services: 2020 certainly brought FSMB's Continuing Medical Education (CME) program some challenges in these unprecedented times. With guidance from the Accreditation Council on Continuing Medical Education (ACCME), the CME program worked actively to facilitate the transformation of mostly live activities into completely virtual events. Despite the shift in learning formats, in 2020, FSMB's CME program accredited a total of 30 activities including 16 live courses via the internet and 14 online, enduring activities for a total of 41 AMA PRA Category 1 credit hours. Many of the activities were jointly provided by the Washington Medical Commission.

As the CME program navigates these uncertain times, we have continued to make efforts to improve the program by ensuring that we are well prepared for reaccreditation in March 2021. This past year, we utilized *BlueSky eLearn,* a CME learning management system, to help capture our virtual educational content and offer learners a streamlined way to earn, track and generate CME certificates at no charge. We also implemented a new review and documentation mechanism to help resolve and manage identified conflicts of interest. For any individual disclosing relevant financial relationships with commercial interest, staff now utilizes a resolution COI form as part of the accreditation process. This document captures the identified conflict and describes the methods used to resolve the conflict to ensure that the resolution is compliant with ACCME accreditation requirements and policies and standards for commercial support.

ACCME Re-Accreditation Status: We are pleased to report that as of March 22, 2021, the FSMB has received full Re-Accreditation status with the Accreditation Council for Continuing Medical Education (ACCME.) FSMB will be an accredited CME provider for another four (4) years, through March 2025.

Operational Update

During the past year, much time was spent responding to the COVID-19 pandemic with the goals of providing a safe working environment for FSMB staff and to continue providing services to our member boards and our physician user community with as little disruption as possible.

In early March of 2020, FSMB began working in an alternate model that was designed to provide a safe work environment for staff according to CDC guidelines. In addition to masks and social distancing, physical changes such as extended plexiglass shields were implemented. The phrase 'Next Normal' was adapted due to the fluidity of the environment. Acquisition and distribution of additional hardware was completed by the end of March. This allowed the transition to a fully virtual model, excepting the few roles that require physical presence in the office.

Like organizations across the globe, FSMB experienced the highs and lows of transitioning to a completely new working model. Staff and managers across all groups have done a commendable job during making this transition and have maintained a high level of productivity. Leaders are currently in the process of defining a go forward working model that we expect to implement this fall. The new model is likely to contain elements of our current environment and of our pre-pandemic environment.

Federation Credential Verification Service: In 2020, FCVS delivered a total of 64,915 profiles, 59,588 were specifically delivered to state medical boards. This represents an 18% increase over 2019. Overall Cycle time for 2020 is 19 days vs. 17 days in 2019. This can be attributed to the delay caused by the transition to remote work due to the pandemic for many of our strategic partners including institutions and programs.

Overall Customer Satisfaction ratings for 2020 were at 87% Satisfaction, vs. 90% in 2019. Cycle time was also higher over the previous year for 9 out of 12 months.

FSMB provides access to National Practitioner Data Bank reports through the FCVS service. There are currently (21) SMBs that are participating in our NPDB service. There are 15 that are using our one-time query and (6) SMBs participating in the NDPB Continuous Query report.

FSMB stores information for 55 programs and 200+ specialties as part of our closed program verification service. We are transitioning this service to a fully digital process. Using our new model, we have processed 306 secure digital closed program verifications for physicians. In January 2021, we launched a new Third Party application for requesting closed program verifications. The application also allows inquiries for Program Verifications from completed FCVS profiles.

Year over year (2020 vs. 2019) total call volume decreased by 8% for a total of 51,252 inbound calls. A total of 8,715 Live Chats sessions have been executed which is 300+% increase. Since inception, we are now experiencing 100+ chats per week with at an average of 13 minutes each. The longest chat averages were 15-21 minutes occurred in March-June 2020. As in the previous year, the primary chat topic continues to be centered around profile status updates.

As part of the Uniform Application (UA), 19,428 applications were processed in 2020. This represents 10.5% increase in applications over 2019.

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

Key statistics during 2020 include the delivery of 139,329 detailed profile reports and 15,213 disciplinary alerts delivered to our member boards. Additionally, the Data Integration team loaded 145 licensure on average files each month with over 8.6 million records and 23,000 manually matched records.

Exhibitions/Outreach: In an effort to promote the use of FCVS, the PDC and the UA through other channels, FSMB typically exhibits at a number of regular meetings. In person meetings were limited this year; however, several virtual meetings such as the National Association of Medical Staff Services (NAMSS) offered the opportunity for a virtual exhibit space.

Beginning in July of 2020, FSMB launched a number of digital marketing campaigns on the LinkedIn platform. These campaigns have been very effective due to the ability to display ads to professionals in a specific group. These ads have been displayed more than 500,000 times and have resulted in several new customers.

Research: The research team provides support for collaborative research efforts, research requests for individual state boards as well as internal survey and research. Highlights for the past year include:

- Annual State Board Survey – supporting needs of workgroups, committees and topics referred to the FSMB Board of Directors.
- U.S. Medical Regulatory Trends and Actions Report – for publication on the FSMB website.
- Medical Regulatory Survey – used to compile information regarding board composition, governance structure and other details.
- Journal of Medical Regulation (JMR) Readership Survey – used to better understand reading habits, journal ratings and reader preferences.
- USMLE Attempts and Board Actions – research used for publication.
- USMLE Irregular Behavior – supporting a manuscript published by the JMR.
- FSMB Staff Survey – employee survey over employee engagement, diversity, and COID-19 response.
- State specific requests –
- Operational Quality Projects – specific audits looking for data anomalies and methods to improve data quality.

Editorial Services

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

FSMB Publications: The FSMB published its *2020 Annual Report: Milestones*, which highlighted FSMB's service to its members, the public and its partners in health care. The *Annual Report* included a special two-page section highlighting steps the medical regulatory community took this year as the COVID pandemic hit and summarized a productive and historically significant year for the FSMB that was marked by advances in key initiatives.

During 2020, FSMB distributed 100 issues of the twice-weekly *FSMB eNews* e-mail bulletin to more than 5,000 individuals in the medical regulatory community, government, and affiliated organizations with helpful information about FSMB events and initiatives, state medical board news and relevant health care news.

FSMB's quarterly peer-reviewed, scholarly journal, the *Journal of Medical Regulation (JMR),* continued to provide a worldwide forum of original research articles to inform and engage medical regulators on innovative strategies and solutions to improve public protection. Staff continued to recruit authors from state medical boards and the international regulatory community to contribute manuscripts on issues impacting medical regulation.

JMR continued several recently launched initiatives to raise the publication's visibility and improve its accessibility to both readers and researchers:

- Launched in 2019, the "JMR Podcasts" series features interviews with authors of published JMR articles discussing what spurred their interest in the research topic and the importance of the findings for medical regulators. Recent podcasts included representatives from the Rhode Island Board of Medical Licensure and Discipline discussing their article on disciplinary actions taken by the board regarding controlled substances; Dr. Christine Moutier, Chief Medical Officer of the American Foundation for Suicide Prevention, discussing her JMR award-winning article, "Physician Mental Health: An Evidence-based Approach to Change"; representatives from ECFMG providing an update on ECFMG's 2023 Medical School Accreditation Requirement; and an update from the Washington Medical Commission on the Commission's initiative to engage solo health care practitioners to prevent medical errors and burnout.

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

FSMB Editorial Committee: Under the leadership of Editor-in-Chief Heidi Koenig, MD, the Committee met in September 2020 to provide editorial guidance and article ideas to staff. Throughout the year, Committee members served on peer-review panels to evaluate each manuscript submitted to the *Journal of Medical Regulation* for potential publication.

FSMB Roundtable Webinars: FSMB's Editorial Services department coordinates the program of video conferences that provide regular opportunities for member boards to communicate with one other on current issues, public policy, and legislative trends.

In the spring of 2020, FSMB convened several special online forums for FSMB staff and state medical and osteopathic boards to share the various approaches being taken by regulators in response to the unfolding COVID-19 pandemic. These included:

- Sharing ideas across boards and helping create support systems to assist boards as they prepared for contingency measures during the pandemic
- Facilitating the licensure and mobilization of the health care workforce during the pandemic
- A special forum on planning the future of medical licensing post-COVID-19 pandemic

Additional webinars included:

April 2020 – Patricia King, MD, PhD, Immediate Past Chair of the FSMB and Chair of the FSMB's Workgroup on Physician Sexual Misconduct, provided an overview of the final draft of the workgroup's report.

January 2021 – University of Minnesota Epidemiologist Michael Osterholm, PhD, who had been recently appointed to President-elect Biden's 13-member Transition COVID-19 Advisory Board, provided his unique perspective on the national response to the COVID pandemic, as well as updates on recent developments on the pandemic.

FSMB Library: Staff completed data mapping work and the migration of FSMB's Library InMagic database platform to a new system (Genie Plus) that will enable staff to create new knowledge repositories more quickly and easily with custom metadata structures and retrieve information for staff, state medical boards and other organizations. InMagic is a web-based library management system used to manage FSMB's publication subscriptions that provides access to the various periodicals, documents, articles and newsletters the organization has collected since the Library's inception in 1994. More than 25,000 items were migrated to the new Genie Plus platform.

FSMB FOUNDATION

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

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

Through generous support of the FSMB and its member boards, the FSMB Foundation has facilitated several successful and well-received initiatives and will continue to bring innovative tools and resources to state medical boards. Earlier this year, the FSMB Foundation widened its grant program and awarded grants to four (4) organizations a total of $100,000.00 in grant funding for projects to study the way states and health systems have responded to health care impacts of the COVID-19 pandemic. The long-term goal of the FSMB Foundation COVID-19 grants program is to support the development and implementation of sustainable models and policies that can guide state preparedness and responses to similar emergencies in the future, as well as their capacity for recovery planning. The program also intends to promote health equity and reduce disparities in health care.

Additionally, during FSMB's 2020 virtual educational program series, the FSMB Foundation hosted its eighth fundraiser on August 5, 2020. The keynote speaker for the event was *New York Times* reporter and author Megan Twohey, whose coverage of the Harvey Weinstein case earned a Pulitzer Prize. Ms. Twohey discussed sexual misconduct in the workplace and the book she co-wrote titled "She Said: Breaking the Sexual Harassment Story That Helped Ignite a Movement."

INTERNATIONAL ORGANIZATIONS

IAMRA

IAMRA is a membership organization whose purpose is to promote effective medical regulation worldwide by supporting best practice, innovation, collaboration, and knowledge sharing in the interest of public safety and in support of the medical profession. IAMRA membership currently consists of 118 organizations from 48 countries, including the FSMB, a founding member. The FSMB continues to serve as the secretariat for IAMRA.

IAMRA Conferences: IAMRA was to hold its 14th International Conference on Medical Regulation in Johannesburg, South Africa in September 2020, with the Health Professions Council of South Africa hosting. Due to the COVID-19 Pandemic, it became necessary to postpone the in-person Conference until 2022.

IAMRA will be holding a Virtual Conference October 12-14, 2021. The Members General Assembly will take place virtually on October 26, 2021.

IAMRA Webinars: In 2020, IAMRA began hosting a series of webinars on various topics, including: *COVID-19 and the Impact on Medical Regulation*; *The Medical Regulator's Role in Cultural Safety and Health Equity; Registration Assessments in a Pandemic Environment; Professional Conduct and Discipline in the Era of COVID-19; Emerging COVID-19 Challenges for the Safety and Standards of Patient Care;* and most recently, *Physician Health and Wellness* hosted by Dr. Humayun Chaudhry. Several FSMB staff and state medical boards have participated in the webinars.

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

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

Chair: Dr. Tebogo Kgosietsile Solomon Letlape, Immediate Past President, Health Professions Council of South Africa
Chair-elect: Dr. Heidi Oetter, Registrar, College of Physicians and Surgeons of British Columbia (Canada)
Secretary: Dr. Humayun Chaudhry, President and Chief Executive Officer, Federation of State Medical Boards of the United States

Members-at-Large:

Mr. Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency
Ms. Nicole Krishnaswami, J.D., Executive Director, Oregon Medical Board (U.S.)
Prof. Chak-sing Lau, Past President, Hong Kong Academy of Medicine
Mr. Paul Reynolds, Director of Strategic Communications and Engagement, General Medical Council (U.K.)
Dr. Mauro Luiz de Britto Ribeiro, President, Brazilian Federal Medical Council
Mrs. Joan Simeon, Chief Executive Officer, Medical Council of New Zealand
Mr. Daniel Yumbya, Chief Executive Officer, Kenya Medical Practitioners and Dentists Board

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

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

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

International Academy for CPD Accreditation

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

OTHER CONFERENCES AND MEETINGS

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

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
May 3, 2020	Chair and CEO Teleconference	*C. Walker-McGill* *H. Chaudhry*
May 3, 2020	Board of Directors Videoconference	*C. Walker-McGill* *M. Arsiwala* *J. Carter* *M. de Leon* *J. Geimer-Flanders* *A. Hayden* *J. Landau* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard* *K. Templeton* *S. TerKonda* *B. Walker* *J. Willett* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
May 4, 2020	"USMLE Update: Step 1 Score Reporting Change and USMLE Test Center Re-opening Plans" Webinar	*C. Walker-McGill* *H. Chaudhry* *D. Johnson*
May 4, 2020	Interview with JAMA	*H. Chaudhry*
May 5, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
May 5, 2020	CTel "Interstate Occupational Licensure Compacts, EMAC and the Pandemic" Webinar	*H. Chaudhry*
May 5, 2020	USMLE Test Recovery Efforts Webex	*C. Walker-McGill* *K. Simons* *H. Chaudhry* *E. Fish* *D. Johnson*
May 6, 2020	USMLE Advocacy Videoconference	*H. Chaudhry* *D. Johnson*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
May 6, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
May 6, 2020	ABMS Professionalism Taskforce Webinar	*J. Carter*
May 6, 2020	Committee and Workgroup Appointments Teleconference	*C. Walker-McGill* *H. Chaudhry* *L. Robin*
May 6, 2020	Composite Committee Agenda Review Webex	*H. Chaudhry* *D. Johnson*
May 6, 2020	AOGME Membership COVID 19 Videoconference	*H. Chaudhry*
May 6, 2020	Weekly Operations Meeting	*M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
May 6, 2020	Emergency Preparedness and Response Workgroup Videoconference	*C. Walker-McGill* *K. Simons* *S. Steingard* *H. Chaudhry*
May 7, 2020	Coalition for Physician Accountability Workgroup B Teleconference	*H. Chaudhry*
May 7, 2020	ACCME 2020 Online Plenary Session *Panelist:* Teachable Moments: Learning Together at a Critical Time	*H. Chaudhry*
May 7, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
May 8, 2020	AAHM "Pandemic: Creating a Useable Past: Epidemic History, COVID 19 and the Future of Health" Webinar	*H. Chaudhry*
May 8, 2020	Teleconference with Patty Salazar, Executive Director, Department of Regulatory Agencies (DORA)	*H. Chaudhry*
May 11, 2020	FSMB-ACCME Data Sharing Videoconference	*H. Chaudhry* *M. Dugan*
May 12, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
May 12, 2020	Videoconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
May 12, 2020	"Telehealth: Understanding Waivers, Regulatory Leniency and HIPPA" Webinar	*H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
May 12, 2020	USMLE Step 2 CS Planning Videoconference	*H. Chaudhry* *D. Johnson*
May 12, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
May 12, 2020	Teleconference with Tom Granatir, Sr. VP, Policy and External Relations, ABMS	*C. Walker-McGill*
May 12, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
May 13, 2020	Prebriefing Teleconference with Alysia Jones, Executive Administrator, Alaska State Medical Board	*J. Geimer-Flanders* *H. Chaudhry* *L. Robin*
May 13, 2020	CPE Webinar Panelist Videoconference	*H. Chaudhry*
May 13, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
May 13, 2020	APHA and NAM "Toward the New Normal – Protecting Public Health as American Reopens" Webinar	*H. Chaudhry*
May 13, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
May 14, 2020	Harvard Health Policy and Management Executive Council Virtual Meeting	*H. Chaudhry*
May 14, 2020	NCQA "COVID, Telehealth and Quality: What's Now, What's Next?" Webex	*C. Walker-McGill* *H. Chaudhry*
May 14, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
May 14, 2020	Board of Directors Videoconference	*C. Walker-McGill* *M. Arsiwala* *J. Carter* *M. de Leon* *J. Geimer-Flanders* *A. Hayden* *J. Landau* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard* *K. Templeton* *S. TerKonda* *B. Walker*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		J. Willett *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
May 14, 2020	Weekly Operations Meeting	*M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
May 15, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
May 15, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
May 15, 2020	FARB Videoconference: What are examinees asking?	*D. Johnson*
May 16, 2020	Chair and CEO Teleconference	*C. Walker-McGill* *H. Chaudhry*
May 18, 2020	Teleconference with Dr. John Gimpel, CEO, NBOME	*H. Chaudhry*
May 18, 2020	Chair and CEO Teleconference	*C. Walker-McGill* *H. Chaudhry*
May 18, 2020	Advisory Council of Board Executives Videoconference	*M. de Leon* *F. Meyers* *H. Chaudhry* *D. Johnson*
May 18, 2020	Emergency Preparedness and Response Workgroup Prebriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
May 18, 2020	Webex with NBME and ECFMG/FAIMER Chairs and CEOs	*C. Walker-McGill* *H. Chaudhry*
May 18, 2020	Prebriefing Teleconference with Dr. Danny Takanishi, Chair, Workgroup on Physician Impairment and support staff	*C. Walker-McGill*
May 18, 2020	Coalition for Physician Accountability Workgroup B Videoconference	*H. Chaudhry*
May 19, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
May 19, 2020	"Feasibility and Sustainability of a Telehealth Program and Technology in Post COVID 19 World" Webinar	*H. Chaudhry*
May 19, 2020	FSMB Clearinghouse Proposal Videoconference	*C. Walker-McGill* *H. Chaudhry* *M. Dugan* *L. Robin*
May 19, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
May 20, 2020	IAMRA "COVID 19 and the Impact on Medical Regulation" Webinar	*C. Walker-McGill* *K. Simons* *H. Chaudhry* *D. Johnson*
May 20, 2020	AOGME Membership COVID 19 Videoconference	*H. Chaudhry*
May 20, 2020	Leadership Teleconference for Governance Committee	*C. Walker-McGill* *S. Parker* *E. Fish*
May 20, 2020	Leadership Teleconference for Workgroup on Board Action Content Evaluation (BACE)	*C. Walker-McGill* *M. de Leon* *E. Fish*
May 20, 2020	Emergency Preparedness and Response Workgroup Videoconference	*C. Walker-McGill* *K. Simons* *S. Steingard* *H. Chaudhry* *D. Johnson*
May 21, 2020	NAM Opioid Collaborative Public Symposium	*H. Chaudhry*
May 21, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
May 21, 2020	Weekly Operations Meeting	*M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
May 21, 2020	Leadership Teleconference for Ethics and Professionalism Committee	*C. Walker-McGill* *J. Carter*
May 21-22, 2020	USMLE Remote Proctoring Videoconference	*D. Johnson*
May 22, 2020	NAM Opioid Collaborative Action Collaborative Videoconference	*H. Chaudhry*
May 22, 2020	Alaska State Medical Board Virtual BSV Meeting *Presentation: FSMB Update*	*J. Geimer-Flanders* *H. Chaudhry* *L. Robin*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
May 22, 2020	Emergency Preparedness and Response Workgroup Debriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
May 22, 2020	USMLE Update with Medical Student and Resident Advisory Panel Videoconference	*D. Johnson*
May 25, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
May 26, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
May 26, 2020	NAM Opioid Collaborative Steering Committee Videoconference	*H. Chaudhry*
May 26, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
May 26, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
May 26, 2020	USMLE Remote Proctoring Videoconference	*D. Johnson*
May 27, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
May 27, 2020	Chair and CEO Teleconference	*C. Walker-McGill* *H. Chaudhry*
May 27, 2020	Teleconference with Dr. Jacqui Watson, Chief of Staff, DC Department of Health	*H. Chaudhry*
May 27, 2020	Teleconference with Dr. Dan Gifford	*H. Chaudhry*
May 27, 2020	Teleconference with Dr. Maureen Topps, Executive Director and CEO, Medical Council of Canada	*H. Chaudhry*
May 27, 2020	NYIT Advisory Board Virtual Meeting	*H. Chaudhry*
May 28, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
May 28, 2020	Interview for American Association of Veterinary State Boards Virtual Meeting	*H. Chaudhry*
May 28, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF ACTIVITY SUMMARY

May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
May 28, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
May 28, 2020	Invitational Discussion with Member Medical Boards Videoconference Topic: Planning the Future of Medical Licensing Post-COVID 19 Pandemic	*C. Walker-McGill* *J. Carter* *M. de Leon* *J. Geimer-Flanders* *J. Landau* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard* *K. Templeton* *S. TerKonda* *B. Walker* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *L. Robin*
May 28, 2020	Weekly Operations Meeting	*M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
May 28-29, 2020	USMLE Composite Committee WebEx	*C. Walker-McGill* *K. Simons* *H. Chaudhry* *D. Johnson*
May 29, 2020	Step 2 CS WebEx with NBME and ECFMG/FAIMER Chairs and CEOs	*C. Walker-McGill* *H. Chaudhry*
May 29, 2020	Chair and CEO Teleconference	*C. Walker-McGill* *H. Chaudhry*
May 29, 2020	USMLE Remote Proctoring Videoconference	*D. Johnson*
June 1, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
June 1, 2020	New Directors Videoconference with FSMB Support Staff	*M. de Leon* *K. Templeton* *B. Walker*
June 2, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		T. Phillips *L. Robin*
June 2, 2020	New Directors Orientation Videoconference	*C. Walker-McGill* *M. de Leon* *K. Templeton* *B. Walker* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
June 2, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
June 2, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
June 2, 2020	USMLE Remote Proctoring Videoconference	*D. Johnson*
June 3, 2020	CPE "Medical Assessment and Regulation in a Time of COVID 19: Challenges and Changes" Webinar *Panelist (Chaudhry)*	*C. Walker-McGill* *H. Chaudhry*
June 3, 2020	Treasurer and CFO Teleconference	*J. Landau* *T. Phillips*
June 3, 2020	AOGME Membership COVID 19 Videoconference	*H. Chaudhry*
June 3, 2020	Teleconference with Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
June 4, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
June 4, 2020	Teleconference with Dr. Robert Cain, CEO, AACOM	*H. Chaudhry*
June 4, 2020	RCPE Evening Update on COVID 19 Webinar	*H. Chaudhry*
June 4, 2020	Teleconference with Dr. Michael Wieting, President, AAOE	*H. Chaudhry*
June 4, 2020	HHS COVID 19 Teleconference	*H. Chaudhry*
June 4, 2020	IAMRA Management Committee Videoconference	*H. Chaudhry*
June 4, 2020	Prebriefing Teleconference with Ms. Lathran Woodard, presenter, Workgroup on Emergency Preparedness and Response	*C. Walker-McGill*
June 4, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
June 4, 2020	USMLE Step 2 CS Planning Videoconference	*D. Johnson*
June 4, 2020	Weekly Operations Meeting	*M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
June 4-5, 2020	USMLE Remote Proctoring Videoconference	*D. Johnson*
June 5, 2020	C-Suite Teleconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
June 5, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
June 7, 2020	AMA Virtual HOD Meeting and COVID 19 Town Hall	*C. Walker-McGill* *K. Simons* *H. Chaudhry*
June 8, 2020	Weekly Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
June 8, 2020	Emergency Preparedness and Response Workgroup Prebriefing Teleconference	*C. Walker-McGill*
June 8, 2020	Performance-Based Needs Assessment Videoconference	*D. Johnson*
June 9, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
June 9, 2020	SOMA Town Hall Videoconference	*H. Chaudhry*
June 9, 2020	Leroy Place Neighborhood Virtual Meeting	*H. Chaudhry* *L. Robin*
June 9, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
June 9, 2020	USMLE Remote Proctoring Videoconference	*D. Johnson*
June 10, 2020	Emergency Preparedness and Response Workgroup Videoconference	*C. Walker-McGill* *F. Meyers* *K. Simons*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		S. Steingard *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
June 10, 2020	NYSOM "COVID 19: Lessons Learned" Webinar	*H. Chaudhry*
June 10, 2020	USMLE Step 2 CS Planning Videoconference	*D. Johnson*
June 11, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
June 11, 2020	SOMA Discussion with USMLE during COVID 19 Videoconference	*H. Chaudhry* *D. Johnson*
June 11, 2020	Weekly Operations Meeting	*M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
June 11-12, 2020	USMLE Remote Proctoring Videoconference	*D. Johnson*
June 12, 2020	Emergency Preparedness and Response Workgroup Debriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
June 12, 2020	Performance-Based Needs Assessment Videoconference	*D. Johnson*
June 12, 2020	USMLE CBT Recovery and CS Work Videoconference	*H. Chaudhry* *D. Johnson*
June 13, 2020	ACGME BOD Spring Educational Symposium Videoconference	*K. Simons*
June 15, 2020	Weekly Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
June 15, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
June 15, 2020	USMLE Timeline for Transitioning to Pass-Fail Reporting for Step 1 Videoconference	*C. Walker-McGill* *H. Chaudhry* *D. Johnson*
June 16-18, 2020	AHIP Institute and Expo Online 2020	*H. Chaudhry*
June 16, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		T. Phillips *L. Robin*
June 16, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
June 16, 2020	Foundation Board of Directors Videoconference	*C. Walker-McGill* *K. Simons* *H. Chaudhry* *L. Robin*
June 16, 2020	USMLE Remote Proctoring Videoconference	*D. Johnson*
June 17, 2020	ATA-FSMB Staff Teleconference	*H. Chaudhry* *L. Robin*
June 17, 2020	Teleconference with Denise Pines, MBA, President, Medical Board of California for Workgroup on Emergency Preparedness and Response	*C. Walker-McGill*
June 17-18, 2020	Performance-Based Needs Assessment Videoconference	*D. Johnson*
June 18, 2020	NYIT Mentorship Videoconference	*H. Chaudhry*
June 18, 2020	FSMB Clearinghouse Videoconference	*C. Walker-McGill* *H. Chaudhry* *M. Dugan* *L. Robin*
June 18, 2020	KornFerry "Race Matters" Webinar	*H. Chaudhry*
June 18, 2020	Weekly Operations Meeting	*M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
June 18, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
June 22, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
June 22, 2020	Weekly Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
June 22, 2020	Prebriefing Teleconference for June USMLE Composite Committee Meeting	*C. Walker-McGill* *K. Simons* *H. Chaudhry* *D. Johnson*
June 22, 2020	Ethics and Professionalism Committee Videoconference	*C. Walker-McGill* *J. Carter* *K. Simons*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
June 23, 2020	IAMRA "ECFMG Response to COVID 19 – Upholding Standards in a Global Pandemic" Webinar	*C. Walker-McGill* *J. Geimer-Flanders* *S. Parker* *K. Simons* *S. Steingard* *B. Walker* *H. Chaudhry*
June 23, 2020	AAVSB International Network of Regulators Webinar	*H. Chaudhry*
June 23, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
June 23, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
June 23, 2020	Governance Committee Videoconference	*C. Walker-McGill* *A. Hayden* *S. Parker* *K. Simons* *K. Templeton* *B. Walker* *J. Willett* *H. Chaudhry* *E. Fish*
June 23, 2020	Performance-Based Needs Assessment Videoconference	*D. Johnson*
June 23, 2020	USMLE Remote Proctoring Videoconference	*D. Johnson*
June 24, 2020	CEO Update "Gone Virtual: What We've Learned so Far" Webinar	*H. Chaudhry*
June 24, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
June 24, 2020	Workgroup on Board Action Content Evaluation (BACE) Videoconference	*C. Walker-McGill* *M. de Leon* *K. Simons* *K. Templeton* *H. Chaudhry*
June 24, 2020	ATA Twitter Chat on Telemedicine	*H. Chaudhry*
June 24, 2020	USMLE State Board Advisory Panel Videoconference	*D. Johnson*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
June 25, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
June 25, 2020	Operation Smile "Pathways to Re-opening Medical Schools During the COVID 19 Pandemic" Webinar	*H. Chaudhry*
June 25, 2020	Videoconference with CliftonLarsonAllen Auditors	*H. Chaudhry*
June 25, 2020	RCPE Evening Update on COVID 19 Webinar	*H. Chaudhry*
June 25, 2020	ABMS Professionalism Pivot to Promotion of Professionalism Teleconference	*J. Carter*
June 25, 2020	Weekly Operations Meeting	*M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
June 25, 2020	Teleconference with Dr. Michael Wieting, President, AAOE	*H. Chaudhry*
June 25, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
June 26, 2020	FSPHP Education Session Webinar	*C. Walker-McGill* *H. Chaudhry*
June 26, 2020	FSMB Investment Portfolio and Strategy Teleconference with Investment Advisor	*J. Landau* *T. Phillips*
June 29, 2020	Teleconference with Dr. Robert Cain, CEO, AACOM	*H. Chaudhry*
June 29, 2020	Colorado Medical Board Stakeholder Webinar	*H. Chaudhry*
June 29, 2020	Weekly Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
June 29, 2020	NCQA "Telehealth and the Future of Quality" Webinar	*C. Walker-McGill*
June 29, 2020	Performance-Based Needs Assessment Videoconference	*D. Johnson*
June 29, 2020	Prebriefing Videoconference for USMLE Composite Committee	*C. Walker-McGill* *K. Simons* *H. Chaudhry* *D. Johnson*
June 30, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
June 30, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
June 30, 2020	Workgroup on Physician Impairment Videoconference	*C. Walker-McGill* *K. Simons* *H. Chaudhry*
June 30, 2020	ABMS Professionalism Taskforce Webinar	*J. Carter*
June 30, 2020	USMLE Remote Proctoring Videoconference	*D. Johnson*
July 1, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
July 1, 2020	Emergency Preparedness and Response Workgroup Videoconference	*C. Walker-McGill* *K. Simons* *S. Steingard* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
July 1, 2020	Performance-Based Needs Assessment Videoconference	*D. Johnson*
July 1, 2020	ATA Twitter Chat on Telemedicine	*H. Chaudhry*
July 6, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
July 6, 2020	Emergency Preparedness and Response Workgroup Debriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
July 6, 2020	USMLE Composite Committee WebEx	*C. Walker-McGill* *K. Simons* *H. Chaudhry* *D. Johnson*
July 6-7, 2020	Performance-Based Needs Assessment Videoconference	*D. Johnson*
July 7, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
July 7, 2020	Weekly Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
July 7, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
July 7, 2020	USMLE Remote Proctoring Videoconference	*D. Johnson*
July 8, 2020	NBME Virtual Business Meeting	*C. Walker-McGill*
July 8, 2020	FSMB-AIM Leadership Teleconference with Anne Lawler, AIM President	*H. Chaudhry*
July 9, 2020	All-Staff Videoconference	*C. Walker-McGill* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
July 9, 2020	Teleconference with Dr. Kevin Klauer, CEO, American Osteopathic Association	*H. Chaudhry*
July 9, 2020	Teleconference with New York Board Leadership	*H. Chaudhry* *D. Johnson*
July 9, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
July 9, 2020	Education Committee Videoconference	*C. Walker-McGill* *K. Simons* *S. Steingard* *J. Willett* *H. Chaudhry* *L. Robin*
July 9, 2020	Weekly Operations Meeting	*M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
July 12, 2020	Chair-CEO Teleconference	*C. Walker-McGill* *H. Chaudhry*
July 13, 2020	Weekly Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
July 13, 2020	ATA-FSMB Staff Teleconference	*H. Chaudhry* *L. Robin*
July 13, 2020	Virtual Meeting with Megan Twohey, Speaker, Foundation Special Event	*H. Chaudhry*
July 14, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		D. Johnson *T. Phillips* *L. Robin*
July 14, 2020	FSMB Virtual Educational Session - Dr. Bryant L. Galusha Lecture Speaker: John Whyte, MD, MPH, Chief Medical Officer, WebMD Topic: "Where Will the Empowered Health Care Consumer Lead Us?"	*C. Walker-McGill* *M. de Leon* *S. Parker* *K. Simons* *S. Steingard* *S. TerKonda* *B. Walker* *J. Willett* *H. Chaudhry*
July 14, 2020	NAS "Evidence-Based Practice: Public Health Emergency Preparedness and Response" Webinar	*C. Walker-McGill* *K. Simons* *S. Steingard* *H. Chaudhry*
July 14, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
July 14, 2020	USMLE Remote Proctoring Videoconference	*D. Johnson*
July 15, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
July 15, 2020	Videoconference with Dr. Victor Dzau, President, NAM and NAM Project Staff	*H. Chaudhry*
July 15, 2020	USMLE Step 2 Teleconference with Greater New York Hospital Association Staff	*H. Chaudhry* *D. Johnson*
July 15, 2020	SOMA Resolution Videoconference	*H. Chaudhry* *D. Johnson*
July 15, 2020	IAMRA Management Committee Videoconference	*H. Chaudhry*
July 15, 2020	ABMS Professionalism Taskforce Webinar	*J. Carter*
July 15, 2020	Workgroup on Board Education, Service & Training (BEST) Videoconference	*C. Walker-McGill* *K. Simons* *H. Chaudhry*
July 15-16, 2020	Performance-Based Needs Assessment Videoconference	*D. Johnson*
July 16, 2020	"Problems with the Aging Physicians" Webinar	*H. Chaudhry*
July 16, 2020	Teleconference with Dr. Mariann Burnetti-Atwell, CEO, ASPPB and Dr. Matt Turner, Senior Director, Examinations, ASPPB	*H. Chaudhry* *D. Johnson*
July 16, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
July 16, 2020	Weekly Operations Meeting	*M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
July 17, 2020	NYITCOM Virtual Retreat *Presentation: Navigating the Next Normal*	*H. Chaudhry*
July 17, 2020	AOA Board of Trustees Virtual Meeting	*C. Walker-McGill* *K. Simons* *S. Steingard* *H. Chaudhry*
July 17, 2020	USMLE Remote Proctoring Videoconference	*D. Johnson*
July 17, 2020	USMLE Step 2 CS Planning Videoconference	*D. Johnson*
July 18, 2020	AOA House of Delegates Virtual Meeting	*C. Walker-McGill* *K. Simons* *S. Steingard* *H. Chaudry*
July 20, 2020	Healthcare Regulatory CEO Virtual Meeting	*H. Chaudhry*
July 20, 2020	Weekly Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
July 20, 2020	"Applying Systems Thinking to Address Structural Racism" Webinar	*H. Chaudhry*
July 20, 2020	NAM Opioid Collaborative Steering Committee Videoconference	*H. Chaudhry*
July 20, 2020	UChicago School of Business Webinar *Panelist: Changes to Healthcare Delivery and Innovation post COVID-19*	*H. Chaudhry*
July 20, 2020	Performance-Based Needs Assessment Videoconference	*D. Johnson*
July 21, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
July 21, 2020	"Applying Systems Thinking to Address Structural Racism" Webinar Discussion	*H. Chaudhry*
July 21, 2020	Investment/Compensation/Executive Committee Videoconferences	*C. Walker-McGill* *M. Arsiwala* *J. Landau*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		F. Meyers *K. Simons* *S. Steingard* *S. TerKonda* *H. Chaudhry*
July 21, 2020	Emergency Preparedness and Response Workgroup Prebriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
July 21, 2020	Sale of DC Office Teleconference	*C. Walker-McGill* *J. Landau* *K. Simons* *S. Steingard* *H. Chaudhry* *T. Phillips*
July 21, 2020	Sale of DC Office Teleconference	*C. Walker-McGill* *J. Landau* *H. Chaudhry* *T. Phillips*
July 22, 2020	AOGME Membership COVID 19 Videoconference	*H. Chaudhry*
July 22, 2020	FSPHP Physician Mental Health Webinar	*H. Chaudhry*
July 22, 2020	ABMS Committee on Continuing Certification Webinar	*J. Carter*
July 22, 2020	Emergency Preparedness and Response Workgroup Videoconference	*C. Walker-McGill* *K. Simons* *S. Steingard* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
July 22-24, 2020	Board of Directors Videoconference	*C. Walker-McGill* *M. Arsiwala* *J. Carter* *M. de Leon* *J. Geimer-Flanders* *A. Hayden* *J. Landau* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		K. Templeton *S. TerKonda* *B. Walker* *J. Willett* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
July 23, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
July 23, 2020	Interview with WebMD	*H. Chaudhry*
July 23, 2020	Weekly Operations Meeting	*M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
July 27, 2020	Coalition for Physician Accountability Virtual Meeting	*C. Walker-McGill* *K. Simons* *H. Chaudhry*
July 27, 2020	Royal Society of Medicine "COVID 19" Webinar	*H. Chaudhry*
July 27, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
July 27, 2020	Teleconference with Dana Lichtenberg, AMA	*L. Robin*
July 27, 2020	Teleconference with Megan Thompson, Office of Senator Jackey Rosen	*L. Robin*
July 27, 2020	Teleconference with Elizabeth Darnall, Office of Senator Chris Murphy	*L. Robin*
July 27, 2020	Teleconference with Conor Sheehey, Office of Senator Tim Scott	*L. Robin*
July 27, 2020	Teleconference with Rob Butora, Office of Senator Bill Cassidy	*L. Robin*
July 27, 2020	Moderator Rehearsal with Dr. Cary Coglianese, Lecturer, FSMB Virtual Educational Session and Blue Sky Staff	*S. Steingard*
July 27, 2020	USMLE Composite Committee Planning Webex	*H. Chaudhry* *D. Johnson*
July 28, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		D. Johnson *T. Phillips* *L. Robin*
July 28, 2020	Emergency Preparedness and Response Workgroup Debriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
July 28, 2020	NYIT Podcast Interview	*H. Chaudhry*
July 28, 2020	World Congress "Future of Primary Care" Webinar	*H. Chaudhry*
July 28, 2020	USMLE Composite Committee Step 3 Eligibility WebEx	*C. Walker-McGill* *K. Simons* *H. Chaudhry* *D. Johnson*
July 28, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
July 29, 2020	CSEC Steering Committee Webex	*H. Chaudhry* *D. Johnson* *T. Phillips*
July 29, 2020	Teleconference with Ian Hunter, Office of Senator Maggie Hassan	*L. Robin*
July 29, 2020	Teleconference with Nevada Audit Team	*L. Robin*
July 30, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
July 30, 2020	Teleconference with Mayura Iyer, Office of Senator Tim Kaine	*L. Robin*
July 30, 2020	FSMB Virtual Educational Session Moderator: Scott Steingard, DO Speaker: Cary Coglianese, JD, PhD, Edward B. Shils Professor of Law and Political Science, University of PA Law School Topic: Achieving Regulatory Excellence in a World of Advanced Technologies and Complex Risks	*C. Walker-McGill* *M. de Leon* *S. Steingard* *S. TerKonda* *H. Chaudhry*
July 30, 2020	Workgroup on Physician Impairment Videoconference	*C. Walker-McGill* *S. Parker* *K. Simons*
July 30, 2020	Leadership Teleconference	*C. Walker-McGill* *H. Chaudhry*
July 30, 2020	Operations Weekly Meeting	*M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF ACTIVITY SUMMARY

May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
July 31, 2020	Teleconference with Hanna Gross, Auditor, CliftonLarsonAllen	*A. Hayden*
July 31, 2020	Teleconference with Glenn Tecker, CEO, Tecker International	*L. Robin*
July 31, 2020	Federation of Associations of Regulatory Boards Virtual FARBside Chat Addressing Remote Proctoring	*D. Johnson*
July 31-August 4, 2020	National Medical Association (NMA) Virtual Annual Convention	*C. Walker-McGill* *H. Chaudhry*
August 3, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
August 3, 2020	IAMRA U.S. Members and Partners Teleconference	*M. de Leon* *H. Chaudhry*
August 3, 2020	Teleconference with Al Carter, CEO, NABP	*H. Chaudhry*
August 4, 2020	Alliance for Connected Care, NCQA and ATA Taskforce on Telehealth Policy Town Hall Videoconference	*C. Walker-McGill* *H. Chaudhry*
August 4, 2020	Chair and CEO Teleconference	*C. Walker-McGill* *H. Chaudhry*
August 4, 2020	Osteopathic Health Policy Fellowship Virtual Meeting *Presentation: Medical Regulation in the Time of COVID*	*H. Chaudhry*
August 5, 2020	FSMB-AIM Leadership Teleconference with Anne Lawler, AIM President	*H. Chaudhry*
August 5, 2020	Harvard "When Public Health Means Business" Webinar	*H. Chaudhry*
August 5, 2020	Arizona College of Osteopathic Medicine Virtual Orientation	*H. Chaudhry*
August 5, 2020	FSMB Foundation "A Conversation with Megan Twohey" Webinar	*C. Walker-McGill* *J. Carter* *M. de Leon* *J. Landau* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard* *K. Templeton* *S. TerKonda* *B. Walker* *H. Chaudhry* *M. Dugan* *E. Fish* *T. Phillips* *L. Robin*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
August 6, 2020	IAMRA "The Medical Regulator's Role in Cultural Safety and Health Equity" Webinar	*C. Walker-McGill* *A. Hayden* *S. Parker* *K. Simons* *S. TerKonda* *H. Chaudhry*
August 6, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
August 6, 2020	FSMB - CEO Trust Advisory Council Meeting	*M. Dugan*
August 7, 2020	NAM "Equitable Allocation of Vaccines Against COVID 19" Webinar	*H. Chaudhry*
August 10, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
August 10, 2020	Emergency Preparedness and Response Workgroup Prebriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
August 11, 2020	C-Suite Videoconference	*H. Chaudhry* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
August 11, 2020	DiMeoSchneider Distinguished Speaker Series	*H. Chaudhry*
August 11, 2020	Teleconference with Kyle Zebley, Director, Public Policy, American Telemedicine Association	*L. Robin*
August 11, 2020	National Governors Association Expert Roundtable *Panelist: The Future of Telehealth*	*L. Robin*
August 11, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
August 11, 2020	Medical Quality Symposium Teleconference	*C. Walker-McGill* *H. Chaudhry* *L. Robin*
August 12, 2020	USMLE Budget Committee WebEx	*C. Walker-McGill* *J. Landau* *K. Simons* *H. Chaudhry* *D. Johnson* *T. Phillips*
August 12, 2020	NCSBN Virtual Annual Meeting	*H. Chaudhry*
August 12, 2020	Teleconference with Zach Bennett and Agnes Rigg, Office of Senator Rand Paul	*L. Robin*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
August 12, 2020	Emergency Preparedness and Response Workgroup Videoconference	*C. Walker-McGill* *F. Meyers* *K. Simons* *S. Steingard* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
August 12, 2020	Workgroup on Physician Impairment Debriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
August 12, 2020	Rhode Island Board of Medical Licensure & Discipline Virtual Board Site Visit *Presentation: FSMB Update*	*S. Parker* *D. Johnson*
August 13, 2020	Teleconference with Dr. Victor Dzau, President, NAM	*H. Chaudhry*
August 13, 2020	AOGME "Is There a Missing Link to COVID 19 Treatment" Webinar	*H. Chaudhry*
August 13, 2020	Chair and Staff October BOD Meeting Planning Teleconference	*C. Walker-McGill*
August 13, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
August 13, 2020	Harvard Club of New York "COVID: Conversation with Dr. Frieden" Webinar	*H. Chaudhry*
August 14, 2020	Teleconference with Dr. Kgosi Letlape, Chair, IAMRA and Dr. Heidi Oetter, Chair-elect, IAMRA	*H. Chaudhry*
August 14, 2020	Minnesota Medical Board Policy and Planning Committee Presentation	*L. Robin*
August 14, 2020	National Medical Association (NMA) President Dr. Leon McDougle Council on Clinical Practice Teleconference	*C. Walker-McGill*
August 14, 2020	Council on Medical Education Virtual Meeting	*D. Johnson*
August 17, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
August 17, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
August 17, 2020	Teleconference with Jerry Landau, JD, FSMB Treasurer	*H. Chaudhry* *T. Phillips*
August 17, 2020	Medical Quality Symposium Teleconference	*C. Walker-McGill* *H. Chaudhry* *L. Robin*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
August 17, 2020	Emergency Preparedness and Response Workgroup Debriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
August 18, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
August 19, 2020	IAMRA Management Committee Videoconference	*H. Chaudhry*
August 19, 2020	Immediate Past Chair and CEO Teleconference	*S. Steingard* *H. Chaudhry*
August 19, 2020	AOGME Membership COVID 19 Videoconference	*H. Chaudhry*
August 19, 2020	Nominating Committee Videoconference	*S. Steingard* *H. Chaudhry* *E. Fish*
August 20, 2020	NBME Membership Survey Teleconference	*H. Chaudhry*
August 21, 2020	Executive Committee Videoconference	*C. Walker-McGill* *M. Arsiwala* *J. Landau* *F. Meyers* *K. Simons* *S. Steingard* *S. TerKonda* *H. Chaudhry*
August 21, 2020	Interstate Healthcare Collaborative Teleconference	*M. Dugan* *L. Robin*
August 22, 2020	NBOME Liaison Committee WebEx	*C. Walker-McGill* *H. Chaudhry*
August 24, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
August 24, 2020	HRSA Grantee Teleconference	*L. Robin*
August 25, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
August 25, 2020	Teleconference with Tom Granatir, Sr. VP, Policy and External Relations, ABMS	*L. Robin*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF ACTIVITY SUMMARY

May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
August 25, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
August 26, 2020	IAMRA "COVID-19 and the Acceleration of Virtual Care and Virtual Regulation - Lessons and Questions from Canada" Webinar	*C. Walker-McGill* *S. Parker* *S. TerKonda* *H. Chaudhry*
August 26, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME and Dr. Kgosi Letlape, President, Health Professions Council of South Africa	*H. Chaudhry*
August 26, 2020	Workgroup on Board Action Content Evaluation Videoconference	*C. Walker-McGill* *M. de Leon* *K. Simons* *K. Templeton* *H. Chaudhry*
August 27, 2020	NAM Opioid Collaborative Videoconference	*H. Chaudhry*
August 27, 2020	Network for Excellence in Health Innovation (NEHI) "Looming Challenges of COVID 19 Immunizations" Webinar	*H. Chaudhry*
August 27, 2020	Invitational Discussion with Member Medical Boards Videoconference Topic: The Impact COVID-19 on Physician Well-being and Patient Safety	*C. Walker-McGill* *J. Carter* *M. de Leon* *J. Geimer-Flanders* *A. Hayden* *J. Landau* *S. Parker* *K. Simons* *S. Steingard* *K. Templeton* *S. TerKonda* *B. Walker* *H. Chaudhry* *L. Robin*
August 28, 2020	Interview with USA Today	*H. Chaudhry*
August 28, 2020	Teleconference with Dr. Stacy Lankford	*H. Chaudhry*
August 28, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
August 28, 2020	Teleconference with Dr. Barbara Schneidman	*H. Chaudhry*
August 28, 2020	Teleconference with Dr. Regina Benjamin	*H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
August 28, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
August 31, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
August 31, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
August 31, 2020	Teleconference with Dr. Richard Hawkins, CEO, ABMS	*J. Carter*
August 31, 2020	Emergency Preparedness and Response Workgroup Prebriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
August 31, 2020	Chair and CEO Teleconference	*C. Walker-McGill* *H. Chaudhry*
September 1, 2020	Teleconference with Susan Spaulding	*H. Chaudhry*
September 1, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
September 1, 2020	Interview with Politico	*L. Robin*
September 1, 2020	ABMS Professionalism Subgroup Teleconference	*J. Carter*
September 1, 2020	USMLE Composite Committee Webex	*C. Walker-McGill* *K. Simons* *H. Chaudhry* *D. Johnson*
September 1, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
September 1, 2020	Teleconference with Dr. Jon Thomas	*H. Chaudhry*
September 2, 2020	Teleconference with Elizabeth Darnall, Office of Senator Chris Murphy	*L. Robin*
September 2, 2020	Emergency Preparedness and Response Workgroup Videoconference	*C. Walker-McGill* *F. Meyers* *K. Simons* *S. Steingard* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
September 3, 2020	NCQA Follow-up Teleconference	*C. Walker-McGill* *H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF ACTIVITY SUMMARY

May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
September 3, 2020	International Association of Medical Science Educators (IAMSE) "Medical School Admissions in The Time of COVID 19" Webinar	*H. Chaudhry*
September 3, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
September 4, 2020	Teleconference with Dr. Jim Thompson	*H. Chaudhry*
September 4, 2020	Teleconference with Dr. Robert Cain, CEO, AACOM	*H. Chaudhry*
September 4, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
September 4, 2020	USMLE Step 2 CS Webex	*H. Chaudhry* *D. Johnson*
September 4, 2020	Teleconference with Rick Masters, Dan Logsdan, Council of State Governments and Carson Walker, American Academy of Physician Assistants (AAPA)	*L. Robin*
September 8, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
September 8, 2020	Teleconference with Ann Mond Johnson, CEO, ATA	*H. Chaudhry* *L. Robin*
September 8, 2020	Teleconference with Dr. Freda Bush	*H. Chaudhry*
September 8, 2020	Teleconference with Dr. Marty Crane	*H. Chaudhry*
September 8, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
September 8, 2020	Emergency Preparedness and Response Workgroup Debriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
September 9, 2020	Teleconference with Dr. Lance Talmage	*H. Chaudhry*
September 9, 2020	Teleconference with Dr. Don Polk	*H. Chaudhry*
September 9, 2020	Teleconference with Dr. Greg Snyder	*H. Chaudhry*
September 10, 2020	Review 2021 Annual Meeting Scholarships	*J. Landau* *T. Phillips*
September 10, 2020	FSMB Virtual Educational Session Panelists: Patricia A. King, MD, PhD, Past Chair, Federation of State Medical Boards, Melanie de Leon, JD, MPA, Executive	*C. Walker-McGill* *M. de Leon* *S. Parker* *S. Steingard*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
	Director of the Washington Medical Commission; and Kerrie Webb, JD, Senior Staff Counsel, Medical Board of California. Topic: "Physician Sexual Misconduct: New Policies and Approaches"	*S. TerKonda* *B. Walker* *H. Chaudhry*
September 10, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
September 10-11, 2020	Cologne Consensus Virtual Conference *Panelist: Promoting the Value and Measuring the Impact of International Standards for Substantive Equivalency*	*H. Chaudhry*
September 11, 2020	Editorial Committee Virtual Meeting	*D. Johnson*
September 12, 2020	Chair-elect and CEO Teleconference	*K. Simons* *H. Chaudhry*
September 12, 2020	Minnesota Medical Board Presentation	*L. Robin*
September 14, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
September 14, 2020	Chair and CEO Teleconference	*C. Walker-McGill* *H. Chaudhry*
September 15, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
September 15, 2020	NCQA "Taskforce on Telehealth Policy Final Report" Webinar	*H. Chaudhry*
September 15, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
September 15, 2020	MedBiquitous Community Connection Webinar	*M. Dugan*
September 16, 2020	NAM Opioid Collaborative Steering Committee Videoconference	*H. Chaudhry*
September 16, 2020	Interstate Medical Licensure Compact Committee Presentation	*L. Robin*
September 16, 2020	Executive Committee Prebriefing Videoconference	*C. Walker-McGill* *K. Simons* *S. Steingard* *H. Chaudhry* *E. Fish* *D. Johnson* *T. Phillips*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
September 16, 2020	Executive Committee Videoconference	*C. Walker-McGill* *J. Landau* *F. Meyers* *K. Simons* *S. Steingard* *S. TerKonda* *H. Chaudhry* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
September 16-17, 2020	WHO Western Pacific Region Innovation Forum	*H. Chaudhry*
September 17, 2020	IAMRA Members General Assembly Videoconference	*K. Simons* *H. Chaudhry*
September 17, 2020	Litchfield CEO Virtual Meeting	*H. Chaudhry*
September 17, 2020	Ethics and Professionalism Committee Leadership Teleconference	*C. Walker-McGill* *J. Carter* *H. Chaudhry* *L. Robin*
September 17, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
September 17, 2020	FSMB-NBME Leadership Videoconference	*C. Walker-McGill* *H. Chaudhry* *E. Fish*
September 17, 2020	Teleconference with FSMB Investment Advisor	*J. Landau* *T. Phillips*
September 18, 2020	Teleconference with Dennis Chornenky, Presidential Innovation Fellow, White House Office of Science and Technology	*H. Chaudhry*
September 21, 2020	Teleconference with Angela Coppell, National Emergency Management Association and Trina Sheets, Emergency Management Assistance Compact	*L. Robin*
September 21, 2020	Board of Directors Virtual Hill Day Prebriefing Videoconference	*C. Walker-McGill* *J. Carter* *M. de Leon* *A. Hayden* *J. Landau* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard* *K. Templeton*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		S. TerKonda *B. Walker* *J. Willett* *H. Chaudhry* *L. Robin*
September 21, 2020	Emergency Preparedness and Response Workgroup Prebriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
September 21, 2020	ABMS Professionalism Taskforce Webinar	*J. Carter*
September 21, 2020	FSMB - CEO Trust Advisory Council Meeting	*M. Dugan*
September 22, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
September 22, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
September 22, 2020	NEHI Virtual Summit Meeting	*H Chaudhry*
September 22, 2020	Artificial Intelligence Taskforce Videoconference	*C. Walker-McGill* *K. Simons* *S. TerKonda* *H. Chaudhry* *M. Dugan* *E. Fish*
September 23, 2020	Harvard "When Public Health Means Business, Part 5" Webinar	*H. Chaudhry*
September 23, 2020	AOGME Membership Discussion Forum	*H. Chaudhry*
September 23, 2020	Emergency Preparedness and Response Workgroup Videoconference	*C. Walker-McGill* *F. Meyers* *K. Simons* *S. Steingard* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
September 23, 2020	Chair-elect and CEO Teleconference	*K. Simons* *H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
September 23-24, 2020	ABMS Virtual Conference 2020	*J. Carter* *H. Chaudhry*
September 24, 2020	Teleconference with Ann Mond Johnson, CEO, ATA	*H. Chaudhry* *L. Robin*
September 24, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
September 24, 2020	Teleconference with Dr. Jim Winn	*H. Chaudhry*
September 27, 2020	ACGME BOD Virtual Meeting	*K. Simons* *H. Chaudhry*
September 28, 2020	IAMRA "Registration Assessments in a Pandemic Environment" Webinar	*C. Walker-McGill* *S. Parker* *K. Simons* *B. Walker* *H. Chaudhry* *D. Johnson*
September 28, 2020	State Medical Societies COVID 19 Webinar *Presentation: Changes to Board Requirements Due to COVID 19*	*H. Chaudhry*
September 28, 2020	FL Delegation Hill Day Pre-briefing Teleconference	*A. Hayden* *S. TerKonda*
September 28, 2020	Emergency Preparedness and Response Workgroup Debriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
September 29, 2020	Osteopathic International Alliance "Influencing Risk Perception about COVID 19" Webinar	*H. Chaudhry*
September 29, 2020	Colorado Medical Board Stakeholder Virtual Meeting	*H. Chaudhry*
September 29, 2020	Clinical Skills Webex with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry* *D. Johnson*
September 29, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
September 29, 2020	AZ Delegation Hill Day Pre-briefing Teleconference	*J. Landau* *S. Steingard*
September 29, 2020	NC Delegation Hill Day Pre-briefing Teleconference	*C. Walker-McGill* *S. Parker* *B. Walker*
September 29, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
September 29, 2020	Ethics and Professionalism Committee Videoconference	*C. Walker-McGill* *J. Carter* *K. Simons* *H. Chaudhry*
September 29, 2020	CSEC Steering Committee Virtual Meeting	*D. Johnson*
September 30, 2020	Board of Directors Virtual Hill Day	*C. Walker-McGill* *M. Arsiwala* *J. Carter* *M. de Leon* *J. Geimer-Flanders* *A. Hayden* *J. Landau* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard* *K. Templeton* *S. TerKonda* *B. Walker* *J. Willett* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
October 1, 2020	Teleconference with Legislative Director for Rep. Alma Adams	*C. Walker-McGill* *H. Chaudhry*
October 1, 2020	Coalition for Physician Accountability Virtual Meeting *Presentation (Chaudhry): H1N1 and SARS-CoV-2: Pandemics in the New Millennium* *Panelist (Walker-McGill): Challenges and Opportunities in the COVID Era*	*C. Walker-McGill* *K. Simons* *H. Chaudhry*
October 1, 2020	Interview with Modern Healthcare	*L. Robin*
October 1, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
October 2, 2020	Teleconference with Office for Rep. Glenn Grothman	*K. Simons* *L. Robin*
October 5, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
October 7, 2020	FSMB-NBME Leadership Videoconference	*C. Walker-McGill* *H. Chaudhry* *T. Phillips*
October 8, 2020	IAMRA Management Committee Videoconference	*H. Chaudhry*
October 8, 2020	Workgroup on Physician Impairment Videoconference	*C. Walker-McGill* *S. Parker* *K. Simons*
October 8, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
October 8-9, 2020	Missouri Board of Registration for the Healing Arts Board Meeting Presentation *Presentation: FSMB Update*	*J. Carter*
October 12, 2020	Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
October 12, 2020	Chair and CEO Teleconference	*C. Walker-McGill* *H. Chaudhry*
October 13, 2020	Podcast Interview with American Association for Physician Leadership "SoundPractice"	*H. Chaudhry*
October 13, 2020	USMLE Composite Committee Meeting Planning Webex	*H. Chaudhry* *D. Johnson*
October 13, 2020	Clinical Skills Webex with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry* *D. Johnson*
October 13, 2020	Shaping Public Policy to Foster Equitable Care Discussion	*C. Walker-McGill*
October 13, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
October 13, 2020	Emergency Preparedness and Response Workgroup Prebriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
October 13, 2020	Board of Directors Videoconference	*C. Walker-McGill* *M. Arsiwala* *J. Carter* *M. de Leon* *A. Hayden* *J. Landau* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard* *K. Templeton* *S. TerKonda* *B. Walker* *J. Willett*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		H. Chaudhry *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
October 13-14, 2020	AOA House of Delegates Virtual Meeting	*S. Steingard* *H. Chaudhry*
October 14, 2020	Coffee with Graham (McMahon) Podcast	*H. Chaudhry*
October 14, 2020	NBME Membership Update on Governance Review Webinar	*C. Walker-McGill*
October 14, 2020	Emergency Preparedness and Response Workgroup Videoconference	*C. Walker-McGill* *F. Meyers* *K. Simons* *S. Steingard* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
October 15, 2020	NAM Opioid Collaborative State Licensing Board Meeting Planning Videoconference	*H. Chaudhry*
October 15, 2020	CPE "Quality and Professionalism in the Digital Era: Impact on Physician Assessment and Remediation" Webinar	*C. Walker-McGill* *K. Simons* *H. Chaudhry*
October 15, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
October 15, 2020	Board Leadership Prebriefing Videoconference	*C. Walker-McGill* *J. Landau* *K. Simons* *S. Steingard* *H. Chaudhry*
October 15-18, 2020	OMED 2020 Virtual Meeting	*H. Chaudhry*
October 16, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
October 18-19	NAM Virtual Annual Meeting	*H. Chaudhry*
October 19, 2020	FCVS Advisory Council Videoconference	*C. Walker-McGill* *H. Chaudhry* *M. Dugan*
October 19, 2020	NAM Clinician Well-being Meeting Panelist Prep Videoconference	*H. Chaudhry*
October 19, 2020	Emergency Preparedness and Response Workgroup Debriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
October 20, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
October 20, 2020	AOA-FSMB Data Sharing Agreement Teleconference	*H. Chaudhry* *M. Dugan* *E. Fish*
October 20, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
October 20, 2020	Workgroup to Study Risk and Support Factors Affecting Physician Performance Videoconference	*C. Walker-McGill* *K. Simons* *S. Steingard* *H. Chaudhry*
October 20, 2020	Audit Committee Videoconference	*C. Walker-McGill* *K. Simons* *J. Geimer-Flanders* *A. Hayden* *J. Landau* *F. Meyers* *H. Chaudhry* *T. Phillips*
October 21-24, 2020	Investment and Executive Committee Videoconference Board of Directors Videoconference Board of Directors and Foundation Board of Directors Joint Videoconference	*C. Walker-McGill* *J. Carter* *M. de Leon* *J. Geimer-Flanders* *A. Hayden* *J. Landau* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard* *K. Templeton*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		S. TerKonda *B. Walker* *J. Willett* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
October 22, 2020	Coalition Subcommittee on Public Health Videoconference	*H. Chaudhry*
October 22, 2020	Litchfield CEO Virtual Meeting	*H. Chaudhry*
October 22, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
October 24, 2020	FSMB Foundation Board of Directors Videoconference	*C. Walker-McGill* *K. Simons* *H. Chaudhry* *L. Robin*
October 25, 2020	Teleconference with Dr. Robert Cain, CEO, AACOM	*H. Chaudhry*
October 26, 2020	Staff Committee for the Review of Anomalous Performance (SCRAP) Videoconference	*D. Johnson*
October 27, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *L. Robin*
October 27, 2020	AIM Fall Executive Virtual Workshop	*H. Chaudhry* *D. Johnson*
October 27, 2020	Regional Telehealth Initiatives Virtual Meeting with CSG, NCSBN, IMLCC and FSBPT	*L. Robin*
October 27, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
October 28, 2020	IAMRA "Professional Conduct and Discipline in the Era of COVID-19" Webinar	*S. Parker* *K. Simons* *H. Chaudhry* *D. Johnson*
October 28, 2020	Teleconference with Dr. George Abraham, Chair, Massachusetts Board of Registration in Medicine	*H. Chaudhry*
October 28, 2020	Emergency Preparedness and Response Workgroup Prebriefing Teleconference with Dr. Aletha Maybank, Group VP and Chief Health Equity Officer, AMA	*C. Walker-McGill*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
October 28-29, 2020	NAM Collaborative on Clinician Wellbeing Virtual Meeting *Panelist: Coordinating National Actions for Change – Immediate Steps Forward*	*H. Chaudhry*
October 29, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
October 29-30, 2020	CMSS Virtual Annual Meeting	*H. Chaudhry*
October 30, 2020	ACCME Accreditation Interview	*H. Chaudhry* *L. Robin*
November 2, 2020	Weekly Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
November 2, 2020	Chair and CEO Teleconference	*C. Walker-McGill* *H. Chaudhry*
November 3, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
November 3, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
November 3, 2020	USMLE Step 2 CS Videoconference	*H. Chaudhry* *D. Johnson*
November 4, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
November 4, 2020	USMLE Composite Committee WebEx	*C. Walker-McGill* *K. Simons* *H. Chaudhry* *D. Johnson*
November 4, 2020	Emergency Preparedness and Response Workgroup Videoconference	*C. Walker-McGill* *K. Simons* *S. Steingard* *H. Chaudhry* *M. Dugan* *D. Johnson*
November 5, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
November 5, 2020	Webex with Dr. John Gimpel, CEO, NBOME	*H. Chaudhry* *D. Johnson*
November 5, 2020	USMLE State Board Advisory Panel Videoconference	*D. Johnson*
November 6, 2020	Teleconference with Dr. Michael Wieting, Chair, AAOE	*H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF ACTIVITY SUMMARY

May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
November 6, 2020	Oklahoma State Medical Association Webinar *Presentation: SARS-COV-2 and Medical Licensure and Regulation*	*H. Chaudhry*
November 6, 2020	ABMS Committee on Continuing Certification Videoconference	*J. Carter*
November 6, 2020	USMLE Orientation Videoconference *Presentation: Overview of the USMLE Program*	*D. Johnson*
November 7, 2020	Weill Cornell "Doctors From a Distance: COVID 19 and the Future of International Telemedicine" Webinar *Presentation: Licensing and Telemedicine in the U.S. Regulating in Uncertain Times*	*H. Chaudhry*
November 7, 2020	AMA Plenary Session "Interview with Dr. Fauci" Webinar	*C. Walker-McGill* *K. Simons* *H. Chaudhry*
November 7, 2020	AOA HOD Virtual Special Session	*H. Chaudhry*
November 9, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
November 9, 2020	Tri-Regulator Collaborative Virtual Meeting	*C. Walker-McGill* *K. Simons* *H. Chaudhry*
November 9, 2020	Weekly Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
November 9, 2020	Emergency Preparedness and Response Workgroup Debriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
November 9, 2020	Board Leadership and Staff Videoconference	*C. Walker-McGill* *J. Landau* *K. Simons* *S. Steingard* *H. Chaudhry* *E. Fish* *D. Johnson* *T. Phillips*
November 10, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
November 10, 2020	CATO Institute "Race and Medical Licensing Laws" Webinar	*C. Walker-McGill* *K. Simons* *S. Steingard* *H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
November 10, 2020	FSMB Foundation Grants Committee Meeting	*L. Robin*
November 10, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
November 10, 2020	USMLE Management Committee Videoconference	*D. Johnson*
November 11, 2020	NBME Virtual Town Hall	*H. Chaudhry* *D. Johnson*
November 12, 2020	NAM Opioid Collaborative Virtual Symposium	*H. Chaudhry*
November 12, 2020	FSMB Virtual Educational Session Moderator: Sarvam TerKonda, MD Panelists: Mei Wa Kwong, JD, Executive Director, Center for Connected Health Policy and Jeremy Sherer, JD, Hooper, Bundy and Bookman PC Topic: New Pandemic-Related Developments in Telemedicine	*C. Walker-McGill* *J. Carter* *S. Parker* *S. Steingard* *S. TerKonda* *B. Walker* *J. Willett* *H. Chaudhry* *L. Robin*
November 12, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
November 12, 2020	AMA Council on Medical Education Virtual Stakeholders Forum	*C. Walker-McGill* *K. Simons* *H. Chaudhry*
November 12, 2020	AMA Virtual HOD Practice Session	*H. Chaudhry*
November 13, 2020	NAM Opioid Collaborative Virtual Meeting	*H. Chaudhry*
November 13, 2020	Videoconference with Linda Bresnahan, Executive Director and Dr. Chris Bundy, President, FSPHP	*H. Chaudhry*
November 13-17, 2020	AMA Virtual Interim HOD Meeting	*C. Walker-McGill* *K. Simons* *H. Chaudhry*
November 16, 2020	Teleconference with Dr. Pater Katsufrakis, CEO, NBME	*H. Chaudhry*
November 16, 2020	C-Suite Videoconference with Glenn Tecker, CEO, Tecker International	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
November 16, 2020	NAM Opioid Collaborative State Licensing Board Meeting Prebriefing Videoconference	*H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
November 16, 2020	Weekly Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
November 16-18, 2020	AAMC Virtual Annual Meeting	*H. Chaudhry*
November 17, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
November 18, 2020	NAM Opioid Collaborative State Licensing Board Meeting Prebriefing Videoconference	*H. Chaudhry*
November 18, 2020	AOGME Membership Discussion Videoconference	*H. Chaudhry*
November 18, 2020	NAM/APHA "COVID 19 Vaccine Update" Webinar	*H. Chaudhry*
November 18, 2020	FSMB Foundation Videoconference	*H. Chaudhry* *T. Phillips*
November 19, 2020	NAM Opioid Collaborative State Licensing Board Meeting Prebriefing Videoconference	*C. Walker-McGill* *H. Chaudhry*
November 19, 2020	ACGME Conference Panel Prebriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
November 19, 2020	Step 2 CS Videoconference	*H. Chaudhry* *D. Johnson*
November 19, 2020	Southern Historical Association Virtual Conference	*D. Johnson*
November 20, 2020	Interview with AAMC News	*H. Chaudhry*
November 20, 2020	Teleconference with Ann Mond Johnson, CEO and Kyle Zebley, Director, Public Policy, American Telemedicine Association	*H. Chaudry* *L. Robin*
November 20, 2020	Interstate Healthcare Collaborative	*L. Robin*
November 20, 2020	ABMS Professionalism Taskforce Webinar	*J. Carter*
November 23, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry* *T. Phillips* *M. Dugan* *D. Johnson*
November 23, 2020	NAM Opioid Collaborative State Licensing Board Virtual Symposium	*C. Walker-McGill* *J. Landau* *K. Simons* *S. Steingard*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		H. Chaudhry *L. Robin*
November 25, 2020	FSMB Foundation Grants Committee	*L. Robin*
November 30, 2020	FSPHP Physician Suicide Prevention Webinar Run of Show	*H. Chaudhry*
November 30, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
November 30, 2020	Teleconference with Fleur-Ange Lefebvre, CEO, FMRAC	*H. Chaudhry*
November 30, 2020	Weekly Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
November 30, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
November 30, 2020	Tri-Lateral Board Prebriefing Videoconference	*C. Walker-McGill* *J. Landau* *K. Simons* *S. Steingard* *H. Chaudhry* *E. Fish*
November 30, 2020	COMLEX Exams in Canada Teleconference with AOA	*H. Chaudhry*
December 1, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
December 1, 2020	COVID 19 Licensure Waiver Webinar	*H. Chaudhry*
December 1, 2020	Teleconference with Franci Rooney, Office of Senator John Cornyn	*L. Robin*
December 1, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
December 1, 2020	Tri-Lateral Board Leadership and Staff WebEx	*C. Walker-McGill* *J. Landau* *K. Simons* *S. Steingard* *H. Chaudhry* *E. Fish* *D. Johnson* *T. Phillips*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF ACTIVITY SUMMARY

May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
December 1, 2020	Tri-Lateral WebEx Debriefing Videoconference	*C. Walker-McGill* *J. Landau* *K. Simons* *S. Steingard* *H. Chaudhry* *E. Fish* *D. Johnson* *T. Phillips*
December 2, 2020	WHO "The Challenge: Infomatics and the Media – Learning From the Past" Webinar	*H. Chaudhry*
December 2, 2020	Teleconference with Dr. Weinfeld, Director, Medical Student Education, Department of Family Medicine, Georgetown University	*H. Chaudhry*
December 2, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
December 2, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
December 2, 2020	AMA-FSMB Staff Teleconference	*H. Chaudhry*
December 2, 2020	FSMB Virtual Educational Session Moderator: Lisa Robin, MLA Panelists: David Loewenstein, Director, Division of Practitioner Data Bank, Bureau of Health Workforce, HRSA and Harnam Singh, PhD, Chief Research and Data Officer, Division of Practitioner Data Bank Topic: National Practitioner Data Bank Update: New Tools for Regulators	*C. Walker-McGill* *J. Carter* *S. Parker* *K. Simons* *S. Steingard* *B. Walker* *L. Robin*
December 2, 2020	NAM Opioid Collaborative Steering Committee Videoconference	*H. Chaudhry*
December 2, 2020	Weekly Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
December 2, 2020	Bylaws Committee Videoconference	*K. Simons* *H. Chaudhry* *E. Fish*
December 3, 2020	Exam Evolution Videoconference with Australian Medical Council, General Medical Council, Medical Council of Canada and NBME	*D. Johnson*
December 3, 2020	ACCME Virtual Board Meeting	*H. Chaudhry*
December 3, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
December 3, 2020	AAOE Virtual Business Meeting *Presentation: FSMB Update*	*H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF ACTIVITY SUMMARY

May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
December 4, 2020	NYS Board of Medicine Webex Meeting *Presentation: COVID 19 and Medical Licensure and Regulation*	*H. Chaudhry*
December 4, 2020	USMLE Orientation for State Board Members Videoconference	*D. Johnson*
December 4, 2020	Virtual Meeting with Kim Horvath, JD, AMA	*L. Robin*
December 6, 2020	Healthcare Future Summit Healthcare Regulator Pillar Panelist *Presentation: A Role Model for Innovative Regulation: Where Are We and What's Next?*	*H. Chaudhry*
December 6-8	IHI Forum 2020 Virtual Meeting	*H. Chaudhry*
December 7, 2020	Healthcare Regulatory CEO Virtual Meeting	*H. Chaudhry*
December 7, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
December 7, 2020	Weekly Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
December 7, 2020	FSPHP Physician Suicide Awareness Session	*H. Chaudhry*
December 7, 2020	Board of Directors and Executive Staff Videoconference	*C. Walker-McGill* *M. Arsiwala* *J. Carter* *J. Geimer-Flanders* *A. Hayden* *J. Landau* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard* *S. TerKonda* *K. Templeton* *B. Walker* *J. Willett* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
December 8, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		D. Johnson *T. Phillips* *L. Robin*
December 8, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
December 8, 2020	Education Committee Videoconference	*C. Walker-McGill* *K. Simons* *S. Steingard* *J. Willett* *H. Chaudhry* *L. Robin*
December 9, 2020	WHO "The Solution: Infodemics and the Media – Preparing for The Future" Webinar	*H. Chaudhry*
December 9, 2020	IAMRA Management Committee Videoconference	*H. Chaudhry*
December 9, 2020	"Vaccines – The Realities of the Next Steps" Webinar	*H. Chaudhry*
December 9, 2020	Videoconference with Dr. Pat King	*H. Chaudhry*
December 9, 2020	USMLE Committee for Individualized Review Videoconference	*D. Johnson*
December 10, 2020	Executive Council "Roundtable Cybersecurity Leaders" Webinar	*H. Chaudhry*
December 10, 2020	Interview with the Washington Post	*H. Chaudhry*
December 10, 2020	FSMB Educational Session Prebriefing Videoconference with Dr. Bryant Marks	*C. Walker-McGill*
December 10, 2020	IAMRA "Emerging COVID-19 Challenges for the Safety and Standards of Patient Care" Webinar	*S. Steingard* *B. Walker* *H. Chaudhry* *M. Dugan*
December 10, 2020	Teleconference with Ruth Martinez, Executive Director, Minnesota Board of Medical Practice	*H. Chaudhry*
December 10, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
December 10, 2020	USMLE Management Committee Videoconference	*D. Johnson*
December 11, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
December 11, 2020	PBS "Second Opinion with Joan Lunden" Recording with Dr. Louis Papa	*H. Chaudhry*
December 11, 2020	Tri-Lateral CEO and Chair Videoconference	*C. Walker-McGill* *H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
December 14, 2020	"Is AI the Key to Fighting Fake News" Webinar	*H. Chaudhry*
December 14, 2020	Teleconference with Dr. Shantanu Agrawal, President and CEO, National Quality Forum	*H. Chaudhry*
December 14, 2020	Weekly Webex with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
December 14, 2020	NASEM "Mental Health and Substance Use Disorders in the Era of COVID-19" Webinar	*H. Chaudhry*
December 14, 2020	FSMB Educational Session Webinar Training Session	*C. Walker-McGill*
December 14, 2020	Emergency Preparedness and Response Workgroup Prebriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
December 15, 2020	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
December 15, 2020	Teleconference with Pakistan Medical Council and NBME	*H. Chaudhry* *D. Johnson*
December 15, 2020	Advisory Council of Board Executives Virtual Meeting	*L. Robin*
December 15, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
December 15, 2020	ACGME Conference Presentation Recording Session	*C. Walker-McGill* *H. Chaudhry*
December 15, 2020	CSEC Steering Committee Videoconference	*D. Johnson*
December 16, 2020	Videoconference with Dr. John Whyte, Chief Medical Officer, WebMD	*H. Chaudhry*
December 16, 2020	FSMB-AIM Leadership Teleconference with Anne Lawler, President, AIM	*H. Chaudhry*
December 16, 2020	FSMB Virtual Educational Session Moderator: Cheryl Walker-McGill, MD Speaker: Bryant T. Marks, Sr., PhD Topic: Ensuring Fairness in Medical Regulation: Can Implicit Bias Be Overcome?	*C. Walker-McGill* *S. Parker* *K. Simons* *S. Steingard* *B. Walker* *H. Chaudhry* *L. Robin*
December 16, 2020	Chair-elect and CEO Teleconference	*K. Simons* *H. Chaudhry*
December 16, 2020	Emergency Preparedness and Response Workgroup Videoconference	*C. Walker-McGill* *K. Simons*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		S. Steingard *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *L. Robin*
December 16, 2020	ACGME Conference Presentation Recording Session	*D. Johnson*
December 17, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
December 18, 2020	"Coffee & Cocoa with Cheryl and Hank" Virtual Gathering with FSMB staff	*C. Walker-McGill* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
December 18, 2020	NYSOMS "What Clinicians Need to Know About the Pfizer-BioNtech and Moderna COVID-19 Vaccines" Webinar	*H. Chaudhry*
December 18, 2020	AAFP/NAM "Best Practices, Research Gaps and Future Priorities to Support Tapering Patients on Long-term Opioid Therapy" Webinar	*H. Chaudhry*
December 21, 2020	Telehealth Summit Teleconference with Dr. Chad Mathis	*H. Chaudhry*
December 21, 2020	Emergency Preparedness and Response Workgroup Debriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
December 22, 2020	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
December 22, 2020	Telehealth Summit Virtual Meeting	*H. Chaudhry*
December 22, 2020	Teleconference with Dr. Kristin Dillon, RWJF Fellow, Office of Nancy Pelosi	*L. Robin*
December 23, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
December 23, 2020	TATRC-Provider Bridge Virtual Meeting	*M. Dugan* *L. Robin*
December 29, 2020	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
January 4, 2021	Planning Committee Prebriefing Videoconference	*K. Simons* *H. Chaudhry* *L. Robin*
January 4, 2021	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
January 4, 2021	Emergency Preparedness and Response Workgroup Prebriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
January 5, 2021	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
January 5, 2021	Newsday "A COVID-19 Vaccine Discussion with Dr. Fauci" Webinar	*H. Chaudhry*
January 5, 2021	Composite Committee Agenda Planning Videoconference	*H. Chaudhry* *D. Johnson*
January 5, 2021	Teleconference with Daniel Tsang, Office of Rep. Jason Crow	*L. Robin*
January 5, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
January 5, 2021	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
January 5, 2021	Emergency Preparedness and Response Workgroup Videoconference	*C. Walker-McGill* *K. Simons* *S. Steingard* *H. Chaudhry* *M. Dugan* *D. Johnson* *L. Robin*
January 6, 2021	Videoconference with Dr. John Whyte, Chief Medical Officer, WebMD	*H. Chaudhry*
January 6, 2021	Videoconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
January 6, 2021	Planning Committee Videoconference	*C. Walker-McGill* *J. Carter* *M. de Leon* *S. Parker* *K. Simons* *K. Templeton* *S. TerKonda* *H. Chaudhry* *L. Robin*
January 7, 2021	IAMSE USMLE Step 1 Webinar Series	*H. Chaudhry*
January 7, 2021	NASEM "Crisis Standards of Care During the COVID 19 Pandemic – Realtime Legal Issues and Solutions" Webinar	*H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF ACTIVITY SUMMARY

May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
January 7, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
January 7-8, 2021	Royal College of Physicians Virtual Medicine 2021	*C. Walker-McGill* *H. Chaudhry*
January 8, 2021	USMLE Management Committee Videoconference	*D. Johnson*
January 9, 2021	Teleconference with Lisa Robin, Chief Advocacy Officer	*H. Chaudhry*
January 9, 2021	Videoconference with Dr. Peter Katsufrakis, CEO and Dr. Al Tallia, Chair, NBME	*C. Walker-McGill* *H. Chaudhry*
January 11, 2021	Weekly Videoconference with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
January 11, 2021	Emergency Preparedness and Response Workgroup Debriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
January 11, 2021	Tri-Lateral Videoconference	*C. Walker-McGill* *H. Chaudhry*
January 11, 2021	USMLE Committee for Individualized Review Videoconference	*D. Johnson*
January 12	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
January 12, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
January 13, 2021	Videoconference with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry* *D. Johnson*
January 13, 2021	Proposed Policy on Professional Standing Virtual Meeting with ABMS Staff	*L. Robin*
January 13, 2021	Chair-elect and CEO Videoconference	*K. Simons* *H. Chaudhry*
January 14, 2021	IAMSE USMLE Step 1 Webinar Series	*H. Chaudhry*
January 14, 2021	FSMB Special Webinar Introductions: Cheryl Walker-McGill, MD Moderator: Hank Chaudhry, DO Speaker: Michael Osterholm, PhD, Epidemiologist, Biden COVID-19 Advisory Board Topic: COVID-19 in 2021: A Conversation with Dr. Michael Osterholm	*C. Walker-McGill* *J. Landau* *F. Meyers* *S. Parker* *K. Templeton* *S. TerKonda* *B. Walker* *H. Chaudhry* *M. Dugan*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		L. Robin
January 14, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
January 15, 2021	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
January 18, 2021	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
January 18, 2021	FMRAC "The Foundational Aspects of AI: Towards a Basic Understanding" Webinar	*H. Chaudhry*
January 18, 2021	Weekly Videoconference with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
January 18, 2021	Immediate Past Chair and CEO Teleconference	*S. Steingard* *H. Chaudhry*
January 19, 2021	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
January 19, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
January 19, 2021	Awards Committee Videoconference	*C. Walker-McGill* *M. de Leon* *K. Simons* *S. Steingard* *B. Walker* *J. Willett* *H. Chaudhry* *L. Robin*
January 20, 2021	Teleconference with Kelly Alfred, Director, Education Services, FSMB	*C. Walker-McGill*
January 20, 2021	ABMS Committee on Continuing Certification (3C) WebEx	*J. Carter*
January 20, 2021	Nominating Committee Videoconference	*S. Steingard* *H. Chaudhry* *E. Fish*
January 21, 2021	Teleconference with Dr. Helen Burstin, CEO, CMSS	*J. Carter*
January 21, 2021	IAMSE USMLE Step 1 Webinar Series	*H. Chaudhry*
January 21, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
January 22, 2021	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
January 22, 2021	"COVID-19 Vaccine: Efficacy, Trust, Awareness and Empowerment" Webinar	*C. Walker-McGill*
January 22, 2021	ACP and Annals COVID-19 Vaccine Forum III	*H. Chaudhry*
January 22, 2021	FSMB BOD and Staff Videoconference	*C. Walker-McGill* *M. Arsiwala* *J. Carter* *M. de Leon* *J. Geimer-Flanders* *A. Hayden* *J. Landau* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard* *K. Templeton* *S. TerKonda* *B. Walker* *J. Willett* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
January 25, 2021	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
January 25, 2021	FSMB Symposium Rehearsal	*C. Walker-McGill* *H. Chaudhry*
January 25, 2021	Weekly Videoconference with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
January 25, 2021	Emergency Preparedness and Response Workgroup Prebriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
January 25, 2021	Teleconference with Ahmed Faruk, FSMB Investment Advisor	*J. Landau* *T. Phillips*
January 25, 2021	Finance Committee Prebriefing Teleconference	*J. Landau* *T. Phillips*
January 26, 2021	Teleconference with Fleur-Ange Lefebvre, CEO, FMRAC	*H. Chaudhry*
January 26, 2021	C-Suite Videoconference	*H. Chaudhry* *M. Dugan*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		E. Fish *D. Johnson* *T. Phillips* *L. Robin*
January 26, 2021	Teleconference with Dr. John Gimpel, CEO, NBOME	*H. Chaudhry*
January 26, 2021	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
January 26, 2021	FSMB Virtual Symposium Introductions: Cheryl Walker-McGill, MD Moderator: Hank Chaudhry, DO Keynote Speakers: Mark Morial, JD, President and CEO, National Urban League and Mark McClellan, MD, PhD, Director, Duke-Robert J. Margolis Center for Health Policy Panelists: Diana Currie, MD, member, Washington Medical Commission; Aletha Maybank, MD, MPH, Chief Health Equity Officer, AMA and Leonard Weather, Jr., MD, RPh, member, Louisiana State Board of Medical Examiners and Past President, NMA Topic: Health Equity and Medical Regulation: How Disparities are Impacting U.S. Health Care Quality and Delivery and Why It Matters	*C. Walker-McGill* *J. Carter* *M. de Leon* *A. Hayden* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard* *S. TerKonda* *B. Walker* *H. Chaudhry* *M. Dugan* *E. Fish* *L. Robin*
January 27, 2021	Teleconference with Dr. Robert Cain, CEO, AACOM	*H. Chaudhry*
January 27, 2021	West Virginia State Medical Association Healthcare Summit Videoconference	*H. Chaudhry*
January 27, 2021	NYS COGME Plenary Session	*H. Chaudhry*
January 27, 2021	Virtual Meeting with AMA Government Relations Staff	*L. Robin*
January 27, 2021	Virtual Meeting with AAPA, NCCPA and CSG	*L. Robin*
January 27, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
January 27, 2021	Emergency Preparedness and Response Workgroup Videoconference	*C. Walker-McGill* *F. Meyers* *K. Simons* *S. Steingard* *H. Chaudhry* *D. Johnson*
January 28, 2021	Leadership Teleconference	*H. Chaudhry* *E. Fish* *D. Johnson*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		T. Phillips
January 28, 2021	IAMSE USMLE Step 1 Webinar Series	*H. Chaudhry*
January 28, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
January 28, 2021	Ethics and Professionalism Committee Videoconference	*C. Walker-McGill* *J. Carter* *H. Chaudhry*
January 28, 2021	Workgroup on Physician Impairment Videoconference	*C. Walker-McGill* *S. Parker* *K. Simons* *H. Chaudhry*
January 29, 2021	Finance Committee Videoconference	*C. Walker-McGill* *J. Landau* *K. Simons* *H. Chaudhry* *T. Phillips*
February 1, 2021	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
February 1, 2021	Weekly Videoconference with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
February 1, 2021	Emergency Preparedness and Response Workgroup Debriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
February 1, 2021	Governance Committee Videoconference	*C. Walker-McGill* *A. Hayden* *S. Parker* *K. Simons* *K. Templeton* *B. Walker* *J. Willett* *H. Chaudhry* *E. Fish*
February 2, 2021	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
February 2, 2021	Teleconference with Dr. Peter Katsufrakis, CEO, NBME	*H. Chaudhry*
February 2, 2021	Emergency Preparedness and Response Workgroup Prebriefing Teleconference with Robin Hunter Busky	*C. Walker-McGill*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF ACTIVITY SUMMARY

May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
February 2, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
February 3, 2021	Teleconference with Dr. Maureen Topps, CEO, Medical Council of Canada	*H. Chaudhry*
February 3, 2021	IMLC Research Virtual Meeting with HRSA and University of Arkansas Medical School	*L. Robin*
February 4, 2021	IAMSE USMLE Step 1 Webinar Series	*H. Chaudhry*
February 4, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
February 4, 2021	Workgroup on Physician Impairment Videoconference	*C. Walker-McGill* *S. Parker* *K. Simons* *H. Chaudhry*
February 5, 2021	ACGME Conference Speaker Training Session	*C. Walker-McGill* *H. Chaudhry* *D. Johnson*
February 5, 2021	Staff Committee for the Review of Anomalous Performance (SCRAP) Videoconference	*D. Johnson*
February 7, 2021	ACGME Board of Directors Virtual Meeting	*K. Simons*
February 8, 2021	Weekly Videoconference with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
February 9, 2021	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
February 9, 2021	FSMB Virtual Educational Session Moderator: Hank Chaudhry, DO Speakers: Rachael Anatol, PhD, Deputy Director, Office of Tissues and Advanced Therapies, and Melissa Mendoza, JD, Deputy Director, Office of Compliance and Biologics Quality, FDA Topic: FDA's Regulatory Oversight of Human Cells, Tissues and Cellular and Tissue-Based Products"	*C. Walker-McGill* *K. Simons* *S. Steingard* *H. Chaudhry*
February 9, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
February 9, 2021	Workgroup on Risk and Support Factors Affecting Physician Performance Videoconference	*C. Walker-McGill* *M. Arsiwala* *K. Simons* *S. Steingard*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		H. Chaudhry
February 10, 2021	USMLE Composite Committee Videoconference	*C. Walker-McGill* *K. Simons* *H. Chaudhry* *E. Fish* *D. Johnson*
February 11, 2020	Tri-Regulator Collaborative Virtual Meeting	*C. Walker-McGill* *H. Chaudhry*
February 11, 2021	FSMB-AIM Leadership Teleconference with Anne Lawler, President, AIM	*H. Chaudhry*
February 11, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
February 11, 2021	NABP PMP Interoperability Forum	*L. Robin*
February 12, 2021	Teleconference with Dr. Richard Hawkins, CEO, ABMS	*H. Chaudhry*
February 12, 2021	Teleconference with Dr. Wolfgang Gilliar, Dean, Touro University College of Osteopathic Medicine in Nevada	*H. Chaudhry*
February 12, 2021	Emergency Preparedness and Response Workgroup Prebriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
February 15, 2021	Weekly Videoconference with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
February 16, 2021	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
February 16, 2021	Teleconference with Dr. Michael Clearfield, Dean, Touro University College of Osteopathic Medicine of California	*H. Chaudhry*
February 16, 2021	Litchfield CEO Group Videoconference	*H. Chaudhry*
February 16, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
February 16, 2021	Emergency Preparedness and Response Workgroup Videoconference	*C. Walker-McGill* *F. Meyers* *K. Simons* *S. Steingard* *H. Chaudhry* *D. Johnson*
February 17-19, 2021	Investment Committee Videoconference Board of Directors Videoconference	*C. Walker-McGill* *M. Arsiwala*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		J. Carter *M. de Leon* *J. Geimer-Flanders* *A. Hayden* *J. Landau* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard* *K. Templeton* *S. TerKonda* *B. Walker* *J. Willett* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
February 18, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
February 18, 2021	ABMS Professionalism Task Force Webex	*J. Carter*
February 22, 2021	FDA-FSMB Staff Videoconference	*H. Chaudhry* *L. Robin*
February 22, 2021	Weekly Videoconference with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
February 22, 2021	AADB Speaker Training Videoconference	*H. Chaudhry*
February 22, 2021	IAMRA Management Committee Videoconference	*H. Chaudhry*
February 22, 2021	Emergency Preparedness and Response Workgroup Debriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
February 23, 2021	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
February 23, 2021	Teleconference with Dr. Michael Wieting, Chair, AAOE	*H. Chaudhry*
February 23, 2021	USMLE State Board Advisory Panel Videoconference	*D. Johnson*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
February 23, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
February 23, 2021	FSMB Foundation Board Videoconference	*C. Walker-McGill* *K. Simons* *H. Chaudhry* *L. Robin*
February 24, 2021	APHA/NAM "A New Year of COVID: The State of the Pandemic & US" Webinar	*H. Chaudhry*
February 24-26, 2021	ACGME Virtual Educational Conference Feb. 25 Speakers: Drs. Walker-McGill and Chaudhry *Presentation: State Medical Boards and COVID-19: Agility and Adaptability in Uncertain Times* Feb. 26 Speaker: David Johnson *Presentation: USMLE Update: Looking Back at 2020 & Forward to 2021*	*C. Walker-McGill* *K. Simons* *H. Chaudhry* *D. Johnson*
February 25, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
February 26, 2021	USMLE Management Committee Videoconference	*D. Johnson*
February 27, 2021	AADB Virtual Meeting Presentation: *Interprofessional Collaboration to Confront the Opioid Epidemic*	*H. Chaudhry*
March 1, 2021	USMLE Composite Committee Videoconference	*C. Walker-McGill* *K. Simons* *H. Chaudhry* *E. Fish* *D. Johnson*
March 1, 2021	Committee Appointment Review Videoconference	*K. Simons* *H. Chaudhry* *L. Robin*
March 2, 2021	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
March 2, 2021	New York Tech Interview	*H. Chaudhry*
March 2, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
March 2, 2021	Planning Committee Videoconference	*C. Walker-McGill* *J. Carter* *M. de Leon*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		S. Parker *K. Simons* *K. Templeton* *S. TerKonda* *H. Chaudhry* *L. Robin*
March 3, 2021	AAOE USMLE/COMLEX Videoconference	*H. Chaudhry*
March 4, 2021	"Hot Topic from The Hill: Driving Diversity, Equity & Inclusion" Webinar	*H. Chaudhry*
March 4, 2021	Teleconference with Stephen Boese, Executive Director, New York State Board for Medicine	*J. Landau* *H. Chaudhry*
March 4, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
March 4, 2021	AI Task Force Planning Teleconference	*K. Simons* *S. TerKonda* *H. Chaudhry* *E. Fish*
March 5, 2021	Qnary "Uncaged with Bant Breen" Interview	*H. Chaudhry*
March 5, 2021	NASEM GME Data Workshop Follow-Up Videoconference	*H. Chaudhry*
March 5, 2021	Videoconference with Lori Tinkler, MBA, CEO, National Board for Respiratory Care	*M. Dugan* *L. Robin*
March 8, 2021	Teleconference with Dr. Robert Cain, CEO, AACOM	*H. Chaudhry*
March 8, 2021	Weekly Videoconference with Dr. Peter Katsufrakis, CEO, NBME and Dr. Bill Pinsky, CEO, ECFMG	*H. Chaudhry*
March 8, 2021	Emergency Preparedness and Response Workgroup Prebriefing Teleconference	*C. Walker-McGill* *H. Chaudhry*
March 9, 2021	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
March 9, 2021	Chair-elect and CEO Teleconference	*K. Simons* *H. Chaudhry*
March 9, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
March 10, 2021	Emergency Preparedness and Response Workgroup Videoconference	*C. Walker-McGill* *F. Meyers* *K. Simons*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		S. Steingard *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
March 11, 2021	FSMB Roundtable Webinar Speakers: Dr. Chris Feddock, Executive Director, Clinical Skills Evaluation Collaboration (CSEC) and David Johnson, MA, Chief Advocacy Officer, FSMB Topic: Discontinuation of the USMLE Step 2 CS Exam: What Does It Mean for State Medical Boards?	*J. Carter* *M. de Leon* *S. Steingard* *K. Templeton* *H. Chaudhry* *M. Dugan* *D. Johnson*
March 11, 2021	Litchfield CEO Virtual Meeting	*H. Chaudhry*
March 11, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
March 12, 2021	Healthcare Regulatory CEO Virtual Meeting	*H. Chaudhry*
March 13, 2021	NMA Council on Clinical Practice Meeting	*C. Walker-McGill*
March 15, 2021	Emergency Preparedness and Response Workgroup Debriefing Teleconference	*C. Walker-McGill*
March 16, 2021	Videoconference with Andrew Soloman, Senior Program Manager, MCD Public Health	*M. Dugan*
March 16, 2021	CPE Journal Club	*C. Walker-McGill*
March 16, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
March 17, 2021	NAM "Moving Past COVID-19: Lessons Learned from Across the World" Webinar	*H. Chaudhry*
March 18-19, 2021	ACCME Board of Directors Videoconference	*J. Geimer-Flanders*
March 19, 2021	Chair and Chair-elect Weekly Teleconference	*C. Walker-McGill* *K. Simons*
March 22, 2021	ACCME Keynote Planning Videoconference	*H. Chaudhry*
March 22-24, 2021	Committee for Individualized Review Virtual Meeting	*D. Johnson*
March 23, 2021	Epstein, Becker, Green Law Firm "Bias in Artificial Intelligence: Legal Risks and Solutions" Webinar	*S. TerKonda*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
March 23, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
March 24, 2021	FSMB Roundtable Webinar Speaker: John R. Gimpel, DO, MEd, President and CEO, NBOME Topic: Update on COMLEX-USA and Level-2 Performance Evaluation Exam	*C. Walker-McGill* *S. Parker* *K. Simons* *S. Steingard* *B. Walker* *H. Chaudhry* *M. Dugan* *D. Johnson*
March 24, 2021	ABMS Professionalism Task Force WebEx	*J. Carter*
March 25, 2021	NBME Virtual Annual Meeting	*C. Walker-McGill* *K. Simons* *S. Steingard* *H. Chaudhry* *D. Johnson*
March 25, 2021	Videoconference with Barbara Fleming, Inventures	*M. Dugan*
March 26, 2021	USMLE Management Committee Videoconference	*D. Johnson*
March 26, 2021	Chair and Chair-elect Weekly Teleconference	*C. Walker-McGill* *K. Simons*
March 29, 2021	IAMRA "Physician Health and Wellness" Webinar Presentation (Chaudhry): *Covid-19: Physician Health and Wellness*	*C. Walker-McGill* *K. Simons* *S. Steingard* *H. Chaudhry* *D. Johnson*
March 30, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
March 30, 2021	Ad Hoc Task Force on Health Equity and Medical Regulation Videoconference	*C. Walker-McGill* *J. Carter* *A. Hayden* *K. Simons* *K. Templeton* *S. TerKonda* *H. Chaudhry*
March 30-31, 2021	GME Stakeholders Congress	*H. Chaudhry*
March 31, 2021	Teleconference with Dr. Richard Hawkins, CEO, ABMS	*H. Chaudhry*
March 31, 2021	Annual Meeting Video Filming	*C. Walker-McGill*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
April 1, 2021	Teleconference with Dr. Graham McMahon, CEO, ACCME	*H. Chaudhry* *M. Dugan*
April 1, 2021	FSPHP Virtual Education Conference	*C. Walker-McGill* *H. Chaudhry*
April 1, 2021	Annual Meeting Video Filming	*H. Chaudhry*
April 1, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
April 2, 2021	Microsoft Teams Training	*C. Walker-McGill*
April 2, 2021	Chair and Chair-elect Weekly Teleconference	*C. Walker-McGill* *K. Simons*
April 5, 2021	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
April 6, 2021	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
April 6, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
April 6, 2021	HOD Script Review Videoconference	*C. Walker-McGill* *H. Chaudhry*
April 7, 2021	USMLE Staff Committee for the Review of Anomalous Performance Videoconference	*D. Johnson*
April 7, 2021	FSMB House of Delegates Presenter Virtual Training	*C. Walker-McGill* *J. Landau* *K. Simons* *S. Steingard* *H. Chaudhry* *M. Dugan*
April 7, 2021	Nominating Committee Videoconference	*S. Steingard* *H. Chaudhry* *E. Fish*
April 8, 2021	Wall Street Journal/IBM Cloud Digital Reinvention Summit	*H. Chaudhry*
April 8, 2021	USMLE Staff Committee on Irregular Behavior Videoconference	*D. Johnson*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
April 8, 2021	FSPHP Virtual Education Conference	*C. Walker-McGill* *H. Chaudhry*
April 8, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
April 8, 2021	Ad Hoc Task Force on Health Equity and Medical Regulation Videoconference	*C. Walker-McGill* *J. Carter* *A. Hayden* *K. Simons* *K. Templeton* *S. TerKonda* *H. Chaudhry*
April 9, 2021	Chair and Chair-elect Weekly Teleconference	*C. Walker-McGill* *K. Simons*
April 12, 2021	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
April 12, 2021	USMLE Budget Committee Videoconference	*C. Walker-McGill* *J. Landau* *K. Simons* *H. Chaudhry* *D. Johnson* *T. Phillips*
April 12, 2021	FSMB House of Delegates Head Table Virtual Training	*C. Walker-McGill* *H. Chaudhry* *E. Fish*
April 13, 2021	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
April 13, 2021	FSMB House of Delegates Support Team Final Virtual Training	*H. Chaudhry*
April 13, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
April 13, 2021	Rules Committee Videoconference	*K. Simons* *H. Chaudhry* *E. Fish*
April 14, 2021	USMLE Composite Committee Videoconference	*C. Walker-McGill* *K. Simons*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		H. Chaudhry *E. Fish* *D. Johnson*
April 14, 2021	FSMB Candidate Forum Recording Session	*M. Arsiwala* *J. Geimer-Flanders* *S. Steingard* *S. TerKonda*
April 15, 2021	IAMRA Management Committee Videoconference	*H. Chaudhry*
April 15, 2021	Treasurer and CFO Teleconference	*J. Landau* *T. Phillips*
April 15, 2021	FSPHP Virtual Education Conference	*C. Walker-McGill* *H. Chaudhry*
April 15, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
April 16, 2021	Chair and Chair-elect Weekly Teleconference	*C. Walker-McGill* *K. Simons*
April 16-17, 2021	NYSOM Virtual Regional Osteopathic Convention *Keynote Presentation*: *COVID-19: Licensure, Advocacy and Policy*	*H. Chaudhry*
April 19, 2021	Coalition for Physician Accountability Virtual Meeting	*C. Walker-McGill* *K. Simons* *H. Chaudhry*
April 20, 2021	C-Suite Videoconference	*H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
April 20, 2021	IAMRA "Humanizing Medical Regulation" Webinar	*H. Chaudhry* *D. Johnson*
April 20, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
April 20, 2021	Reference Committee Videoconference	*H. Chaudhry* *E. Fish* *L. Robin*
April 21, 2021	FSMB House of Delegates Final Presenter Virtual Training	*C. Walker-McGill* *J. Landau* *K. Simons* *S. Steingard* *H. Chaudhry*
April 21-22, 2021	USMLE Management Committee Virtual Meeting	*D. Johnson*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
April 22, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
April 22, 2021	HOD Script Review Teleconference	*C. Walker-McGill* *H. Chaudhry*
April 23, 2021	Chair and Chair-elect Weekly Teleconference	*C. Walker-McGill* *K. Simons*
April 26, 2021	House of Delegates Voting Delegate Final Virtual Training	*H. Chaudhry* *M. Dugan*
April 27, 2021	ACCME Virtual Annual Meeting *<u>Keynote Presentation:</u> Planning for the Post-pandemic Future: Strategies for Adapting to a Transformed Healthcare Ecosystem*	*H. Chaudhry*
April 27, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
April 27, 2021	Investment and Compensation Committee Videoconferences	*C. Walker-McGill* *M. Arsiwala* *J. Landau* *F. Meyers* *S. Steingard* *K. Simons* *S. TerKonda* *H. Chaudhry* *T. Phillips*
April 28, 2021	AIM Virtual Meeting	*C. Walker-McGill* *M. Arsiwala* *J. Carter* *M. de Leon* *J. Geimer-Flanders* *A. Hayden* *J. Landau* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard* *K. Templeton* *S. TerKonda* *B. Walker* *J. Willett* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
April 28, 2021	Board of Directors Videoconference	*C. Walker-McGill* *M. Arsiwala* *J. Carter* *M. de Leon* *J. Geimer-Flanders* *A. Hayden* *J. Landau* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard* *K. Templeton* *S. TerKonda* *B. Walker* *J. Willett* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
April 28, 2021	Minnesota Virtual Welcome Reception	*C. Walker-McGill* *M. Arsiwala* *J. Carter* *M. de Leon* *J. Geimer-Flanders* *A. Hayden* *J. Landau* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard* *K. Templeton* *S. TerKonda* *B. Walker* *J. Willett* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
April 29, 2021	Chair and CEO Weekly Teleconference	*C. Walker-McGill* *H. Chaudhry*
April 29-30, 2021	FSMB Virtual Annual Meeting	*C. Walker-McGill* *M. Arsiwala* *J. Carter* *M. de Leon* *J. Geimer-Flanders* *A. Hayden* *J. Landau* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard* *K. Templeton* *S. TerKonda* *B. Walker* *J. Willett* *H. Chaudhry* *M. Dugan* *E. Fish* *D. Johnson* *T. Phillips* *L. Robin*
April 30, 2021	Chair and Chair-elect Weekly Teleconference	*C. Walker-McGill* *K. Simons*
May 1, 2021	FSMB Virtual House of Delegates Meeting Virtual Chair, Chair-elect, Treasurer and new Board Members Installation	*C. Walker-McGill* *M. Arsiwala* *J. Carter* *M. de Leon* *J. Geimer-Flanders* *A. Hayden* *J. Landau* *F. Meyers* *S. Parker* *K. Simons* *S. Steingard* *K. Templeton* *S. TerKonda* *B. Walker* *J. Willett* *H. Chaudhry* *M. Dugan* *E. Fish*

FSMB BOARD OF DIRECTORS AND EXECUTIVE STAFF
ACTIVITY SUMMARY
May 3, 2020 through May 1, 2021

DATE	MEETING/EVENT	BOD/EXEC
		D. Johnson *T. Phillips* *L. Robin*

Report to the House of Delegates on the FSMB Strategic Plan

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

Goal I: State Medical Board Support

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

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

- As of March 2021, 30 states, the District of Columbia, and Guam have enacted the Compact and seven additional states have introduced the legislation.
- In May 2019, the FSMB was awarded a five-year grant of $250,000 annually from the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, to support the IMLC and further enhance license portability for physicians and physician assistants (PAs). The five-year HRSA grant will be used to support license portability for PAs, enhance the IMLC technology platform, and expand outreach to educate stakeholders on how to utilize the IMLC to improve access to care using telemedicine across state lines.
- As part of the grant, FSMB conducted outreach to state medical boards and other stakeholders to discuss required criminal background checks and factors impacting their efficiency.
- The FSMB Data Integration staff supported the IMLCC in analyzing physician data in order to 1) have updated statistics of physician eligibility for licensure through the IMLC from Compact states; and 2) summarize IMLC applications and licenses issued by states and the average cycle time of the IMLC licensing process.

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

- *FSMB Editorial Committee:* The Committee met in September 2020 to provide guidance and article ideas to staff facilitating development of editorial content for the *Journal of Medical Regulation (JMR).* Throughout the year, Committee members served on peer-review panels to evaluate each manuscript submitted to *JMR* for potential publication.
- *Ethics and Professionalism Committee*: Chaired by Jeffrey D. Carter, MD, the Committee's activities for 2020-21 included 1) providing direction regarding the professional responsibility to wear a face covering during patient care to limit the spread of COVID-19; 2) developing a position statement on physician treatment of self, family members, and close personal relations, and 3) drafting guidance on key considerations for obtaining and working with expert reviewers in quality-of-care cases. The Committee's direction regarding face coverings was provided to the FSMB Board of Directors and informed a press release on the topic which was published in October 2020. The Committee consulted with state medical boards on a draft position statement on the treatment of self, family members, and close personal relations in summer 2020. A revised draft which incorporates member board feedback will be considered for adoption by the FSMB House of Delegates at its 2021 meeting. The House of Delegates will also consider an informational report on Board Practices Regarding Expert Reviews in Quality-of-Care Cases.
- *Advisory Council of Board Executives:* Charged with conducting a triennial review of *Guidelines for the Structure and Function of a State Medical and Osteopathic Board (2018)*, the Advisory Council discussed the *Guidelines* section by section and suggested revisions and language clarifications to bring the document in line with current best practices. The final document is completed and will be considered by the FSMB House of Delegates in May 2021.
- *Workgroup on Board Education, Service and Training (BEST)*: Among the FSMB's many educational and board-service initiatives is the ongoing effort by the Workgroup on Board Education Service and Training (BEST) to provide new learning resources for state medical

board members. The BEST workgroup's educational series, "Understanding Medical Regulation in the United States," periodically publishes tutorial slide presentations, with audio narration, on a wide range of topics of interest to state medical board members. The BEST workgroup posted its third online learning-module, "Understanding Physician Assistant Licensure," in February 2021 and is now working on the next installment in the series, titled "Understanding Discipline in Medical Regulation," which will be posted later this year.

- *Workgroup on Physician Impairment*: The Workgroup on Physician Impairment was appointed by Dr. Scott Steingard in 2019. Chaired by Danny Takanishi, MD, the Workgroup is responsible for revising and expanding the existing FSMB Policy on Physician Impairment in light of new and emerging issues. The Workgroup held several virtual meetings from 2019 to 2021, circulated a draft report to member boards and external stakeholder organizations in the fall of 2020, and submitted a final draft to the FSMB Board of Directors which will be considered for adoption by the House of Delegates at its 2021 meeting. In addition to providing guidance on how state medical boards can work with Physician Health Programs to support patient safety and physician health, the report offers suggestions for reducing stigma associated with seeking treatment and considerations regarding licensees who receive medications for the treatment of opioid use disorder.
- *Workgroup to Study Risk and Support Factors Affecting Physician Performance:* Chaired by Mohammed Arsiwala, MD, this Workgroup is charged with: 1) Collecting and evaluating data and research on factors affecting physician performance and ability to practice medicine safely, including but not limited to practice context (specialty, workload, solo/group, urban/rural), gender, time in practice, examination scores, and culture; 2) Convening stakeholder organizations and experts to engage in collaborative discussions about patient safety issues and ethical and professional responsibilities as they relate to physician performance, including the duty to report; 3) Identifying principles, strategies, resources and best practices for assessing and mitigating potential impacts on physician performance; and 4) Providing information to state medical boards about the risk and support factors affecting physician performance throughout their careers, how these can impact patient care, and what key principles should be applied to consideration of fair, equitable and transparent regulatory processes. The Workgroup has drafted an informational report containing information about risk and support factors affecting physician performance, a summary of state medical board approaches to these factors and educational offerings for licensees, visual representations of risk and support factors categorized according to their relationship with health and wellness, experience and transitions, and the practice environment, and suggestions for furthering FSMB support of member board resources and practices.
- *Workgroup on Emergency Preparedness and Response:* Chaired by Cheryl Walker-McGill, MD, MBA, this Workgroup was formed in May 2020 to discuss the experiences and lessons learned from state and territorial medical boards (and other health professional regulatory boards, such as nursing and pharmacy) during the COVID-19 pandemic, identify key learnings and best practices, and consider potential recommendations for the ongoing crisis and to better prepare for future pandemics. The Workgroup continued the work of the Ad Hoc Task Force on Pandemic Preparedness, formed in February 2020 by former FSMB Chair Scott Steingard, DO, and chaired by FSMB CEO Humayun Chaudhry, DO, MS, MACP. The Workgroup met 14 times and has prepared a report and recommendations which will be considered by the FSMB House of Delegates in May 2021.

The FSMB works directly with state medical boards to achieve their individual legislative and policy priorities. In 2020-2021, FSMB State Legislative and Policy staff:

- Routinely responded to numerous research inquiries and requests for support from state boards.
- Attended state legislative hearings to testify and distribute policy documents directly to legislative and policymaking bodies. Legislative bills that the FSMB provided letters of support for included the Interstate Medical Licensure Compact (Louisiana, Missouri, and Texas).
- Assisted state boards by monitoring, tracking, and analyzing relevant legislation and regulations.
- Maintained a robust portfolio of policy documents, which are continually updated to reflect the most current regulatory and legal landscape. Legislative summaries that were updated during

2020 included: Continuing Medical Education, Pain Management, Prescription Drug Monitoring Programs, Telemedicine, COVID-19, Interstate Medical Licensure Compact (IMLC), License Portability, Occupational Licensure Reform, and Board Structure & Function. Board-by-Board Overview charts that were updated during 2020 included: Continuing Medical Education, Expert Witness, Marijuana, Pain Management, and Telemedicine.

- Mobilized its data and advocacy resources to assist state medical boards and the public, in the wake of the COVID-19 pandemic, while staying informed on emergency regulatory changes and efforts to address workforce needs. Important information and resources, including a chart of state-by-state emergency declarations and licensing waivers, is updated regularly on the FSMB's COVID-19 website.

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

- In December 2019, the State Medical Board of Ohio requested and accepted a proposal from the FSMB to review and evaluate the Board's administrative processes and operational effectiveness regarding its handling of complaints and investigations of sexual impropriety. The Review Team analyzed the Board's administrative processes through document review and interviews with Board members and Board staff conducted via web conference. A final report was submitted to the State Medical Board of Ohio in June and the Review Team presented its findings before the Board in August.
- In January 2020, the FSMB was notified that it had been awarded a contract with the State of Nevada to conduct a performance audit of the Nevada State Board of Medical Examiners. The FSMB assembled a team of experts to perform the audit, which conducted interviews and met virtually to complete the report. The report was submitted to the Nevada Legislative Commission in November 2020.
- FSMB completed its' 2020 edition of U.S. Medical Regulatory Trends and Actions Report. This report is updated every two years and is a valuable resource for boards and others as it details how the 71 medical and osteopathic boards operate and regulate medical professionals.

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

- The FSMB Physician Data Center (PDC) is a central repository for actions taken against physicians and physician assistants by state licensing and disciplinary boards and other national and international regulatory bodies. The PDC notifies querying organizations and state medical boards if the physician of interest has been disciplined, as well as other states in which the physician is licensed. State medical boards queried the PDC 139,329 times in 2020. State boards also continue to successfully collaborate in using the FSMB's Disciplinary Alert Service (DAS) to prevent disciplined physicians with multiple licenses from resuming practice undetected in new locations. In 2020, state boards received 15,213 alerts from the FSMB's DAS.

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

- The FSMB and NBME co-hosted the 14th annual USMLE orientation for current and former members of state medical boards to identify individuals interested in participating with the USMLE. To date, over 200 individuals representing 52 state medical and osteopathic boards have participated in these workshops. Approximately 44% of the individuals have gone on to serve subsequently on a USMLE committee, workgroup or standard-setting panels.
- The State Board Advisory Panel to USMLE, which consists of representatives from 10 state boards, provided guidance to FSMB and NBME staff on issues impacting the program.
- Twenty-five representatives from 18 state medical boards participated in the USMLE program in 2020, including service on item-writing committees, advisory or standard-setting panels, governance committees, and task forces.

- The USMLE program has continued to increase its use of social media to supplement and strengthen communication and outreach via the USMLE website. The USMLE Facebook, Twitter and LinkedIn accounts help the program reach and communicate with the more than 100,000 individual examinees taking the USMLE each year, as well as medical educators at both the undergraduate and graduate levels and members of the state medical board community.
- In March 2020, the FSMB issued its first quarterly update on USMLE as part of ongoing educational outreach efforts to state medical boards. Updates are distributed to state boards via email every quarter (March, June, September, December).
- USMLE program staff from the FSMB and the NBME hosted two webinars with state medical boards in 2020 to discuss upcoming USMLE policy changes and the impact of the COVID-19 pandemic on USMLE.
- In 2020, the FSMB and NBME announced upcoming changes to the USMLE program: changing Step 1 score reporting from a three-digit numeric score to reporting only pass/fail (implementation no earlier than 2022); and reducing the allowable number of exam attempts on each Step or Step Component from six to four (implementation no earlier than July 2021).
- The COVID-19 pandemic significantly impacted USMLE testing in 2020, including the suspension of all computer-based examinations at Prometric testing centers from mid-March through May 1.
- Following the May 2020 suspension of Step 2 CS due to the COVID-19 pandemic, the FSMB and NBME announced their intention to take 12-18 months to bring back a modified USMLE Step 2 Clinical Skills (CS) exam that was appreciably better than the prior assessment. After reviewing current and anticipated progress with the exam and in consideration of the rapidly evolving medical education, practice and technology landscapes, the FSMB and NBME decided in January 2021 to discontinue Step 2 CS. While there are no plans to bring back Step 2 CS, the intent is to take this opportunity to focus on working with colleagues in medical education and at the state medical boards to determine innovative ways to assess clinical skills.
- In 2020, the FSMB's *Journal of Medical Regulation* (JMR) included an article about irregular behavior in connection with the USMLE titled, "Characteristics and Outcomes of Individuals Engaging in USMLE Irregular Behavior, 2006-2015." The article reviews data about individuals who engaged in irregular behavior, common sanctions taken against them and their ability to ultimately obtain licensure.

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

- An updated SPEX exam was implemented in January 2019. The changes made to SPEX help ensure that the exam continues to be relevant to current standards of practice. Specific improvements included an update of the exam blueprint, an update of the item pool (i.e., new test forms and questions), and implementation of new item formats (e.g., drug ads and abstracts). The exam was also shortened by 2.5 hours (from 8.5 hours to 6 hours) to better accommodate physicians' busy schedules. Work to refresh the exam will commence again in 2021.
- Representatives from the Iowa and Hawaii boards served on the SPEX Oversight Committee in 2020.

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

- *FSMB eNews* is distributed twice weekly to more than 5,000 individuals in the medical regulatory community and individuals interested in medical regulation, with updates on FSMB, state medical board activities, and breaking health care news.
- The *Journal of Medical Regulation (JMR)*, the FSMB's peer-viewed, quarterly journal, published articles during 2020 that illuminated various issues of interest to medical boards. *JMR* continued a new initiative to raise the publication's visibility and improve its accessibility to both readers and researchers, including the new JMR Podcasts series, which features interviews with authors

of select published JMR articles discussing what spurred their interest in the research topic and the importance of the findings for medical regulators.
- Staff completed data mapping work and the migration of FSMB's Library InMagic database platform to a new system (Genie Plus) that will enable staff to create new knowledge repositories more quickly and easily with custom metadata structures and retrieve information for staff, state medical boards and other organizations.
- The FSMB educates the public and policymakers on the work of FSMB and state medical boards by distributing press releases announcing policy updates, new FSMB publications and special reports, and hosting educational events such as the Annual Meeting.
- The FSMB is frequently contacted by members of the U.S. and international media to comment on, and be interviewed for, stories related to medical regulation. In the past year, FSMB communications and senior staff have spoken to dozens of reporters and members of the media and the FSMB has been mentioned in more than 1,400 news stories.

Goal II: Advocacy and Policy Leadership

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

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

- FSMB met with federal agencies and Congressional offices to answer questions about the importance of state-based licensure and verification processes, tracked major COVID-19 legislative packages passed by Congress, and provided state medical boards with legislative updates.
- FSMB's BOD participated in a Virtual Hill Day in September 2020, meeting with over 35 Congressional Offices to discuss issues of importance to state medical boards during COVID-19.
- FSMB submitted a comment on the *Department of Veterans Affairs Interim Final Rule - Authority of VA Professionals to Practice Health Care*, highlighting the importance of ensuring that veterans receive the same level of quality care and appropriate regulatory oversight as the general public, through robust reporting standards and appropriate training. The FSMB also asked for clarification regarding the process that will be used to develop the "National Standards of Practice" for practitioners within the VA.
- The FSMB continued outreach to the Administration, including the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), Department of Defense (DOD), and the Drug Enforcement Administration (DEA).
- FSMB's *Advocacy Alert* E-Newsletter provides regular updates on federal and state legislative and regulatory activity and includes occasional "calls to action" in support/opposition to legislation.
- FSMB provided legislative and research assistance to many member boards and organizations on various issues, including camp doctor licensure, occupational licensure reform, prescription drug monitoring programs, the Interstate Medical Licensure Compact, telemedicine, state death certificate programs, medical malpractice and licensure, opioid prescribing for chronic pain, residency training licenses, public information and data sharing, criminal background checks, medication-assisted treatment, and locum tenens license applications.
- The FSMB regularly responds to information requests from state medical boards, professional associations and government agencies, as well as international medical regulatory entities.

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

- The *Evaluating Disparities and Outcomes of Telehealth During the COVID-19 Emergency Act of 2020 (EDOT Act)* would require CMS to report on the effects of changes made during COVID-19

on telehealth services in Medicare. This report would include information on utilization rates, services provided, geographic data, and demographic characteristics of beneficiaries utilizing telehealth.

- The *KEEP Telehealth Options Act* would require HHS and GAO to conduct studies of telehealth use and outcomes in Medicare, Medicaid and CHIP during the coronavirus emergency.
- The *Coronavirus Health Care Worker Wellness Act* would make grants to health care providers establishing or expanding programs supporting mental wellness of their workers on the front lines of COVID-19 and authorize a comprehensive study by HHS on health care worker mental health and burnout, including an assessment of the impact of the COVID-19 crisis.
- The *Dr. Lorna Breen Health Care Provider Protection Act* would address high levels of mental and physical stress and burnout in the healthcare workforce through grants for training healthcare professionals in evidence-informed strategies to reduce and prevent suicide, burnout, mental health conditions, and substance use disorders, encouraging those at risk to seek support and treatment, and requiring a comprehensive study on health care professional mental and behavioral health and burnout.
- The FSMB continued to advocate for antitrust damages relief, supporting the introduction of *The Occupational Licensing Board Antitrust Damages Relief Act of 2020*, which would provide antitrust damages relief to state boards, their members and staff if the board meets certain requirements, including: operating under a state law that requires an occupational license for the occupation regulated by the board, specifies the qualifications for the license, and requires that professional and ethical standards be met; has all members of the board appointed by the state's chief executive officer, the legislature, or other designated elected state officer; includes members of the public who are not market participants in the regulated profession; and provides mechanisms allowing people aggrieved by the board to contest its actions including judicial review.

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

- The FSMB created the Artificial Intelligence Taskforce after recognizing the need to study the regulatory structures necessary for the use of AI in a clinical setting without sacrificing patient safety. The Taskforce provides educational resources to state boards and the public that focus on emerging technologies that may impact the practice of medicine and safe delivery of care, including a dedicated resource website at fsmb.org/ai.
- In response to the COVID-19 pandemic, the FSMB mobilized its data and advocacy resources to assist state medical boards and the public with staying informed on emergency regulatory changes and efforts to address workforce needs. The FSMB engaged with federal and state authorities, individual state medical boards, and representatives of the medical regulatory community to ensure information regarding state medical licensure is timely and accurate. Important information and resources, including a chart of state-by-state emergency declarations and licensing waivers, is updated on the FSMB's COVID-19 website created for use by individual state medical boards and the public. To date, the FSMB's COVID-19 website has been visited more than 70,000 times.

Goal III: Collaboration

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

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

- The FSMB Member Medical Board application of the Medical Licensure Commission of Alabama was approved by the FSMB Board of Directors in February 2020, which raises the FSMB's total membership from 70 state medical and osteopathic boards to 71.
- The FSMB Affiliate Member application of the Texas Physician Assistant (PA) Board was approved by the FSMB Board of Directors in February 2020. The Texas PA Board joins the PA boards from Tennessee and Arizona, as well as the Federation of Medical Regulatory Authorities of Canada (FMRAC), as an Affiliate Member of the organization.
- FSMB continues its long-time collaborative efforts with the National Board of Medical Examiners (NBME) through ongoing programs supporting state medical board needs, such as the United States Medical Licensing Examination (USMLE), the Special Purpose Examination (SPEX) for physicians who are already licensed, and the Post-Licensure Assessment System (PLAS), which provides diagnostic tools for evaluating the ongoing competence of currently or previously licensed physicians.
- The FSMB maintains communications with health policy representatives from the American Medical Association (AMA), the American Osteopathic Association (AOA), and the American Academy of Physician Assistants, as well as representatives of state governments, including the Council of State Governments (CSG), the National Conference of State Legislatures (NCSL), and associations of professional licensing boards.
- The FSMB continues to work closely with the Federation of State Physician Health Programs through regular communications, as well as a joint research project aimed at examining referral data from state physician health programs and comparing these across states based on licensing processes.
- The FSMB continues to work with the National Academy of Medicine (NAM) to support two action collaboratives (one on clinician wellness, and the other on the opioid epidemic).
- The FSMB participates in several distinguished health care organizations and coalitions, including, the Coalition for Physician Accountability and the Professional Licensing Coalition.
- The FSMB provides support to the ABMS as it continues to implement the recommendations of its Vision Commission to evolve the framework for specialty certification in the U.S. Members of the FSMB Board of Directors have presented and participated in discussions about the importance of medical professionalism, patient safety and continued competence.

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

- The FSMB is a founding member of the International Association of Medical Regulatory Authorities (IAMRA) and continues to serve as the organization's Secretariat.
- FSMB President and CEO Dr. Humayun Chaudhry serves as Secretary of IAMRA.
- Representatives of the FSMB serve on various IAMRA committees, including the IAMRA Membership and Programs Committee, the Physician Information Exchange Working Group, and the Research Working Group.
- The FSMB continued to engage in collaborative activities with international medical regulatory authorities and education accreditation organizations and consortia, including the International Academy for CPD Accreditation and International Society for Quality in Health Care.
- The *Journal of Medical Regulation* continues to solicit submissions from authors addressing international regulatory concerns.

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

- The FSMB continues to work closely with its partners from the CME community in the U.S., including the organizations that are responsible for accreditation of CME providers, as well as accreditation and certification of CME activities.
- The FSMB provided in-kind support to the Coalition for Physician Enhancement (CPE). CPE is an organization representing programs and individuals responsible for the assessment and

remediation of physicians in both the U.S. and Canada. The services of many of CPE's organizational members are often used by state medical boards to support decisions about re-entry to practice and remedial practice pathways for licensees.

Goal IV: Education

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

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

- Upon cancellation of the in-person 2020 Annual Meeting, the FSMB launched a virtual educational learning hub on July 14, 2020, with the first of six educational webinars. All six (6) live webinars were recorded as on-demand internet activities and were accredited for *1.0 AMA PRA Category 1 Credit™*.
- On January 14, 2021, the FSMB hosted a special online event with renowned epidemiologist, Michael Osterholm, PhD, MPH**.** Dr. Osterholm, who was recently appointed to President Biden's 13-member transition COVID-19 Advisory Board, shared his perspective on the national response to the pandemic and what 2021 may have in store.
- On January 26, FSMB hosted a virtual symposium titled *Health Equity and Medical Regulation: How Disparities are Impacting U.S. Health Care Quality and Delivery – and Why It Matters*. During this three-hour virtual event, guest speakers addressed the impact of racism and implicit bias on health disparities and the need for change to eliminate barriers to access to quality care for at-risk communities.

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

- Since becoming an accredited CME provider through the ACCME in 2016, the FSMB has educated more than 14,000 physician and non-physician learners.
- On March 22, 2021, the FSMB received full Re-Accreditation status with the Accreditation Council for Continuing Medical Education (ACCME.) FSMB will be an accredited CME provider for another four (4) years, through March 2025.
- With guidance from the Accreditation Council on Continuing Medical Education (ACCME), the CME program worked actively to facilitate the transformation of mostly live activities into completely virtual events. Despite the shift in learning formats, in 2020, FSMB's CME program accredited a total of 30 activities including 16 live courses via the internet and 14 online, enduring activities for a total of 41 *AMA PRA Category 1* credit hours.
- In 2020, FSMB partnered with the Washington Medical Commission to provide sixteen (16) live and on-demand accredited CME activities on a variety of important topics.

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

- FSMB's monthly Roundtable Webinars during 2020-21 addressed issues of interest to the medical board community, including several special online forums for FSMB staff and state medical and osteopathic boards to share the various approaches being taken by regulators in response to the unfolding COVID-19 pandemic; an overview of the FSMB's Workgroup on Physician Sexual Misconduct's final report; and updates on changes to the USMLE and COMLEX licensing exams.

Goal V: Data and Research Services

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

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

- FSMB continues to improve efficiencies and customer satisfaction by implementing a series of system enhancements throughout its technical infrastructure.
- FSMB continues to make major investments in technology and a system-wide integration of its previously diverse data systems into a single, integrated enterprise.
- The FSMB is working to match and integrate Medical Identification Number of Canada (MINC) to FSMB data to facilitate information sharing with Canadian provinces.
- August 2020 marked the first time in FSMB history that it received and loaded a licensure data file from each of the U.S. and Puerto Rico boards in a single month.

To support state medical boards and FSMB employees during the pandemic, the FSMB was involved with several different data and survey projects related to COVID-19, including 1) assisting state medical boards with vetting more than 12,000 practitioners who had "hard to match" records in an effort to help several state medical boards issue either limited or temporary licenses to physicians to see patients during COVID-19; 2) estimating the count of active, retired and inactive physician licenses in the U.S. as a way to capture physician capacity during the pandemic; and 3) hosting an online survey to state boards on physician complaints and telemedicine to help measure quality of care during the pandemic. Internally, the FSMB conducted a Gallup survey to FSMB employees to help measure employee engagement, diversity and COVID-19 response as an intentional, yet anonymous way to check-in with and support employees during the pandemic.

The FSMB received a $2.5 million grant from the U.S. Health Resources and Services Administration, Coronavirus License Portability Grant Program funded under the Coronavirus Aid, Relief and Economic Security (CARES) Act, to provide resources and a technical platform (ProviderBridge.org) to support the mobilization of health care professionals during the COVID-19 pandemic and future public health emergencies.

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

- In a national survey of state medical board executive directors conducted by the FSMB, boards ranked what they considered the five most important topics to the regulatory community in 2020. Opioid prescribing was the most frequently cited topic, followed by physician sexual misconduct and physician wellness and burnout.
- The FSMB revamped the Medical Regulatory Trends and Actions Report. Medical regulatory data at the state level is now collected through an online survey to help with boards to more conveniently update their data. Disciplinary and license data from this report will now be published on FSMB's website.
- With colleagues from the American Board of Surgery (ABS), FSMB authors published findings in *JAMA Surgery* on the association between ABS certified physicians and receiving fewer severe actions from boards than non-ABS certified physicians.
- In conjunction with the American Board of Anesthesiology, Mayo Clinic, Stanford University and The University of Chicago, the FSMB contributed to a manuscript published in *Anesthesia and Analgesia* examining the demographic shifts among U.S. anesthesiologists between 30 and 59 years of age who possessed an active medical license between 2005 and 2015.

- The FSMB published a manuscript in the *Journal of Medical Regulation* looking at the demographic, examination, sanction and licensure outcome data of individuals who had irregular behavior associated with the USMLE.

The FCVS provides a centralized, uniform process for state medical boards to obtain a verified, primary-source record of a physician and physician assistant's core medical credentials. As part of FSMB's response to the Coronavirus pandemic in March 2020, FSMB all team members were moved to Remote Work from Home:

- Overall Cycle time for 2020 is 19 days vs. 17 days in 2019. This can be attributed to the delay caused by the transition to remote work due to the pandemic for many of our strategic partners and institutions.
- Overall Customer Satisfaction ratings for 2020 were at 87% Satisfaction, vs. 90% in 2019. Cycle time was also higher over the previous year for 9 out of 12 months.
- In 2020, FCVS delivered a total of 64,915 profiles, of which 59,588 were specifically delivered to state medical boards. This represents an 18% increase over 2019.
- Twenty-one state medical boards now participate in the optional service to systematically add an NPDB report to the FCVS profile. This feature reduces steps in the licensure process for both member boards and physicians.
- Both Arkansas and Louisiana are now accepting the FCVS processes for Physician Assistants in their states, for a total for 42 states who require or accept FCVS as part of the Physician Assistant licensure process.
- FCVS implemented a Robot (RPA) to assist with processing rote tasks that do not require extensive human oversight, which has improved overall processing time. Other opportunities are also being identified to utilize this tool, which can process 24/7, seven days a week if needed.
- With the addition of Live Chat to our Customer Support services, year over year (2020 vs. 2019) total call volume decreased by 8% for a total of 51,252 inbound calls. A total of 8,715 Live Chats sessions have been executed, which is 300+% increase. Since inception, we are now experiencing 100+ chats per week with at an average of 13 minutes each. The longest chat averages were 15-21 minutes in March-June 2020. As in the previous year, the primary chat topic continues to be centered around profile status updates.

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

- The UA has been adopted by 28 state boards. Both Alabama and Maryland now require the UA as part of their medical licensure process. The functionality has also been adopted by six state boards for Physician Assistants.
- Over 19,000 applications were processed in 2020 which represents 10.5% increase in applications over 2019.

FSMB's Closed Residency Programs service provides ongoing storage of training records for physicians who attended a training program that no longer exists. There are 55 programs and 200+ specialties stored in our closed program process inventory. This is an important service for those physicians and state medical boards. This service has transitioned to a digital collection format, away from the historic use of paper and completion of unique verification requests.

- Four additional programs were onboarded through the digital collection format in 2020.
- A third-party portal replaced email inquiries this past year, to allow entities to query and purchase training verifications from our current Closed Program repository.
- We have processed 306 secure digital closed program verifications for physicians, who can use this portable verification for employment or privileging.

Goal VI: Organizational Strength and Excellence

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

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

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

Treasurer's Report

It goes without saying that the past year has proved to be very unusual for the FSMB as well as most other organizations around the world. However, I am proud to say that despite the interruption of many facets of daily life, including those of health care providers and State Medical Boards, FSMB and its staff adapted quickly so that services critical to the functions of licensing and discipline could continue without major disruption.

FSMB Staff was deployed from the office to 'Work from Home' in March 2020, and with the exception of a small on-site crew, has continued to deliver service to State Medical Boards, physicians, and others from remote locales. Despite considerable headwinds confronting FSMB, results of operations for FY2020 were similar to recent years.

Evidence of the organization's healthy performance over the past two years was noted in the Auditor's "Report and Financial Statements for Fiscal Years ended April 30, 2020 and 2019", which is provided under **Attachment 1**. In this report, accounting firm Clifton+LarsonAllen issued an opinion that the consolidated financial statements presented fairly the financial position of FSMB in all material respects. This report was reviewed and approved by the Audit Committee in October 2020, then was accepted by the FSMB Board of Directors later that month.

The FY2021 Budget (for the period May 1, 2020 through April 30, 2021) was developed over several months, beginning with work by Staff and the Finance Committee, and ultimately approved by the Board of Directors in February 2020 and the House of Delegates in April 2020.

Though the pandemic was raging, the decision was made that the budget should *not* be adjusted prior to the House of Delegates meeting in April 2020 due to the future uncertainties caused by the unpredictable COVID environment and knowing that there would likely be some impact to revenue over the course of the year that could spill over into future periods.

In last year's Report of the Treasurer, I noted that "*COVID-19, social distancing, shelter-in-place, and the interruption of many aspects of life will have an impact on revenue in FY2021 which begins May 1, 2020. It remains unknown at this time whether the impact will be a simple matter of timing within the year, or if lower revenue will be realized due to interruption of normal medical education, examination, and state licensing routines*." The organization successfully navigated the waters during this period, and continues to generate conservatively healthy results, but we remain in a period of uncertainty as to when medical education, examinations, and state licensing routines will return to normal.

Through three quarters of FY2021, revenue is off by 5%, expenses have been trimmed by 5%, and results of operations lag a little behind budget. FY2021 'Actual' performance compared to 'Budget' through three quarters (May 1, 2020–January 31, 2021) is included under **Attachment 2**. All segments of FSMB's operations remain strong and examinations are expected to pre-pandemic levels in the years ahead.

The Investment Committee, working and meeting regularly with the Investment Advisor, developed and deployed an investment policy that is conservative and defensive in nature, and

consistent with organization's long-term strategic plan. This approach has served the organization well. When the market fell considerably in February 2020, FSMB stayed the course and had recovered 80% of the losses prior to fiscal year end at April 30, 2020. Investment performance in Fiscal Year 2021, which began May 1 of 2020, has been very healthy, as the market has climbed to historic highs. (also noted in **Attachment 2**).

Our Chief Financial Officer, Staff, the Finance Committee, and the BOD approached the budget similarly this year. We anticipate that FCVS and the Physician Data Center will remain steady and strong, and we expect examination volumes to return to historic norms. The Budget for FY2022 is provided under **Attachment 3** for the House of Delegates' consideration.

As was also stated last year, the CFO, Staff and the Board of Directors will continue to monitor the situation carefully and will adjust fiscal decisions, as necessary, to ensure FSMB's ability to continue providing critical services to State Medical Boards, the medical community, and the public.

As I wrap up my three year term as Treasurer of the FSMB, I would like to thank each member of the Finance, Investment, and Audit Committees, FSMB management, the Board of Directors, and the House of Delegates for allowing me and the Accounting/Finance team to serve you.

I have had the honor and pleasure of working with three Finance Committees, three Investment Committees and three Audit Committees. Our Chief Financial Officer, Todd Phillips is exceptional as is our Director of Finance and Accounting, Keith Clark. Their staff is top notch. Thank you to the three Chairs I worked with during my term, Doctors Pat King, Scott Steingard (to whom I am especially appreciative for convincing me to seek appointment to the Arizona Osteopathic Board and for introducing me into Federation leadership), and Dr. Cheryl Walker-McGill. All the best to the incoming chair, Dr. Ken Simmons.

I leave you in exceptional hands as our incoming treasurer, my good friend, Dr. Jone Geimer-Flanders, will serve you well.

Madam Chair, that concludes my report.

Respectfully submitted,
Jerry G. Landau, JD
FSMB Treasurer

ITEM FOR ACTION:

APPROVE the proposed FY2022 Budget (ATTACHMENT 3) as recommended by the FSMB Finance Committee and Board of Directors.

Attachment 1

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

CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION WITH INDEPENDENT AUDITORS' REPORT

YEARS ENDED APRIL 30, 2020 AND 2019

FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC. AND SUBSIDIARY
TABLE OF CONTENTS
YEARS ENDED APRIL 30, 2020 AND 2019

CliftonLarsonAllen LLP
CLAconnect.com

INDEPENDENT AUDITORS' REPORT

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

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Federation of State Medical Boards of the United States, Inc. and Subsidiary (Federation of State Medical Boards Research and Education Foundation), which comprise the consolidated statements of financial position as of April 30, 2020 and 2019, and the related consolidated statements of activities, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Federation of State Medical Boards of the United States, Inc. and Subsidiary (Federation of State Medical Boards Research and Education Foundation) as of April 30, 2020 and 2019, and the changes in their net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

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

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Fort Worth, Texas
October 20, 2020

FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC. AND SUBSIDIARY CONSOLIDATED STATEMENTS OF FINANCIAL POSITION APRIL 30, 2020 AND 2019

	2020	2019
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	$ 17,438,246	$ 11,894,389
Accounts Receivable:		
Disciplinary Searches	225,463	361,567
Other	288,785	164,499
Prepaid Expenses	895,141	895,115
Other Assets	150,455	25,779
Total Current Assets	18,998,090	13,341,349
NONCURRENT ASSETS		
Investments	33,958,258	39,080,588
Prepaid Expenses	35,613	27,868
Property and Equipment, Net	9,005,458	8,770,956
Total Noncurrent Assets	42,999,329	47,879,412
Total Assets	$ 61,997,419	$ 61,220,761
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable	$ 1,997,135	$ 3,900,286
Unearned Revenue - USMLE and SPEX	12,278,282	12,376,923
Deferred Compensation	1,107,140	1,621,854
Capital Lease Payable	-	13,289
Total Current Liabilities	15,382,557	17,912,352
NET ASSETS		
Without Donor Restrictions:		
Board-Designated Endowment	2,563,456	2,561,788
Undesignated	44,051,406	40,746,621
Total Net Assets	46,614,862	43,308,409
Total Liabilities and Net Assets	$ 61,997,419	$ 61,220,761

See accompanying Notes to Consolidated Financial Statements.

FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC. AND SUBSIDIARY CONSOLIDATED STATEMENTS OF ACTIVITIES YEARS ENDED APRIL 30, 2020 AND 2019

	April 30, 2020			April 30, 2019		
		Unaudited			Unaudited	
			Variance			Variance
	Without Donor Restrictions	Budget	Favorable (Unfavorable)	Without Donor Restrictions	Budget	Favorable (Unfavorable)
REVENUES AND GAINS						
Examination Revenue - USMLE	$ 28,551,945	$27,583,330	$ 968,615	$ 27,769,615	$26,436,800	$ 1,332,815
Examination Revenue - PLAS	139,100	156,000	(16,900)	149,500	234,000	(84,500)
Transfer Fees - USMLE	(20,621,375)	(19,859,998)	(761,377)	(20,219,655)	(19,298,864)	(920,791)
Transfer Fees - PLAS	(86,433)	(150,000)	63,567	(118,000)	(225,000)	107,000
Subtotal	7,983,237	7,729,332	253,905	7,581,460	7,146,936	434,524
Examination History Reports	6,980,153	6,500,000	480,153	6,687,642	6,334,000	353,642
Other Exam Revenue	958,160	904,088	54,072	985,415	851,627	133,788
Physician Data Center	1,552,518	1,701,400	(148,882)	1,789,713	1,635,945	153,768
Registration Fees	4,480	134,450	(129,970)	131,215	134,300	(3,085)
FCVS Revenue	10,980,381	8,861,916	2,118,465	9,907,611	9,029,496	878,115
Member Dues	177,025	175,275	1,750	173,675	174,775	(1,100)
Shipping and Handling Fees	64,300	76,000	(11,700)	73,075	82,500	(9,425)
Grants and Contributions	228,049	-	228,049	300,306	-	300,306
Interest and Dividends	1,327,722	560,000	767,722	1,024,426	500,000	524,426
Net Investment Gain (Loss)	(3,515,696)	(160,200)	(3,355,496)	1,011,325	(144,000)	1,155,325
Loss on Sale of Fixed Assets	(8,244)	-	(8,244)	(25,496)	-	(25,496)
Other Revenue	832,323	515,250	317,073	537,793	312,500	225,293
Total Revenues and Gains	27,564,408	26,997,511	566,897	30,178,160	26,058,079	4,120,081
EXPENSES						
Salary and Benefits	15,327,069	16,629,030	1,301,961	15,586,109	16,193,452	607,343
Data Processing	1,177,769	885,507	(292,262)	958,624	909,148	(49,476)
General Office	3,396,458	3,311,441	(85,017)	3,204,897	3,268,717	63,820
Travel and Program	1,254,258	2,082,798	828,540	1,844,230	2,066,436	222,206
Occupancy	1,071,520	936,087	(135,433)	724,871	885,088	160,217
Professional Services and Dues	844,606	734,795	(109,811)	725,533	794,909	69,376
Legislative and Legal	275,807	280,000	4,193	375,510	270,000	(105,510)
Contributions	32,536	-	-	35,000	-	(35,000)
Total Expenses	23,380,023	24,859,658	1,512,171	23,454,774	24,387,750	932,976
CHANGES IN NET ASSETS BEFORE DEPRECIATION	4,184,385	$ 2,137,853	$ 2,079,068	6,723,386	$ 1,670,329	$ 5,053,057
Depreciation	877,932			988,303		
CHANGE IN NET ASSETS	3,306,453			5,735,083		
Net Assets - Beginning of Year	43,308,409			37,573,326		
NET ASSETS - END OF YEAR	$ 46,614,862			$43,308,409		

See accompanying Notes to Consolidated Financial Statements.

FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC. AND SUBSIDIARY CONSOLIDATED STATEMENTS OF CASH FLOWS YEARS ENDED APRIL 30, 2020 AND 2019

	2020	2019
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in Net Assets	$ 3,306,453	$ 5,735,083
Adjustments to Reconcile Change in Net Assets to Net Cash Provided by Operating Activities:		
Depreciation	877,932	988,303
Realized and Unrealized (Gain) Loss	3,313,537	(1,011,325)
Loss on Disposal of Fixed Assets	8,244	25,496
Change in:		
Accounts Receivable	11,818	(214,194)
Prepaid Expenses	(7,771)	(165,899)
Other Assets	(124,676)	46,771
Accounts Payable	(1,903,151)	(339,689)
Unearned Revenue - USMLE and SPEX	(98,641)	900,761
Deferred Compensation	(514,714)	189,845
Net Cash Provided by Operating Activities	4,869,031	6,155,152
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from Sales and Maturities of Marketable Securities	6,560,042	18,534,620
Purchase of Marketable Securities	(4,751,249)	(19,392,526)
Purchases of Property and Equipment	(1,120,678)	(780,443)
Net Cash Used by Investing Activities	688,115	(1,638,349)
CASH FLOWS FROM FINANCING ACTIVITIES		
Payments on Capital Lease Obligation	(13,289)	(18,531)
Net Cash Used by Financing Activities	(13,289)	(18,531)
NET CHANGES IN CASH AND CASH EQUIVALENTS	5,543,857	4,498,272
Cash and Cash Equivalents - Beginning of Year	11,894,389	7,396,117
CASH AND CASH EQUIVALENTS - END OF YEAR	$ 17,438,246	$ 11,894,389

See accompanying Notes to Consolidated Financial Statements.

FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC. AND SUBSIDIARY NOTES TO CONSOLIDATED FINANCIAL STATEMENTS APRIL 30, 2020 AND 2019

NOTE 1 NATURE OF ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization and History

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

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

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

Principles of Consolidation

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

Use of Estimates

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

Cash and Cash Equivalents

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

Accounts Receivable

The Federation records accounts receivable as services are rendered. An allowance is established for an estimate of any uncollectible accounts. If a receivable is deemed to be uncollectible in full, the entire amount is charged off at that time. No allowance was deemed necessary at April 30, 2020 and 2019.

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
APRIL 30, 2020 AND 2019

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

Investments

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

As of the year ended April 30, 2020, the Federation carries its interests in four investment partnerships at fair value due to the insignificant ownership percentage in each partnership. The underlying investments of these partnerships are comprised primarily of marketable securities and private equity interests for which there is no actively traded market. The estimated fair value of these limited partnership investments is based on valuations provided by the external investment managers. The Federation reviews the estimated values and agrees with the methods and assumptions used in determining the fair value of these alternative investments. Because these alternative investments are not readily marketable and redemption of some amounts is restricted until future years, their estimated value may differ materially from the value that would have been used had a ready market for such investments existed. Unrealized gains or losses on these investments are recorded in the consolidated statements of activities in the year that fluctuations in fair value occur.

Property and Equipment

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

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

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

Deferred Compensation

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

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
APRIL 30, 2020 AND 2019

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

Net Assets

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

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

Net Assets With Donor Restrictions – Net assets subject to donor- (or certain grantor-) imposed restrictions. Some donor-imposed restrictions are temporary in nature, such as those that will be met by the passage of time or other events specified by the donor. Other donor-imposed restrictions are perpetual in nature, where the donor stipulates that resources be maintained in perpetuity. The Federation and the Foundation did not have any net assets with donor restrictions or related activity for the years ended April 30, 2020 and 2019.

Revenue Recognition

The Federation recognizes examination revenue when the test scores are released. Unearned revenues are reflected on the consolidated statements of financial position as deferred revenue. Other program revenues are recognized when the event occurs or services are provided, or when the Federation is entitled to the fee without recourse.

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

Transfer Fees

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

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
APRIL 30, 2020 AND 2019

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

Functional Expenses

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

Contingencies

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

The Federation is currently a defendant in certain litigation arising from normal business activities. Management, with the advice of legal counsel, is of the opinion that the ultimate resolution of these matters will not have a material adverse effect on the consolidated financial statements.

During the year ended April 30, 2020, the World Health Organization declared the spread of Coronavirus Disease (COVID-19) a worldwide pandemic. The COVID-19 pandemic is having significant effects on global markets, supply chains, businesses, and communities. Specific to the Federation, COVID-19 impacted various parts of its 2020 operations and financial results, including, but not limited to, event cancellation and loss of revenue due to reductions in certain revenue streams. Management believes the Federation is taking appropriate actions to mitigate the negative impact. However, the full impact of COVID-19 is unknown and cannot be reasonably estimated as these events have continued and are still developing subsequent to year-end.

Income Taxes

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

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

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

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
APRIL 30, 2020 AND 2019

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

Change in Accounting Principle

In June 2018, FASB issued Accounting Standards (ASU) 2018-08, *Accounting Guidance for Contributions Received and Made*. This ASU was issued to clarify accounting guidance for contributions received and contributions made. The amendments to this ASU assists entities in (1) evaluating whether transactions should be accounted for as contributions (nonreciprocal transactions) within the scope of Topic 958, Not-for-Profit Entities, or as an exchange (reciprocal) transactions subject to other guidance and (2) determining whether a contribution is conditional. There was no impact on the consolidated financial statements from the adoption of this amendment.

On June 3, the FASB issued guidance, Accounting Standards Update (ASU) 2020-05 – Revenue from Contracts with Customers (Topic 606), that defers the effective dates of the revenue standard, Account Standards Codification (ASC) 606, for entities that have not yet issued financial statements adopting the standards. Early adoption is still permitted. The deferrals of this standard is intended to provide relief to nonpublic companies and not-for-profit entities that have had their implementation efforts delayed by the COVID-19 pandemic. As a result, the Federation has elected to defer implementation of ASC 606 to the next year.

Subsequent Events

In preparing these consolidated financial statements, the Federation has evaluated events and transactions for potential recognition or disclosure through October 20, 2020, the date the consolidated financial statements were available to be issued. There were no events or transactions subsequent to year-end requiring recognition or disclosure.

NOTE 2 INVESTMENTS

Investments are comprised of the following at April 30:

	2020	2019
Mutual Funds - Fixed Income	$ 10,866,075	$ 11,759,701
Mutual Funds - Equity	13,754,279	17,179,201
Stocks	7,518,702	8,228,814
Absolute Return Investments	6,929	59,376
Private Equity	1,750,715	1,853,496
Real Estate	61,558	-
Total	$ 33,958,258	$ 39,080,588

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
APRIL 30, 2020 AND 2019

NOTE 3 FAIR VALUE MEASUREMENTS

The Federation categorizes its financial instruments, based on the priority of the inputs to the valuation technique, into a three-level fair value hierarchy. The fair value hierarchy gives the highest priority to quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). If the inputs used to measure the financial instruments fall within different levels of the hierarchy, the categorization is based on the lowest level input that is significant to the fair value measurement of the instrument.

Financial assets and liabilities recorded on the consolidated statements of financial position are categorized based on the inputs to the valuation techniques as follows:

Level 1 – Financial assets and liabilities, whose values are based on unadjusted quoted prices for identical assets or liabilities in an active market that the Federation has the ability to access.

Level 2 – Financial assets and liabilities whose values are based on quoted prices in markets that are not active or model inputs that are observable either directly or indirectly for substantially the full term of the asset or liability. Level 2 inputs include the following:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in nonactive markets;
- Pricing models whose inputs are observable for substantially the full term of the asset or liability; and
- Pricing models whose inputs are derived principally from or corroborated by observable market data through correlation or other means for substantially the full term of the asset or liability.

Level 3 – Financial assets and liabilities, whose values are based on prices or valuation techniques that require inputs that are both unobservable and significant to the overall fair value measurement. These inputs reflect management's own assumptions about the assumptions a market participant would use in pricing the asset or liability.

Equity securities and mutual funds listed on a national market or exchange are valued at the last sales price. Such investments are included in Level 1. The Federation elected the fair value option for certain other investments under ASC 825. The Foundation also early adopted the standard on disclosures for investments in certain entities that calculate net asset value (NAV) per share or its equivalent, which removes those investments that calculated NAV per share from the fair value disclosure.

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
APRIL 30, 2020 AND 2019

NOTE 3 FAIR VALUE MEASUREMENTS (CONTINUED)

The following tables present the Federation's fair value for those assets measured at fair value on a recurring basis as of April 30:

	2020			
	Level 1	Level 2	Level 3	Total
Mutual Funds - Fixed Income	$ 10,866,075	$ -	$ -	$ 10,866,075
Mutual Funds - Equity	13,754,279	-	-	13,754,279
Stocks	7,518,702	-	-	7,518,702
Real Estate	61,558	-	-	61,558
Total	32,139,056	-	-	32,200,614
NAV Funds	-	-	-	1,757,644
Total Investments	$ 32,139,056	$ -	$ -	$ 33,958,258

	2019			
	Level 1	Level 2	Level 3	Total
Mutual Funds - Fixed Income	$ 11,759,701	$ -	$ -	$ 11,759,701
Mutual Funds - Equity	17,179,201	-	-	17,179,201
Stocks	8,228,814	-	-	8,228,814
Total	37,167,716	-	-	37,167,716
NAV Funds	-	-	-	1,912,872
Total Investments	$ 37,167,716	$ -	$ -	$ 39,080,588

Fair value measurements of investments in certain funds that calculate net asset value per share (or its equivalent) as of April 30 is as follows:

	2020			
	Net Asset Value	Unfunded Commitments	Redemption Frequency	Notice Period
Absolute Return Investments	$ 6,929	$ -	Quarterly	Quarterly
Private Equity Funds	1,750,715	-	Quarterly	Quarterly
Total	$ 1,757,644	$ -		

	2019			
	Net Asset Value	Unfunded Commitments	Redemption Frequency	Notice Period
Absolute Return Investments	$ 59,376	$ -	Quarterly	Quarterly
Private Equity Funds	1,853,496	-	Quarterly	Quarterly
Total	$ 1,912,872	$ -		

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
APRIL 30, 2020 AND 2019

NOTE 3 FAIR VALUE MEASUREMENTS (CONTINUED)

Absolute Return Funds invests using two primary styles (Event-Driven and Relative Value). Event-Driven strategies typically will include investment in common and preferred equities and various types of debt. Relative Value strategies may include long and short positions in common and preferred equity, convertible securities, and various forms of senior and junior debt. Investment under this style may also include index options, options on futures contracts, and other derivatives.

Private Equity Fund of Funds includes private equity funds that invest primarily in nonpublicly traded companies in need of capital. These funds may vary widely as to sector, size, stage, duration, and liquidity. Certain of these funds may also focus on the secondary market, buying interest in existing private equity funds, often at a discount.

NOTE 4 PROPERTY AND EQUIPMENT

Property and equipment consists of the following at April 30:

	2020	2019
Land	$ 1,540,151	$ 1,540,151
Buildings	9,186,040	8,440,582
Furniture, Fixtures, and Equipment	670,418	642,923
Computer Systems	16,701,734	16,368,622
Total	28,098,343	26,992,278
Less: Accumulated Depreciation and Amortization	(19,092,885)	(18,221,322)
Total Property and Equipment	$ 9,005,458	$ 8,770,956

NOTE 5 BOARD-DESIGNATED ENDOWMENT

In 2009, the Federation contributed $1,000,000 to establish a board-designated endowment. In 2010 the Federation contributed an additional $1,000,000 towards the board-designated endowment. In 2017, the Foundation moved an additional $221,000 to the board-designated endowment. Earnings from the board-designated endowment are to be used as deemed necessary in support of the Foundation's mission to undertake educational and scientific research projects designed to expand public and medical professional awareness and knowledge of challenges impacting health care and health care regulation in order to create stronger and more effective medical licensure and regulation.

The Foundation is subject to the enacted version of the Uniform Prudent Management of Institutional Funds Act of 2006 (UPMIFA) and is required to make disclosures about endowment funds, both donor-restricted endowment funds and board-designated endowment funds.

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
APRIL 30, 2020 AND 2019

NOTE 5 BOARD-DESIGNATED ENDOWMENT (CONTINUED)

Endowment Investment and Spending Policies

The Federation has adopted investment and spending policies for endowment assets that seek to provide a predictable stream of funding to programs supported by its endowment while maintaining the purchasing power of the endowment assets. The Federation's spending and investment policies work together to achieve this objective. Actual returns in any given year may vary from this amount.

To achieve its investment objectives over long periods of time, the Federation has adopted an investment strategy that invests in fixed income securities, equity securities, mutual funds, and alternative investments. The primary performance objective is to achieve an annualized total rate of return, net of investment fees, that is equal to or greater than 6.5% over long periods of time.

The Federation's policy for the use of endowment funding is a spending formula based on an amount approved for appropriation each year by the board of directors. In establishing this policy, the Federation considered the long-term expected return on its endowment. At no time will the distributions reduce the value of the endowment below the endowment contributions.

Endowment net asset composition by type of fund as of April 30, 2020 and 2019 is as follows:

	Without Donor Restrictions
Endowment Fund Balance, April 30, 2019	$ 2,561,788
Additions	-
Earnings and Expenses:	
Investment Income	5,238
Investment Expenses	(2,558)
Unrealized and Realized Gains	(1,012)
Total Earnings and Expenses	1,668
Appropriations	-
Endowment Fund Balance, April 30, 2020	$ 2,563,456

	Without Donor Restrictions
Endowment Fund Balance, April 30, 2018	$ 2,467,504
Additions	-
Earnings and Expenses:	
Investment Income	19,933
Investment Expenses	(7,927)
Unrealized and Realized Gains	236,778
Total Earnings and Expenses	248,784
Appropriations	(154,500)
Endowment Fund Balance, April 30, 2019	$ 2,561,788

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
APRIL 30, 2020 AND 2019

NOTE 6 CAPITAL LEASE

In January 2015, the Federation began leasing equipment under a capital lease obligation which expired in the year ended April 30, 2020. The Federation exercised the lease's purchase option at expiration. Assets leased under such capital lease obligations and included in property and equipment are as follows at April 30:

	2020	2019
Equipment	$ 83,063	$ 83,063
Less: Accumulated Depreciation	(83,063)	(71,912)
Assets Under Capital Lease, Net	$ -	$ 11,151

Included in depreciation expense for the years ended April 30, 2020 and 2019 was $11,151 of amortization expense for assets under capital lease.

NOTE 7 OPERATING LEASE

The Federation leases space in Washington, D.C., for lobbying and administrative purposes under the terms of a 12-month noncancelable operating lease beginning on December 1, 2019. The Federation also leases equipment under a noncancelable operating lease ending in September 2024. Future minimum rental payments due under the leases are as follows:

Year Ending April 30,	Amount
2021	$ 107,136
2022	2,130
2023	2,130
2024	888
2025	-
Total	$ 112,284

Rental expense totaled $164,366 for the year ended April 30, 2020.

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
APRIL 30, 2020 AND 2019

NOTE 8 FINANCIAL INSTRUMENTS AND CONCENTRATION OF CREDIT RISK

Financial instruments, which potentially subject the Federation to concentrations of credit risk, are cash and cash equivalents and investments. The Federation places its cash with high-credit quality financial institutions and periodically maintains deposits in amounts which exceed FDIC insurance coverage. Management does not believe the Federation is exposed to any significant credit risk on cash and cash equivalents.

The Federation's marketable securities primarily consist of investments in mutual funds, equity collective funds, stocks, absolute return investment, among others. Management believes diversity within the portfolio avoids significant concentration of credit risk with respect to these investments.

The Federation currently has investments in three limited partnerships, which are not considered material to these consolidated financial statements as of April 30, 2020. These investments are carried at fair value, and in total amount to less than 5% of total assets.

NOTE 9 RETIREMENT AND DEFERRED COMPENSATION PLANS

The Federation has a defined contribution plan, which covers substantially all of its employees. The plan allows for employee contributions and discretionary matching contributions by the Federation, as well as discretionary profit sharing contributions. Contributions by the Federation to this qualified, defined contribution plan were $1,632,049 during 2020 and $1,462,797 during 2019, and are included in Salary and Benefits expense in the consolidated statements of activities.

The Federation sponsors nonqualified deferred compensation plans for certain key executives. The plans provide for payment upon retirement, death, or disability based on the amounts contributed to the plans adjusted by investment gains or losses. Benefits vest over a five-year period or upon termination without cause. Compensation expense related to these plans amounted to $77,689 and $66,814 during 2020 and 2019, respectively, and is included in Salary and Benefits expense in the consolidated statements of activities.

NOTE 10 COMMITMENTS

Hotel Commitments

The Federation has entered into hotel agreements to provide for room accommodations for its future meetings. These agreements contain clauses that provide for the loss of revenue to the hotel in the event of cancellation or nonperformance by the Federation. At April 30, 2020, the potential liability to the Federation is approximately $366,326 for meetings contracted through fiscal year 2021. Based on prior performance, management believes the likelihood of cancellations to be remote.

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
APRIL 30, 2020 AND 2019

NOTE 11 FUNCTIONAL EXPENSES

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

	2020											
			Program									
	Total Expenses	Administration	Member Services	Governance	Other Initiatives	Examination Services	Uniform Application	FCVS	Physician Data Center	Information Services	FSMB Foundation	Total Program
Salary and Benefits	$ 15,327,069	$ 4,753,352	$ 534,560	$ -	$ -	$ 1,218,630	$ 87,938	$ 4,485,703	$ 1,229,442	$ 3,017,444	$ -	$ 10,573,717
Data Processing	1,177,769	88,857	56,040	-	-	14,389	-	159,558	13,630	845,295	-	1,088,912
General Office	3,396,458	651,077	85,752	260,568	241	882,172	14,141	1,214,754	119,474	166,886	1,393	2,745,381
Travel and Program	1,254,258	179,424	276,409	573,449	29,712	116,042	-	27,814	12,695	27,378	11,335	1,074,834
Occupancy	1,071,520	816,230	6,778	-	-	15,473	-	131,012	29,576	72,451	-	255,290
Professional Services and Dues	844,606	280,990	280,131	34,549	-	21,614	-	186,753	6,731	30,862	2,976	563,616
Legislative and Legal	275,807	143,744	132,063	-	-	-	-	-	-	-	-	132,063
Contribution	32,536	-	-	5,000	-	-	-	-	-	-	27,536	32,536
Depreciation	877,932	265,648	54,118	-	-	89,491	4,027	244,825	55,689	164,134	-	612,284
Total	$ 24,257,955	$ 7,179,322	$ 1,425,851	$ 873,566	$ 29,953	$ 2,357,811	$ 106,106	$ 6,450,419	$ 1,467,237	$ 4,324,450	$ 43,240	$ 17,078,633

	2019											
			Program									
	Total	Administration	Member Services	Governance	Other Initiatives	Examination Services	Uniform Application	FCVS	Physician Data Center	Information Services	FSMB Foundation	Total Program
Salary and Benefits	$ 15,586,109	$ 5,341,277	$ 432,941	$ -	$ -	$ 1,177,600	$ 85,908	$ 4,588,054	$ 1,113,035	$ 2,847,296	$ -	$ 10,244,832
Data Processing	958,624	65,773	63,898	540	-	11,123	-	72,327	13,319	731,644	-	892,851
General Office	3,204,897	617,843	71,579	254,119	286	871,023	13,343	1,128,914	107,202	132,478	8,110	2,587,054
Travel and Program	1,844,230	201,884	848,312	457,595	131,110	106,898	-	30,125	6,272	21,185	40,849	1,642,346
Occupancy	724,871	430,653	7,169	-	-	16,365	-	162,778	31,280	76,626	-	294,218
Professional Services and Dues	725,533	289,045	289,429	28,080	-	355	-	54,241	250	46,229	17,904	436,488
Legislative and Legal	375,510	348,922	26,588	-	-	-	-	-	-	-	-	26,588
Contribution	35,000	-	-	-	-	-	-	-	-	-	35,000	35,000
Depreciation	988,303	325,775	75,909	-	-	95,256	4,330	263,359	55,467	168,207	-	662,528
Total	$ 24,443,077	$ 7,621,172	$ 1,815,825	$ 740,334	$ 131,396	$ 2,278,620	$ 103,579	$ 6,299,798	$ 1,326,825	$ 4,023,665	$ 101,863	$ 16,821,905

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
APRIL 30, 2020 AND 2019

NOTE 11 FUNCTIONAL EXPENSES (CONTINUED)

As reported above, certain categories of expenses are attributed to more than one program or supporting function. Therefore, expenses require allocation on a reasonable basis that is consistently applied. The expenses that are allocated include salary and benefits, which are allocated based on the number of full-time equivalents in each cost center, and occupancy, which is allocated based on square footage.

NOTE 12 MARGIN LOAN

The Federation has an available margin borrowing agreement with its investment broker that functions as a line of credit. The amount available to withdraw fluctuates based on the amount of qualifying securities held in the related brokerage account. The interest rate on the margin loan also varies based on the amount borrowed, at a base rate subject to change at the broker's discretion plus an additional percentage. At April 30, 2020 and 2019, the interest rate ranges were 4.50% to 8.32% and 6.00% to 9.82%, respectively. As of April 30, 2020 and 2019, the funds available to withdraw totaled $5,280,038 and $6,362,570, respectively, and there was no amounts outstanding.

NOTE 13 LIQUIDITY AND AVILABILITY

Financial assets available for general expenditure, that is, without donor or other restrictions limiting their use, within one year of the statement of financial position date, comprise the following:

	2020	2019
Cash and Cash Eqivalents	$ 17,438,246	$ 11,894,389
Accounts Receivable:		
Disciplinary Searches	225,463	361,567
Other	288,785	164,499
Operating Investments	32,139,056	37,167,716
Less: Board-Designated Endowment	(2,563,456)	(2,561,788)
Total financial assets available for general expenditures in the next 12 months	$ 47,528,094	$ 47,026,383

The Foundation's board-designated endowment is subject to a spending formula based on an amount approved for appropriation each year by the board of directors. Although the Foundation does not intend to spend from this board-designated endowment (other than amounts appropriated for general expenditure as part of the Board's annual budget approval and appropriation), these amounts could be made available if necessary.

The Federation regularly monitors the liquidity required to meet its operating needs and other contractual commitments, while also striving to maximize the investment of its available funds. The Federation has various sources of liquidity at its disposal, including cash and cash equivalents, marketable debt and equity securities, and lines of credit.

FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AND SUBSIDIARY
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
APRIL 30, 2020 AND 2019

NOTE 13 LIQUIDITY AND AVAILABILITY (CONTINUED)

For purposes of analyzing resources available to meet general expenditures over a 12-month period, the Federation considers all expenditures related to its ongoing activities, as well as the conduct of services undertaken to support those activities to be general expenditures.

In addition to financial assets available to meet general expenditures over the next 12 months, the Federation operates with a balanced budget and anticipates collecting sufficient revenue to cover general expenditures.

NOTE 14 RELATED PARTIES

The Federation is a member of International Association of Medical Regulatory Authorities (IAMRA), and provides management services to IAMRA. Amounts due from IAMRA at April 30, 2020 and 2019 totaled $93,565 and $11,346, respectively.

FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC. AND SUBSIDIARY
CONSOLIDATING STATEMENT OF FINANCIAL POSITION
APRIL 30, 2020
(SEE INDEPENDENT AUDITORS' REPORT)

	FSMB	Foundation	Eliminations	Consolidated
ASSETS				
CURRENT ASSETS				
Cash and Cash Equivalents	$ 17,193,294	$ 244,952	$ -	$ 17,438,246
Accounts Receivable:				
Disciplinary Searches	225,463	-	-	225,463
Other	297,235	3,850	(12,300)	288,785
Prepaid Expenses	895,141	-	-	895,141
Other Assets	149,955	500	-	150,455
Total Current Assets	18,761,088	249,302	(12,300)	18,998,090
NONCURRENT ASSETS				
Investments	30,820,208	3,138,050	-	33,958,258
Prepaid Expenses	35,613	-	-	35,613
Property and Equipment, Net	9,005,458	-	-	9,005,458
Total Noncurrent Assets	39,861,279	3,138,050	-	42,999,329
Total Assets	$ 58,622,367	$ 3,387,352	$ (12,300)	$ 61,997,419
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Accounts Payable	$ 1,997,897	$ 11,538	$ (12,300)	$ 1,997,135
Unearned Revenue - USMLE and SPEX	12,278,282	-	-	12,278,282
Deferred Compensation	1,107,140	-	-	1,107,140
Total Current Liabilities	15,383,319	11,538	(12,300)	15,382,557
NET ASSETS				
Without Donor Restrictions:				
Board-Designated Endowment	-	2,563,456	-	2,563,456
Undesignated	43,239,048	812,358	-	44,051,406
Total Net Assets	43,239,048	3,375,814	-	46,614,862
Total Liabilities and Net Assets	$ 58,622,367	$ 3,387,352	$ (12,300)	$ 61,997,419

FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC. AND SUBSIDIARY
CONSOLIDATING STATEMENT OF ACTIVITIES
YEAR ENDED APRIL 30, 2020
(SEE INDEPENDENT AUDITORS' REPORT)

	FSMB	Foundation				Consolidated		
	Without Donor Restrictions	Without Donor Restrictions	With Donor Restrictions	Total	Consolidating Eliminations	Without Donor Restrictions	With Donor Restrictions	Total
REVENUES AND GAINS								
Examination Revenue - USMLE	$ 28,551,945	$ -	$ -	$ -	$ -	$ 28,551,945	$ -	$ 28,551,945
Examination Revenue - PLAS	139,100	-	-	-	-	139,100	-	139,100
Transfer Fees - USMLE	(20,621,375)	-	-	-	-	(20,621,375)	-	(20,621,375)
Transfer Fees - PLAS	(86,433)	-	-	-	-	(86,433)	-	(86,433)
Subtotal	7,983,237	-	-	-	-	7,983,237	-	7,983,237
Examination History Reports	6,980,153	-	-	-	-	6,980,153	-	6,980,153
Other Exam Revenue	958,160	-	-	-	-	958,160	-	958,160
Physician Data Center	1,552,518	-	-	-	-	1,552,518	-	1,552,518
Registration Fees	4,480	-	-	-	-	4,480	-	4,480
FCVS Revenue	10,980,381	-	-	-	-	10,980,381	-	10,980,381
Member Dues	177,025	-	-	-	-	177,025	-	177,025
Shipping and Handling Fees	64,300	-	-	-	-	64,300	-	64,300
Grants and Contributions	212,849	15,200	-	15,200	-	228,049	-	228,049
Interest and Dividends	1,312,474	15,248	-	15,248	-	1,327,722	-	1,327,722
Net Investment Loss	(3,494,944)	(20,752)	-	(20,752)	-	(3,515,696)	-	(3,515,696)
Loss on Sale of Fixed Assets	(8,244)	-	-	-	-	(8,244)	-	(8,244)
Other Revenue	832,323	-	-	-	-	832,323	-	832,323
Total Revenues and Gains	27,554,712	9,696	-	9,696	-	27,564,408	-	27,564,408
EXPENSES								
Salary and Benefits	15,327,069	-	-	-	-	15,327,069	-	15,327,069
Data Processing	1,177,769	-	-	-	-	1,177,769	-	1,177,769
General Office	3,395,065	1,393	-	1,393	-	3,396,458	-	3,396,458
Travel and Program	1,242,923	11,335	-	11,335	-	1,254,258	-	1,254,258
Occupancy	1,071,520	-	-	-	-	1,071,520	-	1,071,520
Professional Services and Dues	841,630	2,976	-	2,976	-	844,606	-	844,606
Legislative and Legal	275,807	-	-	-	-	275,807	-	275,807
Contributions	5,000	27,536	-	27,536	-	32,536	-	32,536
Total Expenses	23,336,783	43,240	-	43,240	-	23,380,023	-	23,380,023
CHANGES IN NET ASSETS - BEFORE DEPRECIATION	4,217,929	(33,544)	-	(33,544)	-	4,184,385	-	4,184,385
Depreciation	877,932	-	-	-	-	877,932	-	877,932
CHANGE IN NET ASSETS	3,339,997	(33,544)	-	(33,544)	-	3,306,453	-	3,306,453
Net Assets - Beginning of Year	39,899,051	3,409,358	-	3,409,358	-	43,308,409	-	43,308,409
NET ASSETS - END OF YEAR	$ 43,239,048	$ 3,375,814	$ -	$ 3,375,814	$ -	$ 46,614,862	$ -	$ 46,614,862

Attachment 2

FEDERATION OF STATE MEDICAL BOARDS
Variance Report
Through 3rd Quarter Ended January 31, 2021

Unrestricted Revenues and Gains from Operations	**YTD Actuals**	**Budget**	**Variance $ Favorable (Unfavorable)**	**Variance % Favorable (Unfavorable)**	**Comments**
USMLE					
Examinations	$ 17,926,775	$ 22,579,375	(4,652,600)	(21%)	USMLE revenue under projection due to impact of pandemic, but delayed revenue is expected to be made up later in FY2021 or FY2022.
Transfer Fees	(15,128,740)	(16,172,910)	1,044,170	6%	
Examination History Reports	4,981,414	4,485,000	496,414	11%	
Eligibility Extension Fees	49,640	273,341	(223,701)	(82%)	Extension fees waved for a period due to unavoidable delays/interruptions for examinees caused by COVID 19
Other Exam Revenue-Rescoring & Admin, S&H	44,025	92,438	(48,413)	(52%)	
Physician Data Center:					
PDC Profile (formerly "disciplinary searches")	697,688	855,000	(157,312)	(18%)	Overall, PDC is down less than 5% compared to budget
Disciplinary Alert, PDC Monitoring & ABMS services	623,241	457,051	166,189	36%	
Data Licensing Revenue	653,083	749,997	(96,914)	(13%)	
FCVS Revenue	8,249,699	7,579,902	669,796	9%	Continuing revenue growth trends from previous periods
Uniform Application Fee	409,980	331,700	78,280	24%	
Other Revenue					
Publication Revenue	3,335	3,000	335	11%	
Annual Meeting Fees/CME fees		2,500	(2,500)	(100%)	
Member Dues	5,675				
Grant Revenue-Federal	1,595,500		1,595,500	100%	Pass-through to Licensure Compact & COVID Grant
Other Revenue	15,164		15,164	100%	
Total Unrestricted Revenues and Gains from Operations	$ 20,126,479	$ 21,236,394	$ (1,109,915)	(5%)	

FEDERATION OF STATE MEDICAL BOARDS
Variance Report
Through 3rd Quarter Ended January 31, 2021

Expense	YTD Actuals	Budget	Variance $ Favorable (Unfavorable)	Variance % Favorable (Unfavorable)	Comments
Salary Expense:					
Exempt	$ 5,574,506	$ 5,935,149	360,643	6%	
Non-Exempt	2,868,613	2,703,882	(164,731)	(6%)	
Temporary	77,741	279,361	201,620	72%	Lower staff turnover leads to hiring fewer "Temps"
Benefits Expense	2,229,446	2,848,922	619,477	22%	Lower retirement contributions and lower health premiums than budgeted
HR & Employee Relations	101,090	131,300	30,210	23%	
	10,851,395	11,898,614			
Travel and Program Expense					
Annual Meeting	28,763		(28,763)	(100%)	2020 Virtual Annual Mtg invoices received in FY2021
Board Meetings	22,737	387,134	364,397	94%	All Travel cancelled due to pandemic. Some meeting
Board Site Visits	33	72,155	72,122	100%	expenses incurred for virtual meetings.
Other Meetings	37,757	681,477	643,720	94%	
	89,290	1,140,766			
Credit Card Processing	832,801	868,719	35,917		
Direct Cost of Sales	577,040	539,043	(37,997)	(7%)	FCVS direct costs up slightly in conjunction with higher volume
General Office Expense	860,181	1,040,169	179,988	17%	Timing.
Occupancy Expense	415,256	549,806	134,550	24%	
Data Processing Expense	930,920	898,364	(32,557)	(4%)	
Chair / Chair Elect / Past Chair Stipend	165,000	165,000	-	0%	
Licensure Compact (not reimbursed by grant)	2,064		(2,064)		
Compact Grant (reimbursed by grant)	138,990		(138,990)	(100%)	Pass through tied to Grant Revenue (see previous page)
COVID Grant	1,456,510		(1,456,510)	(100%)	Pass through tied to Grant Revenue (see previous page)
	1,597,564				
Legal Expense (External)	32,257	157,500	125,243	80%	
Government Relations	80,000	90,000	10,000.00		
Professional Services	541,995	459,039	(82,956.91)	(18%)	
Total Expense	$ 16,973,700	$ 17,807,018	$ 833,318	5%	

FEDERATION OF STATE MEDICAL BOARDS
Variance Report
Through 3rd Quarter Ended January 31, 2021

	YTD Actuals	Budget	Variance $ Favorable (Unfavorable)	Variance % Favorable (Unfavorable)	Comments
Total Unrestricted Revenues and Gains from Operations	$ 20,126,479	$ 21,236,394	$ (1,109,915)	(5%)	Fewer USMLE exams delivered due to Covid related interruptions.
Total Expense	16,973,700	17,807,018	833,318	5%	Lower Salary/Benefit expense
Change in Net Assets before depreciation and investment gains	3,152,779	3,429,376	(276,597)	(8%)	Despite some interruption to normal business cycles, the company has made adjustments to offset lower revenue.
Depreciation Expense	662,746	900,000	237,254	26%	
Investment Gain	7,961,760	420,000			The market has climbed steadily throughout FY2021
Investment Management Fee/Interest exp.	(139,830)	(156,000)			
	7,821,930	264,000	7,557,930		
Change in Net Assets	**$ 10,311,963**	**$ 2,793,376**	**$ 7,518,587**	269%	Increase in bottom line driven primarily by market return on LT investments

Attachment 3

FEDERATION OF STATE MEDICAL BOARDS
FY 2022 PROPOSED BUDGET
VS FY 2021 ADOPTED BUDGET AND FY2020 ACTUAL RESULTS

Unrestricted Revenues and Gains from Operations	2020 Actual Results	2021 Adopted Budget	2022 Proposed Budget	Variance $ Favorable (Unfavorable)	Variance %	Comments
USMLE						
Examination Revenue	28,691,045	29,495,375	30,566,500	1,071,125	3.63%	Projected 34,000 USMLE Step 3 Administrations, offsetting some of the delayed volume from FY21.
Transfer Fees	(20,707,808)	(21,244,350)	(24,464,000)	(3,219,650)	15.16%	Anticipated increase to cover FSMB's share of the CSEC unwinding expenses.
Examination History Reports	6,980,153	6,500,000	6,500,000	0	0.00%	
Exam Eligibility Extension Fee	320,895	350,455	315,865	(34,590)	-9.87%	
Other Exam Revenue-Rescoring & Admin, S&H	129,415	123,750	53,950	(69,800)	-56.40%	
Physician Data Center						
PDC Profile (formerly "disciplinary searches")	941,718	1,140,000	1,020,000	(120,000)	-10.53%	
Disciplinary Alert, PDC Monitoring, & ABMS servi	610,800	609,402	780,854	171,452	28.13%	
Data Licensing Revenue	801,348	999,996	1,100,000	100,004	10.00%	Existing Customers plus new contracts expected in 2021
FCVS & Student Records	10,997,275	11,115,961	10,987,190	(128,770)	-1.16%	Power BI projection using 24 months of data; Budgeting close
Uniform Application	570,720	525,000	539,096	14,096	2.68%	
Other Revenue						
Publication Revenue	3,625	3,000	3,000	0	0.00%	
Registration Fees/Exhibitor Fees	4,480	148,500	148,040	(460)	-0.31%	
Member Dues	170,400	168,000	168,000	0	0.00%	
Grant Revenue-Federal	212,849	0	0	0	0.00%	Compact Grant in 2020
Grant Revenue-Other	0	0	0	0	0.00%	
Other Revenue	18,509	7,275	7,275	0	0.00%	
Total Unrestricted Revenues and Gains from Operations	29,745,423	29,942,363	27,725,770	(2,216,593)	-7.40%	

FEDERATION OF STATE MEDICAL BOARDS
FY 2022 PROPOSED BUDGET
VS FY 2021 ADOPTED BUDGET AND FY2020 ACTUAL RESULTS

Unrestricted Expenses	2020 Actual Results	2021 Adopted Budget	2022 Proposed Budget	Variance $ (Reduced) Increased	Variance %	Comments
Salary Expense						
Salaries-Exempt	7,806,847	8,771,240	8,755,203	*(16,037)*	-0.18%	
Salaries-Non-exempt	3,713,410	3,865,860	4,286,323	*420,462*	10.88%	Reflects adjustments to the mix of Non-exempt and Temp employees. Also adjusted some comp strategies
Temporary Help	496,824	415,371	339,000	*(76,371)*	-18.39%	
Benefits Expense	3,313,987	4,122,808	4,127,400	*4,592*	0.11%	Improved deductible for EE's & Dependent Ins Subsidy continue
HR & Employee Relations (Other Emp Exp)	120,480	169,600	157,970	*(11,630)*	-6.86%	
Total	15,451,547	17,344,880	17,665,896	*321,016*	1.85%	
Travel and Program Expense						
Annual Meeting	63,655	645,750	645,750	*0*	0.00%	
Board Meetings	385,981	432,590	432,590	*0*	0.00%	
Board Site Visits	55,630	95,120	78,780	*(16,340)*	-17.18%	
Other Meetings	697,575	1,005,593	587,634	*(417,959)*	-41.56%	
	1,202,841	2,179,053	1,744,754	*(434,299)*	-19.93%	Reduced travel costs for most departments in 2022
Credit Card Processing	1,122,020	1,193,256	1,219,644	*26,389*	2.21%	Direct correlation between revenue and cc charges
Direct Cost of Sales	814,159	879,338	829,825	*(49,513)*	-5.63%	
General Office Expenses	979,632	1,220,937	1,035,795	*(185,142)*	-15.16%	Much of Online Access moved to Software Subscriptions to align with actuals/ Gartner membership not renewed
Texas Occupancy	623,111	622,074	677,007	*54,932*	8.83%	Slight increase in Utilities/Budget for maintenance/repair
DC Rent	164,366	120,750	154,600	*33,850*	28.03%	Rent increase for DC office
DC Building	477,609	123,000	108,876	*(14,124)*	-11.48%	Slightly lower Costs expected for upcoming year. Once sold, this line item will go away.
Data Processing Expense	1,176,408	1,090,640	1,285,003	*194,362*	17.82%	Increased Security and Website costs/Software Subscription budget moved from online access to reflect actuals
Chair/Chair Elect / Past Chair Stipend	215,000	220,000	220,000	*0*	0.00%	
Licensure Compact - Grant	212,849	0	0	*0*	0.00%	Since these are "pass throughs" and grants are not guaranteed to continue, we do not budget for revenue or expense
Licensure Compact - (not reimb by grant)	4,566	0	0	*0*	0.00%	
Legal Expense (External)	143,744	210,000	210,000	*0*	0.00%	
Government Relations	120,000	120,000	120,000	*0*	0.00%	
Professional Services/Consulting	627,926	702,993	886,434	*183,441*	26.09%	New consulting projects for 2022
Total Unrestricted Expenses	23,335,778	26,026,921	26,157,833	*130,912*	0.50%	

FEDERATION OF STATE MEDICAL BOARDS
FY 2022 PROPOSED BUDGET
VS FY 2021 ADOPTED BUDGET AND FY2020 ACTUAL RESULTS

	2020 Actual Results	2021 Adopted Budget	2022 Proposed Budget	Variance $ Favorable (Unfavorable)	Variance %
Total Unrestricted Revenues and Gains from Operations	29,745,423	29,942,363	27,725,770	**(2,216,593)**	**-7.40%**
Total Unrestricted Expenses	(23,335,778)	(26,026,921)	(26,157,833)	***(130,912)***	**-0.50%**
Change in Net Assets-Unrestricted before depreciation and investment gains	6,409,646	3,915,442	1,567,937	***(2,347,505)***	**-59.96%**
Depreciation Expenses	(877,932)	(1,200,000)	(850,000)	***350,000***	**-29.17%**
Investment Gains/(Losses)	(1,982,869)	560,000	560,000	***0***	**0.00%**
Investment Management Fees	(199,601)	(208,000)	(208,000)	***0***	**0.00%**
	(2,182,470)	352,000	352,000	***0***	**0.00%**
Change in Net Assets-Unrestricted	3,349,244	3,067,442	1,069,937	***(1,997,505)***	**-65.12%**

Tab H: Report of the Reference Committee

MANAGEMENT NOTE:

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

1. Report of the Bylaws Committee *(FOR ACTION)*
2. BRD RPT 21-1: Guidelines for the Structure and Function of a State Medical and Osteopathic Board *(FOR ACTION)*
3. BRD RPT 21-2: Report of the FSMB Ethics and Professionalism Committee: Treatment of Self, Family Members and Close Relations *(FOR ACTION)*
4. BRD RPT 21-3: Report of the FSMB Ethics and Professionalism Committee: Board Practices Regarding Expert Reviews in Quality-of-Care Cases *(FOR INFORMATION)*
5. BRD RPT 21-4: Report of the FSMB Workgroup on Emergency Preparedness and Response *(FOR ACTION)*
6. BRD RPT 21-5: Report of the FSMB Workgroup on Physician Impairment *(FOR ACTION)*
7. BRD RPT 21-6: Report of the FSMB Workgroup to Study Risk and Support Factors Affecting Physician Performance *(FOR INFORMATION)*
8. RESOLUTION 21-1: Incorporating the Care of Persons with Intellectual and Developmental Disabilities into the Medical School Curriculum *(FOR ACTION)*

During the Reference Committee's deliberations on April 20, 2021, the Committee will consider written testimony submitted by the Member Medical Boards. The deadline for submitting testimony is **April 15**. The testimony should be in the form of a letter addressed to:

Jorge A. Alsip, MD, MBA
Reference Committee Chair
Send to: pmccarty@fsmb.org

Following the deliberations of the Reference Committee, a report containing the Committee's recommendations will be posted on the FSMB Member Portal no later than **April 23** and presented to the House of Delegates by Dr. Alsip on **May 1**.

REPORT OF THE BYLAWS COMMITTEE

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

REFERRED TO: **REFERENCE COMMITTEE**

The Bylaws Committee, chaired by W. Reeves Johnson, Jr. MD, met on December 2, 2020 to consider the current Bylaws, review proposed amendments and additional commentary submitted for consideration, and make recommendations for any necessary changes. In keeping with its charge, the Committee also discussed the FSMB Articles of Incorporation as they relate to the Bylaws. Members of the Committee include: Lawrence J. Epstein, MD, Sandra Schwemmer, DO, Amit M. Shelat, DO, Janice Truitt, and Laura E. Forester, JD. Ex officio members include FSMB Chair Cheryl L. Walker-McGill, MD, MBA, FSMB Chair-Elect Kenneth B. Simons, MD and FSMB President-CEO Humayun J. Chaudhry, DO.

In accordance with Article XIV, Section A of the FSMB Bylaws, notice of the meeting of the Bylaws Committee was provided on August 20. 2020.

The Bylaws Committee received a set of comments from the North Carolina Medical Board which requested review of specific sections in the Bylaws for possible amendment. The Bylaws Committee also received commentary from the FSMB Board of Directors suggesting review of the membership categories.

The first area of review suggested by the North Carolina Medical Board directed the attention to several of the procedural elements for discipline under Article IV, Section E of the Bylaws. After review, the Bylaws Committee declined to act on this suggestion, determining that sufficient due process rights exist under the applicable nonprofit statutes as well as the applicable sections of parliamentary procedure. Additionally, the Bylaws Committee noted that the FSMB Board of Directors adopted significant due process related to member and officer discipline. The second request addressed procedures for filling vacancies, and the possible need to align Article V, Section F with Article III, Section E (4) of the Bylaws. The Bylaws Committee discussed the procedures for filling vacancies for a director position and the treasurer position, ultimately determining that the current election procedures and related term limits sufficiently address the comments of the North Carolina Medical Board. The third area of review identified by the North Carolina Medical Board suggested a review of Article XII – Disciplinary Action and suggested modification to the procedures for expulsion of a Member Medical Board. The Bylaws Committee thoroughly discussed this provision and agreed on the recommendation presented below.

After thorough review of the Bylaws and consideration of all questions, comments and proposed amendments, the Bylaws Committee presents the following two proposed amendments for consideration. In accordance with the Bylaws these proposals are approved by the House of Delegates if approved by *two-thirds* of those present and voting. Any action that amends the Articles of

Incorporation requires an affirmative vote of at least three-fourths of the Medical Board members present and voting.

PROPOSED AMENDMENT #1

The North Carolina Medical Board proposed a review of Article XII – Disciplinary Action and an assessment of whether expulsion of a Member Medical Board should be subject to approval by the House of Delegates.

Article XII applies to a broad category of members, including Member Medical Board, a Fellow, an Honorary Fellow, an Associate Member, an Affiliate Member, Courtesy Member, or Official Observer. Under Article II, the Board of Directors has the authority to approve applications for membership by a Member Medical Board and other classes of membership, except for Courtesy Member. Although approval of new Member Medical Boards is rare, in February 2020 the Board of Directors approved the application of the Medical Licensure Commission of Alabama. Approval of Courtesy Member applications traditionally has been deferred to action by the President-CEO due to the nature of the membership class approval and the sporadic nature of the applications by interested individuals.

The Bylaws Committee reviewed the section and found that as written, the authority to expel aligns with the Board of Director's power to approve membership applications. However, the Bylaws Committee further discussed the impact of such an action, and ultimately agreed that the gravity of expelling a Member Medical Board should be subject to review of the House of Delegates. The Bylaws Committee determined that subjecting an expulsion of a Member Medical Board to a process of ratification by the House of Delegates accomplished the intent of the question from the North Carolina Medical Board. The Bylaws Committee also reviewed the Standard Code of Parliamentary Procedure to determine any practical considerations of this change. The Bylaws Committee determined that this amendment aligns with parliamentary procedures. Under the Standard Code, ratification would be a debatable motion when presented to the House of Delegates.

Proposed Amendment #1

ARTICLE XII. DISCIPLINARY ACTION

SECTION A. MEMBER

For the purposes of this Article, a member shall be defined as a Member Medical Board, a Fellow, an Honorary Fellow, an Associate Member, an Affiliate Member, Courtesy Member or Official Observer.

SECTION B. AUTHORIZATION

The Board of Directors, on behalf of the House of Delegates, may enforce disciplinary measures, including expulsion, suspension, censure and reprimand, and impose terms and conditions of probation or such sanctions as it may deem appropriate, for any of the following reasons:

1. Failure of the member to comply or act in accordance with these Bylaws, the Articles of Incorporation of the FSMB, or other duly adopted rules or regulations of the FSMB;

2. Failure of the member to comply with any contract or agreement between the FSMB and such member or with any contract or agreement of the FSMB that binds such member;

3. Failure of the member to maintain confidentiality or security, or the permitting of conditions that allow a breach of confidentiality or security, in any manner dealing with the licensing examination process or the confidentiality of FSMB records, including the storage, administration, grading or reporting of examinations and information relating to the examination process; or

4. The imposition of a sanction, judgment, disciplinary penalty or other similar action by a Member Medical Board that licenses the member or by a state or federal court, or other competent tribunal, whether or not related to the practice of medicine and including conduct as a member of a Member Medical Board.

SECTION C. PROCEDURE

1. Any member alleged to have acted in such manner as to be subject to disciplinary action shall be accorded, at a minimum, the procedural protection set forth in the Manual for Disciplinary Procedures, which is available from the FSMB upon the written request of any member.

2. In event of a decision to expel a Member Medical Board pursuant to Section B, the House of Delegates shall ratify the decision at its next regularly scheduled meeting, or at an earlier meeting specially called for by the Chair in accordance with Article VII, Section B.

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.

PROPOSED AMENDMENT #2

Article II of the Bylaws creates categories of FSMB Membership. Under Section E, any physician or physician assistant licensed by a Member Medical Board or an Affiliate Member Board and not eligible for any other type of membership may become a Courtesy Member of the FSMB upon approval of the candidate's application.

A Courtesy Member may serve as a member of a committee and in any other capacity upon appointment by the FSMB Chair. Benefits for FSMB Courtesy Members also include access to FSMB educational events and programs, reduced registration rates for certain FSMB activities, and complimentary subscription to the *Journal of Medical Regulation*. Individuals seeking Courtesy

Membership indicate their interest by submitting an online form. After receipt of the form, FSMB staff query the Physician Data Center to see if the individual has any disciplinary history. If the query is clean, the application is sent to the FSMB President-CEO for approval. Annual dues for Courtesy Membership are $75.

In 2019 and early 2020, the FSMB received three (3) applications for Courtesy Membership. This was a unique number of requests, as there was only one prior courtesy member. In Summer 2020, the FSMB Board Members recommended that the Bylaws Committee review the definition and function of this category and determine whether the category is still necessary.

The Bylaws Committee reviewed the origins of this category of membership. The Courtesy Member designation historically was used as an avenue to encourage individuals with specific subject matter expertise to become members so they could serve on FSMB committees. The Bylaws Committee reviewed the current appointment processes and guidelines and determined that the current processes allow the Chair and CEO sufficient latitude to call upon such individuals, citing both the recent history of appointments as well as the very small number of members in this category. The Bylaws Committee acknowledged that the growth of the FSMB's advocacy presence has had the welcome result of broad participation by national and international experts in the FSMB policy making process. Therefore, the intended purpose of this category of membership is no longer relevant to achieve organizational goals such as diversity on committees, improved knowledge of regulation across the profession, and general impact in healthcare. The Bylaws Committee also discussed how this category of membership may be used to by individual physicians to overstate an affiliation with the FSMB as a means of seeking additional influence in some circles, to the detriment of the FSMB.

Because the deletion of this category of membership would require a change to the Articles of Incorporation, approval of by the affirmative vote of at least three-fourths of the Medical Board members present and voting is required. Additionally, the Bylaws would be modified as needed to reflect this decision.

Proposed Amendment #2

ARTICLES OF INCORPORATION OF
THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC

ARTICLE V

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

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

The qualifications, rights, obligations and manner of election of the members in each of the various categories of membership shall be set forth in the corporation's Bylaws. The corporation shall not issue stock and shall declare no dividends.

BRD RPT 21-1

REPORT OF THE BOARD OF DIRECTORS

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

Referred to: Reference Committee

In 2018, the FSMB merged *Guide to the Essentials of a Modern Medical Practice Act* and *Elements of a State Medical and Osteopathic Board* into one document known as the *Guidelines for the Structure and Function of a State Medical and Osteopathic Board.* This policy serves as a highly effective stimulus to medical boards and state legislatures to periodically review their statutes in relation to the structure and functions in their medical practice act. As was the *Essentials*, this policy will be subject to update every three years. The Board of Directors has charged the Advisory Council of Board Executives to review the document and make recommendations to bring the document current. The Board of Directors thanks members of the Advisory Council: Stephen Brint Carlton, JD (TX); David Henderson, JD (NC); Micah T. Matthews, MPA (WA-M); Anne Lawler, JD, RN (ID); Patricia E. McSorley, JD (AZ-M); Melanie de Leon, JD, MPA (WA-M); and Frank B. Meyers, JD (DC).

The Advisory Council reviewed the 2018 Guidelines section by section, suggested revisions and language clarification, and thereafter discussed the document in its entirety in December 2020.

In addition to language clarifications throughout, the *Guidelines* have been revised --

- To align with the FSMB policy on Physician Wellness and Burnout;
- To include language for issuing licenses in accordance with the Interstate Medical Licensure Compact
- To provide flexibility for Board operations during public health emergencies;
- To emphasize diversity of board composition by drawing upon different regions of the state, diverse specialties, and reflecting demographics of the state;
- To include gender identity, sexual orientation, and marital status to the list of qualifications that should not preclude Board membership;
- To allow for the use of electronic verification of documents and credentials; and
- To update the physician assistant section to reflect current trends.

This policy is intended to accommodate the unique characteristics of state medical boards while maintaining the integrity of the overall spirit of its purpose. Some sections empower boards to adopt alternatives of their choice, provided they are in accord with other state statutes, while other sections are phrased loosely to allow boards necessary discretionary authority. These guidelines may thus be seen not as one proposal but as various proposals. Each is applicable in one form or another to a diversity of settings, and all are aimed at increasing or refining the ability of state medical boards to protect the health, safety, and welfare of the public.

A draft of the *Guidelines for the Structure and Function of a State Medical and Osteopathic Board* was distributed to FSMB member boards and other key stakeholder organizations in January 2020 with comments due February 15, 2021.

ITEM FOR ACTION:

The Board of Directors recommends that:

The House of Delegates ADOPT *Guidelines for the Structure and Function of a State Medical and Osteopathic Board*, superseding the previous edition.

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

Submitted to the Federation of State Medical Boards House of Delegates
May 2021

INTRODUCTION

As early as 1914, the Federation of State Medical Boards (FSMB), which now represents 71 state and territorial medical and osteopathic licensing and disciplinary boards (hereafter referred to as "state medical board(s)" or "Board(s)"), recognized the need for a guidance document supporting U.S. states and territories in their development, and updating as needed, of their medical practice acts, and the corresponding structures and functions of their medical boards.

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

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

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

The guidance document adopted in 2018, *Guidelines for the Structure and Function of a State Medical and Osteopathic Board ("Structure and Function"),* incorporated the contents of prior *Elements* and *Essentials* documents, containing the principles of state medical board responsibility, duty, empowerment, and accountability that the initial documents outlined, as well as detailing the essential components for the structure and function of a state medical board.

The *Structure and Function* was reviewed and updated in 2021 to reflect not only relevant characteristics of effective medical boards, but also a number of innovative concepts not yet widely implemented. This guidance document is worthy of consideration for adaptation to the requirements of any state or territorial jurisdiction. Although it could hardly be expected that any one jurisdiction would accept every component of this model, it should lead every jurisdiction to assess its present board structure and function. Does the status quo provide

maximum potential for protection of the public interest? Though presented for consideration as an integrated whole, the guidelines offer approaches to a variety of issues that concern many boards, including: funding and budgeting, confidentiality, board authority, personnel and staffing, administration, emergency powers, training of board members, immunity and indemnity, standards of evidence, and the transparency.

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

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

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

Table of Contents

Section I. Definitions
The following terms have the following meanings:

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

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

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

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

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

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

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

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

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

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

"Physician assistant" means a skilled person who by training, scholarly achievements, submission of acceptable letters of recommendation, and satisfaction of other requirements of the Board has been licensed for the provision of patient services with a practice agreement in place.

"Practice of medicine" is consistent with the following:

1. Advertising, holding out to the public, or representing in any manner that one is authorized to practice medicine in the jurisdiction;
2. Offering or undertaking to prescribe, order, give, or administer any drug or medicine for

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

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

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

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

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

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

Section II. The Medical Practice Act

The structure and function of each of the 71 medical regulatory boards (allopathic, osteopathic and composite) within the United States and its territories are determined by a unique state statute (or group of statutes), usually referred to as a medical practice act. The differences among these statutes are related to the general administrative structure of each jurisdiction and to the needs of the public as they are perceived by each responsible legislative body.

The medical practice act should provide for a separate state medical board, acting as a governmental agency to regulate the practice of medicine, in order to protect the public from unlawful, incompetent, unqualified, impaired, or unprofessional practitioners of medicine, through licensure, regulation, and rehabilitation of the medical profession in the state.

Generally, the medical practice act should authorize Boards to promulgate rules and regulations to facilitate the enforcement of the act. Boards should be authorized to adopt and enforce rules and regulations to carry out the provisions of the medical practice act and to fulfill their duties under the act. Boards should adopt rules and regulations in accord with administrative procedures established in the respective jurisdiction.

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

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

Sample Statement of Purpose:

> *As a matter of public policy, the practice of medicine is a privilege granted by the people of the State acting through their elected representatives by their adoption of the Medical Practice Act. Therefore, in the interests of public health, safety and welfare, and to protect the public from any unprofessional, improper, incompetent, unlawful, fraudulent, and/or deceptive practice of medicine, it is necessary to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine and to ensure, as much as possible, that only qualified*

and fit persons hold that privilege. The Board's primary responsibility and obligation is to protect the public, and any license, certificate or other practice authorization issued pursuant to this statute shall be a revocable privilege and no holder of such a privilege shall acquire thereby any irrevocable right.

Exemptions

The medical practice act should not apply to:

1. Students while engaged in training in a medical school approved or recognized by the state medical board, unless the board licenses or registers the student;
2. Those providing service in cases of emergency where no fee or other consideration is contemplated, charged or received by the physician or anyone on behalf of the physician;
3. Commissioned medical officers of the armed forces of the United States and medical officers of the United States Public Health Service or the Veterans Administration of the United States in the discharge of their official duties and/or within federally controlled facilities, provided that such persons who hold medical licenses in the jurisdiction should be subject to the provisions of the act and provided that all such persons should be fully licensed to practice medicine in one or more jurisdictions of the United States. Further, the military physician should be subject to the Military Health System Clinical Quality Assurance (CQA) Program 10 U.S.C.A. § 1094; Regulation DOD 6025.13-R;
4. Those practicing dentistry, nursing, optometry, psychology, or any other of the healing arts in accord with and as provided by the laws of the jurisdiction;
5. Those practicing the tenets of a religion or ministering religious based medical procedures or ministering to the sick or suffering by mental or spiritual means in accord with such tenets;
6. Those administering a lawful domestic or family remedy to a member of one's own family;
7. Those fully licensed to practice medicine in another jurisdiction of the United States who temporarily render emergency medical treatment or briefly provide critical medical service at the specific lawful direction of a medical institution or federal agency that assumes full responsibility for that treatment or service and is approved by the state medical board; and
8. Those fully licensed to practice medicine in another jurisdiction of the United States who is employed or formally designated as the team physician by an athletic team visiting the jurisdiction for a specific sporting event, and the physician limits the practice of medicine in the jurisdiction to medical treatment of the members, coaches, and staff of the sports entity that employs (or has designated) the physician.

Unlawful Practice of Medicine

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

1. It should be unlawful to perform any act constituting the practice of medicine as defined in the medical practice act without first obtaining authorization in accordance with the requirements of the act and the rules and regulations of the Board. Other licensed health care professionals may provide medical services within the scope of the laws governing that profession.
2. The Board should be authorized to seek civil remedies pursuant to state law to address the unlawful practice of medicine.
3. It should be a felony for any person, corporation, or association that performs any act constituting the practice of medicine as defined in the medical practice act, or causing or aiding and abetting such actions.
4. Unless rules governing the practice of medicine are suspended or temporarily modified by an executive order or action of the Board, a physician located in another state practicing within the state by electronic or other means without a license (full, special purpose or authorization) issued by the Board should be deemed guilty of a felonious offense.

Section III. State Medical Board Duty, Responsibility, and Power

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

It is necessary that Boards have the responsibilities and powers necessary to fulfill the duties conferred on the Board by the medical practice act. These duties, responsibilities, and powers are to be liberally construed to protect the health, safety, and welfare of the people of the Board's State. It is the duty of Boards to determine a physician's initial and continuing qualification and fitness for the practice of medicine. Boards should be empowered to initiate proceedings against the unprofessional, improper, incompetent, unlawful, fraudulent, deceptive, or unlicensed practice of medicine, and enforce the medical practice act and related rules. Boards should discharge these duties and responsibilities in accord with the medical practice act and other governing laws.

In addition to any other duty, responsibility, and power provided to the Board in the medical practice act, the Board, acting in accord with its medical practice act and the requirements of due process, should:

1. Enforce the provisions of the medical practice act;
2. Develop, adopt and enforce rules and regulations to affect the provisions of the medical practice act and to fulfill the Board's duties thereunder;
3. Select and/or administer licensing examination(s);
4. Employ or contract with one or more organizations or agencies known to provide acceptable examinations for the preparation, administration, and scoring of required examinations;
5. Prepare, select, conduct, or direct the conduct of, set passing requirements for, assure security of, and impose conditions for (e.g., time or attempt limits) successful completion of the licensing and other required examinations;
6. Impose conditions, sanctions, deny licensure, levy fines, seek appropriate civil and/or criminal penalties, or any combination of these, against those who violate or attempt to violate examination security, those who obtain or attempt to obtain licensure by fraud or deception, and those who knowingly assist in such activities;
7. Acquire information about and evaluate medical education and training of applicants;
8. Determine which professional schools, colleges, universities, training institutions, and educational programs are acceptable relating to licensure under the medical practice act and are appropriately preparing physicians for the practice of medicine, and to accept the approval of such facilities and programs by Board-recognized accrediting bodies in the United States and Canada;
9. Develop and use applications and other necessary forms and related procedures it finds appropriate for purposes of the medical practice act;
10. Require supporting documentation or other acceptable verifying evidence of any information provided the Board by an applicant or licensee;
11. Require information on and evaluate an applicant's or a licensee's fitness, qualification, and previous professional record and performance from recognized data sources, including, but not limited to, the Federation of State Medical Boards' Federation Physician Data Center, other national data repositories, licensing and disciplinary authorities of other jurisdictions, professional education and training institutions, liability insurers, health care institutions, and law enforcement agencies;
12. Issue, condition, or deny initial or endorsement licenses;
13. Maintain secure and complete records on individual licensees including, but not limited to license application, verified credentials, disciplinary information, and malpractice history;
14. Provide the public with a profile of all licensed physicians;
15. Process and approve or deny applications for license renewal, including review of a licensee's activities for that time period;
16. Develop and implement methods to identify physicians who are in violation of the

medical practice act;

17. Require the self-reporting by applicants or licensees of any information the Board determines may indicate possible deficiencies in practice, performance, fitness, or qualification.
18. Require all licensees, healthcare professionals, healthcare facilities, and medical societies and organizations to report to the Board information that appears to show another licensee is, or may be, professionally incompetent, engaging in unprofessional conduct, or mentally or physically unable to engage safely in practice, and to report to the Board and/or to an agency designated by the Board a licensee's possible dependence on alcohol or other addictive substances which have the potential to impair. Require licensees, malpractice insurance companies, attorneys, and healthcare facilities to report any payments on a demand, claim, settlement, arbitration award or judgment by or on behalf of a licensee;
19. Develop and implement methods to identify and rehabilitate, if appropriate, physicians with an alcohol, drug, and/or psychiatric illness;
20. When deemed appropriate by the Board to do so, require professional competency, physical, mental or chemical dependency examination, and evaluations of any applicant or licensee, including withdrawal and laboratory examination of bodily fluids;
21. Establish a mechanism, which, at the Board's discretion, may involve cooperation with and/or participation by one or more Board-approved professional organizations, for the identification and monitored treatment of licensees who are dependent on or abuse alcohol or other addictive substances which have the potential to impair;
22. Establish a mechanism by which licensees who 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 report themselves confidentially to a professional organization approved by the Board to seek assistance and monitored treatment;
23. Receive, review, and investigate complaints and adverse information about licensees, including *sua sponte* complaints;
24. Review and investigate reports received from entities having information pertinent to the professional performance of licensees;
25. Act to halt the unlicensed or illegal practice of medicine; review, investigate, and take appropriate action to enjoin reports received concerning the unlicensed practice of medicine; and seek penalties against those engaged in such practices;
26. Adjudicate those matters that come before it for judgement under the medical practice act and issue final decisions on such matters;
27. Share investigative information at any stage of a complaint investigation with other Boards;
28. Obtain court orders and injunctions to halt unlicensed practice, violation of the medical practice act or the rules of the Board;
29. Institute actions in its own name and enjoin violators of the medical practice act;

30. Act on its own motion in disciplinary matters, administer oaths, issue notices, issue subpoenas in the name of the state including for patient records, receive testimony, conduct hearings, institute court proceedings for contempt to compel testimony or obedience to its orders and subpoenas, take evidentiary depositions, and perform such other acts as are reasonably necessary under the medical practice act or other laws to carry out its duties;
31. Issue subpoenas in the course of an investigation, including for *duces tecum* to compel production of documents or testimony to any party or entity that may possess relevant information regarding the subject of the investigation;
32. Institute proceedings in courts of competent jurisdiction to enforce its orders and the provisions of the medical practice act;
33. Use preponderance of the evidence as the standard of proof and to issue final decisions;
34. Present to the proper authorities information it believes indicates an applicant or licensee may be subject to criminal prosecution;
35. Discipline licensees found in violation of the medical practice act;
36. Issue conditioned, restricted, or otherwise circumscribed licenses as it determines necessary;
37. Take the following actions, in accord with applicable state statutes, alone or in combination, against those found in violation of the medical practice act:
    a. Revoke, suspend, condition, restrict, and/or otherwise limit the license;
    b. Place the licensee on probation with conditions;
    c. Levy fines and/or assess the costs of proceedings against the licensee;
    d. Censure, reprimand and/or otherwise admonish the licensee;
    e. Require the licensee to provide monetary redress to another party, and/or provide a period of free public or community service;
    f. Require the licensee to satisfactorily complete an educational, training, and/or treatment program or programs;
    g. Require the licensee to successfully complete an examination, examinations, or evaluations designated by the Board; and
    h. Summarily suspend a license when there is imminent risk of the public health and safety prior to hearing and final adjudication;
38. Enforce final disciplinary action against a licensee as deemed necessary to protect public health and safety;
39. Report all final disciplinary actions, non-administrative license withdrawals as defined by the Board, license denials, and voluntary license limitations or surrenders related to physicians, with any accompanying license limitations or surrenders related to physicians, with any accompanying Board orders, findings of fact and conclusions of law, to the Federation Physician Data Center of the Federation of State Medical Boards of the United States and to any other data repository required by law, and report all such actions, denials and limitations or surrenders related to other licensees, with the same supporting documentation, to the National Practitioner Data Bank as required by law;
40. Develop policies for disciplining or rehabilitating physicians who demonstrate

inappropriate sexual behavior with patients or other professional boundaries violations;
41. 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;
42. Develop and implement methods to identify dyscompetent physicians and physicians who fail to meet acceptable standards of care;
43. Develop or identify and implement methods to assess and improve physician practice;
44. Develop or identify and implement methods to ensure the ongoing competence of licensees;
45. Determine and direct the Board's operating, administrative, personnel, and budget policies and procedures in accord with applicable state statutes;
46. Acquire real property or other capital for the administration and operation of the Board;
47. Set necessary fees and charges to ensure active and effective pursuit of all of its responsibilities, legal and otherwise;
48. Develop and adopt its budget;
49. Employ, direct, reimburse, evaluate, and dismiss when appropriate the Board's executive director, in accord with the Board's state's procedures; Supervision of staff is the purview of the executive director.
50. Develop, recommend, and adopt rules, standards, policies, and guidelines related to qualifications of physicians and medical practice;
51. Engage in a full exchange of information with the licensing and disciplinary boards of other states and jurisdictions of the United States and foreign countries;
52. Direct the preparation and circulation of educational material, policies, and guidelines the Board determines are helpful and proper for licensees;
53. 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;
54. Delegate to the executive director the Board's authority to discharge its duties as appropriate; and
55. Recommend to the Legislature those changes in, or amendments to, the medical practice act that the Board determines would benefit the health, safety, and welfare of the public.

Section IV. State Medical Board Membership

State medical boards bear primary responsibility for licensing and regulating the medical profession for the protection of the public. Every board should include physician and public members. All board members should act to further the public interest, not their personal or professional interests.

Composition and Size

The board should consist of enough members to appropriately discharge its duties, and at least 25% should be public members. The board should consider several factors when determining the appropriate size and composition, 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 described throughout this document. The board should be of sufficient size to allow for recusals due to conflicts of interest and occasional member absences to avoid concentrating final decisions in the hands of too few members or loss of a quorum.

Qualifications

Board membership should be drawn from different regions of the state and diverse specialties, and should reflect the demographics of the state.

Sex, race, national or ethnic origin, creed, religion, disability, gender identity, sexual orientation, marital status, or age above majority should not preclude an individual from serving on the board.

All physician board members should reside in the state and be in active practice[1] at least 20 hours per week, hold a full and unrestricted medical licenses in the jurisdiction, be persons of recognized professional ability and integrity, and resided or practiced in the jurisdiction long enough to be familiar with the laws, policies, and practice in the jurisdiction (e.g., five years). In addition, physician members should not have had any public disciplinary action by any licensing board during the past ten years before applying for appointment, no history of felony convictions of any kind, and no misdemeanor convictions related to the practice of medicine.

Public members should reside in the state and be persons of recognized ability and integrity; not be licensed physicians, providers of health care, or retired physicians or health care providers; have no past or current substantial personal or financial interests in the practice of medicine or with any organization regulated by the board (except as a patient or caregiver of a patient); and have no immediate familial relationships with any licensees or any organization regulated by the Board, unless otherwise required by law. Public members should represent a wide range of careers.

Board members should not be registered as a lobbyist representing any health care interest or association nor be an officer, board member, or employee of a state or national organization established for advocating the interests of individuals involved in the practice of medicine or any organization regulated by the board.

Terms

Appointed board members should serve staggered terms to ensure continuity. Term lengths should be set to permit development of effective skills and experience by members (e.g., three or four years). However, a limit should be set on consecutive terms of service (e.g., two or three consecutive terms).

A board member may be reappointed two years after completion of such service. A person who serves more than half of an un-expired term should be considered to have served a full term.

[1] FSMB Report of the Special Committee on Reentry to Practice (HOD 2012) defines the clinically active physician as one who, at the time of license renewal, is engaged in direct, consultative, or supervisory patient care, or as further defined by the states.

Requirements
Before assuming the duties of office, the following should be required of each board member:

1. Take a constitutional oath or affirmation of office;
2. Swear or affirm that the member is qualified to serve under all applicable statutes;
3. Sign a statement agreeing to disclose any potential conflicts of interest that may arise for that member in the conduct of board business;
4. Sign a confidentiality and ethics statement agreeing to maintain the confidentiality of confidential board business and patient identification and uphold high ethical standards in discharging board duties.

The Board should also conduct, and new members should attend, an annual training program designed to familiarize new members with their duties and the ethics of public service.

Appointment
Board members should be appointed by the Governor or Legislature, and the appointment should be made at least 30 calendar days prior to the beginning of the board term. The appointing authority should fill an unexpired term within 30 calendar days of the vacancy's occurrence. The incumbent should serve until the appointing authority names a replacement. Any individual, organization or group should be permitted to recommend potential board appointees.

Removal
The appointing authority should remove board members from the board if they:

1. Cease to be qualified;
2. Submit a written resignation to the appointing authority;
3. Are absent from the state for a period of more than six months;
4. Are found guilty of a felony or an unlawful act involving moral turpitude by a court of competent jurisdiction;
5. Are found guilty of malfeasance, misfeasance, or nonfeasance in relation to their Board duties by a court of competent jurisdiction;
6. Are found to be mentally incompetent by a court of competent jurisdiction;
7. Fail to attend three successive board meetings without just cause as determined by the board, or if a new member fails to attend the new members' training program without just cause as determined by the board;
8. Are found to be in violation of the medical practice act; or
9. Are found to be in violation of the conflict of interest/ethics law.

Compensation/Reimbursement
Board members should receive appropriate compensation for services and reimbursement for expenses.

- Compensation: Service on the Board should not present an undue economic hardship.

Board members should therefore receive compensation in an amount sufficient to allow full participation and not preclude qualified individuals from serving.

- Expenses: Each board member's reasonable travel expenses necessarily and properly incurred for active board service should be reimbursed.
- Education/Training: Travel expenses, and daily compensation should also be paid for each board member's attendance, in or out of the board's jurisdiction, at education or training programs approved by the board and directly related to board duties.

Section V. State Medical Board Structure

Officers

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

- President/Chair: The president/chair should approve board meeting agendas, preside at Board meetings, appoint board committees and their chairs, and perform those other duties assigned by the board and the medical practice act.
- Vice President/Vice-Chair: The vice president/vice-chair should assist the president/chair in all duties as requested by the president/chair and should perform the duties of the president/chair in that officer's absence.
- Secretary/Treasurer: The secretary-treasurer should ensure the maintenance of the minutes of all meetings of the board and that the expenditure of funds complies with respective state law.

Committees

To effectively facilitate its work, fulfill its duties and exercise its powers, the board should establish standing committees. Examples include licensing, investigation, finance, administration, personnel, rules, legislative, communications, and public information committees.

The chair should also be empowered to name ad hoc committees as required.

Funding

Board fees should be adequate to fund the board's ability to effectively regulate the practice of medicine under the act, and fees paid by licensees should be used only for purposes related to licensure, discipline, education and board administration. The board should deposit all revenues in an appropriate account, and the board should also receive all income earned on the deposit of such revenues.

All fines levied by the board may be deposited in the State General Fund or other fund as legally required. All administrative, investigative and adjudicatory costs recouped should be deposited in the board's account.

A designated officer of the board or employee, at the direction of the board, should oversee the collection and disbursement of funds. 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.

In the event the Legislature imposes additional responsibilities on the board beyond its statutory responsibilities for licensure and discipline, the Legislature should appropriate additional funds to the board sufficient to carry out such additional responsibilities.

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

Setting Fees and Charges
All board fees and charges should be set by law or rule. The board should provide reasonable notice to the regulated healthcare professional and the public of all proposed increases or decreases in fees and charges.

Fiscal Year
The Board should operate on the same fiscal year as the State.

Section VI. Meetings of the Board and Committees of the Board

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

Teleconference and videoconference are acceptable forms of board meetings if, as per board bylaws and open meetings laws, it is determined the board's business can be properly conducted in this way. The board should be authorized to establish procedures by which its committees may meet by telephone or other telecommunication conference system.

Frequency, Duration
The board should meet at least bimonthly for a period sufficient to complete the work before it at that time. One meeting per quarter may be sufficient for states with small licensee populations. Committees should meet as directed by the board.

Emergency and Special Meetings
Emergency and special meetings of the board may be called at any time by the president/chair,

or as provided by board bylaws, if required to enforce the medical practice act. The board may establish procedures by which its committees may call emergency and special meetings in accordance with the State's open meeting laws.

Notice
The board should establish a system for giving its members reasonable notice of all board and committee meetings. The board should comply with the State's open meetings laws.

Quorum
A majority of members constitutes a quorum for the transaction of business by the board or any committee of the board.

Conflict of Interest
No board member shall participate in the deliberation, making of any decision, or taking of any action affecting the member's own personal, professional, or pecuniary interest, or that of a known relative or of a business or professional associate. With advice of legal counsel, the board shall adopt and annually review a conflict of interest policy to enforce this section.

Minutes
Minutes of all board and committee meetings and proceedings, and other board and committee materials, shall be prepared and kept in accord with the board's adopted rules of parliamentary procedure and applicable State laws; e.g., Public Records Act.

Open Meetings
All board and committee meetings should be open to the public in accordance with the State's open meeting laws, with the following exceptions:

1. Meetings to receive testimony or evidence the public disclosure of which the Board determines would constitute an unreasonable invasion of personal privacy;
2. Meetings to consult with legal counsel, and to deliberate disciplinary judgments;
3. Meetings regarding investigations;
4. Meetings regarding license applications; and
5. Meetings regarding personnel actions.

The board should ratify all recommendations or decisions made in nonpublic meetings in public, which should be matters of public record.

Confidentiality
The minutes and all records of nonpublic meetings are privileged and confidential and should not be disclosed, except to the board or its designees for the enforcement of the medical practice act, except that all licensing decisions made by the board and all disciplinary orders, with the associated findings of fact and conclusions of law and order, issued by the board should be matters of public record.

The following should be privileged and confidential:

1. Application and renewal forms and any evidence submitted in proof or support of an application to practice, except that the following items of information about each applicant or licensee included on such forms should be matters of public record:
    a. Full name;
    b. Name(s) and location(s) of professional schools attended;
    c. School awarding professional degree, date of award, and designation of degree;
    d. Site(s) and date(s) of graduate certification(s) held and date(s) granted;
    e. Specialty certifications;
    f. Year of initial licensure in the State;
    g. Other states in which licensed to practice; and
    h. Current office address, telephone number, website, and email address.
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; and
4. A complaint and the identity of an individual or entity filing an initial complaint with the Board.

Notwithstanding the foregoing provisions, the board may cooperate with and provide documentation to other boards, agencies or law enforcement bodies of the State, other states, other jurisdictions, or the United States upon written official request by such entity(s). The board should share investigative information at the any stage 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.

Section VII. Administration of the State Medical Board

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

Administration
The Board should establish the function, operation, and administration structure of its offices.

Staff, Special Personnel
To effectively perform its duties under the medical practice act, the Board should be empowered to hire an Executive Director, who will determine its staff needs and to employ, fix compensation for, evaluate, discipline, and remove its own full-time, part-time, temporary, and contract staff in accord with the statutory requirements of the State. The Board should also be assigned adequate legal counsel by the office of the attorney general and/or be authorized to employ private counsel or its own full-time attorney. The Board should define the duties of and qualifications for the executive director, if not already defined in statute or in addition to statutory requirements. Staff

benefits should be provided in accord with the statutes of the State.

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

- An executive director, who, among administrative and other delegated responsibilities, may assist, at the Board's discretion, in the discharge of the duties of the secretary-treasurer and if one exists, the licensing committee, the disciplinary committee, and any other standing or ad hoc committee;
- One or more assistant executive directors;
- One or more medical consultants or director, who shall be licensed to practice medicine in the State without restriction;
- Office and clerical staff;
- One or more attorneys, who may be full-time employees of the Board, contractors of the Board, or assigned from the Office of the State Attorney General by agreement between the Board and that office, or in private practice to provide legal advice to the Board;
- One or more attorneys on staff to prosecute alleged violations of the medical practice act in administrative hearings and procedures; and/or
- One or more investigators, who shall be trained in and knowledgeable about the investigation of medical and related health care practice.

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

Section VIII. Immunity, Indemnity, Protected Communication

The medical practice act or other statutes should provide legal protection for the members of the Board and its staff and for those providing information to the Board in good faith.

Qualified Immunity and Indemnity
The medical practice act or other statute should provide the following:

1. There shall be no liability on the part of, and no action for damages against, any member of the Board, its agents, its employees, or any member of an examining committee of physicians appointed or designated by the Board, for any action undertaken or performed by such person within the scope of the duties, powers, and functions of the Board or such examining committee when such person is acting in good faith and in the reasonable belief that the action taken by such person is warranted.

2. If a current or former member, officer, administrator, staff member, committee member, examiner, representative, agent, consultant, or any other person serving or having served the Board requests the State to defend them against any claim or action arising out of any act, omission, proceeding, conduct, or decision related to their duties undertaken or performed in good faith in furtherance of the purposes of the medical practice act and within the scope of the function of the Board, and if such a request is made in writing at a reasonable time before trial, and if the person requesting defense cooperates in good faith in the defense of the claim or action, the State shall provide and pay for such defense and shall pay any resulting judgment, compromise, or settlement.
3. No person, committee, association, organization, firm, or corporation providing information to the Board in good faith and in the reasonable belief that such information is accurate and, whether as a witness or otherwise, shall be held, by reason of having provided such information, to be liable in damages under the law of the state or any political subdivision thereof.
4. In any suit brought against the Board, its employees or agents, any member of an examining committee appointed by the Board or any individual or person, corporation, or other entity providing services to the Board, when any such defendant substantially prevails in such suit, the court shall, at the conclusion of the action, award to any such substantially prevailing party defendant against any such claimant the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the claim was frivolous, unreasonable, without foundation, or in bad faith. For the purposes of this Section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.
5. There shall be no liability on the part of and no action for damages against any person, individual, corporation, or entity acting in good faith as an instrumentality of the Board to identify, investigate, counsel, monitor, or assist any licensed physician who suffers or may suffer from any condition that could compromise a physician's fitness and ability to practice medicine with reasonable skill and safety to patients.
6. The state should defend a current or former member, officer, administrator, staff member, committee member, examiner, representative, agent, employee, consultant, witness, contractor, or any other person serving or having served the Board against any claim or action arising out of the medical practice act, omission, proceeding, conduct, or decision related to the person's duties undertaken or performed in good faith and within the scope of the function of the Board. The State should provide and pay for such defense and should pay any resulting judgment, compromise, or settlement.

Confidential Communication

Every communication made by or on behalf of any person, institution, agency, or organization to the Board or to any person designated by the Board, relating to an investigation or the initiation of an investigation, whether by way of report, complaint, or statement, should be confidential. No action or proceeding, civil or criminal, should be permitted against any such person, institution, agency, or organization by whom or on whose behalf such a communication was

made in good faith.

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

Section IX. Reports of the Board

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

1. The total number of persons fully licensed by the State and the number of those licensees currently practicing in the State;
2. The number of persons who are fully licensed, and practicing, in the State, but are residing in another state;
3. The number of licensees holding each form of limited license authorized by the medical practice act;
4. The number of persons granted a full license by the State for the first time in the past year, the average time to issue the first time license, the number of those licensees currently practicing in the State, and the number of full licenses denied in the past year;
5. The number of licensees currently practicing about whom a complaint, a charge or an adverse item of information required by law was received in the past year;
6. The number and the source, by category, of complaints, charges and adverse items of information required by law received about licensees practicing in the past year and the number of these found not to warrant action under this statute and the rules of the Board;
7. The number of disciplinary investigations conducted by the Board or its representatives concerning licensees practicing in the past year and the average time to complete the investigation;
8. The number of disciplinary actions, by category, taken by the Board in the past year against all licensees and the average time to resolve the initial complaint;
9. A ranking, by frequency, of primary causes for disciplinary action against all licensees in the past year;
10. A review of disciplinary activity related to holders of limited forms of license in the past year;
11. 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;
12. A schedule of all current fees and charges;

13. A revenue and expenditure statement for the past year indicating, but not limited to, the percentage of revenue from and expenditures for each regulated profession, revenue generated from licensing, revenue generated from fines, and expenditures related to investigations;
14. A summary of other Board activities and a schedule of days met by the Board and each of its committees during the year;
15. A summary of administrative and legislative activity in the past year;
16. A summary of the goals and objectives established by the Board for the coming fiscal year; and
17. A copy of the Board's strategic plan.

Public Record, Action Reports

Each of the Board's non-administrative license application withdrawals, license denials and final disciplinary orders, including any associated findings of fact and conclusions of law, should be matters of public record. Voluntary surrenders of or limitations on licenses shall also be matters of public record. The Board should promptly report all denials, orders, surrenders, and limitations to the public, all health care institutions in the State, appropriate State and federal agencies, related professional societies or associations in the State, and any data repository. The Board should make the information readily accessible to the public via the physician's profile as allowed by statute.

The Board should update the profile at least annually and offer the licensee an opportunity to correct erroneous information. A licensee's profile shall contain, but not be limited to:

1. Demographic Information: name and license number, gender, business or practice address, and birth date.
2. Medical Education: medical school(s)' name, address, year of graduation and degree, post-graduate training program(s)' name, address, years attended, and year completed.
3. License and Board Certification Information: license status, license type, original license date, license renewal date, specialty and type of practice, and board certification by a certifying authority recognized by the Board.
4. Criminal Convictions: a description of any conviction in which either the offense, or the facts and circumstances of the circumstances, would violate the ethical standards associated with the practice of medicine in the state within the last five years, including cases with a deferred adjudication.
5. Malpractice History:
    a. The number of awards or judgments within the past 10 years;
    b. When the number exceeds 3, the number of demands, claims, and/or settlements paid by the licensee or on behalf of the licensee in the past 5 years; and
    c. A statement that malpractice payments do not necessarily demonstrate the quality of care provided by a physician, and that the Board independently investigates reports of payment in malpractice cases, which will appear in the licensee's disciplinary history if the Board completed the investigation and took disciplinary

action.

6. Disciplinary and Non-Disciplinary History:
    a. All disciplinary actions taken by the Board;
    b. All active non-disciplinary board actions such as remedial plans;
    c. A brief description of the reason for a disciplinary or non-disciplinary action;
    d. All disciplinary actions taken by other state medical/osteopathic boards and a brief description of the reason for discipline if available;
    e. All disciplinary actions taken by hospitals;
    f. An explanation of the types of discipline the Board takes and its effects on the licensee's ability to practice; and
    g. A statement that hospitals may take disciplinary actions for reasons that do not violate the governing statutes.

Section X. Examinations

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

In order to ensure a high quality, valid, and reliable examination of physician preparedness to practice medicine, the Board may delegate the responsibilities for examination development, administration, scoring, and security to a third party or nationally recognized testing entity. Such an examination should be consistent with recognized national standards for professional testing such as those reflected in Standards for Educational and Psychological Testing[2].

No individual should receive a license to practice medicine in the jurisdiction unless they have successfully completed all components of an examination(s) identified as satisfactory to the Board:

- The currently administered United States Medical Licensing Examination (USMLE) Steps 1, 2, 3 or The Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Levels 1, 2, 3; or
- Previously administered examinations such as the Federation Licensing Examination (FLEX), National Board of Medical Examiners (NBME) Parts or National Board of Osteopathic Medical Examiners (NBOME) Parts; or
- A combination of these examinations identified as acceptable by the Board.

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

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

[2] 2014 edition jointly developed by the American Educational Research Association (AERA), the American Psychological Association (APA) and the National Council on Measurement in Education (NCME).

developers of the examination.

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

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

Section XI. Requirements for Full Licensure

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

1. The applicant should provide the Board, or its agent, and attest to, or provide the means to obtain and verify the following information and documentation in a manner required by the Board:
    a. The applicant's full name and all aliases or other names ever used, current address, Social Security number, and date and place of birth;
    b. All original or electronically verified documents and credentials required by the Board, notarized photocopies, or other verification acceptable to the Board of such documents and credentials;
    c. A list of all jurisdictions, United States or foreign, in which the applicant has been licensed, denied licensure or authorization to practice medicine or any other health care profession, has voluntarily surrendered a license or an authorization to practice medicine or any other health care profession, or withdrawn any license application;
    d. 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;
    e. A detailed educational history, including places, institutions, dates, and program descriptions of all the applicant's education including all college, pre-professional, professional, and professional postgraduate education;
    f. A detailed employment history for the five years prior to application, including periods of absence from the active practice of medicine;
    g. A list and current status of all specialty certifications and the name of certifying organization; and
    h. Any other information or documentation the Board determines necessary.

2. The applicant should possess the degree of Doctor of Medicine or Doctor of Osteopathic Medicine/Doctor of Osteopathy from a medical college or school located in the United States, its territories or possessions, or Canada that was approved by the Board or by a private nonprofit accrediting body approved by the Board at the time the degree was conferred. No person who graduated from a medical school that was not approved at the time of graduation should be examined for licensure or be licensed in the jurisdiction based on credentials or documentation from that school nor should such a person be licensed by endorsement.
3. Should the applicant graduate from a medical school in a foreign country, other than Canada, the applicant should meet all the requirements established by the Board to determine the applicant's fitness to practice medicine.
4. The applicant should have satisfactorily completed at least thirty-six (36) months of progressive postgraduate medical training (also termed graduate medical education, or GME) accredited by the Board, the Accreditation Council for Graduate Medical Education (ACGME), the Commission on Osteopathic College Accreditation (COCA), the Royal College of Physicians and Surgeons of Canada (RCPSC), or the College of Family Physicians of Canada (CFPC).
5. The applicant should have passed the USMLE Steps 1, 2, 3 or COMLEX Levels 1, 2, 3 or a predecessor examination (FLEX, NBME Parts, NBOME Parts) or a combination of these examinations identified as acceptable by the Board.
6. The applicant should attest to a familiarity with the statutes and regulations of the jurisdiction relating to the practice of medicine and the appropriate use of controlled or dangerous substances.
7. The applicant should not be currently suffering from any condition for which they are not being appropriately treated that impairs their judgement or that would otherwise adversely affect their ability to practice medicine in a competent, ethical, and professional manner.
8. The applicant should not have been found guilty by a competent authority, United States or foreign, of any conduct that would constitute grounds for disciplinary action under the regulations of the Board or the act. The Board may be authorized, at its discretion, to modify this restriction for cause, but it should be directed to use such discretionary authority in a consistent manner.
9. If the applicant's license is denied or in accordance with Board policy, the applicant should be allowed a personal appearance before the Board or a representative thereof for interview, examination or review of credentials. At the discretion of the Board, the applicant should be required to present the applicant's original medical education credentials for inspection at the time of personal appearance.
10. The applicant should be held responsible for verifying to the satisfaction of the Board the validity of all credentials required for the applicant's medical licensure. The Board or its agent should verify medical licensure credentials directly from primary sources, and utilize recognized national physician information services (e.g., the Federation of State Medical Boards' Physician Data Center (PDC), which includes its Board Action Data

Bank, and Federation Credentials Verification Service (FCVS); the files of the American Medical Association and the American Osteopathic Association; National Practitioner Data Bank; and other national data banks and information resources.)

11. The applicant should have paid all fees and have completed and attested to the accuracy of all application and information forms required by the Board before the Board's verification process begins. The Board should require the applicant to authorize the Board to investigate and/or verify any information provided to it on the licensure application.
12. Applicants should have satisfactorily passed a criminal background check.

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

Graduates of Foreign Medical Schools

The medical practice act should provide minimum requirements, in addition to those otherwise established, for full licensure of applicants who are graduates of schools located outside the United States, its territories or possessions, or Canada. These provisions of the act should implement or be consistent with the following:

1. Such applicants should possess the degree of Doctor of Medicine, Bachelor of Medicine, or a Board-approved equivalent based on satisfactory completion of educational programs acceptable to the Board.
2. Such applicants should be eligible by virtue of their medical education, training, and examination for unrestricted licensure or authorization to practice medicine in the country in which they received that education and training.
3. Such applicants should have passed an examination acceptable to the Board that adequately assesses the applicants' medical knowledge.
4. Such applicants should be certified by the Educational Commission for Foreign Medical Graduates or its Board-approved successor(s), or by an equivalent Board-approved entity.
5. Such applicants should have a demonstrated command of the English language satisfactory to the Board.
6. Such applicants should have satisfactorily completed at least thirty-six (36) months of progressive post-graduate medical training accredited by the Board, the Accreditation Council for Graduate Medical Education (ACGME), or the American Osteopathic Association (AOA).
7. All credentials, diplomas, and other required documentation in a foreign language submitted to the Board by or on behalf of such applicants should be accompanied by certified English translations acceptable to the Board.
8. Such applicants have satisfied or are able to satisfy all applicable requirements of the United States Citizenship and Immigration Services.

Section XII. Licensure by Endorsement, Expedited Licensure by Endorsement, and Temporary and Special Licensure

The medical practice act should provide for licensure by endorsement, expedited licensure by endorsement, and in certain clearly defined cases, for temporary and special licensure.

Endorsement for Licensed Applicants

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

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

Expedited Licensure by Endorsement or Interstate Medical Licensure Compact

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

1. Identity as required by the Board;
2. All jurisdictions in which the applicant holds a full and unrestricted license;
3. Graduation from an approved medical school:
    a. Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA) of the American Osteopathic Association (AOA) approved medical school;
    b. Educational Commission for Foreign Medical Graduates (ECFMG) certificate.
4. Passing one or more of the following examinations acceptable for initial licensure within three attempts per step/level:
    a. United States Medical Licensing Examination (USMLE) Steps 1-3 or its predecessor examinations, the National Board of Medical Examiners (NBME) I-III or the Federation Licensing Examination (FLEX);
    b. Comprehensive Osteopathic Medical Licensure Examination (COMLEX-USA) Levels 1-3 or its predecessor examinations, the National Board of Osteopathic Medical Examiners Levels 1-3 or its predecessor examination(s); and/or
    c. Medical Council of Canada Qualifying Examinations (MCCQE) or its predecessor examination(s) offered by the 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) the COCA, the RCPSC, or the CFPC; and/or
7. Obtained certification or recertification by a specialty board recognized by the American Board of Medical Specialties (ABMS) or the Bureau of Osteopathic Specialists (BOS) within the previous ten (10) years.

Lifetime certificate holders who have not passed a written specialty recertification examination must demonstrate successful completion of the Special Purpose Examination (SPEX), Comprehensive Osteopathic Medical Variable Purpose Examination (COMVEX) or applicable specialty recertification examination.Boards should obtain supplemental documentation including, but not limited to:

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

Physicians desiring an expedited process for licensure may utilize the Federation Credentials Verification Service (FCVS), or credentials verification meeting equivalent standards for verification of core credentials, or rely on the primary source verification of the state board of first licensure for:

1. Medical school transcript;
2. Examination history;
3. Disciplinary history;
4. Identity (certified birth certificate or original passport);
5. ECFMG certificate, if applicable; and
6. Postgraduate training verification.

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

1. Be granted only to an applicant demonstrably qualified for a full and unrestricted medical license under the requirements set by the medical practice act and the regulations of the Board;
2. Be granted only to an applicant on a short-term or emergency basis;
3. Automatically terminate within a period specified by the Board.

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

1. To provide medical services to a traveling sports team, coaches, and staff for the duration of the sports event;

2. To provide volunteer medical services to under-insured/uninsured patients;
3. To provide medical services to youth camp enrollees, counselors, and staff for the duration of the youth camp;
4. To engage in the limited practice of medicine in an institutional setting by a physician who is licensed in another jurisdiction in the United States; and
5. To provide medical services in response to disasters, public health emergencies, and mass casualties.

Section XIII. Limited Licensure for Physicians in Postgraduate Training

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

1. To be eligible for limited licensure, the applicant should have completed all the requirements for full and unrestricted medical licensure except postgraduate training or specific examination requirements.
2. Issuance of a limited license specifically for postgraduate training should occur only after the applicant demonstrates that he/she is accepted in a residency program. The application for limited licensure should be made directly to the Board in the jurisdiction where the applicant's postgraduate training is to take place.
3. The Board should establish by regulation restrictions for the limited license to assure that the holder will practice only under appropriate supervision and within the confines of the program within which the resident is enrolled.
4. The limited license should be renewable annually.
5. The disciplinary provisions of the medical practice act should apply to the holders of the limited and postgraduate training license as if they held full and unrestricted medical licensure.
6. The issuance of a limited license should not be construed to imply that a full and unrestricted medical license would be issued at any future date.

Postgraduate Training Program Reporting Requirements
Program directors responsible for postgraduate training should inform the Board about program participants who have departed or been terminated from the program or have received disciplinary actions within 10 days of said action.

Program directors 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; resignations from the program or nonrenewal of the program contract; dismissals from the program for performance or behavioral reasons; and referrals to substance abuse programs not approved by the Board.

Failure to report such actions shall be considered a violation of the mandatory reporting provisions

of the medical practice act and shall be grounds to initiate such disciplinary action as the Board deems appropriate, including fines levied against the supervising institution and suspension of the program director's medical license.

Section XIV: Periodic Renewal

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

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

1. Any action taken for acts or conduct similar to acts or conduct described in the medical practice act as grounds for disciplinary action against a licensee by:
    a. Any jurisdiction or authority (United States or foreign) that licenses or authorizes the practice of medicine or participation in a payment or practice program;
    b. Any peer review body;
    c. Any specialty certification board;
    d. Any health care organization;
    e. Any law enforcement agency;
    f. Any health insurance company;
    g. Any malpractice insurance company;
    h. Any court; and
    i. Any governmental agency.
2. Any adverse judgment, settlement, or award against the licensee or payment by or on behalf of the licensee arising from a professional liability demand, claim, or case.
3. The licensee's voluntary surrender of or voluntary limitation on any license or authorization to practice medicine in any jurisdiction, including military, public health, and foreign.
4. Any denial to the licensee of a license or authorization to practice medicine by any jurisdiction, including military, public health, and foreign.
5. The licensee's voluntary resignation from the medical staff of any health care organization or voluntary limitation of the licensee's staff privileges at such an organization if that action occurred while the licensee was under formal or informal investigation by the organization or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct, or mental, physical, alcohol, or drug impairment.
6. The licensee's voluntary resignation or withdrawal from a national, state, or county medical society, association, or organization if that action occurred while the licensee

was under formal or informal investigation or review by that body for any reason related to possible medical incompetence, unprofessional conduct, mental, physical, alcohol, or drug impairment.

7. Whether the licensee is currently suffering from any condition for which they are not being appropriately treated that impairs their judgment or that would otherwise adversely affect their ability to practice medicine in a competent, ethical and professional manner.
8. The licensee's completion of continuing medical education or other forms of professional maintenance and/or evaluation, including specialty board certification or recertification, within the renewal period.

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

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

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

Failure to report fully and correctly according to timelines specified by the board as outlined above should be grounds for disciplinary action by the Board.

Section XV. Disciplinary Process

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

Range of Actions

A range of progressive disciplinary and remedial actions should be made available to the Board. The Board should be authorized, at its discretion, to take disciplinary, non-disciplinary, public or non-public actions, singly or in combination, as the nature of the violation requires and to promote public protection. These include, but are not limited to, the following:

1. Revocation of the medical license;
2. Suspension of the medical license;
3. Probation;
4. Stipulations, limitations, restrictions, probation, and conditions relating to practice;
5. Censure (including specific redress, if appropriate);
6. Reprimand;
7. Letters of concern and advisory letters:

   a. The Board should be authorized to issue a confidential (if allowed by state law), non-reportable, non-disciplinary letter of concern, or advisory letter to a licensee when evidence does not warrant formal discipline, but the Board has noted indications of possible errant conduct by the licensee that could lead to serious consequences and formal action if the conduct were to continue. In its letter of concern or advisory letter, the Board should also be authorized, at its discretion, to request clarifying information from the licensee.
8. Monetary redress to another party;
9. A period of free public service, either medical or non-medical;
10. Satisfactory completion of an educational, training and/or treatment program(s), or professional developmental plan:
    a. The Board should be authorized, at its discretion, to require professional competency, physical, mental, or chemical dependency examination(s) or evaluation(s) of any applicant or licensee, including withdrawal and laboratory examination of bodily fluids, tissues, hair, or nails.
11. Levy fines; and
12. Payment of administrative and disciplinary costs.

Grounds for Action

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

1. Fraud or misrepresentation in applying for or procuring a medical license or in connection with applying for or procuring periodic renewal of a medical license;
2. Cheating on or attempting to subvert the medical licensing examination(s);
3. The commission or conviction or the entry of a guilty, nolo contendere plea, or deferred adjudication (without expungement) of:
    a. A misdemeanor related to the practice of medicine and any crime involving moral turpitude; or
    b. A felony related to the practice of medicine. The Board shall revoke a licensee's license following conviction of a felony, unless a 2/3 majority vote of the board members present and voting determined by clear and convincing evidence that such licensee will not pose a threat to the public in such person's capacity as a licensee and that such person has been sufficiently rehabilitated to warrant the public trust;
4. Conduct likely to deceive, defraud, or harm the public;
5. Disruptive behavior and/or interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient;
6. Making a false or misleading statement regarding the licensee's skill or the efficacy or value of the medicine, treatment, or remedy prescribed by the licensee or at the licensee's direction in the treatment of any disease or other condition of the body or mind;
7. Representing to a patient that an incurable condition, sickness, disease, or injury can be

cured;

8. Willfully or negligently violating the confidentiality between physician and patient except as required by law;
9. Professional incompetency as one or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes negligence, as determined by the Board;
10. Being found mentally incompetent or of unsound mind by any court of competent jurisdiction;
11. Being physically or mentally unable to engage in the practice of medicine with reasonable skill and safety;
12. Practice or other behavior that demonstrates an incapacity or incompetence to practice medicine;
13. The use of any false, fraudulent, or deceptive statement in any document connected with the practice of medicine;
14. Giving false, fraudulent, or deceptive testimony while serving as an expert witness;
15. Practicing medicine under a false or assumed name;
16. Aiding or abetting the practice of medicine by an unlicensed, incompetent, or impaired person;
17. Allowing another person or organization to use the licensee's license to practice medicine;
18. Commission of any act of sexual misconduct, including sexual contact with patient surrogates or key third parties, which exploits the physician-patient relationship in a sexual way;
19. Habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability;
20. Failing or refusing to submit to an examination or any other examination that may detect the presence of alcohol or drugs or any other form of impairment upon Board order;
21. Prescribing, selling, administering, distributing, diverting, ordering or giving any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug for other than medically accepted therapeutic purposes;
22. Knowingly prescribing, selling, administering, distributing, ordering, or giving to a habitual user or addict or any person previously drug dependent, any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug, except as otherwise permitted by law or in compliance with rules, regulations, or guidelines for use of controlled substances and the management of pain as promulgated by the Board;
23. Prescribing, selling, administering, distributing, ordering, or giving any drug legally classified as a controlled substance or recognized as an addictive drug to a family member or to the licensee themselves;
24. Violating any state or federal law or regulation relating to controlled substances;
25. Signing a blank, undated, or predated prescription form;
26. Obtaining any fee by fraud, deceit, or misrepresentation;
27. Employing abusive, illegal, deceptive, or fraudulent billing practices;

28. Directly or indirectly giving or receiving any fee, commission, rebate, or other compensation for professional services not actually and personally rendered, though this prohibition should not preclude the legal functioning of lawful professional partnerships, corporations, or associations;
29. Disciplinary action in another state or federal jurisdiction against a license or other authorization to practice medicine or participate in a federal program (payment or treatment) based upon acts or conduct by the licensee similar to acts or conduct that would constitute grounds for action as defined in this section, a certified copy of the record of the action taken by the other state or jurisdiction being conclusive evidence thereof;
30. Failure to report to the Board any adverse action taken against oneself by another licensing jurisdiction (United States or foreign), by any peer review body, by any health care institution, by any professional or medical society or association, by any governmental agency, by any law enforcement agency, or by any court for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
31. Failure to report or cause a report to be made to the Board of any physician upon whom a physician has evidence or information that appears to show that the physician is incompetent, guilty of negligence, guilty of a violation of this act, engaging in inappropriate relationships with patients, is mentally or physically unable to practice safely, or has an alcohol or drug abuse problem;
32. Failure of physician who is the chief executive officer, medical officer, or medical staff to report to the Board any adverse action taken by a health care institution or peer review body, in addition to the reporting requirement in 31. (Note: a report under 31 may need to wait until the peer review and due process procedures are completed, but the report under 30 must be reported immediately without waiting for the final action of the health care institution and applies to all physicians not just staff physicians);
33. Failure to report to the Board a surrender of a license, a limitation or any restriction to practice medicine in another state or jurisdiction, or a surrender of membership on any medical staff or in any medical or professional association or society resulting in the surrender of the authority to utilize controlled substances issued by any state or federal agency, or any agreement for the limitation or restriction of privileges at any medical care facility while under investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
34. Failure to report any adverse judgment, award, or settlement against the licensee resulting from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
35. Failure to report to the Board any adverse judgment, settlement, or award arising from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
36. Failure to provide pertinent and necessary medical records to another physician or patient

in a timely fashion when legally requested to do so by the subject patient or by a legally designated representative of the subject patient regardless of whether the patient owes a fee for services;

37. Improper management of medical records, including failure to maintain timely, legible, accurate, and complete medical records and to comply with the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Part 160 and 164, of the Health Insurance Portability and Accountability Act of 1996;
38. Failure to furnish the Board, its investigators, or representatives information legally requested by the Board or failure to comply with a Board subpoena or order;
39. Failure to cooperate with a lawful investigation conducted by the Board;
40. Violation of any provision(s) of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board;
41. Engaging in conduct calculated to, or having the effect of, bringing the medical profession into disrepute or conduct unbecoming of the medical profession, including but not limited to, violation of any provision of a national code of ethics acknowledged by the Board and/or failing to uphold the standards of the profession;
42. Failure to follow generally accepted infection control procedures;
43. Failure to comply with any state statute or board regulation regarding a licensee's reporting responsibility for HIV, HBV (hepatitis B virus), seropositive status or any other reportable condition (including child abuse and vulnerable adult abuse) or disease;
44. Practicing medicine in another state or jurisdiction without appropriate licensure;
45. Conduct which violates patient trust, exploits the physician-patient relationship, or violates professional boundaries, regardless of the medium;
46. Failure to offer appropriate procedures/studies, failure to protest inappropriate managed care denials, failure to provide necessary service, or failure to refer to an appropriate provider within such actions are taken for the sole purpose of positively influencing the physician's or the plan's financial wellbeing;
47. Providing treatment or consultation recommendations, including issuing a prescription via electronic or other means, unless the physician has obtained a history and physical evaluation of the patient adequate to establish diagnosis and identify underlying conditions and/or contraindications to the treatment recommended/provided;
48. Violating a Board formal order, condition of probation, consent agreement, or stipulation;
49. Representing, claiming, or causing the appearance that the physician possesses a particular medical specialty certification by a Board recognized certifying organization (ABMS, AOA) if not true;
50. Failing to obtain adequate patient informed consent;
51. Any conduct that may be harmful to the patient or the public;
52. 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;
53. Conduct likely to deceive, defraud, or harm the public;
54. 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;

55. 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;
56. 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;
57. 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
58. Failing to properly supervise, direct, or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation, or practice protocols.

Enforcement and Disciplinary Action Procedures

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

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

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

patient records and peer review records should have the same legal protection from disclosure as they have when in the possession of the licensee, the patient or the peer-review organization.

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

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

Summary Suspension: The Board should be authorized to summarily suspend or restrict a license prior to a formal hearing when it believes such action is required to protect the public from an imminent threat to public health and safety. The Board should be permitted to summarily suspend or restrict a license by means of a vote conducted by telephone conference call or other electronic means if appropriate Board officials believe such prompt action is required. Proceedings for a formal hearing should be instituted simultaneously with the summary suspension. The hearing should be set within a reasonable time of the date of the summary suspension. No court should be empowered to lift or otherwise interfere with such suspension while the Board proceeds in a timely fashion.

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

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

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

Section XVI: Compulsory Reporting and Investigation

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

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

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

1. All licensees licensed under the act,
2. All licensed health care providers,
3. The state medical associations and its components,
4. All hospitals and other health care organizations in the state, to include hospitals, medical centers, long term care facilities, managed care organizations, ambulatory surgery centers, clinics, group practices, coroners, etc.,
5. All chiefs of staff, medical directors, department administrators, service directors, attending physicians, residency directors, etc.,
6. All liability insurance organizations,
7. All state agencies,
8. All law enforcement agencies in the state,
9. All courts in the state,
10. All federal agencies (e.g., Drug Enforcement Administration, Food and Drug Administration, Centers for Medicare and Medicaid Services, Veterans Health Administration, and Department of Defense),
11. All peer review bodies in the state, and
12. All resident training program directors.

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

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

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

Any person, institution, agency, or organization who reports in good faith and not made in bad faith, a licensee pursuant to paragraphs 2 and 3 of this section should not be subject to civil damages or criminal prosecution for so reporting. A bad faith report is grounds for disciplinary action under the medical practice act. There should be no monetary liability on the part of, and no cause of action for damages should arise against, any person, institution, agency, or organization for reporting in good faith.

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

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

Section XVII. Impaired Physicians

The medical practice act should provide for the limitation, restriction, conditioning, suspension or revocation of the medical license of any licensee whose mental or physical ability to practice medicine with reasonable skill and safety is impaired. The Board should also have the ability to create a safe harbor for applicants to gain a license if they are known to the confidential physician health program approved by the Board.

The Board should have available to it a confidential impaired physician program approved by the Board and charged with the evaluation and treatment of licensees who are in need of rehabilitation. The Board may directly provide such programs or through a formalized contractual relationship with an independent entity whose program meets standards set by the Board. The Board shall have the ability to monitor or audit the program to ensure the program meets the requirements of the Board. The program approved by the Board shall by contract not have any financial relationship or incentive with those evaluation and treatment programs to which they refer practitioners. If available, the impaired physician program shall by contract be accredited by the appropriate national or international accrediting body and maintain those

standards throughout the duration of the contract. Per the contract, participants in the program must sign irrevocable disclosure confidentiality waivers, to include federal protections, that allow the program to share information with the Board, evaluators, treatment programs, and other entities as necessary to the monitoring and rehabilitation process.

The Board should be authorized, at its discretion, to require a licensee or applicant to submit to a mental or physical examination, body fluid, nail, or hair follicle test, or a chemical addiction, abuse, or dependency evaluation conducted by an independent evaluator designated or approved in advance by the Board. The results of the examination or evaluation should be admissible in any hearing before the Board or hearing officer, despite any claim of privilege under a contrary rule or statute. Every person who receives a license to practice medicine or who files an application for a license to practice medicine should be deemed to have given consent to submit to mental or physical examination or a chemical addition, abuse, or dependency evaluation, and to have waived all objections to the admissibility of the results in any hearing before the Board. If a licensee or applicant fails to submit to an examination or evaluation when properly directed to do so by the Board, the Board should be permitted to enter a final order upon proper notice, hearing, and proof of refusal.

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

1. Direct the licensee to submit to therapy, medical care, counseling, or treatment acceptable to the Board and comply with monitoring to ensure compliance;
2. Suspend, limit, restrict, or place conditions on the licensee's medical license for the duration of the impairment and monitoring or treatment; and/or
3. Revoke the licensee's medical license without further proof, need to establish a pattern, or a demonstration that the licensee is unable to be rehabilitated.

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.

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, unless or until the impaired licensee ceases to participate satisfactorily in the program. The Board should require a PHP to report any impaired licensee whose participation is unsatisfactory to the Board as soon as that determination is made. Participation in an approved PHP should not protect an impaired licensee from Board action

resulting from a report of licensee impairment from another source or resulting from an investigation of other medical practice violations. The Board should be the final authority for approval of a PHP, should conduct a review of its approved program(s) on a regular basis and should be permitted to withdraw or deny its approval at its discretion. The PHP should be required to report to the Board information regarding any violation of the medical practice act by a PHP participant, other than the impairment, even if the violation is unrelated to the licensee's impairment.

Section XVIII: Dyscompetent and Incompetent Licensees

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

The Board should be authorized to develop and implement methods to identify dyscompetent or incompetent licensees and licensees who fail to provide the appropriate quality of care. The Board should also be authorized to develop and implement methods to assess and improve licensee practices.

The Board should have access to a Board-approved assessment program(s) charged with assessing licensees' clinical competency and fitness for duty.

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

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

1. Suspend, revoke, or deny the licensee's medical license or application;
2. Restrict or limit the licensee's practice to those areas of demonstrated competence and comply with monitoring to ensure compliance;
3. Place conditions on the licensee's license; and/or
4. Direct the licensee to submit to a Board approved remediation program and comply with

monitoring to ensure compliance to resolve any identified deficits in medical knowledge or clinical skills acceptable to the Board.

Any licensee or applicant for licensure who is prohibited from practicing medicine, or who has had restrictions or conditions placed upon their license, under the above section, should be afforded, at reasonable intervals, an opportunity to demonstrate to the satisfaction of the Board that he/she can resume or begin the practice of medicine, or can practice without the restrictions or conditions, with reasonable skill and safety.

The Board should be authorized to require the assessment program to provide to the Board a written report of the results of the assessment with recommendations for remediation of the identified deficiencies. The assessment program shall treat the Board order requiring the assessment of the applicant or licensee as undisputed fact. The assessment program shall notify the board if the applicant or licensee attempts to submit other materials or alternative narratives that counter the facts from the Board.

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

Section XIX: Physician Assistants

The medical practice act should provide for the Board to license and regulate physician assistants.

Administration
Physician assistants should have full representation as full voting members on the board to include business, discipline, and hearing decisions on both physician and physician assistant matters.

Licensing
No person should perform or attempt to practice as a physician assistant without first obtaining a license from the Board and having a practice agreement in place.

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.

Each licensed physician assistant should renew their license and file updated documentation

stating their name and current address and any additional information as required by the Board. A fee set by the Board should accompany each renewal and filing of updated documentation.

The Board may require written notification if a practice agreement is changed or severed for a reason that would have an adverse effect for patient care.

Persons not licensed by the Board who hold themselves out as physician assistants should be subject to penalties applicable to the unlicensed practice of medicine.

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

1. Setting qualifications of education, skill, and experience for the licensing of a person as a physician assistant and providing forms and procedures for licensure and for renewal; and
2. Evaluating applicants for licensure as physician assistants.

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

Duties and Scope of Practice
A physician assistant should be permitted to provide those medical services that are within their training and experience and pursuant to a practice agreement.

Supervision and Practice Arrangements
The Board should be authorized to allow for individual, alternate, and/or group delegation/supervision models for physician assistants. Every physician supervising or employing a physician assistant should be legally responsible for the delegation of health care tasks to physician assistant and establishing a quality assurance mechanism within the practice agreement to fulfil the responsibilities of supervision. Nothing in these provisions, however, should be construed to relieve the physician assistant of any legal liability or 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 or not in a group supervision setting, he or she must provide for appropriate support of the physician assistant by another licensed physician. Each and every relationship should adhere to all statutory requirements for licensure.

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

FSMB Advisory Council of Board Executives

2020-2021 Members:

Stephen Brint Carlton, JD, Texas Medical Board

David Henderson, JD, North Carolina Medical Board

Micah Matthews, MPA, Washington Medical Commission

Ex Officio Members:

Anne Lawler, JD, RN, President, Administrators in Medicine

Patricia McSorley, JD, Vice President, Administrators in Medicine

Melanie de Leon, JD, MPA, FSMB Board of Directors, Washington Medical Commission

Frank Meyers, JD, FSMB Board of Directors, District of Columbia Board of Medicine

FSMB Staff Support:

John Bremer, Director of State Legislation & Policy

BRD RPT 21-2

REPORT OF THE BOARD OF DIRECTORS

Subject: **Report of the FSMB Ethics and Professionalism Committee: *Treatment of Self, Family Members, and Close Relations***

Referred to: **Reference Committee**

The Ethics and Professionalism Committee (The Committee) is a standing committee of the Federation of State Medical Boards. The committee charge, as stated in the FSMB bylaws, is to address ethical and professional issues pertinent to medical regulation. To this end, Committee tasks include:

1. Addressing Ethical and/or professional concerns expressed by State Medical Boards (SMBs).
2. Researching data pertinent to the issues and/or obtaining input from experts from the particular subject areas being considered.
3. Developing model policies for use by SMBs to be submitted for approval by the FSMB House of Delegates.

The 2020-21 Committee has drafted a position statement on the *Treatment of Self, Family Members, and Close Relations* to outline professional expectations for the avoidance of treatment for self, family, and close relations, except for in urgent or emergent situations, or where geographic isolation or other circumstances prevent access to care from another health professional.

The Committee met via videoconference in June of 2020 to consider a draft position statement, which was then circulated to state medical boards and external partner organizations in August and September of 2020. The Committee incorporated feedback received in September of 2020 and the FSMB Board of Directors considered a final draft at its October 2020 meeting.

ITEM FOR ACTION:

The Board of Directors recommends that:

The House of Delegates ADOPT the position statement on *Treatment of Self, Family Members, and Close Relations.*

Position Statement: Treatment of Self, Family Members, and Close Relations

When a member of a physician's immediate family such as a child, sibling, spouse or parent, or even a close personal contact, is in need of medical care, it is recommended that care be sought from and delivered by a different provider, rather than the physician with whom they have a personal relationship. Physicians should also avoid treating themselves, even for what may appear to be mild medical conditions, and instead seek medical treatment from another, more objective physician.

Physicians may be tempted for reasons of convenience, cost, or accessibility to provide medical treatment to themselves or to their family members. They may also receive requests from social or professional acquaintances for informal medical advice and even for treatment or prescriptions. Physicians may even receive pressure from family members for treatment and advice and feel compelled to provide it, perhaps even beyond their skill or expertise.[1] However, engaging in a treating relationship with someone with whom another pre-existing familial or social relationship exists presents several challenges and ethical concerns.

There may be certain circumstances, however, when treating or prescribing treatment to oneself, one's family members, or other close contacts may be permissible. These include:

- Urgent or emergent situations,
- Instances where necessary care cannot be accessed through another health professional, and
- Geographically isolated situations where one's family member or close personal relation is the only health care provider available.

In such instances, medical care provided must follow accepted standards and protocols, including a complete history and physical examination with required documentation in the patient's medical record. The patient's primary care provider must also be notified at the earliest opportunity of such intervention to ensure continuity of care. In addition, any treatment in these circumstances should be limited to the shortest course possible, ideally not to exceed a 30-day period, and should not include the prescription of controlled substances.

Aside from these limited circumstances, it is strongly recommended that medical care only be sought from an independent, objective provider.

Dual Relationships:

The physician-patient relationship is characterized by an inherent imbalance of power because of the specialized knowledge held by the physician, the significant access the physician has to intimate knowledge of the patient and their personal information, and the high degree of trust the patient typically places in the physician.

[1] American Medical Association, Code of Medical Ethics Opinion 1.2.1

The physician-patient relationship is also characterized by unique sets of responsibilities and expectations held by both the physician and the patient. Many of these responsibilities cannot be carried out effectively or completely in the presence of competing responsibilities or within relationships where intense emotions may be at play. Circumstances where different relationships involving competing responsibilities exist between the same individuals are sometimes labeled as “dual relationships.” Examples include a physician who is also the parent, spouse/partner, sibling or child of the patient, a physician who is treating themselves, and a physician who prescribes to an employee, colleague, or friend.

Dual relationships may result in confusion for the patient and the physician, especially when it is unclear which role is being, or should be, played. Informed consent, shared decision making, and patient autonomy can be significantly impacted when dual relationships exist. Patients might feel compelled to consent to treatment to which they would not otherwise consent when it is being recommended by a family member, or they may be less compliant with a treatment plan that has been prescribed by a family member. Patients may also feel compelled to withhold particular elements of their health history or symptoms that they find embarrassing or would prefer not to divulge to a family member.

Likewise, physicians may avoid embarrassing, awkward or sensitive questions in their history taking, or may decline to perform intimate components of physical examinations even when clinically indicated. Conversely, the appropriateness of such examinations in particular familial relationships are ethically questionable, especially where minor patients are involved. Additionally, professional judgment can become clouded when external, non-clinical considerations enter the picture. This may cause a physician to lose objectivity in decision-making and change their treatment patterns in ways that are contrary to best practices and dangerous for patients.

It is recommended as a best practice that physicians strive to avoid any treatment or prescribing that would put the physician in a dual relationship.

BRD RPT 21-3

REPORT OF THE BOARD OF DIRECTORS

Subject: Report of the FSMB Ethics and Professionalism Committee: Board Practices Regarding Expert Reviews in Quality-of-Care Cases

Referred to: Reference Committee

The Federation of State Medical Boards (FSMB) Ethics and Professionalism Committee is a standing committee of the FSMB charged with addressing ethical and professional issues pertinent to medical regulation.

The Committee is chaired by Jeffrey D. Carter, MD, and members include Andrea A. Anderson, MD, Ronald E. Domen, MD, Warren E. Gall, MD, Rev. Janet Harman, Venkata Jonnalagadda, MD, Patricia N. Hunter, MS, and Veronica Rodriguez de la Cruz, MD.

The Committee's charge for 2020-21 includes reviewing state medical board practices regarding expert reviewers for quality-of-care cases and reporting on key considerations.

The Committee met via videoconference on June 22, 2020, September 29, 2020, and January 28, 2021 to discuss the issue of expert reviews in quality-of-care cases, review research findings, and draft a report. In completing its charge, the Committee reviewed state statutes and rules on expert reviews, conducted a review of all board websites, and developed survey questions for inclusion in the FSMB's Annual State Medical Board Survey.

The report drafted by the Ethics and Professionalism Committee addresses current board practices, including the frequency at which reviews are conducted, models used for obtaining reviewers, recruitment strategies, compensation for reviewers, training and resources provided, challenges faced by boards and key considerations for addressing them.

The Committee's report was submitted to the FSMB Board of Directors and discussed at its meeting on February 18, 2021.

ITEM FOR ACTION:

For Information Only

Board Practices Regarding Expert Reviews in Quality-of-Care Cases

A Report of the FSMB Ethics and Professionalism Committee

Section 1: Introduction and Background

State medical boards depend on medical experts to review complaints and disciplinary cases when the quality of care provided by a licensee comes into question. Boards have adopted a wide variety of approaches for ensuring that regulatory decisions are informed by medical expertise and evidence about accepted standards of practice. In many cases, the required expertise is available from members of the board itself or staff employed by the board. In others, however, boards need to seek experts from outside of the board, often through medical consultants, external organizations, or volunteer licensees.

The FSMB has been made aware of challenges faced by many boards in their efforts to obtain appropriate experts in quality-of-care cases. This is despite the fact that the peer review process has long been "recognized and accepted as a means of promoting professionalism and maintaining trust."[1] As such, the FSMB Ethics and Professionalism Committee (the Committee) has engaged in research on board practices. The purpose of this report is to provide information about current practices among state medical boards, as well as key considerations that may help boards overcome challenges and obtain relevant expertise when needed.

Section 2: Current Board Practices

Frequency of Reviews

The frequency at which state medical boards seek external review in quality-of-care cases varies significantly. Two thirds of boards report seeking reviews up to 25 times in a typical year. However, 21% of boards also report seeking review for more than 100 cases in a year. As expected, many of the boards that license the highest numbers of physicians are among those which conduct the highest number of reviews. However, many smaller and mid-sized boards are found in this category, as are some boards who employ medical staff. Most boards will also seek more than one external review for a single case, when necessary.

Models for Obtaining Reviewers

The most common approach used by state medical boards for obtaining expert reviewers involves seeking medical consultants with expertise related to a given case (67% of responding boards indicated using this approach). Other common approaches include relying on board members with relevant expertise (38%), seeking volunteers from the licensee population (33%),

[1] AMA Code of Medical Ethics, Opinion 9.4.1.

employing medical staff (21%), and working with an external organization that provides expert reviewers (21%). In a small number of instances, boards do not have a role in securing or managing expert reviewers in quality-of-care cases; these processes are led by staff or a committee at the level of state government (3%).

When an in-state reviewer with the relevant expertise cannot be found, nearly all boards have the ability to seek a reviewer from another jurisdiction. Requirements related to expert reviewer opinions, testimony, and qualifications are typically specified in state statute. The FSMB maintains a Board-by-Board Overview of Expert Witness Qualifications which may be helpful for informational purposes. While many statutes provide general qualifications related to knowledge, skills, experience, training, and education, others specify additional criteria related to area of specialization, licensure status, minimum time spent in active clinical practice, and board certification.

Recruitment Strategies

The Committee conducted a review of state medical board websites and newsletters to obtain information about how boards recruit expert reviewers. The Committee found the following examples of approaches used to educate licensees about being expert reviewers and promote reviewer opportunities:

- Advertisements in board newsletters and bulletins
- Tab on top or side banner of board website homepage
- Educational videos about reviews with explanations of how to get involved
- Recruitment forms on board website, often in “board opportunities” section of site
- Information provided in “About the Board” section of board website
- Postings in “News”, “Notices”, or “Special Topics” section of board website
- Email address provided where expressions of interest can be sent

These recruitment strategies offer varying degrees of information and prominence on board websites. In some cases, appeals are made to licensees’ professional responsibility through statements about public protection or calls to “serve the profession.”

Compensation

State medical boards report a wide range of compensation for expert reviews. The majority of states compensate reviewers on an hourly basis. Compensation rates range from $100 to $500 per hour. Where reviewers are compensated on a per-case basis, boards report compensative from $150 per case for simple cases to $3,840 per case for complicated ones. However, many boards report that the range of compensation on a per-case basis can vary significantly depending on the nature of the case. In some instances, expert reviews take place on a purely voluntary basis and reviewers are not compensated. In other instances, incentives such as waivers of CME requirements are offered.

Training, Resources, and Guidance Provided to Reviewers

Nearly all state medical boards provide some form of guidance or training to expert reviewers. This most commonly involves the provision of information about how to conduct a review, including the process involved and how to review material provided. In some instances, this information is conveyed through reading material. In others, boards provide direct training to reviewers. Nearly half of boards report providing information to reviewers about maintaining uniformity among reviews, and more than a third of boards provide resources and guidance to reviewers about mitigating bias, such as detailed instructions for reviewing cases and preparing reports or relevant state statutes that are to be used as criteria in decision making.

Other topics covered by boards include the strict confidentiality of the process and materials involved, information about the expected standard of care in a given case, specific questions the board expects to be addressed as part of the review, expectations for avoiding conflicts of interest, and template reports to be used in reviews. In some instances, investigators who have been assigned a case that is under review are made available to expert reviewers.

Section 3: Challenges Related to Recruiting Reviewers and Conducting Expert Reviews

Most boards report high degrees of satisfaction with their processes for obtaining reviewers, aside from some boards that work with external organizations that provide reviewers. Despite these relatively high rates of satisfaction, boards still expressed difficulties related to recruiting expert reviewers, concerns with the quality of reviews provided, and numerous challenges related to the expert review process. These difficulties and challenges are explained in this section.

Cost and Reimbursement Limits

Several state medical boards have reported that costs associated with reviews are high and that reimbursement limits present barriers to recruiting additional experts. While reimbursement rates vary significantly, as mentioned above, and some boards are not able to reimburse reviewers at all, the Committee has not found a correlation between high reimbursement rates and high satisfaction rates or low rates of difficulty finding reviewers (after accounting for type of model used).

Complexity of Cases

State medical boards have reported facing difficulties finding reviewers based on the complexity of cases for two reasons: 1) complex cases dissuade otherwise willing individuals because of the work and time required to complete the review, and 2) the most complex cases are often the ones where a very specific type of expertise is required, thereby reducing the size of the pool of experts available to review the case.

Availability of Reviewers

The most common difficulty cited by state medical boards in finding expert reviewers relates generally to their availability. A lack of available reviewers has manifested itself for a variety of reasons, including:

- A small in-state or national pool of experts
- Legislative restrictions on the ability of the board to choose a reviewer
- Restrictions placed on physicians' ability to engage in contract work by employers or insurance providers
- Cases address a niche specialty with very few members
- Reluctance on the part of licensees to become involved in disciplinary cases, especially when there is a potential need to testify at a hearing
- Reluctance to criticize peers within the same specialty, healthcare network, or profession

State medical boards have also speculated that increased specialization and healthcare network growth are compounding factors in their ability to obtain expert reviewers.

Boards have reported fewer challenges in obtaining reviewers practicing in internal medicine, radiology, and ophthalmology. Specialties listed as particularly challenging include pain management/opioid prescribing, addiction medicine, psychiatry, nephrology, neurology, neurosurgery, orthopedic spine surgery, and radiation oncology.

Section 4: Considerations for State Medical Boards

Given the variability of approaches, degrees of autonomy available to state medical boards, and rates of satisfaction with board processes for obtaining expert reviewers, it is not possible to delineate a single process, or even several processes, as a best practice for obtaining reviewers. The data available to the Committee suggest that boards need to discover and develop approaches that work best given their local context. The Committee wishes therefore to highlight the following considerations for those boards that may wish and have an ability to alter their processes to overcome the specific challenges they face.

State medical boards can seek ways of broadening the pool of available reviewers by working with legislatures to allow out of state (or even out of country) reviewers, where this is not currently permitted. Boards may also wish to consider seeking assistance from an outside organization which can help in finding, training and vetting reviewers.

It is possible that a clear understanding of the process involved in conducting an expert review might support recruitment efforts. State medical boards may therefore wish to develop additional educational materials about the review process that include redacted sample reports and clear projections of time and work involved. Where board staff, such as investigators, are

available to provide guidance about the process or liaise with reviewers, this can be promoted to prospective reviewers. Resources about mitigation of bias, management of conflicts of interest, clear criteria for decision making, and uniformity among reviews can also help foster trust in the expert review process among licensees and a willingness to serve as reviewers.

Boards may wish to consider how prominently they feature information about applying to be a reviewer and consider multiple modalities for promoting opportunities. Possibilities include multiple pages on board websites, especially through a direct link clearly placed on the board's homepage, and advertisements in board newsletters and bulletins.

Boards may wish to appeal to medical professionalism in their efforts to obtain expert reviewers. This responsibility is enshrined in the codes of ethics of multiple specialties and across many professions. It is also listed in the Code of Ethics of the American Medical Association. The FSMB can also promote the message of professionalism at the national level through its collaborative relationships with the American Medical Association, American Osteopathic Association, and Council of Medical Specialty Societies.

Section 5: Conclusion

State medical boards depend on the expert opinion of medical professionals in order to effectively carry out their mission to protect the public. Ensuring that medical expertise is brought to bear on regulatory decisions is a key part of professional self-regulation and an important responsibility in medical professionalism. While the process of obtaining expert reviewers in quality-of-care cases presents numerous challenges, the Committee hopes that the considerations provided in this report are helpful to state medical boards.

BRD RPT 21-4

REPORT OF THE BOARD OF DIRECTORS

Subject: Report of the FSMB Workgroup on Emergency Preparedness and Response

Referred to: Reference Committee

The Federation of State Medical Boards (FSMB) Workgroup on Emergency Preparedness and Response, chaired by Dr. Cheryl Walker-McGill, is charged with:

1. Coordinating and working with external stakeholders including, but not limited to, representatives from Administrators in Medicine, the National Association of Boards of Pharmacy, the National Council of State Boards of Nursing, the Emergency Management Assistance Compact, and the federal government;[1]
2. Collecting and evaluating federal and state[2] experiences and outcomes in response to the national emergency caused by the COVID-19 pandemic, including those measures related to expedited state and territorial medical licensure and other means of mobilizing and expanding the health care workforce and its resulting impact on quality of, and access to, health care;
3. Evaluating existing policy resources including, but not limited to, the FSMB's policies related to telemedicine, physician wellness, and emergency licensure to identify and recommend policy modifications applicable in times of a public health and/or national emergency;
4. Identifying and recommending critical data elements and regulatory safeguards to ensure the integrity of the deployed health professional workforce during a public health and/or national emergency;
5. Evaluating the capacity and readiness of the FSMB's Physician Data Center (PDC) and other national databases to support the deployment of the healthcare workforce, both in person and through telehealth, in response to a public health and/or national emergency; and
6. Developing recommendations for universal tools and resources that could be used by state and federal agencies to efficiently and safely mobilize and expand the health care workforce in response to a public health and/or national emergency.

[1] *Primarily agencies within the U.S. Department of Health and Human Services*
[2] *"state" to include state and territorial medical and osteopathic boards, state emergency services offices, departments of public health, and other health professional regulatory boards, including nursing and pharmacy.*

The Workgroup continued the work of the Ad Hoc *Task Force on Pandemic Preparedness,* formed in February 2020 by FSMB Chair at the time Scott Steingard, DO, and chaired by FSMB CEO Humayun Chaudhry, DO, MS, MACP.

The Workgroup has met 14 times since May 2020 and has prepared a report and recommendations as it continues its work during the ongoing COVID-19 pandemic. The report includes information on the following subjects:

- Verification of Provider Identity in a Public Health Emergency
- Utilization of Telehealth During Public Health or National Emergencies
- Commitment to the Utilization of Scientific Evidence
- Combatting Racial and Ethnic Disparities in Healthcare and Public Health Emergencies
- State Medical Board Planning for Future Emergencies

The report also includes the following recommendations:

> **Recommendation 1:** The FSMB should work with state medical boards, health professional regulatory boards, and relevant stakeholders to develop model language to clarify emergency licensure processes.
>
> **Recommendation 2:** The FSMB should establish a Workgroup to update the *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (2014),* taking into account the lessons learned during the COVID-19 pandemic.
>
> **Recommendation 3:** The FSMB should develop strategies for state medical boards to help combat health inequities and bias in medical discipline in their jurisdictions.
>
> **Recommendation 4:** State medical boards should engage in periodic reviews of their emergency preparedness plans to ensure that such plans include current contact information for staff, state emergency management offices, partner organizations and procedures for communications.
>
> **Recommendation 5:** The FSMB should review and update its *Emergency and Disaster Preparedness Plan: A Guide for State Medical Boards* document to encompass lessons learned during COVID-19, including plans for additional types of emergencies and disasters that may occur in the future.
>
> **Recommendation 6:** State medical boards should identify their capabilities for remote operations during emergencies and remain informed of any emergency changes to their state's open-meeting laws during such times.

ITEM FOR ACTION:

The Board of Directors recommends that:

The House of Delegates ADOPT the recommendations contained in the *Report of the Workgroup on Emergency Preparedness and Response,* and the remainder of the Report be filed.

Report of the FSMB Workgroup on Emergency Preparedness and Response

INTRODUCTION

The Workgroup on Emergency Preparedness and Response (the "Workgroup"), which is chaired by Dr. Walker-McGill, began meeting in May 2020 to discuss the experiences and lessons learned from state and territorial medical boards (and other health professional regulatory boards, such as nursing and pharmacy) during the COVID-19 pandemic, identify key learnings and best practices, and consider potential recommendations for the ongoing crisis and to better prepare for future pandemics.

BACKGROUND

In February of 2020, the Chair of the Federation of State Medical Boards (FSMB) at the time, Scott Steingard, DO, created an Ad Hoc *Task Force on Pandemic Preparedness,* chaired by FSMB CEO Humayun Chaudhry, DO, MS, to begin addressing the potential needs of state medical and osteopathic boards ("medical boards"), related to medical licensure and regulation, and the U.S. healthcare workforce in the face of a possible pandemic due to the SARS-CoV-2 virus. The novel virus had been identified in Wuhan, China by the World Health Organization (WHO) in December 2019 as the cause of coronavirus disease 2019, also abbreviated COVID-19. On March 11, 2020, the WHO formally declared COVID-19 a global pandemic[1] and two days later, on March 13, 2020, President Donald Trump declared COVID-19 a national emergency in the United States.[2] Emergency declarations by governors in all U.S. states and territories followed shortly thereafter, resulting in widespread adoption of licensure waivers and modifications to enable and expand licensure portability, increase access to care (for in-person care and telemedicine) and expand healthcare workforce capacity.[3] As the impact of COVID-19 continued into May 2020, FSMB's new Chair, Cheryl Walker-McGill, MD, MBA, transformed the *ad hoc* task force into the *Workgroup on Emergency Preparedness and Response.*

The Workgroup held Zoom-based virtual meetings almost every three weeks since its formation to identify challenges and concerns facing medical boards. While the Workgroup will continue to meet in the coming year, it offers the following report and recommendations related to the COVID-19 pandemic and for similar public health and national emergencies that may develop in the future. The Workgroup may bring additional recommendations for consideration next year, including for other types of public health or national emergencies, as the COVID-19 pandemic continues into 2021.

WORKGROUP CHARGE

The *FSMB Workgroup on Emergency Preparedness and Response* was charged with:

1. Coordinating and working with external stakeholders including but not limited to representatives from Administrators in Medicine (AIM), the National Association of Boards of

[1] The Director of the World Health Organization announces the designation of COVID-19 as pandemic.
[2] President Donald Trump issues a Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak.
[3] Information detailing state licensure modification and waivers during the pandemic is available on FSMB's COVID-19 Site.

Pharmacy (NABP), the National Council of State Boards of Nursing (NCSBN), the Emergency Management Assistance Compact (EMAC), and the federal government; [4]

2. Collecting and evaluating federal and state[5] experiences and outcomes in response to the national emergency caused by the COVID-19 pandemic, including those measures related to expedited state and territorial medical licensure and other means of mobilizing and expanding the healthcare workforce and its resulting impact on the quality of, and access to, health care;
3. Evaluating existing policy resources including, but not limited to, the FSMB's policies related to telemedicine, physician wellness, and emergency licensure to identify and recommend policy modifications applicable in times of a public health and/or national emergency;
4. Identifying and recommending critical data elements and regulatory safeguards to ensure the integrity of the deployed health professional workforce during a public health and/or national emergency;
5. Evaluating the capacity and readiness of the FSMB's Physician Data Center (PDC) and other national databases to support the deployment of the healthcare workforce, both in person and through telehealth, in response to a public health and/or national emergency; and
6. Developing recommendations for universal tools and resources that could be used by state and federal agencies to efficiently and safely mobilize and expand the healthcare workforce in response to a public health and/or national emergency.

WORKGROUP PROGRESS & RECOMMENDATIONS TO DATE

Since May 2020, the Workgroup has heard presentations from a number of speakers, including outside experts, and discussed the national and international status of the COVID-19 pandemic; ongoing state and federal response efforts; statistical information related to cases, transmission rates and fatalities; and available updates on vaccine development and administration. The Workgroup used its frequent meetings to identify and discuss the most pressing issues that have arisen, including the application of state and federal Executive and Emergency Orders, the rapidly changing landscape of utilization and regulation of telehealth, the impact of health inequities that the pandemic has underscored, the need to address the spread of misinformation that poses a challenge to public health-focused harm-reduction strategies, and the challenges faced by member medical boards in transitioning work to a remote environment.

The Workgroup has identified several pressing issues that are discussed below and offered several recommendations for further action.

Section 1. Verification of Provider Identity in a Public Health Emergency

At one point or another during the COVID-19 pandemic, all states and territories felt the need to issue temporary emergency waivers and modifications related to licensure requirements to meet surges in healthcare workforce demands.[6] These modifications ranged from the creation of expedited licensure

[4] This primarily includes agencies within the U.S. Department of Health and Human Services.
[5] "state" to include state and territorial medical and osteopathic boards, state emergency services offices, departments of public health, and other health professional regulatory boards, including nursing and pharmacy.
[6] *See* FSMB's COVID-19 Website.

pathways to full waivers of state licensure requirements for certain practitioners with an active license in another state/jurisdiction.[7] As these waivers were put into place, the FSMB's board of directors and senior staff recognized there was a dearth of specific guidance for rapidly mobilizing the healthcare workforce on a national scale and released its *Recommendations for Medical License Portability During the COVID-19 Pandemic.* These timely recommendations outlined critical licensure portability data elements that "contain safeguards that ensure that care being provided balances public health with public safety," including steps that need to be taken to confirm practice eligibility, verify licensure, limit duration, and require documentation of all provider-patient interactions.[8]

The Workgroup discussed the implementation of waivers and modifications and agreed that while enhanced workforce mobility during a public health emergency may be needed to provide necessary patient care, it remains critical that the identity and licensure status of health care practitioners is verified prior to allowing them to provide health care services to patients. The Workgroup identified challenges states were experiencing in conducting and coordinating the necessary verifications in an expeditious manner. In addition to managing large numbers of volunteer applications, particularly in so-called COVID-19 "hot spots," some states also faced challenges in coordinating verification efforts and activating or utilizing existing verification and mobility resources. As one example, the Emergency Management Assistance Compact (EMAC),[9] which was previously adopted as law in all U.S. states, territories, and the District of Columbia, was not immediately activated and utilized in all jurisdictions during COVID-19. The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP),[10] a federal program designed to assist with verification of volunteers' credentials during disasters and was also created prior to COVID-19, was similarly not utilized across all jurisdictions at the onset of the pandemic.

Early in the crisis, the Workgroup decided to appoint a subcommittee to determine consensus on those critical data elements about health care providers that could support a uniform approach to verifying the identity and licensure status of volunteers offering their services across state or territorial boundaries in an emergency. In addition to identifying these data elements, the Workgroup served as a resource for the development and implementation of *ProviderBridge.org*, a new online data platform which was created by the FSMB with funding from the Coronavirus License Portability Grant Program of the Health Resources and Services Administration (HRSA).[11] The *ProviderBridge.org* platform streamlines the process for mobilizing licensed health care professionals during a public health or national emergency such as COVID-19 and is designed to also be useful for future public health or national emergencies, as well."[12] Specific data elements (many of which the subcommittee and Workgroup also discussed) as critical to screen volunteering health care providers include verified information related to: name, current and past

[7] State-specific information available in FSMB's chart titled *U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19*.

[8] FSMB Recommendations for Medical License Portability During COVID-19 Pandemic.

[9] Additional information on the *Emergency Management Assistance Compact* is available at: https://www.emacweb.org/

[10] Additional information on the Emergency System for Advance Registration of Volunteer Health Professionals is available at: https://www.phe.gov/esarvhp/pages/about.aspx

[11] Provider Bridge is made possible by grant funding through the Health Resources and Services Administration (HRSA), the U.S. Department of Health and Human Services (HHS), and the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

[12] Additional information on *ProviderBridge* is available at: https://www.providerbridge.org/

license(s) information, provider type, school, graduation year, specialty certification or area of practice, National Provider Identifier (NPI) number, any history of disciplinary action, and Drug Enforcement Agency (DEA) number. The *ProviderBridge.org* platform offers a customer service hub that contains resources for providers and others seeking to navigate current state licensure requirements, including those specific to telehealth, during these states of emergency.

In addition to the deployment of licensed health care providers across states, the Workgroup discussed the role of medical students, residents and other health care trainees to address workforce capacity during the COVID-19 pandemic. In some cases, fourth-year medical students were given the option of early graduation to provide additional capacity for care (either on the front lines under supervision or to assist with data entry and telephonic and online communications with patients) in heavily impacted regions of the country. Resident physicians were also deployed to assist during the pandemic, oftentimes in areas outside of their area of specialty training in their accredited GME program. A physician in her 5th year of training as a fellow in cardiology, as one example under a type of scenario that was deemed acceptable by the Accreditation Council for Graduate Medical Education, was permitted to spend the bulk of her time engaged in supporting patients in a general medicine inpatient unit. The need for additional health care capacity led to at least 22 states approving pathways to practice for early medical school graduates via temporary permits or emergency licenses. In some states, such as New York, early graduates were given the title of "COVID-19 Junior Physician" to distinguish them from traditional residents and fellows in training. The availability of early graduates prompted national medical organizations, such as the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM), to begin discussing the types of guidance and resources that would be needed for early graduates and residents, including related to training and oversight.[13] The Workgroup noted that while these efforts may be necessary in emergencies, it is critical that early graduates, resident physicians and other health care trainees be appropriately supervised and mentored for their safety and that of patients.

Section 2. Utilization of Telehealth During Public Health or National Emergencies

Enabling continuity of care across state lines can be a major concern during a public health or national emergency, particularly when travel restrictions are in place. In non-emergency times, continuity of care can be an issue for patients who need to travel to see their healthcare providers. This has already led to several states addressing this issue through adoption of legislation or an Executive Order[14] and has also been a major focus of legislative efforts at the federal level during COVID-19. University students who were unable to access their university health care providers, particularly for mental health treatment, received the attention of policy makers due to the lack of clarity of state requirements regarding access

[13] Information on these issues has been made available by the American Medical Association, the Association of American Medical Colleges (AAMC), the American Association of Colleges of Osteopathic Medicine (AACOM), and the Accreditation Council for Graduate Medical Education (ACGME). The Coalition for Physician Accountability's Statement on *Maintaining Quality and Safety Standards Amid COVID-19* and additional consensus statements issued during the COVID-19 pandemic are included in the Appendix.

[14] For example, legislation enacted in New Jersey ensures that out-of-state healthcare practitioners may continue to provide telemedicine to New Jersey residents until 90 days following the public health emergency (S. 2467). In Virginia, Executive Order 57 allowed health care practitioners with an active license issued by another state to provide continuity of care to their current patients who are Virginia residents through telehealth services.

to care across state lines. Healthcare systems utilized the relaxed licensure restrictions to take care of their patients with chronic conditions remotely, reducing the potential for exposure for their most vulnerable patients. However, policy inconsistencies among the states for remote access has been cited as problematic and contributing to confusion on the part of providers and patients alike, leading to a call by some policy makers to address license portability across state lines more uniformly and definitively during COVID-19 and future similar public health emergencies.[15]

Telehealth has been broadly used during the COVID-19 pandemic to address access to care, at one point surpassing all ambulatory in-person visits in the United States during a 6-8 week period early in the crisis. Among its many benefits, telehealth-enabled providers were able to prevent potentially exposing patients and themselves to COVID-19. In late March of 2020, the Center for Medicare and Medicaid Services (CMS) acted under section 1135 of the Social Security Act (1135 Waivers) to expand the list of reimbursable telehealth services and remove the state-based licensure requirement for reimbursement when providing telehealth across state lines during a public health emergency.[16] Many different technology platforms and modalities were deemed acceptable during the pandemic for delivering telehealth. For example, audio-only encounters have been widely utilized during COVID-19,[17] and providers have highlighted the value of audio-only visits for those patients without access to smartphones, computers, or broadband internet access. Audio-only has been temporarily reimbursed at the national level to account for this utilization.[18] Store-and-forward, new technology platforms (i.e. *FaceTime*, *Skype*, *Zoom*), and other online means may need to be made available for telemedicine purposes during emergencies in the future but patient privacy concerns will need to be addressed in all of them. When retrospective data from the COVID-19 pandemic are made available, successful and appropriate forms of telehealth will need to be identified and evaluated to increase access to care as needed during future emergencies.

Nearly all U.S. jurisdictions created mechanisms during the COVID-19 pandemic to allow for the practice of telehealth across state lines in order to provide timely, safe and robust health care during pandemic surges.[19] The variability by jurisdiction for licensing waivers and processes, however, created confusion among some physicians and regulators.[20] The Workgroup concurred that there is value in the development and promulgation of model state legislative language on the use of telehealth during a public health emergency. Such model language should address the following:

[15] In response to these concerns, legislators introduced the *Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act* (S. 4421, H.R. 8382) with bipartisan support to allow health care professionals to provide in-person and telehealth services in any jurisdiction based on their authorization to practice in any one state or territory during a public health emergency.

[16] A summary of the COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers is available at: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

[17] Several states explicitly allowed the use of audio-only telemedicine encounters during the emergency. *See* CT Executive Order 7G, Delaware House Bill 348, Iowa Emergency Proclamation, and Montana Governor's Directive on telemedicine and telehealth services.

[18] The CMS list of covered telehealth services for the COVID-19 pandemic is available at: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

[19] *See* FSMB's chart *titled U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19*.

[20] State medical boards have already recognized the need for some uniformity during emergencies. *See* FSMB Report of the FSMB Board of Directors: Emergency Licensure Following a Natural Disaster.

- Intent of the Executive/Emergency Order.
- Scope and Duration of the Executive/Emergency Order.
- Language providing the jurisdiction in which the patient is located with the ability to verify a provider's identity, investigate complaints, and take disciplinary action against a provider's license in the jurisdiction, when warranted.
- Language clarifying that laws of the state where the patient is located will apply for health care providers practicing across state lines.
- Clarification regarding remote care where there is an existing physician-patient relationship.

FSMB policy affirms that the standard of care in the practice of medicine should be the same regardless of platform or modality, whether in-person or virtual. The Workgroup agreed that this policy should apply to emergency situations, as well.[21]

Section 3. Commitment to the Utilization of Scientific Evidence

The Workgroup has repeatedly discussed the importance of scientific information in combatting a pandemic. Throughout the COVID-19 pandemic, there have been national and international concerns about the spread of false or misleading information undermining containment efforts and endangering public health. The widespread promotion and sharing of misinformation (and even disinformation) have occurred on social media and other platforms, at times by licensed professionals, prompting national and global organizations to affirm the importance of scientific evidence when combatting a global pandemic.[22]

There have been reports of health care providers ignoring scientific evidence regarding the treatment and/or mitigation of COVID-19. An FSMB survey of state medical boards during the pandemic found that 64% of respondents confirmed that they had received complaints of physicians failing to wear face coverings during patient encounters. Accordingly, the FSMB's Ethics and Professionalism Committee, chaired by FSMB Board Member Jeffrey Carter, MD, considered the matter and suggested the FSMB's Board of Directors issue a public statement on the matter, which it did, affirming that "(w)earing a face covering is a harm-reduction strategy to help limit the spread of COVID-19, especially since physical distancing is not possible in health care settings. When seeing patients during in-person clinical encounters, physicians and physician assistants have a professional responsibility to wear a facial covering for their own protection, as well as that of their patients and society as a whole."[23]

Section 4. Combatting Racial and Ethnic Disparities in Healthcare and Public Health Emergencies

Racial and ethnic disparities in healthcare have historically been exacerbated during public health emergencies, and this has been the case with the COVID-19 pandemic.[24] The principle of justice dictates

[21] The FSMB's *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine* identifies the need for a consistent standard of care "notwithstanding the delivery tool or business method in enabling Physician-to-Patient communications," at page 2.
[22] *See* Coalition for Physician Accountability's *Statement to Safeguard the Public, Protect our Health Care Workforce during the COVID-19 Pandemic.*
[23] FSMB Statement on Wearing Face Coverings During Patient Care.
[24] *See* American Medical Association's COVID-19 Health Equity Resources.

that all patients deserve equal consideration and equitable provision of care according to their individual needs. The failure to provide care according to patient needs puts patients at risk. As such, state medical boards have a role in addressing health inequity during emergency and non-emergency times.

The Workgroup heard presentations from esteemed scholars with expertise in health equity addressing the root causes of health disparities, health inequity in Community Health Centers, the historical context of inequality in healthcare, and potential resources and strategies that may be used to identify discrimination and systems that exacerbate inequities. These presentations and the thoughtful Workgroup discussions that followed highlighted the fact that health inequity goes far beyond the scope of the COVID-19 pandemic, and that data related to race, ethnicity, and other factors must inform any strategy for addressing it. The Workgroup recognized the lack of data collection in these areas and limited availability of existing data during the pandemic.

The Workgroup acknowledges the systemic causes of many health disparities and recognizes the important role that state medical boards may be able to play in addressing them. However, progress in this area will be limited without the requisite data to foster a greater understanding of the causes of disparities to inform the development of potential strategies that allow the medical community to combat health inequity beyond the COVID-19 pandemic.

Section 5. State Medical Board Planning for Future Emergencies

The COVID-19 pandemic revealed a dearth of resources for interstate and intrastate coordination in response to national emergencies as states were challenged in facilitating the national mobilization of the healthcare workforce. The pandemic also highlighted challenges related to the emergency training and redeployment of healthcare professionals within their own states, prompting national groups like the *Coalition for Physician Accountability*, of which the FSMB is a charter member, to develop resources for use during COVID-19.[25] In light of these experiences, the Workgroup agreed that it would be beneficial for state public health and emergency management offices and state medical boards to establish working relationships and procedures to prepare for future emergencies. Periodic meetings between state public health and emergency management offices and state medical boards in non-emergency times may also aid strategic planning efforts when emergencies occur.

The Workgroup recommends emergency planning documents include "all-hazards" approaches to address both short-term incidents and long-term/chronic emergencies like COVID-19. CMS defines an all-hazards approach as "an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters…."[26] Such planning documents take an integrated approach and focus on organizational capacity, which would allow state medical boards to be prepared for a range of emergency scenarios. The FSMB's 2010 document, *Emergency and Disaster Preparedness Plan: A Guide for State Medical Boards*, was created after Hurricane Katrina devastated parts of the United States and focused mainly on the needs of state medical boards during a natural disaster, without including many resources specific to long-

[25] Coalition for Physician Accountability's Statement on *Maintaining Quality and Safety Standards Amid COVID-19*.
[26] CMS Emergency Preparedness Regulation, Clarifications on Definitions.

term/chronic events. The document requires updating to include a broader range of emergency planning resources.

The COVID-19 pandemic required every state and territorial medical board to transition daily operations to remote work ("Work from Home") and to conduct board meetings and hearings virtually. This was a challenge as many boards did not have the authority under their state or territory's Open Meeting laws to meet virtually. Accordingly, Open Meeting laws had to be modified by gubernatorial Executive Orders, state and territorial legislative actions, and emergency declarations in at least 40 states to address this issue.[27]

Section 6. Recommendations

The FSMB recommends that:

Recommendation 1: The FSMB should work with state medical boards, health professional regulatory boards, and relevant stakeholders to develop model language to clarify emergency licensure processes.

Recommendation 2: The FSMB should establish a Workgroup to update the *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (2014)*, taking into account the lessons learned during the COVID-19 pandemic.

Recommendation 3: The FSMB should develop strategies for state medical boards to help combat health inequities and bias in medical discipline in their jurisdictions.

Recommendation 4: State medical boards should engage in periodic reviews of their emergency preparedness plans to ensure that such plans include current contact information for staff, state emergency management offices, partner organizations and procedures for communications.

Recommendation 5: The FSMB should review and update its *Emergency and Disaster Preparedness Plan: A Guide for State Medical Boards* document to encompass lessons learned during COVID-19, including plans for additional types of emergencies and disasters that may occur in the future.

Recommendation 6: State medical boards should identify their capabilities for remote operations during emergencies and remain informed of any emergency changes to their state's open-meeting laws during such times.

[27] *See* Law360, *Public Meeting Requirements in the Age of COVID-19*.

WORKGROUP MEMBERS

Cheryl L. Walker-McGill, MD, MBA (Workgroup Chair)
Chair, FSMB Board of Directors;
North Carolina Medical Board

Robin N. Hunter Buskey, DHSc, PA-C
North Carolina Medical Board Presidential Advisory Group

Lawrence J. Epstein, MD
New York State Board for Medicine

Patricia A. King, MD, PhD, FACP
FSMB Board of Directors;
Vermont Board of Medical Practice

Susan Ksiazek, RPh, DPh
National Association of Boards of Pharmacy;
New York State Office of Professional Medical Conduct

Anne K. Lawler, JD, RN
President, Administrators in Medicine;
Idaho Board of Medicine

L. Blanton Marchese
Virginia Board of Medicine

Frank B. Meyers, JD (Alternate)
Member FSMB Board of Directors;
District of Columbia Board of Medicine

Ex Officio:
Kenneth B. Simons, MD
Chair-Elect, FSMB Board of Directors;
Wisconsin Medical Examining Board

Scott A. Steingard, DO
Immediate Past Chair, FSMB Board of Directors;
Arizona Board of Osteopathic Examiners in Medicine & Surgery

Janelle A. Rhyne, MD, MA, MACP
Past Chair, FSMB Board of Directors;
North Carolina Medical Board;
Chair, FSMB Foundation

Candace L. Sloane, MD
Massachusetts Board of Registration in Medicine

Katherine A. Thomas, MN, RN, FAAN
National Council of State Boards of Nursing;
Texas Board of Nursing

Jacqueline A. Watson, DO, MBA, CMBE
District of Columbia Department of Public Health

Sherif Z. Zaafran, MD
Texas Medical Board

Denise Pines, MBA
Medical Board of California

Staff Support:
Humayun J. Chaudhry, DO, MS, MACP
FSMB President-CEO

Michael P. Dugan, MBA
FSMB Chief Operating Officer

Eric M. Fish, JD
FSMB Chief Legal Officer

David A. Johnson, MA
FSMB Chief Assessment Officer

Todd A. Phillips, MBA
FSMB Chief Financial Officer

Lisa A. Robin, MLA
FSMB Chief Advocacy Officer

Kandis McClure, JD, MPH
FSMB Dir., Federal Advocacy and Policy

Appendix

1. Coalition for Physician Accountability's *Statement to Safeguard the Public, Protect our Health Care Workforce during the COVID-19 Pandemic* (April 9, 2020)
2. Coalition for Physician Accountability's *Statement on Maintaining Quality and Safety Standards Amid COVID-19* (May 11, 2020)
3. Coalition for Physician *Accountability's Final Report and Recommendations for Medical Education Institutions of LCME-Accredited, U.S. Osteopathic, and Non-U.S. Medical School Applicants* (May 16, 2020)
4. Coalition for Physician Accountability's *Compendium of Resources for the Implementation of Recommendations for Medical Education Institutions of LCME-Accredited, U.S. Osteopathic, and Non-U.S. Medical School Applications* (May 16, 2020)
5. Coalition for Physician Accountability's *Final Report and Recommendations of the Coalition's Work Group on Learner Transitions from Medical Schools to Residency Programs in 2020* (May 18, 2020)
6. Coalition for Physician Accountability's *Statement on Public Health* (December 1, 2020)
7. Accreditation Council for Graduate Medical Education's ACGME Reaffirms its Four Ongoing Requirement Priorities during COVID-19 Pandemic (April 5, 2020)
8. Accreditation Council for Graduate Medical Education's (ACGME) Updated: Supplemental Guidance Regarding the COVID-19 Pandemic, ACGME Accreditation, and Sponsoring Institution Emergency Categorization (December 21, 2020)

Coalition for Physician Accountability

Safeguard the Public, Protect our Health Care Workforce during the COVID-19 Pandemic

April 9, 2020

The member organizations of the Coalition for Physician Accountability (www.physicianaccountability.org) have released the following statement in support of strengthened efforts that must be in place to safeguard the public, and to protect our nation's health care workforce during the COVID-19 pandemic so they remain able to meet the public's needs.

The Coalition's members include the national organizations responsible for the accreditation, assessment, licensure and certification of physicians throughout their medical career, from medical school through practice. Our membership also includes members of the public and the profession. We share a strong commitment to protect the public's health and safety through the delivery of quality health care.

COVID-19 cases in the United States have now surpassed 450,000 and deaths have exceeded 15,000, an alarming development that has affected patients, families, and communities across the country. We all depend on physicians and other healthcare workers to provide safe and compassionate care. Hundreds of thousands of physicians at every level of training and experience (medical students, residents, and practicing physicians, including retired and inactive physicians volunteering to reenter the workforce) have partnered with countless nurses, respiratory therapists and other health care workers to care for patients. It is critical during this national emergency that the public be provided with the best care possible by qualified health care workers who are themselves adequately protected.

Under the ethical tenets of their profession, physicians routinely care for others despite personal risk. Without safeguards such as proper personal protective equipment (PPE) and adequate testing, they are putting the health of their patients, as well as their own health and that of their families, at risk. The Coalition recognizes that supplies of PPE at this time are inadequate and supports continued studies to examine the safety of reuse and sterilization of PPE as options.

Health care workers are professionally bound to identify inadequate resources that impact their ability to safely treat patients or keep themselves safe. They must not suffer retribution or retaliation for calling attention to unsafe systemic

conditions for patients or caregivers. Conditions for physicians and health care workers on the frontlines of direct patient care must be safe.

It is vital in these uncertain times that our elected leaders and officials be guided by science and evidence-based principles when making decisions on behalf of the entire population to combat the virus causing COVID-19. The American public and the health care workers who care for them in this time of great need are making enormous sacrifices to do their part in stopping the spread of the virus. It is essential that our leaders provide them with resources they need and guidance that is factual and transparent.

Extreme disruption due to the pandemic has occurred in many facets of physician education, training, licensing and credentialing. As rapidly as possible, the Coalition and its member organizations will be providing guidance on important issues such as the trajectory of medical students transitioning from graduation to residency, student and trainee movement across geographic areas for interviews and clinical rotations, guidelines for volunteer work, and maintaining standards for credentials, certification and competencies during this time of emergency. These statements will be carefully reviewed and considered to ensure they represent the best paths forward during these challenging times.

The member organizations of the Coalition are committed to work with governmental agencies and health care delivery systems to safeguard the public, protect our frontline health care workers, and provide our elected leaders with the information they need to support sound, evidence-based decision-making.

The following organizations have signed on to this statement:
Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), 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), Council of Medical Specialty Societies (CMSS), Educational Commission for Foreign Medical Graduates|Foundation for Advancement of International Medical Education and Research (ECFMG®|FAIMER®), Federation of State Medical Boards (FSMB), Liaison Committee on Medical Education (LCME), NBME, and the National Board of Osteopathic Medical Examiners (NBOME).

About the Coalition for Physician Accountability
The Coalition for Physician Accountability is a membership organization designed to advance health care and promote professional accountability by improving the quality, efficiency, and continuity of the education, training, and assessment of physicians. Founded in 2011, current membership consists of senior leadership and governance representatives from the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), 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), Educational Commission for Foreign Medical Graduates|Foundation for Advancement of International Medical Education and Research (ECFMG®|FAIMER®), Federation of State Medical Boards (FSMB), Liaison Committee on Medical Education (LCME), NBME, and the National Board of Osteopathic Medical Examiners (NBOME). In addition, the Joint Commission and the Council of Medical Specialty Societies (CMSS) serve as liaison members. The Coalition also appoints public members to its membership to ensure adequate representation of the public voice in the deliberations of the Coalition.

Coalition for Physician Accountability

Maintaining Quality and Safety Standards Amid COVID-19

May 11, 2020

The member organizations of the Coalition for Physician Accountability (www.physicianaccountability.org) have released the following statement and table of resources to provide guidance and support to healthcare administrators and credentialing staff who are supporting the contributions of new or volunteer physicians to patient care during the COVID-19 pandemic.

The Coalition for Physician Accountability (Coalition), a cross-organizational group including AACOM, AAMC, ABMS, ACCME, ACGME, AMA, AOA, CMSS (OPDA), ECFMG, FSMB, LCME, NBME, and NBOME, was established in 2009 to promote professional accountability by improving the quality, efficiency, and continuity of the education, training, and assessment of physicians. Its membership includes the national organizations responsible for the accreditation of medical education and training and the assessment, licensure and certification of physicians throughout their medical career, from medical school through practice. Our membership also includes members of the public and the profession. We share a strong commitment to protecting the public's health and safety through the delivery of quality health care.

The pandemic has created a public health emergency that is rapidly altering the provision of health care services across the country. Physicians and other clinicians have responded with offers to provide care outside of their previously licensed jurisdiction and beyond their typical scope of practice.

The Coalition members overseeing physician workforce and training have developed the following guidance and resources for the deployment of physicians, physicians in training (interns, residents and fellows), and retired or inactive physicians, to ensure the safe delivery of quality clinical care during this unprecedented emergency.

The Coalition's Guidance for Maintaining Quality and Safety Standards Amid COVID-19 Pandemic include:

- **Planning:** The pandemic poses a direct threat of over-burdening the health system. The stress to health systems is variable, but all health care facilities should be developing strategies for the optimal use of physician resources as the disease spreads and resource demands fluctuate.
- **Verification:** Acknowledging the additional flexibility that regulators have provided, administrators should access readily available licensing, credentialing, and certification data to verify the attestations of volunteers and new recruits.
- **Provision of Care:** The American Medical Association's *Code of Medical Ethics: Guidance in a Pandemic* states that physicians have an ethical obligation to "provide urgent

medical care during disasters," an obligation that holds "even in the face of greater than usual risk to physicians' own safety, health or life." In a crisis, "(t)he risks of providing care to individual patients today should be evaluated against the ability to provide care in the future."

- **Protection:** Healthcare professionals must be equipped with appropriate Personal Protective Equipment (PPE) to safeguard their health and that of their patients, families, and the general public, and physicians must use this protection. The more transmissible the disease, and the higher the risk of occupational exposure, the more urgent the need for protection.
- **Training, Education, and Support:** Healthcare professionals who may be asked to practice outside their areas of training and expertise must have access to training and educational resources for the type(s) of care they are asked to provide during the COVID-19 pandemic to assure safe patient care. Appropriate mentorship, support, training, and supervision must also be available for healthcare professionals who are asked to provide care to which they are unaccustomed.
- **Maintenance of Safety Standards:** Health care facilities should have contingency plans to maintain customary safety standards in the face of a demand surge. Guidance for the adoption of crisis standards of care is available to help leaders make informed decisions that optimize resources while mitigating the risk of harm.

The following are some steps that can be taken to prepare for the arrival of a new volunteer:

	Action Step	Resource	Additional questions/resources
1	Check what licenses the physician has (and/or ECFMG certification if an international medical graduate)	www.Docinfo.org (free service) Physician Data Center www.fsmb.org/PDC/ ECFMG Certification Verification	Email: pdc@fsmb.org Email: cvsonline@ecfmg.org or call ECFMG at 215-386-5900
2	Determine applicable licensing waivers or exceptions (if licensed elsewhere)	FSMB COVID-19 Page for a summary of changes Please check applicable state or territorial medical board website	
3	Check Information on a volunteer's education and training	Physician Data Center www.fsmb.org/PDC/ ECFMG (for IMGS)	Email: pdc@fsmb.org Email: cvsonline@ecfmg.org or call ECFMG at 215-386-5900
4	Determine if the volunteer has a valid	Obtain copy of existing license and see: https://apps.deadiversion.us	https://deanumber.com/default.aspx?relID=33637

	controlled substance license	doj.gov/webforms2/spring/dupeCertLogin?execution=e2s1	
5	Check a volunteer's board certification status	ABMS certification AOA certification https://certification.osteopathic.org/validate/	Call: ABMS Solutions at (800) 733-2267 with questions. Call: AOA at (888)-626-9262
6	Confirm: a) vaccination record b) malpractice insurance c) Review any history of malpractice	Recommended vaccinations for healthcare workers: https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html Guidance on medical liability insurance during the COVID-19 crisis available from the Medical Professional Liability Association National Practitioner Data Bank*: https://www.npdb.hrsa.gov/hcorg/howToSubmitAQuery.jsp	Call: CDC at (800)-232-4636 See also: The Coronavirus Aid, Relief, and Economic Security Act (CARES Act, H.R. 748), *Section 3215: Limitation on Liability for Volunteer Health Care Professionals During COVID-19 Emergency Response* Email: help@npdb.hrsa.gov
7	Other Important Credentialing Resources	NAMSS COVID-19 Resources	Email: info@namss.org

**Only Accessible by Eligible Entities*

If the volunteer is a recently graduated physician, refer to the following resources:

8	Refer to guidance from AAMC, AACOM, ACGME and FSMB	AAMC guidance AACOM Coronavirus Resources ACGME guidance FSMB COVID-19 Page (for training license information)	

To support the volunteer as they start providing care:

9	Provide guidance to the physician	AMA volunteer guide AMA Code of Medical Ethics: Guidance in a Pandemic FSMB COVID-19 Page (for emergency licensure information) AOA COVID-19 Resources	
10	Provide training resources to the physician	ACCME training resources CDC guidance HHS COVID-19 Workforce Virtual Toolkit	Email: info@accme.org
11	Provide information on PPE	CDC guidance for PPE	
12	Share resources on managing telehealth	ACCME telehealth resources AMA Telehealth playbook HRSA Telehealth Website (hhs.telehealth.gov)	Email: info@accme.org

For more information on how to prepare for an anticipated surge in demand for scarce resources during an epidemic:

13	Expand contingency plans to include a process for adopting crisis standards of care to manage scarce physician and other resources	National Academy of Medicine -Discussion Paper on Crisis Standards of Care in response to SARS-CoV-2 National Academy of Medicine -Systems framework for crisis standards of care	

Workgroup Members:

American Board of Medical Specialties (ABMS)
Accreditation Council for Continuing Medical Education (ACCME)
Accreditation Council for Graduate Medical Education (ACGME)
Council of Medical Specialty Societies (CMSS)
Educational Commission for Foreign Medical Graduates (ECFMG)
Federation of State Medical Boards (FSMB)
National Resident Matching Program (NRMP)
Public Member

Final Report and Recommendations for Medical Education Institutions of LCME-Accredited, U.S. Osteopathic, and Non-U.S. Medical School Applicants

Submitted by

The Coalition for Physician Accountability's Work Group on Medical Students in the Class of 2021 Moving Across Institutions for Post Graduate Training

This guidance document was created in response to urgent requests for a consistent approach to medical student away rotations and in-person interviews for the 2020-2021 residency cycle. The organizations supporting the Final Report and Recommendations include the major national medical education organizations, whose representatives worked together to balance the complex needs of the medical education community. These recommendations reflect our collective sense of how to proceed, and we urge each medical school, sponsoring institution, and residency program to carefully consider them and commit to working together to create an equitable, transparent, and successful residency selection cycle.

This guidance is intended to add to, but not supersede, the independent judgment of a medical school, sponsoring institution, or residency program regarding the immediate needs of its patients and the preparation of its learners: Medical school deans have the authority and responsibility to make decisions regarding their medical students, and designated institutional officer (DIOs) and program directors have the authority to make decisions regarding residents in their sponsoring institution and programs. Because students rely on predictable, common practices across schools and programs as they prepare to transition to residency, a shared response to disruptions caused by the COVID-19 pandemic will greatly reduce unnecessary confusion, stress, and inequity among students, while promoting a more successful residency selection process for all.

Introduction

The Coalition for Physician Accountability (Coalition), a cross-organizational group composed of AACOM, AAMC, ABMS, ACCME, ACGME, AMA, AOA, CMSS (OPDA), ECFMG, FSMB, LCME, NBME, and NBOME, was established in 2009 to promote professional accountability by improving the quality, efficiency, and continuity of the education, training, and assessment of physicians. The Coalition has created several work groups to rapidly develop a shared approach to several urgent COVID-19-related education and training issues affecting learners and training programs.

The Coalition established this Work Group on Medical Students in the Class of 2021 Moving Across Institutions for Post Graduate Training (WG) to consider and make recommendations about three major issues facing applicants and training programs as they prepare for the 2020-2021 residency application cycle: (1) away rotations, (2) in-person interviews for residency, and (3) the ERAS® timeline. While there are other important issues to be addressed, the WG was careful to restrict its deliberations to its original charge. WG participants include representatives from AACOM, AAMC, ACGME, AMA, AOGME, ECFMG, NRMP, and OPDA. NBME and NBOME participated for the ERAS timeline discussions.

The COVID-19 pandemic has interrupted the clinical education of most, if not all, medical students. This work group was tasked with considering the impact on current M3/rising senior students, particularly as applicants prepare for the residency selection process. Limitations placed on learners' ability to work in the clinical learning environment, restrictions on individual travel and personal spacing, and inability to complete assessments and educational requirements will render the traditional selection process impossible to

replicate this year. Nonetheless, the WG believes a meaningful and effective selection process can be achieved for both applicants and residency programs.

Strengths of the WG include its diversity of thought and representation from the full spectrum of stakeholders across medical education and the public. The WG established guiding principles as a framework for considering the important issues under its charge:

- Patient care and the safety of the community, patients, and learners are most important.
- Medical schools must prioritize meeting core competencies anchored in accreditation and graduation requirements for their own students. Likewise, residency programs must prioritize fulfilling current residents' competencies and meeting accreditation and specialty board certification requirements.
- The residency selection process should be as equitable as possible for applicants, recognizing the diversity of learners and educational programs and the differing missions and priorities of schools, training programs, and institutions.
- A concerted effort to reduce anxiety and promote well-being of students, program staff, and institutions (home and host) in an already stressed system is critical.
- We anticipate stakeholders will commit to policies that prioritize these guiding principles yet recognize the necessity for innovation and flexibility in this new COVID-19 environment.
- Recommendations at the national level are intended to facilitate transparency, promote fairness across the country, and reinforce our commitment to an equitable process for all.

The WG also considered current data and forecasts about the COVID-19 pandemic. While the temporal progression of the pandemic remains uncertain, estimates indicate there may be an abatement with continued endemicity over the summer and a second surge with geographic variation in the fall or winter. Therefore, periodic limitations on geographic and individual travel will likely persist. The WG recommendations were influenced by concerns that initiating a process only to have it discontinued due to a resurgence of coronavirus would create potential inequities among applicants and increase disruption and stress for both applicants and programs.

The Process

From the outset, the WG sought to be comprehensive, inclusive, and timely in delivering its recommendations, recognizing the urgent need for a common approach to support decision-making around the residency application process. The WG met twice per week over a four-week period, April 14-May 8, to consider the issues within its charge. As the WG deliberated, broader feedback on the guiding principles, away rotations, and in-person interviews was sought from across the constituency and was considered heavily in the WG's deliberations and recommendations. Subject matter experts were invited to discuss the relevant issues and shared feedback and recommendations as appropriate. As final recommendations were drafted, the WG shared them with constituents, member organizations, and the Coalition. The final report has been endorsed by the Coalition organizations. This final report, including recommendations and resources, was released to the public May 11, 2020.

The Deliverables

This document includes:

- An overview of the WG's work, including recommendations for the WG's three assigned issues: (1) medical student away rotations, (2) in-person interviews, and (3) the ERAS timeline.
- An initial compendium of resources to support the implementation of the recommendations.
- General communications guidance for disseminating this report and implementing the recommendations.

As these recommendations are released, the WG recognizes the inherent complexities of the residency selection process (particularly considering COVID-19's impact), the varied circumstances presented by geography, the diversity of applicant and institution type, and the varied missions and strategies of the stakeholders. While there can be no "one size fits all" solution, the WG believes these recommendations can promote consistency and fairness for all applicants.

Recommendation 1 — Away Rotations for Medical Students

Background: As mentioned in the Compendium of Resources, away rotations serve multiple important roles for applicants and residency programs. Applicants use them for career exploration, for support in the residency application process, and for prioritizing geographic preferences. Residency programs use away rotations to assess applicants' capabilities, showcase the benefits of their program and facilities, and preview potential applicants to their programs (which is particularly important to those programs not affiliated with a medical school). Challenges associated with away rotations include the expense to learners (both financial and educational, in lost opportunities at the home institution), competition for rotations that prevents access to some applicants who might be well suited for the specialty or program, the fact that completing an away rotation does not ensure the applicant a residency position at the program or within the specialty, and the burden of onboarding learners into a new clinical environment (the latter is particularly applicable given current stressors on the health systems from the COVID-19 pandemic).

For the 2020-2021 cycle, the COVID-19 pandemic has already created multiple, serious disruptions of core educational experiences and of travel. Limitations placed on students' ability to work in the clinical learning environment, the anticipated surge in students needing clinical experiences created by deferral of core clerkship activities (described as an impending "clinical bulge"), delayed completion of core educational requirements, and restrictions on individual travel and personal spacing (both now and in the eventuality of geographic outbreaks or a national resurgence in the fall or winter) will likely greatly reduce the number of away rotation opportunities available this year. As a result, for most applicants, away rotations may be entirely inaccessible. A shared, altered approach to away rotations may help level the applicant playing field for the upcoming application cycle.

Recommendation: The WG recommends that for the 2020-2021 academic year, away rotations be discouraged, except under the following circumstances:

- Learners who have a specialty interest and do not have access to a clinical experience with a residency program in that specialty in their school's system.
- Learners for whom an away rotation is required for graduation or accreditation requirements.

Individuals meeting these exceptions should limit the number of away rotations as much as possible. Students should consider geographically proximate programs, when appropriate, to meet learning needs.

Programs and specialty societies are encouraged to develop alternate approaches to meeting goals of away rotations, as described in the Compendium of Resources.

Recommendation 2 — Virtual Interviews

Background: Applicants value in-person interviews for gaining a realistic introduction to and experience of the residency program, including the culture and fit. Similarly, programs value the ability to observe and assess applicants' capabilities and fit in the program environment. While forecasts predict the COVID-19 pandemic will diminish over the summer, there will likely be intermittent geographic hotspots and a projected widespread resurgence in late fall or early winter, just as the residency interview season would typically be ramping up. In addition, it is widely anticipated that ongoing "track and trace" programs will limit individual travel conducted on relatively short notice (i.e., if an applicant is identified to have had contact with a new COVID-19 individual, the applicant may be required to quarantine) and that domestic and international travel bans for quarantine rules will exist.

Recommendation: The WG recommends that all programs commit to online interviews and virtual visits for all applicants, including local students, rather than in-person interviews for the entire cycle and that the medical education community commit to creating a robust digital environment and set of tools that will yield the best experiences for programs and applicants.

Even as we adjust to the inevitability of this new normal of virtual interactions, replacing the benefits applicants and programs derive from in-person interviews will require adjustments on both sides. As more medical schools turn to virtual curricula as stopgap measures to keep advancing the third-year curricula, and the clinical environment looks to telemedicine to provide patient care in a COVID-19 environment, we must also consider how technology can be used to support the upcoming residency application cycle. The Compendium documents well the perceived benefits of in-person interviews. While not all benefits can be replicated in a virtual environment, a thoughtful and dedicated approach can maximize the value of remote interactions.

Recommendation 3 — The ERAS Opening for Programs and the Overall Residency Timeline

Background: The COVID-19 pandemic's impact on the medical education curriculum will ensure that practically every applicant for residency during the ERAS 2020-2021 cycle will face obstacles completing activities usually included in their application. Some will be delayed in completing their clerkship curriculum and early senior rotations, which will delay the collection of letters of evaluation and recommendation. Others will be unable to secure timely dates to complete their COMLEX-USA or USMLE exams. This year, programs face making selection decisions with differing amounts and types of data than they have ever had in the past. These changes necessitate evaluating the ERAS opening date for programs and the medical student performance evaluation (MSPE) release date. It is also critically important that programs have the tools they need to use the data they receive to evaluate the applications holistically.

The traditional ERAS opening for programs on Sept. 15 and MSPE release date of Oct. 1 may not allow sufficient time for learners and medical schools to upload the most complete ERAS applications for programs to review and evaluate. Multiple conversations with medical schools, applicants, AAMC affinity groups, specialty organizations, and the ERAS Advisory Committee reached consensus that an ERAS opening for residency programs could occur in mid-to-late October.

Recommendation: The WG recommends a delayed opening of ERAS for residency programs and a delayed release of the MSPE and that the opening and release happen on the same day.

Recommendation 4 — General Communications

Implementation of these recommendations will require transparency and regular, clear communications among all stakeholders. The WG encourages the medical education community to work together to provide consistency and equity for applicants across the country.

- Specialty organizations should work with the individual programs to develop and communicate to applicants and schools clear, consistent plans and practice around both away rotations and interviews as soon as possible.
- Medical schools should develop clear, consistent policies around any limitations of students' participation in away rotations and in acceptance of visiting students, and the schools should communicate these as soon as possible.
- With a goal of decreasing stress and increasing a sense of fairness, we suggest programs and schools commit to a consistent policy for the entire upcoming residency application and selection cycle.
- Both programs and schools should include statements about COVID-19-related training, testing, and quarantine requirements for any away rotations that are allowed.

Conclusion

Since the arrival of COVID-19, the medical education community has experienced many challenges and has shown great courage, resilience, flexibility, and creativity in facing those challenges. As we look to the next 12-18 months, the response can be no less. Both applicants and residency programs have been thrust into an environment not of their choosing. There is great anxiety about the upcoming residency selection process and the effect changes resulting from COVID-19 will have on the Class of 2021. In developing the recommendations provided herein, the WG considered the current environment, future forecasts, the subject matter expertise, and the perspectives of those closest to the issues the WG sought to address.

Acknowledging that these recommendations cannot address every eventuality, they are offered to provide the best path forward to promote consistency and fairness across the country and to reinforce our commitment to an equitable process for all.

Respectfully submitted,

Accreditation Council for Graduate Medical Education
American Association of Colleges of Osteopathic Medicine
American Medical Association
Assembly of Osteopathic Graduate Medical Educators
Association of American Medical Colleges
Council of Medical Specialty Societies/Organization of Program Director Associations
Education Commission for Foreign Medical Graduates
National Resident Matching Program

Compendium of Resources for the Implementation of Recommendations in the *Final Report and Recommendations for Medical Education Institutions of LCME-Accredited, U.S. Osteopathic, and Non-U.S. Medical School Applicants*

The COVID-19 pandemic necessitates changes for the 2020-2021 residency application cycle that are disruptive for all stakeholders: medical schools, applicants, residency programs, and the associated sponsoring institutions. The Coalition's Current Practices of Student Movement Across Institutions for the Class of 2021 Work Group (WG) believes the medical education community, working together, can minimize these disruptions and mitigate the losses. This document provides additional information to support the implementation of the recommendations contained in the *Final Report and Recommendations for Medical Education Institutions of LCME-Accredited, U.S. Osteopathic, and Non-U.S. Medical School Applicants* and can serve as a foundation for continued work across the UME-GME continuum to address the impact of recommended changes on:

- Away and audition rotations.
- Virtual interviews and program visits.
- The shortened ERAS® timeline and holistic review.

The WG gathered information on the perceived benefits of the traditional approach of each of these domains for students, applicants, and programs. The WG then brainstormed how, with the new recommendations, benefits might be reimagined and recreated and how losses might be mitigated.

The WG hopes this compendium is the beginning of dialogue and concerted work across associations, schools, programs, program director associations, and student groups to develop solutions and share resources.

Away Rotations Resources

The Work Group on Student Movement's Subgroup on Away and Audition Rotations considered the importance of away rotations to U.S. (DO and MD) and international applicants for residency and noted the differences between the two groups of medical students in access to school-affiliated resources and to residency-based rotations in both the third and fourth year. (Away and audition rotations are short-term learning opportunities in locations away from students' home institutions. These opportunities, contrasted with core or required clerkships, are sometimes called "away" rotations, "audition" electives, "clinical" rotations, or sub-Is. Available in teaching hospitals, community clinics, and urban or rural sites, they are generally open to preclinical, clinical, and final-year students, as determined by the host institution.)

The group also discussed differences between those returning to the match after a period of formal or informal training, or even already in medical practice, and those in a more traditional time frame for residency placement.

Recommendation 1 — Away Rotations: The WG recommends that for the 2020-2021 academic year, away rotations be discouraged, except under the following circumstances:

- Learners who have a specialty interest and do not have access to a clinical experience with a residency program in that specialty in their school's system.
- Learners for whom an away rotation is required for graduation or accreditation requirements.

Individuals meeting these exceptions should limit the number of away rotations as much as possible. Students should consider geographically proximate programs, when appropriate, to meet learning needs.

Questions have arisen about how schools and programs might best implement this recommendation and how to communicate with students. Based on conversations with multiple stakeholders, the WG offers the following approaches as a starting point for further discussions.

Each school should review the away-rotation recommendation in the context of their individual elective offerings and graduation requirements and develop a policy and plan for communicating the school-specific implementation of this recommendation to their students and faculty, including substantiating exceptions for away rotations.

- Both the medical school and the program should consider playing a role in confirming the student's eligibility for an away rotation.
- Schools should include processes to validate the reason for an away rotation in institutional documents before the documents are released (e.g., transcripts, insurance).
- The program should validate approval from the medical school that the applicant meets at least one of the established exceptions and decline scheduling of an away rotation for any unsubstantiated applications.
- Recognizing that some students will have a need for an away rotation for the reasons identified as exceptions, programs that have the capacity should consider accepting the students who meet the exceptions, particularly if the students are local.

- Requests for approval of students' eligibility should be responded to as quickly as possible to facilitate scheduling for both parties.

Approval of requests for time off for virtual experiences should not require that the student participate in both an in-person clinical experience at the home institution and a virtual external "audition" experience.

The WG considered the perceived value of away rotations from the perspective of both students and program directors to help with developing recommendations and to consider alternate ways to achieve the goals. The collective thinking of the community was included. While not exhaustive, this Table A is meant to serve as foundational thinking for planning for the upcoming residency application cycle.

Table A. Value of Away Rotations and Suggestions for Achieving Goals in a COVID-19 Environment

Value to Students	Value to Program Directors	Potential Substitutes for Away Rotations
Allows applicants to display a breadth of competencies (e.g., teamwork, effort, work ethic) that may be difficult to assess from application materials*	Provides insights into applicants' clinical capabilities, personality, and professionalism that may not be readily assessed from application materials*	• Provide more holistic elements in school reporting that programs can use to evaluate students • Provide longitudinal online group experiences hosted by programs (e.g., journal clubs, case discussions, group projects) • Relax number of LORs, allow nonspecialty LORs, and standardize LORs to provide critical appraisal in key dimensions
Enables applicants to secure feedback, LORs, and SLOEs from residency program faculty in a chosen specialty*	LORs and SLOEs from colleagues in the specialty are helpful in evaluating applicants	Standardize specialty-based local LORs to provide critical appraisal in key dimensions
Allows students to assess the specialty, program features, and culture of the learning environment in ways that inform personal and career fit with the program*	Allows the program director to assess a given candidate's fit with the culture of the program*	• Offer online specialty-based mentoring programs • Provide longitudinal online group experiences hosted by programs (e.g., journal clubs, case discussions, group projects)
Allows applicants to experience clinical environments different from their home institutions	Allows programs to fully demonstrate the capabilities of the local training environment*	• Offer virtual tours of clinical learning environments associated with the program, including distinguishing clinical services and outcomes metrics • Provide longitudinal online group experiences hosted by programs, as above
Gives students access to specialties they are considering but are not available at home institutions	Allows program directors to assess applicants from lesser-known schools	Offer online specialty-based mentoring programs, as above
Establishes connections in a desired geographic area	Allows program directors to preview potential applicants and gauge applicants' interest in their program	Provide longitudinal online group experiences hosted by programs, as above

*The top three benefits mentioned by constituents for each party.

Note: LOR = letter of recommendation; SLOE = Standard Letter of Evaluation.

Both applicants and programs shoulder the financial and educational costs of away rotations (Table B).

Table B. Costs of Away Rotations

Costs or Limitations to Applicants	Costs or Limitations to Programs	Impact of Limitations
Financial costs of travel	Financial costs of orientation and hosting	These costs decrease as the number of away rotations decrease; there could be added investment in technology platforms.
Educational opportunity cost (Is learning taking place during the away rotation? What learning experiences at the home institution are lost?)	• Investment in external learners • Too many visiting students to make a meaningful assessment or connection (Time spent developing learners who will not ultimately be part of the program; potential distraction from providing training and feedback to internal residents and students)	These costs potentially remain for both sides but will decrease overall with fewer rotations.

Encouraging Innovation

Innovative approaches are being developed and implemented by specialties and programs to provide alternatives for students to showcase their knowledge, skills, and attitudes and for programs to ensure applicants receive the curricular content that exposes them to and teaches them about the specialty. The Work Group recommends continued innovation by specialties, institutions, and programs, including developing ways to identify best practices and communicate and share them broadly.

Resources

- American College of Surgeons Fundamentals of Surgery Curriculum (Freely available through May 15, 2020)
- Family Medicine Virtual Clerkship
- Online Diagnostic Radiology Elective
- Virtual Simulation Experiences in an Emergency Medicine Clerkship
- Virtual OB-GYN Clerkship Curriculum

Virtual Interview Resources

Since it is expected that some programs will need additional support, the Work Group on Student Movement's Subgroup on Virtual Interviews met to consider how residency programs might plan for and adjust to residency interviews in a virtual environment and to provide resources to support this effort.

Recommendation 2 — Virtual Interviews: The WG recommends that all programs commit to online interviews and virtual visits for all applicants, including local students, rather than in-person interviews for the entire cycle and that the medical education community commit to creating a robust digital environment and set of tools to create yield the best experiences for programs and applicants.

The in-person interview has been a critical piece of the residency selection process from its inception. The Work Group sought broad input about the importance of in-person interviews from the perspective of both applicants and program directors to determine strategies to recommend that could optimize the virtual interview for the desired goals of each party (Table C).

Table C. The Value of In-Person Interviews to Applicants and Program Directors

Value to Applicants	Value to Program Directors
• To gain a realistic introduction and experience of the residency program, including program culture • To provide a direct face-to-face encounter with the program team to market oneself • To assess program and institution attributes that may affect the applicant's choice of training site • To gather information about the community surrounding the hospital as a potential place to live • To interact with residents in the program in an informal setting to learn about the program and those currently training in it • To observe clinical settings and teaching (e.g., inpatient rounds, morning report, noon conference) to assess the quality of the program and suitability to their role as a learner	• To observe and assess applicants' capabilities and fit in the program environment • To use different methods to gauge applicants' abilities, such as observed behavior, teamwork, and other characteristics best observed in situ • To have the applicant observed in different settings by different people (residents, GME administrative staff, faculty) over a day • To promote the sponsoring institution's and program's educational offerings by demonstrating the capabilities of the training program • To highlight the clinical education experiences at the clinical sites used by the program • To gauge the applicant's interest in the program • To consider applicants from broad geographic areas and schools about which the program has less knowledge and experience

As programs prepare for the 2021 recruitment season, it is expected that the medical education community will prioritize the needs of patients, their care providers, and the safety of applicants and the program personnel considering those applicants. Program staff should consider how best to develop processes that meet program needs while creating an equitable, transparent, and successful residency selection cycle for applicants (Tables D and E).

Table D. Mitigation Strategies for Programs Moving to Virtual Interviews

Impacts for Programs	Possible Mitigation
Resources (e.g., planning, time, deliverable costs) will be required of already financially and time-strapped hospitals and training programs that do not already have virtual touring.	Work collaboratively within the institution to share resources across specialties to highlight the benefits of the institution and the community to applicants; limit programs' investment to highlighting the benefits specific to each program.
Ramp-up time for hospitals and residency programs will be needed to prepare for virtual interviews.	• Begin planning for virtual interviews, incorporating best practices from the literature and other guidance. • Begin preparing or adapting materials for applicants and interviewees that highlight strengths of the program, institution, and clinical training sites. • Acquire appropriate teleconferencing equipment, software, and technology to ensure the program and its interviewers can conduct high-fidelity interactions with applicants.
The programs will need to be able to collect the information they need via virtual interviews to fully evaluate applicants.	• Develop a protocol for interviews that may include group interviews or more structured interviews that have an evidence base of predictive value for identifying applicants who will succeed in the program. • Conduct all interviews (even those of local applicants) in the same manner.
Programs may have a better understanding of the capabilities of applicants from their own medical school than of applicants they can only interact with virtually.	Commit to one standardized process for all applicants for the entire recruitment and use that process consistently.
Costs of technology to ensure high-fidelity interactions for interviews and other virtual interactions with the applicants will need to be accounted for.	Budget for costs of providing meals, transportation, and housing for interviewees

Table E. Mitigation Strategies for Applicants Engaging in Virtual Interviews

Impacts for Applicants	Potential Mitigation
Gaining a realistic introduction to program culture and the community surrounding the hospital is especially difficult to do virtually.	Create virtual tours and record informal interviews with residents; allow virtual attendance at department conferences and teaching rounds.
Opportunity for the applicants to gain valuable insight into the program and its culture while interacting with the program's residents during the time normally allotted for dinners and less formal interactions throughout the day is reduced.	Create informal, private, virtual opportunities to speak directly with residents (individually or in groups).
Interaction with current residents is critical and difficult to replicate in a virtual environment; residents and applicants gain a lot of insight during pre-interview happy hours and dinners.	In addition to the interviews, consider having sessions that include other people from the program who will interact with the applicant, such as an informal Q&A with residents and groups of interviewees or discussions with midlevel providers and research and scholarly activity personnel who support the program.
It is difficult to assess the culture and "fit" of a program virtually without having a secure space to ask difficult questions.	Create informal, private, virtual opportunities to speak directly with residents (individually or in groups). Consider using social media platforms.
Providing applicants with a sense or feel of the environment of the program site and properly introducing the program and the local surrounding community to the candidate are significant challenges.	Ensure applicants can interact with the program team and learn about the program through multiple virtual opportunities and settings.
Applicants may be judged unfairly from virtual encounters; most are not trained in virtual-interview etiquette or have much experience with virtual interviewing.	Develop or disseminate a standard etiquette guide for applicants about how to professionally interact in virtual interviews in various formats, including individual, group, formal, and informal settings.
Applicants from local programs or institutions may be unfairly advantaged because virtual interviews may not replace face-to-face interaction and familiarity.	Implement one interview process for all applicants, regardless of location, and adhere to a standardized interview to mitigate any bias.
Applicants with technical issues or in areas with low bandwidth may be disadvantaged.	Be as flexible as possible with applicants who have challenging technical situations; technical issues can occur for any reason.

Resources

Background research and resources are available at this site.

Other Resources:

- The AAMC Best Practices for Conducting Residency Interviews
- The AAMC Guide for Applicants Preparing for Virtual Interviews
- The AAMC Virtual Interviews: Tips for Program Directors
- University of Utah Health's Virtual Interview Primer
- Jones RE, Abdelfattah KR**.** Virtual interviews in the era of COVID-19: a primer for applicants. *Journal of Surgical Education*. April 2020. doi:https://doi.org/10.1016/j.jsurg.2020.03.020.

Final Report and Recommendations Submitted by The Coalition for Physician Accountability's Work Group on Learner Transitions from Medical Schools to Residency Programs in 2020

Introduction

The COVID-19 pandemic has brought widespread, extreme, and ongoing disruption to healthcare and medical education in the United States. This disruption extends throughout the continuum of physician education, creating novel circumstances for students, residents, faculty members, schools and institutions that provide medical education, and organizations responsible for the regulation of the medical profession. As this disruption continues through the summer of 2020, this year's transition of medical school graduates into their first postgraduate year (PGY-1) appointments in US residency programs demands a coordinated and collaborative approach in order to protect patients, learners, and the healthcare workforce, and to safeguard the interests of the public.

Coalition for Physician Accountability and the Work Group

The Coalition for Physician Accountability (Coalition) "is a membership organization that convenes on a regular basis to engage in discussion and collaboration on matters of common relevance to improve the quality of healthcare."[1] Its members include:

- Accreditation Council for Continuing Medical Education (ACCME)
- Accreditation Council for Graduate Medical Education (ACGME)
- American Association of Colleges of Osteopathic Medicine (AACOM)
- American Board of Medical Specialties (ABMS)
- American Medical Association (AMA)
- American Osteopathic Association (AOA)
- Association of American Medical Colleges (AAMC)
- Council of Medical Specialty Societies (CMSS) *(liaison member)*
- Educational Commission for Foreign Medical Graduates (ECFMG)
- Federation of State Medical Boards (FSMB)
- Joint Commission *(liaison member)*
- Liaison Committee for Medical Education (LCME)
- National Board of Medical Examiners (NBME)
- National Board of Osteopathic Medical Examiners (NBOME)

The Coalition was established to promote professional accountability by improving the quality, efficiency, and continuity of the education and assessment of physicians. Consistent with this purpose, the Coalition created several work groups to develop common

[1] Coalition for Physician Accountability. http://physicianaccountability.org/About.html. Accessed May 3, 2020.

recommendations that address urgent issues related to the COVID-19 pandemic and physician education.

This work group was convened to propose recommendations for the guidance of learners, schools, institutions, and organizations in the transition of medical school graduates into their PGY-1 appointments in US residency programs in 2020. The work group was comprised of representatives from ACGME, AACOM, AAMC, AMA, ECFMG, National Resident Matching Program (NRMP), and Organization of Program Director Associations (OPDA).

Background

In 2020, tens of thousands of medical school graduates will begin PGY-1 appointments in US residency programs accredited by the ACGME. 32,399 graduates have entered into match commitments with programs and institutions through the NRMP to begin their 2020 PGY-1 appointments, and approximately 400 or more graduates have committed to appointments through other matching programs.[2,3] Based on previous years' information,[4,5,6] it is roughly estimated that fewer than 1,000 appointments of PGY-1 residents will be arranged outside of matching programs in 2020. Consistent with well-established precedent in ACGME-accredited Sponsoring Institutions and residency programs, most PGY-1 appointments of residents in 2020 are expected to begin around July 1.

Most incoming PGY-1 residents are graduating from an MD-degree-granting medical school in the United States or Canada accredited by the Liaison Committee on Medical Education (LCME), or from a DO-degree-granting medical school in the United States accredited by the Commission on Osteopathic College Accreditation (COCA).[6,7] The cohort of incoming PGY-1 residents also includes graduates of international medical schools who have obtained a valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) or a full medical license in a United States jurisdiction.[6,7]

The recommendations of the work group are intended to address the entire population of US and international medical school graduates who will begin their PGY-1 residency

[2] National Resident Matching Program (NRMP). 2020 Main Residency Match by the numbers. http://www.nrmp.org/main-residency-match-data/. Accessed May 2, 2020.

[3] American Urological Association. Urology Residency Match statistics. https://www.auanet.org/education/auauniversity/for-residents/urology-and-specialty-matches/urology-match-results. Accessed May 2, 2020.

[4] NRMP. Results and data: 2019 Main Residency Match. http://www.nrmp.org/main-residency-match-data/. Accessed May 2, 2020.

[5] American Osteopathic Association (AOA). AOA Intern/Resident Registration Program. Summary of positions offered and filled by program type: results of the 2019 match. National Matching Services, Inc. https://natmatch.com/aoairp/stats/2019prgstats.html. Accessed May 2, 2020.

[6] Accreditation Council for Graduate Medical Education (ACGME). Data resource book: 2018-2019. https://www.acgme.org/About-Us/Publications-and-Resources/Graduate-Medical-Education-Data-Resource-Book/GraduateMedicalEducation/GraduateMedicalEducationDataResourceBook. Accessed May 2, 2020.

[7] ACGME. Institutional requirements. https://acgme.org/Designated-Institutional-Officials/Institutional-Review-Committee/Institutional-Application-and-Requirements. Effective July 1, 2018. Accessed May 2, 2020.

appointment in the US no later than January 31, 2021, and the institutions and programs that will appoint them.

Process, Goal, and Considerations

In a series of video conference meetings in April and May 2020, work group members described various issues related to the transition of medical school graduates into PGY-1 residency appointments in 2020 and summarized published guidance relevant to those issues. The work group then outlined recommendations addressing aspects of the 2020 transition that were likely to be affected by the pandemic.

The goal of the recommendations is to promote public and professional safety by mitigating the effects of pandemic-related disruption in the transition from undergraduate to graduate medical education (UME to GME). When formulating the recommendations, the work group considered the needs of learners, medical schools, organizations involved in GME, and organizations with regulatory responsibility, and balanced those needs with the interests of patients, communities, and the public.

Some of the work group's considerations deserve explicit mention. It was hypothesized before the COVID-19 pandemic that stressors associated with this transition may compromise the well-being of the learner,[8] and the work group formulated its recommendations with concern that pandemic-related disruption could exacerbate learners' stress. This includes new challenges that US and international medical school graduates may encounter related to relocation, personal health risks, and personal health screening as they transition into PGY-1 residency appointments. Many incoming PGY-1 residents will enter clinical learning environments under considerable stress at a time that institutions and programs are planning for increases in disease burden that may occur this fall and winter. Social isolation of PGY-1 residents outside the clinical learning environment may also be a threat to well-being in some locations.

Many institutions and programs are experienced in supporting and monitoring the well-being of incoming PGY-1 residents and are planning to adapt their approaches to reflect complex well-being challenges that have emerged inside and outside the clinical learning environment this year. The work group's recommendations acknowledge that there may be elevated risks to the well-being of PGY-1 residents in 2020, and that any such risks may persist for the duration of their PGY-1 appointments.

The work group also took into account widespread reports of pandemic-related financial and operational emergencies in healthcare and educational organizations and recognized that international medical graduates may face unique challenges in this year's transition.

Finally, the work group's recommendations are based on the current knowledge of COVID-19 and its anticipated impact in the coming months, which is expected to vary by location. The work group acknowledged that future developments in the pandemic response may affect healthcare and medical education needs in unexpected ways, and therefore may call

[8] Yaghmour NA, Brigham TP, Richter T, et al. Causes of death of residents in ACGME-accredited programs 2000 through 2014: implications for the learning environment. Acad Med. 2017;92:976-983. doi: 10.1097/ACM.0000000000001736

for superseding recommendations from the Coalition for Physician Accountability or its member organizations. The recommendations are not presented in order of priority.

This report and its recommendations were reviewed prior to publication by representatives of ABMS, FSMB, and LCME. (A list of reviewers is Appendix 2.) The work group gratefully acknowledges the reviewers' comments.

Recommendations

1. 2020 Match Participation Agreements
    a. Match participation agreements and match commitments for PGY-1 residency appointments should remain in effect for all residents, programs, and institutions, and all matches (e.g., NRMP, Urology Residency Match Program).
    b. Any modifications to, or cancellations of, match commitments for PGY-1 residency appointments should conform to the policies and procedures of the organization that provides the match (e.g., NRMP waiver process). Programs and applicants seeking waivers of a match commitment due to delays in graduation, United States Medical Licensing Examination (USMLE) or Comprehensive Osteopathic Medical Licensing Examination (COMLEX) testing needs, etc., are encouraged to consider a deferral of training to the next academic year.
    c. Match commitments are contractual obligations. Deployment or assignment of matched applicants to PGY-1 positions should adhere to match participation agreements and match commitments, including any prohibition against enrolling applicants into residency programs into which they did not match.

2. Residency Appointments
    a. Appointment to a PGY-1 residency position should comply with ACGME Institutional Requirements.
    b. Conditions of appointment provided in PGY-1 residency appointment contracts should be consistent with information provided to applicants at the time of recruitment and interview or that were provided in post-match communications.
    c. In accordance with institutional policies and procedures, Sponsoring Institutions should consider requests for leaves of absence or for reasonable accommodations from incoming PGY-1 residents whose ability to participate in resident assignments or the residency program is affected by the COVID-19 pandemic. Additionally, modification or cancellation of a match commitment (e.g., NRMP waiver) must be discussed with the organization that provides the match to determine available options.

3. Transitions to a New Location to Begin a Residency Program
    a. Sponsoring Institutions and their programs are encouraged to provide augmented relocation resources to assist incoming PGY-1 residents in the transition to 2020 appointments. Examples may include referrals for services such as healthcare, housing, legal assistance, transportation, and childcare.
    b. The Sponsoring Institution and its programs should provide policies and communications to incoming PGY-1 residents regarding any quarantine measures to which residents will

be subject before starting their program or rotations. A suggested approach is to allow residents under quarantine to participate in activities such as virtual orientation, information systems training, or research/scholarly activity.

c. The Sponsoring Institution should ensure the provision of appropriate resources to support incoming PGY-1 residents who are subject to quarantine. (See 7.b below.)

d. Orientation to infection protection for residents, including the provision of personal protective equipment (PPE) and training in its use, should precede incoming PGY-1 residents' participation in any clinical setting. If a GME boot camp is required for incoming PGY-1 residents, it should be conducted in accordance with the Sponsoring Institution's policies and procedures for infection protection.

e. It is essential for Sponsoring Institutions to be mindful of regulations pertaining to medical licensure for PGY-1 residents.

4. Flexibility in Requirements

a. See 1.b above.

b. Some variance in ACGME Common and specialty-/subspecialty-specific Program Requirements is available under a Sponsoring Institution's pandemic emergency status, as described on the ACGME web site.

c. There is no variance in ACGME Institutional Requirements.

5. Early Medical School Graduation

a. See published guidance from ACGME, NRMP, AMA, LCME, and COCA.

b. Early medical school graduates should be able to opt out of engaging in clinical care prior to their PGY-1 residency appointments without intimidation or retaliation.

c. Early medical school graduates who engage in clinical care prior to their PGY-1 residency appointments should be provided appropriate PPE, training in its use, and appropriate supervision; and should be released from duty on a schedule that allows for reasonable transition time so that the PGY-1 residents may begin their appointments without delay.

6. Delayed Medical School Graduation; Delayed Arrival in Residency Program

a. Per NRMP guidance, in the absence of a waiver or deferral of a match appointment, matched applicants are to begin their PGY-1 residency appointments by January 31, 2021.

b. During the 2020 appointment year, Sponsoring Institutions should seek to accommodate the delayed graduation of medical students who are transitioning to residency, and the delayed arrival of PGY-1 residents due to reasons that include international travel, health concerns (including quarantine not required by the Sponsoring Institution/program), visa issues, or licensure delays. See Section 3.e.

7. Resident Obligations Regarding Pre-Employment Health Screening or Quarantines

a. See 3 above.

b. Any PGY-1 resident obligations regarding pre-employment health screening or quarantines should be guided by institutional policies and procedures. If a Sponsoring

Institution requires a health screening, it should be provided by the Sponsoring Institution in partnership with its participating sites. If an institution requires pre-employment physicals or quarantines, these requirements should be viewed as responsibilities under the residency appointment.

c. As a resident assignment, time in quarantine should not be classified as vacation or leave of absence within a PGY-1 residency appointment.

8. Impact of Transitioning to a Clinical Environment during the COVID-19 Pandemic

a. Given anticipated challenges to the well-being of PGY-1 residents during the COVID-19 pandemic, Sponsoring Institutions, in partnership with their programs, should consider providing augmented assessment and monitoring of PGY-1 residents' well-being throughout the appointment year.

b. Sponsoring Institutions and programs should disclose to incoming PGY-1 residents any deviations from the expected curriculum due to the response to the COVID-19 pandemic. The disclosure should specify the effects of curriculum deviations on PGY-1 residents' ability to satisfy requirements for program completion, and on eligibility for specialty board examinations.

c. Sponsoring Institutions and programs should consult published ACGME guidance regarding the COVID-19 pandemic to ensure compliance with Institutional Requirements, and with program requirements for safety, supervision, and clinical and educational work hours.

d. Given the clinical environment in 2020, there should be augmented consideration of the amount of incoming PGY-1 residents' previous clinical experience in the United States when determining the residents' initial clinical assignments.

9. International Medical Graduates

a. Sponsoring Institutions, programs, and training program liaisons should proactively communicate with incoming PGY-1 residents who are international medical graduates to confirm their status and to understand if there are any barriers to beginning their residency appointments.

b. Sponsoring Institutions, programs, and training program liaisons should contact ECFMG for information and assistance, as needed.

c. Early appointment of international medical graduates to PGY-1 residency appointments should be consistent with visa-specific regulations and immigration law and should follow ACGME, NRMP, FSMB, and state-specific guidance, requirements, policies, procedures, rules, and regulations.

d. Sponsoring Institutions and their programs are encouraged to provide augmented relocation assistance to incoming PGY-1 residents who are international medical graduates in the transition to 2020 appointments. Examples may include referrals for services such as healthcare, housing, legal assistance, transportation, and childcare.

e. Recognizing the increased risk of social isolation and other unique circumstances related to COVID-19, Sponsoring Institutions, programs, and training program liaisons are strongly encouraged to facilitate enhanced cultural and community support for international medical graduates beginning PGY-1 residency appointments in 2020.

f. See 6.b above

Impact of a COVID-19 and a Shortened ERAS Timeline on Programs' Implementation of Holistic Review Resources

Recommendation 3 — ERAS Timeline: The WG recommends a delayed opening of ERAS for residency programs and a delayed release of the MSPEs and that the opening and release happen on the same day.

Because of COVID-19-related disruptions to the implementation of third-year curricula, Board exam schedules, visa processing, and travel, applicants are experiencing challenges completing the requirements that would normally prepare them for the residency recruitment cycle. This is of concern to all engaged in the residency selection process. As programs consider historical eligibility requirements that may not be readily attainable for every applicant in the COVID-19 environment, they will be faced with individuals who have limited or no clinical experience in the specialty, limited letters of recommendation, and/or incomplete USMLE or COMLEX examinations. Employing the traditional evaluation approach may result in applicants being automatically screen out.

In the pandemic environment, program directors can expect even more challenges to the recruitment cycle as program staff are required to screen applicants with even fewer letters of recommendation, fewer rotation evaluations (away and at home), and fewer test scores. Programs with severe financial burdens may face challenges with availability of program personnel funds. Furthermore, once the acute phase of the pandemic has passed, the clinical workload of program faculty will have increased, which may further affect the faculty's availability for recruiting.

Even as ERAS considers a delayed opening to allow additional time for applicants to complete their applications, it is unclear how long COVID-19-related disruptions may last, how much information programs will have available to make decisions, or how the compressed recruitment cycle will affect programs that wish to conduct holistic review of their applications. This lack of clarity may trigger other behaviors in applicants (e.g., increasing the number of programs they apply to) and programs (e.g., extending more interview invitations) that could exacerbate an already difficult situation.

To ensure a consistent, fair process for all applicants, and to make the most of the recruitment cycle, residency programs should conduct a holistic review of all applicants. They should:

1. Review specialty guidance from their program director organizations, ACGME, and other authoritative organizations.
2. Consider letters of recommendation outside the program's discipline.
3. Consider alternative validated methods of assessment, such as COMAT and NBME shelf examinations, while awaiting completion or availability of USMLE and COMLEX examinations.
4. Consider adapting the virtual interview processes that provide multiple opportunities for maximum information exchange between applicants and programs:
    a. Best practices for applicant assessment may include collating input from official interviewers and current trainees and staff who are encountering the applicants, behaviorally based interview questions, and recording select interview segments.

   b. Best practices for promoting the program may include live or recorded videos of a program overview, community information, informal interaction with current trainees in large and small groups that facilitates frank discussion, and virtual tours of facilities that portray conditions honestly.
5. Be consistent with interview methods throughout the recruitment season, recognizing that the timing of interviews for individual programs and applicants may be affected by the evolving local impact of the pandemic.
6. Clearly inform potential applicants of the eligibility criteria for the program and the program's curriculum and training.
7. Partner with sponsoring institutions and local resources that promote the community.
8. Be aware of variations in the medical student performance evaluations (MSPEs) compared with previous years due to limitations in clinical experiences and other disruptions to medical education due to COVID-19.

Resource

AAMC Holistic Review Resources and Tools for Program Directors

Coalition for Physician Accountability

Statement on Public Health

December 1, 2020

The Coalition for Physician Accountability shares a strong commitment to protect the public's health and safety through the delivery of high-quality health care. Public health officers and physicians involved in various public health roles, including advocacy and leadership, have recently been criticized by elected officials and members of the public for following evidence-based practices. Recognizing that understanding of the SARS-CoV-2 virus and its transmission and pathogenicity continues to evolve, the member organizations of the Coalition for Physician Accountability strongly:

1. Support public health officials and workers at the local, state, territorial, tribal, and national levels committed to acting upon prevailing evidence-based public health practices to contain and mitigate transmission of the virus;
2. Encourage greater integration of public health practices and principles – including epidemiology, statistics, population health, health policy, social determinants of health, and equity and diversity – across the continuum of medical education, from medical school through residency and fellowship training, and throughout practice;
3. Support a commitment from local, state, territorial, tribal, and federal officials to protect the public by closely collaborating with health officials and to substantively increase funding and resources for local, state, territorial, tribal, and federal health departments and agencies, especially for the prevention and management of COVID-19 and future pandemics;

4. Endorse a commitment by all physicians at every level of training and practice to follow prevailing expert advice for the reduction of viral transmission, including wearing a face covering (mask) when engaged in the in-person care of patients; and
5. Recognize that physicians have an ethical responsibility to follow evidence-based practices; provide high quality health care for the nation's most vulnerable populations disproportionately affected by the pandemic; maintain professionalism, accountability and competence; collaborate with colleagues across the health professions; respect science and the scientific method; support ongoing research that improves our understanding of COVID-19 and the impact that health inequities and social determinants of health play; and understand their own role as trusted spokespersons of the medical profession.

Endorsed by Members of the Coalition for Physician Accountability:

Accreditation Council for Continuing Medical Education (ACCME)
Accreditation Council for Graduate Medical Education (ACGME)
American Association of Colleges of Osteopathic Medicine (AACOM)
American Board of Medical Specialties (ABMS)
American Medical Association (AMA)
American Osteopathic Association (AOA)
Association of American Medical Colleges (AAMC)
Council of Medical Specialty Societies (CMSS) (liaison member)
Educational Commission for Foreign Medical Graduates (ECFMG)
Federation of State Medical Boards (FSMB)
Joint Commission (liaison member)
Liaison Committee for Medical Education (LCME)
National Board of Medical Examiners (NBME)
National Board of Osteopathic Medical Examiners (NBOME)

April 5, 2020

ACGME Reaffirms its Four Ongoing Requirement Priorities during COVID-19 Pandemic

As the nation and world face the evolving COVID-19 (SARS COV2) crisis, the ACGME has granted a significant degree of flexibility to accredited Sponsoring Institutions and programs to realign their resident and fellow workforce to meet the increased clinical demands created by the pandemic. This flexibility with expectations is provided consistent with the ACGME's commitment to patient safety and resident/fellow safety. In exchange for this flexibility, the ACGME expects strict compliance with the following four requirements:

1. **Work Hour Requirements**
   The ACGME Common Program Requirements Section VI Work Hour Requirements remain unchanged. Safety of patients and residents/fellows is the ACGME's highest priority, and it is vital all residents and fellows receive adequate rest between clinical duties. Violations of the work hour limitations have been associated with an increase in medical errors, needle sticks, and other adverse events that might lead to lapses in infection control, slips in this area could increase risks for both patients and residents/fellows.

2. **Adequate Resources and Training**
   Any resident, fellow, and faculty member providing care to patients potentially infected with COVID-19 must be fully trained in treatment and infection control protocols and procedures adopted by their local health care setting (e.g., personal protective equipment [PPE]). Clinical learning environments must provide adequate resources, facilities, and training to properly recognize and care for these patients, including the need to take a complete travel and exposure history in patients presenting with signs and symptoms associated with COVID-19.

3. **Adequate Supervision**
   Any resident or fellow who provides care to patients will do so under the appropriate supervision for the clinical circumstance and the level of education of the resident/fellow. Faculty members are expected to have been trained in the treatment and infection control protocols and procedures adopted by their local health care settings. Sponsoring Institutions and programs should continue to monitor the CDC website.

4. **Fellows Functioning in their Core (Primary) Specialty**
   Fellows in ACGME-accredited programs can function within their core specialty (i.e., the specialty in which they completed their residency), consistent with the policies and procedures of the Sponsoring Institution and its participating sites, if:

   a. they are American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) board-eligible or -certified in the core specialty;

   b. they are appointed to the medical staff at the Sponsoring Institution; and,

   c. their time spent on their core specialty service is limited to 20 percent of their annual education time in any academic year.

December 21, 2020

Updated: Supplemental Guidance Regarding the COVID-19 Pandemic, ACGME Accreditation, and Sponsoring Institution Emergency Categorization

The ACGME continues to maintain a process for the Emergency categorization of Sponsoring Institutions that face operational disruption resulting from the COVID-19 pandemic, and to issue guidance statements that address emerging pandemic-related accreditation issues. Based on its continued monitoring of the effects of the pandemic on graduate medical education, health care providers, and the public, the ACGME is providing the following supplemental guidance:

1. The ACGME continues to maintain its process for the Emergency categorization of Sponsoring Institutions as described on the ACGME website. In a modification to this process, the days of a Sponsoring Institution's Emergency Category status will be counted cumulatively in each academic year (July 1-June 30). A Sponsoring Institution's first request for Emergency categorization in a given academic year should be submitted to the ACGME using the Request Form for 1-30 Days.

2. All Sponsoring Institutions, in partnership with their programs, must ensure the safety of resident, fellow, and faculty member assignments that may include responsibilities for the care of patients with COVID-19. As stated in previous ACGME guidance ["ACGME Reaffirms Its Four Ongoing Requirement Priorities during COVID-19 Pandemic"], "any resident, fellow, and faculty member providing care to patients potentially infected with COVID-19 must be fully trained in treatment and infection control protocols and procedures adopted by their local health care setting (e.g., personal protective equipment [PPE])." When setting priorities for vaccination against COVID-19, inclusion of residents/fellows and faculty members who serve as frontline caregivers is considered an essential part of this requirement.

   These obligations to ensure safety extend to the protection of faculty members, residents, and fellows who inform Sponsoring Institutions and programs of health conditions or impairments that are likely to be associated with a high risk of morbidity or mortality in the event of COVID-19 infection. Sponsoring Institutions and programs must ensure that faculty members, residents, and fellows with such health conditions or impairments are informed of safety measures associated with their patient care assignments. Per the ACGME Institutional Requirements, Sponsoring Institutions must have policies addressing leaves of absence and accommodations for disabilities. Sponsoring Institutions should consider requests for leaves of absence or for accommodations made by faculty members, residents, and fellows whose ability to participate in patient care assignments or other program activities is affected by health conditions (including COVID-19-related illness) or impairments. Reasonable accommodations should include arrangements that avoid risks to personal safety associated with residents', fellows', and faculty members' health status (e.g., alternative rotations).

3. All programs must continue to assess residents and fellows in all six Core Competencies, and such assessments must form the basis for decisions regarding promotion to subsequent appointment levels or satisfaction of requirements for program completion. The ACGME has issued guidance ["Guidance Statement on Competency-Based Medical Education during COVID-19 Residency and Fellowship Disruptions"] for program directors, faculty members, and Clinical

Competency Committees in completing the required assessments when educational components of the programs have been disrupted as a result of the COVID-19 pandemic. Programs should follow the principles of competency-based medical education, as described in the above-referenced guidance statement, to make determinations regarding the advancement, graduation, and Board eligibility of individual residents and fellows.

BRD RPT 21-5

REPORT OF THE BOARD OF DIRECTORS

Subject: Report of the FSMB Workgroup on Physician Impairment

Referred to: Reference Committee

The Federation of State Medical Boards (FSMB) Workgroup on Physician Impairment, chaired by Dr. Danny Takanishi, M.D., has been charged with reviewing, in collaboration with the Federation of State Physician Health Programs (FSPHP),[1] the FSMB Policy on Physician Impairment (HoD 2011) and making recommendations to revise and expand the policy in light of new and emerging issues, including but not limited to:

1. Implementation of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (May 2013);
2. Use of medication for the treatment of opioid use disorder by practicing licensees with opioid use disorders;
3. The role of Physician Health Programs (PHPs) to promote licensee wellness and combat burnout;
4. State medical board policies and procedures designed to ensure appropriate working relationships with PHPs;
5. Revised PHP Guidelines (2019) by the FSPHP.

Over the course of two years, the workgroup carried out its charge by reviewing existing research, policy, resources, and strategies for addressing physician impairment. The workgroup held five virtual meetings of the entire workgroup and six additional meetings of workgroup subcommittees from September 4, 2019 to February 4, 2021 to discuss research findings and propose policy revisions. The workgroup's membership was supported by the participation of representatives from the FSPHP and the American Society of Addiction Medicine (ASAM).

A revised draft policy was distributed to state medical boards and external partner organizations with a nexus to physician impairment during a comment period held from November 6, 2020 to January 8, 2021 (late comments were received and accepted until January 26, 2021). Feedback received was categorized according to the following themes:

- Clarify the definition and descriptions of impairment
- Address costs and other potential burdens associated with the PHP model
- Expand content to other topics addressed by PHPs, including burnout, physician education, mental health, retirement planning/life transitions
- Make distinct references to medical students, residents, and fellows, where appropriate
- Provide transparency regarding board processes for addressing impairment in actual or prospective licensees
- Clarify the instances in which a report to the medical board is required

[1] A PHP (Physician Health Program) is a program of prevention, detection, intervention, rehabilitation and monitoring of licensees with impairing illnesses, approved and/or recognized by the state medical board. The FSPHP's mission is to support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care.

- Clarify the instances in which medical board action is necessary in response to impairment
- Bolster content on prevention of impairment, including through a stigma reduction lens that is supportive of licensee recovery

The workgroup met twice via videoconference to discuss feedback received and provide input for its incorporation into a new draft. A revised draft titled *Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health* was distributed to the FSMB Board of Directors electronically and considered at its meeting on February 20, 2021.

ITEM FOR ACTION:

The Board of Directors recommends that:

The House of Delegates ADOPT the *Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health,* and the remainder of the Report be filed.

Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health

Section I – Introduction

In April 2019, Chair of the Federation of State Medical Boards (FSMB), Scott Steingard, DO, established the *FSMB Workgroup on Physician Impairment* to review, in collaboration with the Federation of State Physician Health Programs (FSPHP),[1] the FSMB Policy on Physician Impairment (HoD 2011) and make recommendations to revise and expand the policy in light of new and emerging issues, including but not limited to:

1. implementation of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (May 2013);
2. use of medication for the treatment of opioid use disorder by practicing licensees with opioid use disorders;
3. the role of Physician Health Programs (PHPs) to promote licensee wellness and combat burnout;
4. state medical board policies and procedures designed to ensure appropriate working relationships with PHPs;
5. revised PHP Guidelines (2019) by the FSPHP.

This policy provides guidance to state medical and osteopathic boards (referred to hereinafter as state medical boards) for including PHPs in their efforts to protect the public. There is a need to educate the medical profession and the public about physician illness, impairment, and illness that can lead to impairment. This document represents recommendations for medical boards and PHPs to effectively protect the public through the assistance of licensees, medical students, and trainees with functionally impairing illness(es) based on best practices.

Section II - Model Physician Health Program (PHP)

State medical boards are referred to the Federation of State Physician Health Programs (FSPHP) Physician Health Program Guidelines[2] which, along with this document, serve as a resource in selecting and evaluating any particular PHP. Implementation of these Guidelines will necessarily vary from state to state in accordance with state legal, contractual and/or regulatory requirements.[3]

The purpose of a Physician Health Program (PHP) is to guide the rehabilitation of potentially impaired and impaired physicians, other licensed healthcare professionals, or those in training suffering from substance use disorders, psychiatric, medical, behavioral or other impairing conditions, including burnout, consistent with the needs of public safety. This involves the early identification, evaluation, treatment, monitoring, documentation of adherence, and advocacy, when appropriate, of licensees with potentially impairing illness(es), ideally prior to functional impairment. PHPs should provide services to both voluntary and board mandated referrals

[1] A PHP (Physician Health Program) is a program of prevention, detection, intervention, rehabilitation and monitoring of licensees with impairing illnesses, approved and/or recognized by the state medical board. The FSPHP's mission is to support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care.

[2] Federation of Physician Health Programs, Physician Health Program Guidelines, 2019.

[3] Whenever possible, the medical boards and PHPs should work collaboratively in the development of effective laws and regulations in the promotion of PHPs for the benefit of the public.

without bias and should not provide assistance or guidance for illness outside their scope and expertise. The provision of confidentiality offers an incentive for the medical community and others to confidentially contact the PHP prior to a physician's illness becoming functionally impairing.

Ideally, PHP services would include the following:

- Wellness programs that address physician health, stress management, burnout and early detection of at-risk behavior.
- Educational programs on topics, including but not limited to, the recognition, evaluation, treatment and continuing care of impairing conditions.
- Opportunities to conduct and participate in valid IRB-approved research.
- Educational resources for the profession, the public, and medical boards about the role and function of PHPs.

The decision of a current or future licensee to seek or accept PHP assistance and guidance should not, in and of itself, be used against the physician in disciplinary matters before the board. However, PHPs must report substantive non-adherence with PHP recommendations and monitoring agreements and make periodic reports regarding adherence based on ongoing documentation to appropriate individuals, committees, boards or organizations on behalf of licensees under PHP monitoring.

The dual role of protecting the public through licensing and sanctions as well as the provision of a mechanism for the successful rehabilitation of impaired physicians falls within the statutory public protection mandate of state medical boards. Furthermore, early detection, evaluation, treatment, and monitoring of a physician with an impairing illness enhances a board's ability to protect the public.

It is necessary that PHPs function in a stable environment insulated, as much as possible, from changing political pressures. PHPs must also have a clearly defined mission and avoid any potential negative impact resulting from leadership and/or philosophical changes within the state medical association, state medical board or others. Consequently, the Workgroup optimally recommends that state medical boards enter into agreements with PHPs that have an independent organizational governance structure that prioritizes and allows for the fulfillment of the PHP mission.

Support for the PHP model from state medical boards and medical associations is essential for PHP effectiveness. PHPs and their boards of directors, medical associations and state medical boards should be aware of the competing nature of dual interests, understand the need for separation, and mitigate conflicts of interests where possible by maintaining appropriate boundaries between the medical association, the PHP and the state medical board.

A PHP should be empowered to take action based on verifiable signs and behaviors suggestive of impairment. Unlike the board, which must build a case capable of withstanding legal challenge, a PHP can quickly intervene based on a reasonable concern. The PHP can, therefore, be a significant benefit to public safety. Since 1995, FSMB policy has supported physician remediation via an effective PHP as an alternative to, or in conjunction with, sanctions.

Section III – State Medical Boards and PHPs

The goals and missions of the FSMB, FSPHP, and their partners align in many ways. This is especially true with respect to a desire to see healthy physicians providing excellent care to the patients they serve. While the PHP model is not the only feasible model for supporting impaired or potentially impaired physicians to safely return to practice, PHPs have developed experience and expertise in matters of physician health, they offer a therapeutic alternative to discipline where patient safety is not at risk, and they help encourage physicians to seek treatment early for impairing conditions. PHPs coordinate and monitor intervention, evaluation, treatment and continuing care of the impaired physician as well as those with impairing illnesses.

PHPs, regulatory agencies, and physicians agree that public protection is paramount. Yet, patient safety and physician wellness do not need to be at odds.[4] As stated in the FSMB policy on Physician Wellness and Burnout, "the duty of state medical boards to protect the public includes a responsibility to ensure physician wellness and to work to minimize the impact of policies and procedures that impact negatively on the wellness of licensees, both prospective and current."[5] Safe reintegration of the recovering physician back into the workforce constitutes the ideal scenario. At times, tension may arise among stakeholders regarding an appropriate balance between the goals of protecting the public, on the one hand, and assisting the physician in recovery, on the other. Collaboration among all stakeholders is required to effectively support physicians with impairing illness so that they may provide quality care to patients.

These efforts require that PHPs have a primary commitment to uphold the mission of their state medical and osteopathic boards in order to protect the public. To gain the confidence of regulatory boards, PHPs must develop quality reviews to enhance the effectiveness of their programs that demonstrate an ongoing track record of ensuring safety to the public and reveal deficiencies if they occur. Such transparency and accountability to the medical and osteopathic boards is necessary to the existence and continuation of a viable PHP.

The ideal relationship between a state medical board and a PHP is characterized by:

1. A commitment between both parties to open lines of communication and collaboration within the bounds of applicable confidentiality protections.

2. Mutual understanding of each organization's responsibility to program participants and the public.

3. No discrimination nor denial of PHP services based on a physician's race, creed, color, national origin, religion, sexual orientation, gender, gender identity, specialty, type of professional degree, or membership affiliations.

4. PHP acceptance of physician participants experiencing financial difficulties who otherwise meet program eligibility criteria, and availability for referrals by boards and other individuals or entities in need of services.

5. State medical board endorsement of a PHP and support to ensure the PHP has adequate staff and funding to meet its expected mission and goals.

[4] Lemaire JB, Ewashina D, Polachek AJ, Dixit J, Yiu V (2018) Understanding how patients perceive physician wellness and its links to patient care: A qualitative study. PLOS ONE 13(5): e0196888. https://doi.org/10.1371/journal.pone.0196888

[5] Federation of State Medical Boards *Policy on Physician Wellness and Burnout*, Adopted April 2018.

6. PHP arrangement for emergency interventions and evaluations, where possible.

7. PHP establishment of a health monitoring agreement template designed to optimize continuing care, physician rehabilitation and patient safety. Details of each agreement should be individualized and subject to change based on case specifics.

8. Periodic review of laws and regulations by state medical boards, in consultation with PHPs, to ensure that the PHPs are legally able to adapt to evolving best practices.

A formal agreement should be executed between the state medical board and PHP, establishing the parameters of the relationship. Ideally, such an agreement will be based on the principles of mutual trust, respect, accountability, collaboration, and communication. Transparency of program policies and procedures while maintaining the appropriate confidentiality of individual participants is important.

Section IV – Supporting Physician Health: Key Considerations

For the purposes of this policy, physician impairment is defined as the inability of a physician to provide medical care with reasonable skill and safety due to illness or injury.The discussion of impairment in this policy applies to physicians broadly and includes not only licensed physicians and physician assistants, but also medical students, residents and fellows, and those seeking licensure. It also applies to other healthcare providers in instances where state medical boards license multiple types of healthcare professional.

It is important to distinguish illness from impairment. Illness, per se, does not constitute impairment.[6] When functional impairment exists, it is often the result of an illness in need of treatment. Therefore, with appropriate treatment, the issue of impairment may be prevented or resolved while the diagnosis of illness may remain.

Impairment is a functional classification which exists dynamically on a continuum of severity and can change over time rather than being a static phenomenon. At one end of this continuum can be found mild loss of function such as minimal cognitive decline, minor physical ailments, and other issues which do not, or which minimally, impact performance. At the other end of the continuum can be found more substantial loss of function such as that associated with severe cognitive decline, severe substance use disorder, or major physical, mental or emotional impairments that significantly limit the ability of a physician to provide safe medical treatment to patients. The location of a particular instance of loss of function along this continuum of severity is dictated by its impact on the functional ability of the physician to safely engage in the provision of medical care. An instance of loss of function only merits regulation by a state medical board if it meaningfully limits (and therefore impairs) a physician's ability to provide safe care to patients.

Any impairment should be evaluated according to the particular context of the physician's occupation, their specialty, and the patients and conditions they treat. An essential tremor in a surgeon could be considered a relatively severe impairing condition, whereas it may not be an impairment for a psychiatrist. Each particular instance of impairment should also be considered

[6] Candilis PJ, Kim DT, Snyder Sulmasy L, (2019) Physician Impairment and Rehabilitation: Reintegration into Medical Practice While Ensuring Patient Safety: A Position Paper from the American College of Physicians, *Ann Intern Med*. 170:871-9

according to its severity and functional impact. For example, not every tremor would be too severe to perform simple procedures. Very minimal instances of cognitive impairment may not be significant enough to present risks to patient safety. In many cases, impairments can be improved through effective management.

Stigma and Barriers to Treatment

The stigma associated with illness and impairment, particularly impairment resulting from mental illness, including substance use disorders, can be a powerful obstacle to seeking treatment, especially in the medical community where the presence of this stigma has been described in the literature.[7] Many physicians are averse to seeing themselves in the role of the patient. Physicians may fear the impact that a diagnosis of impairing illness might have on the perceptions of their peers, patients, and others, including their state medical board, regardless of earnestness on the part of boards in treating people fairly and respectfully. This stigma is compounded and perpetuated by questions on applications for licensing, employment, credentialing and recredentialing, and malpractice insurance that inquire about mental health diagnosis and previous treatment. This fear presents significant risks not only to the potentially impaired physician's own health, but also to the safety of their patients.

Reducing the stigma associated with illness and impairment is essential for ensuring that physicians with impairing illness feel comfortable seeking treatment in order to practice safely, or to re-enter practice after a period of treatment and rehabilitation. As recommended in the FSMB Policy on Physician Wellness and Burnout,[8] boards are encouraged to take advantage of opportunities to discuss physician wellness, communicate regularly with licensees about relevant board policies and available resources, and help engender positive cultural change to reduce stigma associated with impairment among those physicians seeking treatment, as well as stigma related to the treatment itself and acknowledging its need. Beyond discussion, boards are encouraged to find ways to promote health, rehabilitation and restoration, and reduce obstacles to seeking treatment, including by allowing treatment to be sought confidentially for impairing illness and not requiring this to be reported as part of the licensing process, while reminding licensees of their professional responsibility to address any health concerns and ensure patient safety. Physicians must be afforded the same access to care as the general public. When boards achieve positive change in these areas, they are encouraged to communicate this to licensees and the public to ensure greater awareness and protect licensees' ability to address health conditions without stigma or delay.

Assessment of Impairment

While each instance of impairment would need to be assessed based on its individual signs and behaviors, there are common features which might indicate impairment in any physician. For example, if a physician is suffering from impairment due to substance use, this may become apparent through changes in mood/affect, decreased productivity, apathy toward patient care, suicidal ideation or behavior, increasing medical errors, inconsistent hours, complaints from patients or other colleagues, deterioration in appearance or physical health, and changes in social interactions.[9] An overall pattern or cluster of signs and behaviors would be more indicative of an individual at imminent risk for impairment than individual and isolated events.

[7] Wallace, JE (2012) Mental Health and Stigma in the Medical Profession, *Health:*, 16(1): 3-18.
[8] Federation of State Medical Boards *Policy on Physician Wellness and Burnout*, Adopted April 2018.
[9] Santucci, Karen. Reporting an impaired colleague difficult but necessary. AAP News, 2018. https://www.aappublications.org/news/2018/11/28/law112818

Medical Students, Residents and Fellows

It has been shown that students whose professionalism lapses in medical school are more likely to exhibit similar behaviors in residency training and practice.[10] Fostering greater understanding of the regulatory role in physician impairment and the purpose of PHPs, encouraging self-care and seeking treatment early among medical students, residents and fellows ("residents and fellows" are hereinafter referred to as "residents", unless otherwise specified) and facilitating dialogue between state medical boards and the medical education community are therefore important elements of patient protection.

Stigma associated with mental health issues and impairment is negatively correlated with adaptive attitudes about help-seeking among medical students, especially those who are already having difficulties.[11] In considering the multitude of issues facing medical students and residents, including burnout, financial difficulties, educational stressors, geographic isolation, and a lack of support systems, supportive resources become invaluable. It is of the utmost importance to promote an awareness of how and when to access these resources. The crucial work of the FSMB's Workgroup on Physician Wellness and Burnout is applicable to medical students and residents and their professional development as well.

The development and provision of resources to help identify and prevent impairment in medical students is not in the direct purview of state medical boards. However, there are strategies boards may wish to implement to encourage and facilitate seeking treatment across the continuum of medical students, residents and practicing physicians. Among these are avoiding the inclusion of questions about current medical or psychiatric conditions or counseling, or previous history of impairment on applications for medical licensure, or offering a "safe haven" alternative of not reporting treatment sought either through the PHP model or a physician expert model that involves comprehensive care management and monitoring. Again, these should be replaced with reminders of the importance of physician wellness, and positive developments in these areas should be promoted widely through communications strategies to raise awareness, reduce stigma, and dispel myths about the ways in which state medical boards approach the issue of impairment.

State medical boards can also be supportive of medical schools relative to the early detection, prevention, evaluation and treatment of impairing conditions according to the same principles of confidentiality, collaboration, communication, accountability, professional assistance, and guidance adopted by the PHP community. These principles are indispensable during transition periods in training such as between medical school and residency and between residency and entry to independent or unsupervised practice. The concept of "warm handover"[12] during these periods, subject to a student's or resident's consent and after they have been accepted into a residency or fellowship program, that includes a confidential and appropriate focus on student well-being can be encouraged by the medical regulatory community.

Medical students, residents, and training programs can also benefit from greater availability of information about the considerations, processes and timelines used by state medical boards in

[10] Krupat E, Dienstag JL, Padrino SL, Mayer JE, Shore MF, Young A, Chaudhry HJ, Pelletier SR, Reis BY, Do Professionalism Lapses in Medical School Predict Problems in Residency and Clinical Practice? *Acad Med*: June 2020, Vol.95(6):888-895.

[11] Schwenk TL, et al. (2010). Depression, Stigma, and Suicidal Ideation in Medical Students. JAMA, 304(11):1181-1190.

[12] Warm, Eric J. MD; Englander, Robert MD; Pereira, Anne MD, MPH; Barach, Paul MD, MPH. Improving Learner Handovers in Medical Education. *Acad Med*: July 2017, Vol.92(7):927-931

arriving at licensing decisions related to impairment. While boards consider each instance of impairment based on the physician's individual context, transparent information about the considerations that factor into boards' decisions can help foster an appreciation for a consistent approach among boards and reduce anxiety associated with the licensing processes among applicants. It could also help reduce stigma associated with impairment and encourage treatment seeking.

State medical boards can also encourage greater awareness of their purpose and procedures by inviting students to attend board meetings and engaging in outreach with medical schools. The concept of student attendance at board meetings has already been adopted by several boards across the country and presents valuable opportunities to foster familiarity with the board and educate about the importance of seeking treatment, the continuum of (and differences between) illness and impairment, the value of early intervention, and the fact that illness can be treated in a safe, confidential, respectful and professional manner without impact on the ability of the medical student to continue their education and ultimately obtain an unrestricted medical license. A greater understanding of these and other medical regulatory concepts can also be gained through the free online educational modules developed by the FSMB which are geared towards medical students and residents. Better educated and informed medical students become better residents who are more aware of their own well-being and behavioral and mental health needs and are better able to serve themselves and their patients after they complete their training.

Reporting

It is essential that state medical boards have timely information about instances of a physician practicing while impaired in order for them to carry out their patient protective functions. Gathering such information about all instances of practicing while impaired is not always possible in the course of state medical boards' typical regulatory processes. Boards will therefore depend on licensees and other individuals and entities to fulfill their ethical "duty to report" such instances. This is a duty of physicians and the profession of medicine to patients and society, to help ensure patients are provided safe medical care and that trust in medicine is maintained. It is also a duty to impaired physicians, as reporting aims to encourage physicians in seeking the assistance, guidance and support they need in order to continue practicing safely.

Some instances of practicing while impaired will require direct reports to state medical boards, including instances of patient harm and substantive non-adherence to agreements with PHPs. However, when a timely intervention to ensure that an impaired physician ceases practicing and receives appropriate PHP assistance is sufficient to protect patients, the ethical duty towards patients and colleagues has been discharged.[13]

While this ethical duty to intervene transcends state lines, legal requirements for reporting vary among states. Language used in state laws indicating when reporting an instance of impairment in a physician colleague is required can include "actual knowledge" of an impairment, "reasonable cause" to believe that an impairment exists, "reasonable belief" that an impairment is present, "first-hand knowledge" of an impairment, and "reasonable probability" (as distinguished from "mere probability") of an impairment.[14] Licensees should be expected to be familiar with reporting requirements in the state(s) in which they are licensed. State medical boards can support licensee understanding of reporting requirements by developing guidance documents in lay rather than legal

[13] AMA Code of Medical Ethics, Opinion 9.3.2

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

terms. Where boards are permitted to work with legislatures on drafting or amending legislation, they may wish to ensure clear language regarding reporting requirements that emphasizes the theme of "reasonability." If it is reasonable to believe that a physician is impaired in such a way that they pose a threat to patient safety, then reporting should be required.

Reporting responsibilities also exist between PHPs and state medical boards. Reporting requirements may vary from state to state based on state laws, program regulations, as well as the relationship and level of trust between the PHP and the board. The PHP should report to the board on the status of program participants in accordance with the agreement between the board and the PHP. Some boards require periodic reports on participants **they have referred** to the PHP. Others may ask for reports on all participants. In that case, board mandated participants are identified by name while confidential participants are identified by number to maintain their confidentiality. Confidential PHP participants (those that are unknown to the board and/or those for whom there is no reporting requirement) risk forfeiting their confidentiality should they have substantive non-adherence to an agreement with their PHP, and will forfeit their confidentiality should they pose a risk to the public. PHPs reporting on those physicians who are board-mandated may report to the board on a periodic basis and include detailed reports on adherence to continuing care plans and monitoring results.

Referral

State medical boards should offer two separate tracks for referral of ill or impaired physicians to PHPs: a voluntary track and a mandated track.

Voluntary Track – A confidential process of seeking assistance and guidance through a PHP whereby the impairing illness is addressed without required personal identification to the state medical board. A voluntary track promotes earlier detection of impairing illness before it becomes functionally impairing. The voluntary track participants are in a safe system whereby substantive non-adherence or relapse, depending on each state's non-adherence reporting requirements, will be promptly reported to the licensure board by name.

Mandated Track – Mandated licensees are those required by the state medical board to participate in a PHP. A mandated referral can be via an informal referral or via a formal public or private censure. In either instance the board may require quarterly progress reports. It is recommended that boards have a non-disciplinary process for referral to encourage early detection and intervention.

FSMB encourages referral to PHPs as an alternative to discipline to facilitate early detection, evaluation, treatment and monitoring before illness progresses to actual impairment. Non-disciplinary tracks also encourage self-referrals and more referrals by concerned colleagues, family members and patients.

FSMB recognizes that, for a variety of reasons, treatment of healthcare professionals may occur with or without oversight by a PHP. As recommended by the American Society of Addiction Medicine, "clinicians who treat healthcare professionals outside of PHPs should thoughtfully appraise their ability to provide credible assurance of safety to practice for professionals in their care and understand their legal and ethical requirements for public safety within the context of the therapeutic relationship. Clinicians with expertise in the treatment of healthcare professionals with

(impairing illness) should understand when participation in a PHP may offer an advantage to (the physician-patient) and (utilize) this additional support."[15]

Criteria for Referral for Professional Assessment

One or more of the following should prompt referral of the physician, for additional screening and diagnostic assessment by a qualified professional evaluator:

1. Information or documentation of excessive use of alcohol or other potentially impairing drugs, regardless of addictive potential (e.g. antipsychotics, anticholinergics, anticonvulsants, hallucinogens, stimulants)

2. Sufficient indications of current alcohol or other drug use that may include positive toxicology results for substances that are not prescribed by a treating healthcare professional.

3. Behavioral, affective, cognitive, or other mental problems that raise reasonable concern for public safety.

4. Information or documentation of psychiatric illness or substance use disorder that impairs the ability to practice.

Evaluation and Diagnosis

PHPs accept self-referrals and calls from collateral sources who may be concerned about a physician. PHPs will gather the necessary information and guide the next steps. Evaluation of a physician may involve referral fora comprehensive clinical and/or multidisciplinary examination. The nature and content of the evaluation will be dictated by the specific circumstances of the physician being evaluated, their reasons for referral, and any concerns raised by the referring entity or individual. For suggestions on specific evaluation criteria, as well as credentials of the evaluator or evaluating team, state medical boards may wish to consult the FSPHP Guidelines.[16] High quality evaluations and treatment options are essential to the successful rehabilitation of providers. As such, state medical boards and PHPs should collaborate to ensure that evaluations of fitness to practice are carried out according to best practices and completed in a timely manner.

Treatment/Rehabilitation

Ensuring that physicians experiencing impairment are appropriately treated and rehabilitated in order to safely reenter practice is part of the mandate of state medical boards. The specific course of treatment and monitoring for rehabilitation of the individual physician participant, however, is under the purview of the treating healthcare professional and PHP, respectively.

In accordance with applicable statutory reporting requirements, PHPs, evaluators and treatment providers must report to the board any physician who is substantively non-adherent to the recommendations of a treatment agreement and poses a reasonable risk to patient safety.

Medications for the Treatment of Opioid Use Disorder

[15] American Society of Addiction Medicine, Public Policy Statement on Physicians and other Healthcare Professionals with Addiction, Adopted by the ASAM Board of Directors February 6, 2020.
[16] Federation of Physician Health Programs, Physician Health Program Guidelines, 2019.

Medications for the Treatment for Opioid Use Disorder (MOUD) refers to the medications that are FDA-approved for the treatment of Opioid Use Disorder (OUD), including methadone, buprenorphine, and naltrexone. These medications are used in combination with an array of counseling, psychiatric, medical and psychosocial and/or spiritual therapies, and recovery support services based on a thorough assessment of individual needs. MOUD is recognized as being the standard of care for OUD and an important component of quality treatment.[17,18]

Methadone:
Methadone is a full opioid agonist[19] and an effective treatment for chronic pain and suppression of symptoms of opioid withdrawal and for treatment of OUD. While methadone is an effective treatment for OUD in the general population,[20,21] its characteristics include the potential for cognitive impairment until tolerance has developed.[22]

Buprenorphine:
Buprenorphine is a partial opioid agonist and is an effective treatment for suppression of symptoms of opioid withdrawal and for treatment of OUD. When buprenorphine is administered appropriately, it has minimal effects which would cause impairment.[23] New injectable buprenorphine formulations eliminate diversion risks associated with sublingual formulations.

Naltrexone:
Naltrexone is an opioid antagonist that is an effective treatment used to prevent relapse to opioid use in patients who are no longer physically dependent on opioids. Naltrexone can be administered orally or as time-release injections. Oral naltrexone has not been demonstrated to be an effective treatment for OUD in studies thus far. Long-acting injectable naltrexone outcomes in a 6-month study

[17] ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, 2020 Focused Update.
[18] Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63. Publication No. PEP20-02-01-006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.
[19] For definitions of opioid agonist, antagonist, and partial agonist, see Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63. Publication No. PEP20-02-01-006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020, p.1-2, Exhibit 1.1. Key Terms.
[20] Mattick RP, Breen C, Kimber J, Davoli M. Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. Cochrane Database Syst Rev. 2009;3:CD002209
[21] Madras, B. K., N. J. Ahmad, J. Wen, J. Sharfstein, and the Prevention, Treatment, and Recovery Working Group of the Action Collaborative on Countering the U.S. Opioid Epidemic. *NAM Perspectives.* Discussion Paper, Washington, DC. https://doi.org/10.31478/202004b
[22] Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63. Publication No. PEP20-02-01-006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.
[23] Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63. Publication No. PEP20-02-01-006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

are similar to those for buprenorphine for patients who successfully initiate the medication.[24]

Substance use disorder (SUD) treatment is most effective when it involves a multimodal approach including evidence-based medical care, psychosocial interventions, and mutual support groups within a chronic disease management model, inclusive of toxicology testing.[25] Physicians and other health care professionals are safety-sensitive workers. It is recognized that safety-sensitive work confers a benefit to society that is not without risk to public safety. As such, safety-sensitive workers, organized medicine, and regulatory agencies have an ethical and legal obligation to take preventive measures to minimize identifiable safety risks and are accountable when harm occurs.

Physicians are just as susceptible to OUD and addiction as the general population and deserve the same consideration in terms of their privacy, treatment and safety. However, the safety-sensitive nature of medical practice and patient care may impact which treatment options are most appropriate for physicians who suffer from OUD *and* wish to continue to practice medicine. Physicians and other clinicians should not be put in a special category of exclusion from treatment options that may effectively treat their addiction, but recognition of the safety-sensitive nature of their work is important. As such, decisions about whether it is safe to practice while receiving MOUD should include the following considerations:

- The potential for cognitive impairment[26] alone or in combination with other psychoactive medications
- The potential for misuse or diversion of the medications
- The presence of co-occurring illness
- The relative importance and availability of complementary psychosocial treatments
- The feasibility of monitoring by a PHP or other board approved physician expert with experience and expertise in the treatment and monitoring of physicians with SUD

As with any patient being assessed for MOUD, determination of the most appropriate course of treatment for a practicing physician should be based on the individual physician's case specific circumstances. Convenience, prescriber preference, and reimbursement rates should not outweigh considerations of patient safety, including both the physician as patient and the patients they treat if they continue to practice while receiving MOUD.

It is strongly recommended that physicians practicing medicine while taking a medication for OUD receive psychosocial treatment, including counselling and other treatment or services as determined based on their individual needs. These psychosocial treatments are

[24] Lee JD, Nunes EV Jr, Novo P, et al. Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicentre, open-label, randomised controlled trial. *Lancet*. 2018;391(10118):309-318. doi:10.1016/S0140-6736(17)32812-X

[25] Merlo LJ, Campbell MD, Skipper GE, Shea CL, DuPont RL. Outcomes for Physicians with Opioid Dependence Treated Without Agonist Pharmacotherapy in Physician Health Programs. *J Subst Abuse Treat*. 2016;64:47-54. doi:10.1016/j.jsat.2016.02.004

[26] The opportunity for over and under dosing in patients receiving an opioid agonist or partial agonist is not readily detectable. Significant fluctuations in dosing can have negative effects on well-being and cognition.

often best understood and coordinated through PHPs or in collaboration with physicians with expertise in the treatment of physicians with addiction.[27] These programs and/or physician experts are also able to support physicians suffering from substance use disorders and associated co-occurring illness and can therefore provide comprehensive care management informed by experience and expertise of the unique needs of this cohort. PHPs represent a model for chronic disease management and monitor (longitudinally over time) health care practitioners who have health conditions that could impair their ability to safely practice, thereby mitigating this risk. The Workgroup recommends that state medical boards not require disclosure related to impairment on licensing applications of treatment sought either through the PHP model or a board approved physician expert model that involves comprehensive care management and monitoring.

Section V – Monitoring and Continuing Care

Monitoring agreements must be established between PHPs and participants. Agreements should clearly state the limits of confidentiality with respect to the PHP's statutory reporting obligations. Circumstances which would trigger a mandatory report to the state medical board, pursuant to statute or contract with the board, should be specified in the monitoring agreement. Reportable event(s) should result in notification of the board and appropriate others in a timely manner. Where abstinence from alcohol or other legal or illegal substances is required as part of a monitoring agreement, it should be understood as the complete avoidance of substances *that are not prescribed by a treating healthcare professional*.

The nature and duration of monitoring will vary based on the impairing illness of the PHP participant and should be informed by the conditions specified in the FSPHP Guidelines.

In the event of relocation of a participant, the PHP should have a mechanism to facilitate the transfer of monitoring to the appropriate state PHP or, in the absence of a PHP or board approved alternative, the licensing board. When a physician is licensed and working in more than one state, either the state of residence or the state in which most professional activities are occurring should agree to assume primary responsibility for monitoring with regular reports to the other state(s). Whenever possible, monitoring should not be duplicated.

Care that follows the acute phase of intervention and initial treatment is referred to as continuing care or aftercare. PHPs oversee and monitor the continuity of care of participants to ensure progress and continued adherence to treatment agreements. Continuing care includes PHP guidance, support, toxicology testing, and accountability through a formal monitoring agreement concurrent with or following an evaluation and treatment process.

Continuing care of the PHP participant is crucial to the successful recovery, safe return to the practice of medicine, and ultimately the successful completion of PHP participation. The board should receive regular monitoring adherence reports prepared by the PHP for all board mandated physicians.

[27] Available evidence has shown that physicians with OUD who are not treated with MOUD have low relapse and comparable success rates to other Substance Use Disorders under the PHP model of care (Merlo LJ, et al., *J Subst Abuse Treat*, 2016;64:47-54). These findings support the fact that long-term recovery from OUD is possible without the use of MOUD in the physician population.

Section VI – Conclusion

State medical boards fulfill their primary mission of protecting the public in many ways. One important way is by supporting the health and well-being of licensees so that they may provide quality care to patients. Boards promote the public health and safety when they ensure that tools and support are available to enable early detection, proper treatment, and professional continuing care of impaired physicians. Furthermore, early intervention with licensees with impairing illness may prevent progression of illness to overt impairment.

All stakeholders should become better informed regarding issues not only related to functional impairment but also to impairing illness. Ideally, state and federal law should facilitate the effective interface between boards, PHPs and physician experts in their effort to support the rehabilitation of licensees with impairing illness because it adds to public protection. State medical boards are encouraged, with input from their PHPs and other qualified experts, to revisit their Medical Practice Act routinely to ensure that it remains consistent with legislation and developments in the field.

Boards, PHPs, and non-PHP clinicians who care for physicians can support each other through developing relationships based on mutual respect and trust. When this occurs, the public benefits. A highly trained licensee who is safely rehabilitated is an asset to the medical community, the state, and the public.

Appendix A: Glossary of Key Terms

Physician Impairment
The inability of a physician to provide medical care with reasonable skill and safety due to illness or injury.

Physician Health Program
A confidential resource for physicians, other licensed healthcare professionals, or those in training suffering from an impairing health condition. Such conditions include, but are not limited to, mental illness, including substance use disorders, non-psychiatric medical conditions and their treatments, and age-related cognitive and motor deterioration.

Substance Use Disorder
Substance use disorder (SUD) is a health condition marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol, nicotine, and/or other drugs despite significant related problems.[28]

Opioid Use Disorder
A substance use disorder involving opioids.

Medication for Opioid Use Disorder (MOUD)
Medications for the Treatment of Opioid Use Disorder (MOUD) refers to the medications that are FDA-approved for the treatment of Opioid Use Disorder (OUD), including methadone, buprenorphine, and naltrexone. These medications are used in combination with an array of counseling, other biological and psychosocial and/or spiritual therapies, and recovery support services based on a thorough assessment of individual needs. MOUD is recognized as the standard of care and an important component of quality treatment.[29,30]

Physician Expert Model of Treatment and Monitoring
A physician expert model of treatment and monitoring for clinicians with impairing illness is an alternative to the PHP model where a PHP either does not exist in a given state or is not appropriate for the treatment or monitoring of a particular participant. For example, some PHPs do not monitor physicians that have been treated for professional sexual misconduct and returned to practice. Such a model is only recommended as an alternative option for the treatment and monitoring of a potentially impaired or impaired physician provided that it involves the evaluation, treatment, monitoring, documentation of adherence with a treatment agreement, and the duty to report impairment in the context of medical practice that are accepted elements of the PHP model.

Physician experts who provide treatment and monitoring through such a model should understand when participation in a PHP may offer an advantage to the physician-patient and utilize this additional support.[31]

[28]American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596
[29] ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, 2020 Focused Update.
[30] Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63. Publication No. PEP20-02-01-006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.
[31] American Society of Addiction Medicine, Public Policy Statement on Physicians and other Healthcare Professionals with Addiction, Adopted by the ASAM Board of Directors February 6, 2020.

Abstinence
Abstinence is defined as the complete avoidance of potentially impairing drugs that are not legitimately prescribed.

Relapse
A process in which an individual who has established disease remission experiences recurrence of signs and symptoms of active addiction, often including resumption of the pathological pursuit of reward and/or relief through the use of substances and other behaviors. When in relapse, there is often disengagement from recovery activities. Relapse can be triggered by exposure to rewarding substances and behaviors, by exposure to environmental cues to use, and by exposure to emotional stressors that trigger heightened activity in brain stress circuits. The event of using substances or re-engaging in addictive behaviors is the latter part of the process, which can be prevented by early intervention.[32] It is important to note that appropriate treatment of some participants may involve the use of prescription medications known to the PHP.

The FSPHP *Physician Health Program Guidelines* define three levels of relapse relevant to the monitored health professional which may be helpful to state medical boards:

- Level 1 Relapse: Behavior without chemical use that is suggestive of impending relapse
- Level 2 Relapse: Relapse, with chemical use, that is not in the context of active medical practice
- Level 3 Relapse: Relapse, with chemical use, in the context of active medical practice[33]

Substantive Non-Adherence
Substantive non-adherence is a pattern of non-adherence, dishonesty, or other behavior that compromises the integrity of PHP continuing care monitoring, or an episode of non-adherence which could place patients at risk.

[32] American Society of Addiction Medicine (ASAM). The ASAM National Practice Guideline For the Treatment of Opioid Use Disorder: 2020 Focused Update. Available at: https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline
[33] Federation of Physician Health Programs, Physician Health Program Guidelines, 2019.

BRD RPT 21-6

REPORT OF THE BOARD OF DIRECTORS

Subject: **Report of the FSMB Workgroup to Study Risk and Support Factors Affecting Physician Performance**

Referred to: **Reference Committee**

In April of 2019, Scott Steingard, DO, FSMB Chair, appointed the FSMB Workgroup to Study Risk and Support Factors Affecting Physician Performance. The Workgroup, chaired by Mohammed Arsiwala, MD, is charged with:

1. Collecting and evaluating data and research on factors affecting physician performance and ability to practice medicine safely, including but not limited to practice context (specialty, workload, solo/group, urban/rural), gender, time in practice, examination scores, and culture;
2. Convening stakeholder organizations and experts to engage in collaborative discussions about patient safety issues and ethical and professional responsibilities as they relate to physician performance, including the duty to report;
3. Identifying principles, strategies, resources and best practices for assessing and mitigating potential impacts on physician performance;
4. Providing information to state medical boards about the risk and support factors affecting physician performance throughout their careers, how these can impact patient care, and what key principles should be applied to consideration of fair, equitable and transparent regulatory processes.

Workgroup members include:

Mohammed A. Arsiwala, MD, (Chair)	FSMB BOD, Michigan Medical
Christopher C. Bundy, MD, MPH	FSPHP
S. Brint Carlton, JD (Staff Fellow)	Texas
Daniel H. Faulkner, MBA	Canada
Amy S. Feitelson, MD	New Hampshire
Joseph E. Fojtik, MD	Illinois
Arthur S. Hengerer, MD	Honorary Fellow
Barbara S. Schneidman, MD, MPH	Honorary Fellow
Scott A. Steingard, DO	Arizona Osteopathic
Pascal O. Udekwu, MD, MBA	North Carolina
Betsy White Williams, PhD, MPH	Professional Renewal Center
Bruce D. White, DO, JD	New York PMC
Richard A. Whitehouse, JD	Kentucky

The Workgroup met three times via videoconference to discuss risk and support factors affecting physician performance, review existing research on the subject, provide direction on visual

representations of risk and support factors, draft survey questions for state medical boards, and draft its report.

The Workgroup met via videoconference on February 9, 2021 to discuss an initial draft report and provide direction for its completion. The draft report includes the following:

- A working definition of risk and support factors
- A summary of current research and common approaches in international jurisdictions that incorporate an understanding of risk and support factors into regulatory processes
- A summary of state medical board approaches to risk factors and various types of support provided, based on FSMB survey data from 2019 and 2020
- Visual representations of risk and support factors to support state medical boards' understanding of these factors with quick "at a glance" diagrams that categorize factors based on their association with 1) health and wellness, 2) experience and transitions, and 3) the practice environment, and link specific types of support to studied risks.
- Considerations for state medical boards related to new risks and potential supports in a practice environment impacted by COVID-19
- Suggestions for furthering FSMB support of member board educational resources, and removing barriers to licensee willingness to seek support, especially for issues related to health and wellness.

Feedback and direction for a final draft was received from Workgroup members via email in early-March and incorporated into a final report. This draft was submitted to the FSMB Board of Directors via email on March 11, 2021 for final approval as an informational report to the House of Delegates.

ITEM FOR ACTION:

For Information Only

Report of the FSMB Workgroup to Study Risk and Support Factors Affecting Physician Performance

Executive Summary

A risk factor in the setting of the practice of medicine is any factor that negatively impacts or alters any facet of a physician's performance, whereas a support factor is any factor that helps to foster, develop or improve a facet of a physician's performance. Common factors studied and published in the literature include the practice environment, type of specialty, experience, scores on various assessments, age, gender, and whether the physician had international versus domestic medical education. Understanding these factors and how they relate to the performance of licensees and the care patients receive from them may provide state medical boards with important tools for helping target their regulatory resources where they are needed most.

The following report provides an overview of recent research on physician risk and support factors, a description of current areas of focus among state medical boards, and considerations for boards related to medical professional culture, licensee wellness and burnout, and the operational use of risk and support factors in medical regulation and public protection. Risk and support factors are analyzed based on their relationship with health and wellness, career transitions, and the practice environment in order to shed light on these factors and to identify areas where greater supportive resources may be needed.

The report suggests that effectively incorporating knowledge of risk and support factors into medical regulation requires a focus on all three categories of factors in order to account for individual and systemic features of physician performance. This also allows for meaningful change to the prevailing medical professional culture to occur, facilitating the development and use of supportive resources that positively impact licensee health, performance, and patient care.

Section 1: Introduction and Workgroup Charge

The ability of a physician to provide safe and high-quality care to patients is influenced by a variety of factors. Quality of training, area of specialty, and practice experience have traditionally been seen as key factors influencing the quality of care a physician is able to provide. More recently, the list of relevant factors has expanded significantly to include specific elements of one's practice, such as the practice environment, practice patterns, and ways of remaining up to date in one's specialty. Physician health and wellness have also garnered significant attention for the ways in which they influence one's ability to practice safely. Less modifiable factors are now also known to be relevant, such as a physician's age, gender, and the systems outside of medical practice with which they interact.

A deeper understanding of why these factors are relevant to medical practice – and how they impact the quality of care patients receive – can influence the ways in which state medical boards carry out their mission to protect the public. In order to contribute to such an understanding, FSMB Chair Scott Steingard, DO, in April of 2019 appointed the FSMB Workgroup to Study Risk and Support Factors Affecting Physician Performance. The Workgroup is chaired by Mohammed Arsiwala, MD, and charged with:

1. Collecting and evaluating data and research on factors affecting physician performance and ability to practice medicine safely, including but not limited to practice context (specialty, workload, solo/group, urban/rural), gender, time in practice, examination scores, and culture;
2. Convening stakeholder organizations and experts to engage in collaborative discussions about patient safety issues and ethical and professional responsibilities as they relate to physician performance, including the duty to report;
3. Identifying principles, strategies, resources and best practices for assessing and mitigating potential impacts on physician performance;
4. Providing information to state medical boards about the risk and support factors affecting physician performance throughout their careers, how these can impact patient care, and what key principles should be applied to consideration of fair, equitable and transparent regulatory processes.

Section 2: Background and Current Focus

Since Donabedian's seminal work on the evaluation of medical care in the 1960s,[1] researchers have been studying factors affecting physician performance. In recent years, this work has been considered by medical regulatory authorities responsible for the licensing and discipline of healthcare professionals. Regulation of medical practice has taken on a risk-based approach in many international jurisdictions. Oftentimes, the purpose of identifying risk factors affecting

[1] Donabedian A (1966) Evaluating the Quality of Medical Care, *Milbank Memorial Fund Quarterly* 44(3 Suppl.): 166-206.

performance in these jurisdictions is to identify sets of practitioners with particular risk factors thought to be predictive of poor performance in order that they may be assessed to determine whether they pose an actual risk to the patients they treat.

This type of approach – which involves identification, assessment, remediation and support of physicians who are perceived to be at risk of poor performance – is common across multiple regulatory approaches in developed countries with well-resourced regulatory authorities. It also depends on a system of regulation that involves conducting assessments of large groups of licensees either exclusively by the regulatory authority, or through a partnership between the regulatory authority and other systems, such as academic medical training institutions or certifying bodies. While such an approach is not currently being considered in the United States, potential partners for such a system do exist.

There are several limitations posed by such a system for medical regulation in the United States, including existing administrative burdens involved in medical practice, high rates of burnout across all medical specialties, and now the additional burden practitioners face as a result of the COVID-19 pandemic. As such, the Workgroup feels it is most appropriate at the present time to first focus on risk factors in order to identify those areas where support is most needed.

Section 3: Definition of Risk and Support Factors

For the purposes of this report, the Workgroup has adopted the definitions of risk and support factors used by Glover Takahashi and colleagues in their work on examining risk and support factors for competence.[2] A risk factor is therefore understood as any factor that negatively impacts or alters any facet of performance, whereas a support factor is understood as any factor that helps to foster, develop or improve a facet of performance.

Section 4a: Current Research on Risk

The aforementioned study by Glover Takahashi and colleagues involved a scoping review of articles published in the literature between 1975 and 2014 on factors affecting physician performance and was commissioned by a group of Canadian medical regulatory authorities and partner organizations. The review yielded 943 articles, 754 of which focused specifically on competence in physicians, and 418 articles focused on risks to competence. The following risks were identified in studies, commentaries or in the gray literature (that is, outside of traditional publishing channels):

- Transitions (including change in status, change in focus of practice, new graduates and transitions) (74 articles)

[2] Glover Takahashi S (2017) Epidemiology of Competence: A Scoping Review to Understand the Risks and Supports to Competence of Four Health Professions, *BMJ Open*, 7(9), 1-12.

- International medical graduates (72 articles)
- Lack of clinical exposure/experience (67 articles)
- Age (66 articles)
- Gender (58 articles)
- Practice features (including location of practice, professional isolation and size of practice) (55 articles)
- Lack of specialty certification (53 articles)
- Wellness (53 articles)
- Resources (including people, money and time) (48 articles)
- Adequacy of medical practice or education (30 articles)
- Area of specialty (22 articles)
- Other risks to competence (9 articles)
- Previous disciplinary action (2 articles)

The review also identified 750 total articles focusing on supports to competence. The following support factors were identified in studies, commentaries, or gray literature:

- Continuing education participation (307 articles)
- Educational information/program features (282 articles)
- Personal support and feedback (including mentorship and peer performance) (127 articles)
- Adequate clinical exposure/experience (96 articles)
- Quality assurance participation (77 articles)
- Support through structure or organization (44 articles)
- Professional organization participation/systems (43 articles)
- Technology (41 articles)
- Other supports to competence (36 articles)
- Reflection and self-assessment (33 articles)
- Assessment and feedback through tools (24 articles)
- Performance review (22 articles)

To build on the information gleaned through this scoping review, additional focused and systematized reviews were conducted, providing a deeper understanding of the degree to which particular risk and support factors have been studied and the strength of evidence supporting each factor as impactful on physician performance. In all, over 900 studies were included in this analysis. Detailed findings, including a categorization of risk factors based on strength of evidence are available in Yen W and Thakkar N (2019) State of the Science on Risk and Support Factors to Physician Performance: A Report from the Pan-Canadian Physician Factors Collaboration, *Journal of Medical Regulation* Vol.105(1).

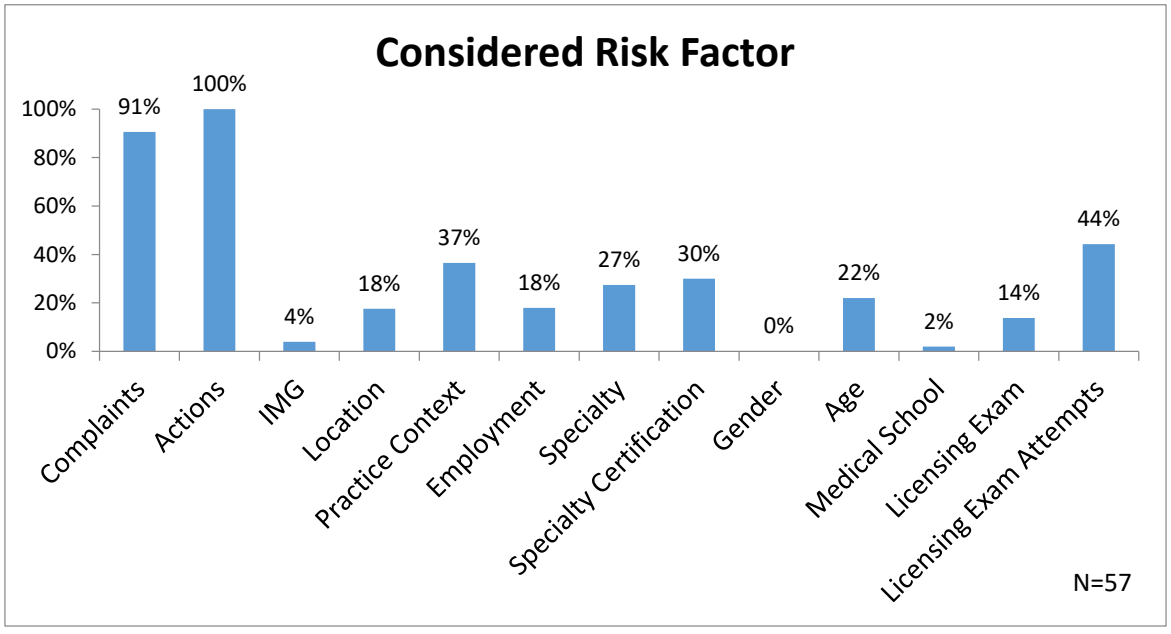
Section 4b: Current Research on Support

While the number of articles addressing supports to physician competence is higher than that studying risks, more than two thirds of these articles focus on participation in continuing professional development and on features of medical education. Nearly all state medical boards currently promote the value of lifelong learning to licensees through guidance, statements and CME requirements for licensure renewal. State medical boards increasingly make a range of educational resources available to licensees and commonly mandate their use as part of disciplinary actions. However, little is known about the uptake of these resources or their impact on physician practice, especially for groups with known risk factors. Further research is needed on the adequacy of supports in place, as well as the range of options applicable to each risk factor or collections of factors.

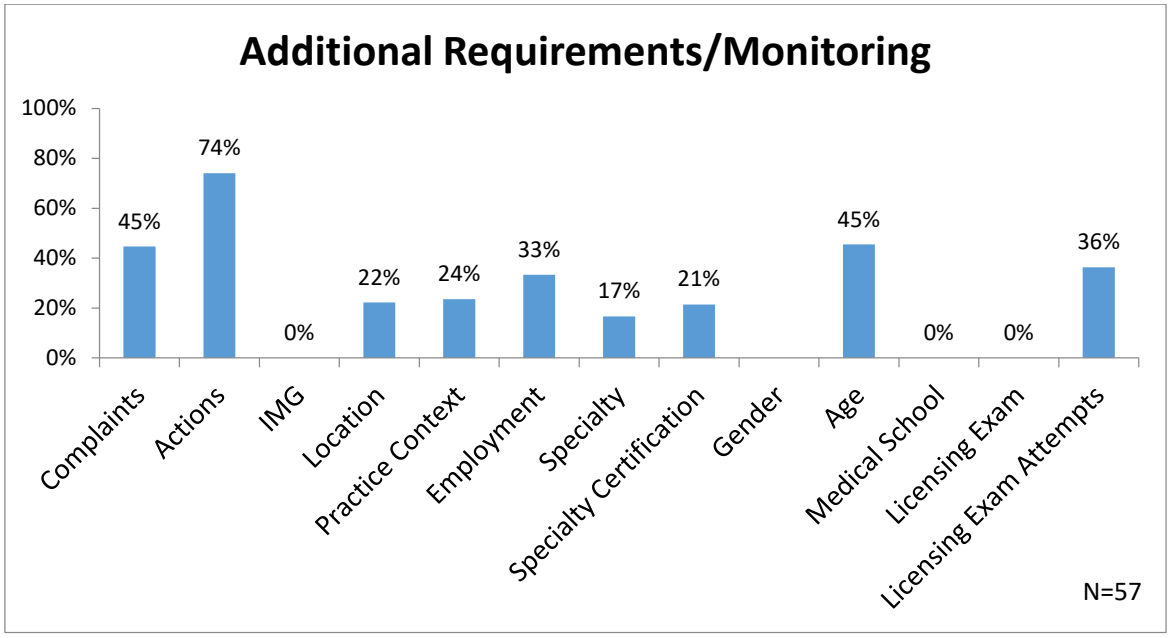
Section 5: Current Areas of Focus Among State Medical Boards

The FSMB has periodically surveyed its member boards about their perceptions of risk factors affecting physician performance, their approaches to managing risk, and the supports they offer to licensees. A 2019 survey demonstrated that boards consider a broad range of risk factors to be relevant to licensee performance, with a history of complaints or disciplinary action as the most frequently cited among perceived risks. These metrics are also the risk factors that lead most commonly to additional requirements or monitoring of physicians by medical boards, followed by licensee age, licensing examination attempts before passing, and employment status (employed vs. self-employed). See Graphs 1 and 2 below for more detail.

Graph 1: Risk Factors According to Medical Boards



Graph 2: Additional Requirements/Monitoring



Most state medical board responses to risk occur after a risk has been identified through a complaint, disciplinary, or other regulatory process. Approaches taken by boards often vary depending on the nature of the risk and context of a licensee's practice: Education (additional CME, re-entry to practice processes, reading requirements, outsourced training courses)

- Supervision/Monitoring (including mentoring in instances of solo or remote practice)
- Stipulated rehabilitation agreement (where confidentiality is maintained as long as the agreement is adhered to)
- Referral to a state Physician Health Program (PHP)
- Assessment, including clinical competency
- Counseling/Direction provided by the board to assist a licensee in overcoming limitations

State medical boards have also reported developing or promoting educational and other resources on several topics to licensees. Table 1 displays the topics of such resources developed and/or offered by boards, while Table 2 displays the topics of such resources that have been created by other organizations before being offered by boards.

Table 1: Topics of Resources Offered by Boards

COVID-19
Closing Practice
Competence Assessment and Education Programs
Core Processes of the Board (including Medical Jurisprudence, Legislation and Rule Changes)
Cultural Competency
Exceptions to Confidentiality
Health Disparities/Health Equity
How to Avoid Misconduct Filing
Human Trafficking
Improving Interprofessional Communication
Information from FSMB eNews and Reports
Investigations and Discipline (including “Disciplinary Pitfalls”)
Laser Surgery/Delegation
Licensure Processes
Duty to Report/Mandatory Reporting Requirements
Medical Marijuana
Medical Record Keeping
Medical Spas
PDMP
Pain Management or Prescribing (Including Controlled Substances)
Problem Based Ethics
Reentry to Clinical Practice Program
Serving as an Expert Reviewer
Standards of Practice
Telemedicine
Wellness

Table 2: Topics of Resources Offered by Boards Created by other Organizations

Behavioral Health Resources
Cannabis Education
CDC
Clinical Education (including Clinical Practice Re-entry Program; Clinical Refresher Courses)
Communication (e.g., Elevating Civility, Managing Difficult Communications in Medicine, Controlling Anger, Avoiding Outbursts, Communicating More)
Evaluation/Assessment Programs
FSMB Resources

Maintaining Mental Health During COVID-19
Medical Director Training
Medical Ethics, Boundaries and Professionalism (including Sexual Misconduct)
Medical Records Documentation and Management
Opioids/Controlled Substances, Prescribing, Pain Management, Addiction, PDMP, MAT Waiver Training, SBIRT Training
Racial Health Disparities in Telemedicine

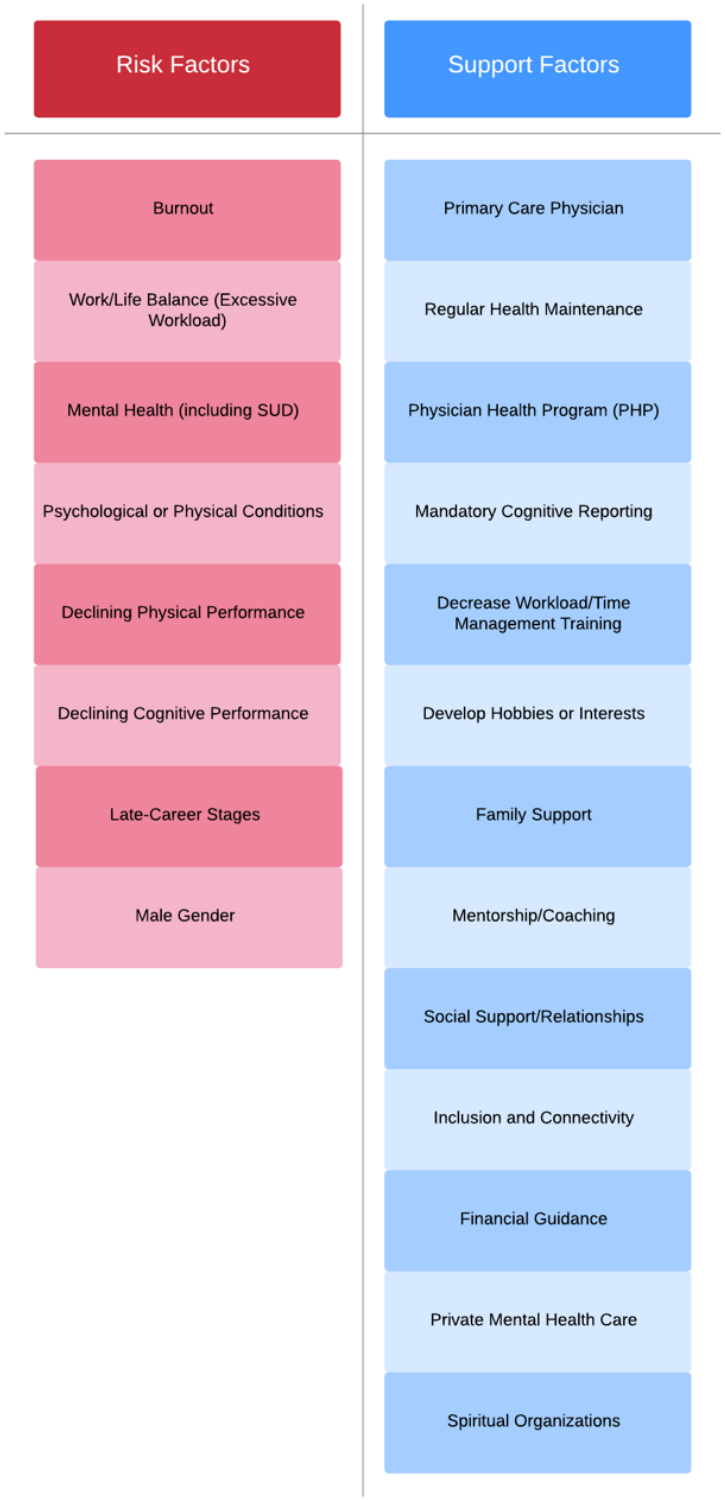
Section 6: Summary and Analysis of Risk and Support Factors

In order to simplify a very complex picture of factors that impact physician performance, this section will address risk and support factors based on their relationship with 1) Health and Wellness, 2) Experience and Transitions, and 3) Practice Environment.

The majority of the discussion of support that follows focuses on types of supportive offerings, rather than support factors in and of themselves. A support factor, as defined above, is any factor that supports competence. Supportive resources such as educational material, peer support groups, and health-related resources are not support factors themselves. However, the availability of such resources, a disposition of a physician to make use of such resources, and a work environment that evidence shows is conducive to safe practice would constitute support factors under this definition.

State medical boards would not be responsible for the creation of many of the supportive offerings mentioned below. However, efforts are encouraged to promote their availability and, where applicable, to allow for their confidential use, especially in the context of resources related to health and self-care.

Health and Wellness



Key risk factors impacting the health and wellness of licensees include conditions they may be experiencing, typically as a result of illness or injury, that limit their ability to provide care with reasonable skill and safety. Conditions may include illness or impairment related to physical or mental health (including substance use disorder), injury, declining cognitive or physical performance (regardless of the age of the licensee), and symptoms of stress and burnout.

Current approaches to assessing the health and wellness of licensees among state medical boards primarily involve screening questions on licensing and license renewal applications, as well as fitness for duty assessment and collaboration with state PHPs, often following an investigation or as a component of disciplinary action. These approaches demonstrate a perception among boards that impairment (and possibly illness) is a risk factor to physician performance. Once a risk has been identified through these approaches, many board responses are aimed at assessing and improving licensee health and wellness, such as a referral to a PHP or assessment for clinical competency. These interventions, though supportive of physician health, are often associated with disciplinary action and are perceived as punitive in nature. They also typically occur after a complaint has been received or harm has occurred. Resources made available to licensees, as outlined in Tables 1 and 2, focus to a greater extent on conditions treated by licensees and the treatment modalities they use than on the health and wellness of the licensees themselves.

Regulatory strategies and interventions should be closely examined to ensure they are “fit for purpose” and achieving expected outcomes. There may be missed opportunities to provide information and resources to licensees proactively in a non-punitive context that support their health and wellness. State medical boards can play a lead role in raising awareness about the importance of self-care and create opportunities for conversation within the medical community. Self-care as a professional responsibility can be promoted, as can the importance of sustained dialogue around wellness, health maintenance, and speaking up and seeking help when needed. Practices such as routine health screening, periodic neurocognitive assessment, and counselling can be promoted and incentivized by state medical boards to encourage licensees to take care of themselves. Less formal opportunities for supporting wellness and engagement can also be offered, such as suggestions for avoiding suffering in silence, approaching a peer or confidant when a conversation is needed, and seeking out mentoring or coaching to support healthy practice and life habits.

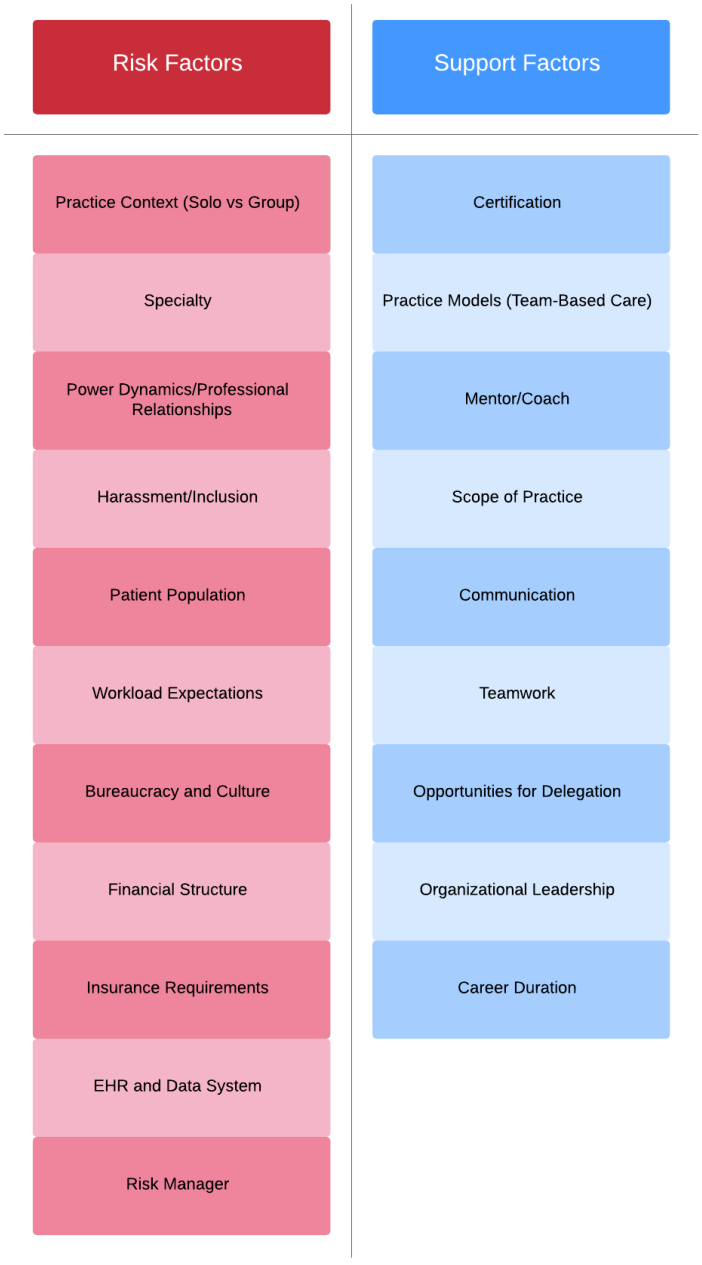
Stigma related to mental illness within the medical community can present a significant barrier to the supportive efforts of state medical boards and others, as well as willingness among licensees to seek care. However, widespread provision of support and concerted efforts to reduce stigma and achieve a culture of support (as opposed to a culture of silence) are likely more effective in terms of mitigating risk, promoting wellness, and protecting patients than a retroactive and punitive response. Boards have demonstrated successes in promoting a culture of lifelong learning among licensees. These can be used in parallel for encouraging “lifelong self-care” and can begin as simply as promoting the value of having one’s own primary care physician.

Experience and Transitions

The category of experience and transitions is meant to capture those risk factors that relate to stages along the continuum of medical education, training, practice, and retirement. Some of these factors, such as low scores or repeated attempts on licensing examinations, lack of specialty board certification, and a history of complaints and discipline offer signals to state medical boards and licensees themselves that a licensee may be at risk for poor performance. Others, such as transitions in training, changes in scope of practice, financial pressures (including retirement planning), and workload variability are events faced by nearly every licensee over the course of their career that merit attention and support in order to ensure they do not present risk to performance in practice. These factors are akin to some of the more personal transitions related to a licensee's culture, personality, and family dynamics that merit similar attention and support to mitigate associated risks.

The medical education community continues to develop a wide array of supportive strategies and resources meant to assist with a safe transition through training and into practice, as noted in the literature on support (see Section 4a above). However, there are fewer resources aimed at supporting licensees once they are in independent practice. Current resources offered by state medical boards include education about communication, "disciplinary pitfalls," re-entry to practice, and the appropriate way to close one's practice. Additional resources aimed at the early stages of practice would help provide support to new physicians at a particularly vulnerable career stage, assisting them in appropriately orienting themselves to the array of risks present throughout one's career. Physicians often face difficult financial decisions at various career stages and would benefit from guidance in this regard. Promotion of supportive offerings from specialty societies and medical societies and the local, state, and national level would also be helpful in supporting licensees at all career stages. Peer support networks can offer additional opportunities for licensees to learn from others and engage in conversation around mutual areas of concern. Finally, there are opportunities available from some PHPs in the areas of stress management and life, family, or career development that can offer support to licensees during difficult transition periods.

Practice Environment



As noted by Yen and Thakkar, some factors associated with the practice environment have been shown to be conducive to greater risk of complaints, discipline, and suboptimal provision of care. For example, there is compelling evidence demonstrating that certain specialties are more prone to complaints (surgery, plastic surgery, dermatology, psychiatry, obstetrics and gynecology, and family medicine) and discipline (family medicine, psychiatry, surgery), and physicians in solo practice have been shown to have a greater likelihood of ordering fewer

tests, performing less well on assessments, and having lower scores on recertification examinations.[3]

Less tangible risk factors associated with the practice environment that are not easily measured through quantitative means are also relevant to performance. Examples include the culture within which one practices and the impacts of power dynamics, professional relationships, bureaucracy, and harassment (as opposed to inclusivity). Available resources, including support staff, technological resources related to patient and data management, including electronic health records, can also have a significant impact on performance and overall well-being. Finally, the patient population, nature and proportion of complex and difficult cases, workload expectations and employment-related requirements can present risk, depending on the individual practitioner.

Less well-represented in the literature and not as well understood in practice are the concepts of engagement and isolation or alienation, both geographic and professional. It is possible that professional isolation or alienation (understood in terms of powerlessness and lack of meaning) negatively impact performance, while a greater degree of engagement in one's work and with one's professional environment have a positive impact.[4] This theory and the supporting data could help state medical boards understand isolation as a risk factor and justify the development and targeting of resources aimed at fostering engagement to geographically isolated licensees practicing in rural or remote areas or ones in solo practice. It can also inform hospitals and health systems about the importance of ensuring a work environment that provides meaningful opportunity for professional engagement among employed clinicians. Such opportunities can include the creation of team-based environments, interprofessional practice models, mentoring programs, and clear pathways to career advancement and leadership opportunities. As these opportunities contribute to safer and higher quality care for patients, they could be recognized and incentivized by state medical boards as continuing professional development efforts among licensees.

[3] Yen W and Thakkar N (2019) State of the Science on Risk and Support Factors to Physician Performance: A Report from the Pan-Canadian Physician Factors Collaboration, *Journal of Medical Regulation* Vol.105(1).
[4] Nazan Kartal (2018): Evaluating the relationship between work engagement, work alienation and work performance of healthcare professionals, *International Journal of Healthcare Management*, DOI: 10.1080/20479700.2018.1453969

Table 3: Risk Factors Associated with Potential Negative Outcomes and Relevant Supports

Risk Factor	Negative Outcomes	Support Factors	Specific Sources of Support
Exam Scores	• Disciplinary Action • Increased Complaints • Impact on Patient Outcomes	• Peer Review for Quality of Care • Remedial Education • Reduce Complexity of Cases • Reduce Caseload • Team-based Care Model • Utilize Practice Support Staff	
Specialty	• Increased Complaints	• Remedial Education • Utilize Support Staff • Reduce Complexity of Cases • Reduce Caseload	
Solo Practice	• Burnout • Reduced Adherence to Guidelines	• Peer Review for Quality of Care • Guided Self-Assessment • Support Structures (Family, Social, Spiritual)	• Medical Society (Local, State, National, Specialty)
International Medical Graduate	• Increased Complaints • Disciplinary Action	• Mentor/Peer Support • Support Structures (Social, Cultural)	
Poor Work-Life Balance (Excessive Workload)	• Burnout • Mental Health (Including Substance Use Disorder) • Impact on Patient Outcomes • Increased Complaints	• Peer Review for Quality of Care • Reduce Complexity of Cases • Reduce Caseload • Team-based Care Model • Utilize Practice Support Staff	• PHP • Medical Society • Peer Support Programs
Career Pressures (Financial, Performance)	• Burnout	• Financial Management Education/Training • Career/Practice Coaching	• PHP • Medical Society

Family Dynamics (Divorce, Child-Related Demands)	• Burnout • Mental Health (Including SUD) • Impact on Patient Outcomes • Increased Complaints	• Support Structures (Peer, Social, Family, Spiritual) • Comprehensive Care/Monitoring • Promote Health and Well-Being	• PHP • Personal Physician
Male Gender	• Disciplinary Action • Increased Complaints • Reduced Adherence to Guidelines (Problems with Prescribing and Test Ordering)	• Peer Review for Quality of Care • Guided Self-Assessment • Mentor/Peer Support • Promote Lifelong Learning including focus on self-care • Communication skills training	• Medical Society (Local, State, National, Specialty)
Lack of Experience (Early-Career)	• Impact on Patient Outcomes	• Mentor/Peer Support • Team-based Care Model • Lifelong learning, including self-care and health promotion	
Time in Practice (Mid-Career)	• Disciplinary Action	• Team-based Care Model • Remedial Education • Counselling and other supportive services • Lifelong learning, including self-care and health promotion	
Time in Practice (Late-Career)	• Disciplinary Action • Increased Complaints • Impact on Patient Outcomes • Reduced Adherence to Guidelines • Declining Physical Performance • Declining Cognitive Performance	• Promote Health and Wellness • Comprehensive Care/Monitoring • Promote Lifelong Learning • Professional Responsibility to Disclose/Address Impairment • Targeted Programs for Late-Career Physicians	• Personal Physician • PHP • Medical Society (Local, State, National, Specialty)

	• Problems with Psychological and Physical Well-Being	(Procedural and Non-Procedural) • Team-Based Care Model • Utilize Support Staff • Peer Reviews for Quality of Care • Guided Self-Assessment • Reduce Complexity of Cases • Reduce Caseload • Mentor/Peer Support	

Section 7: Discussion

Many of the support factors discussed above are meant to improve health and mitigate burnout and are therefore focused on the individual physician, such as peer and social supports, mentoring and coaching, and routine health maintenance. However, too narrow a focus on the provision of individualized support alone (i.e., support related to health and well-being without support related to the practice environment and career transitions) could miss important opportunities to improve environmental and cultural features that are important for the provision of safe and high-quality care.

Viewed through a regulatory lens, inattention to the presence of such environmental risk factors or the lack of associated support factors could merit greater regulatory scrutiny from state medical boards. An accurate picture of physician performance and the various risk and support factors affecting it must consider these individual *and* systemic features. This is in line with the Cambridge Model of physician performance which relates performance to competence but factors in relevant individual and systemic influences.[5] In all instances, however, the prevailing professional culture must be accounted for, both as a potential barrier to effective support at the individual and systemic levels, and a risk factor in and of itself.

Environmental Impact of Culture

Medical professionals are strongly impacted by the culture within which they work and live. Many physicians entered medical practice because of a desire to help patients, often influenced by popular representations of an idealized physician. This physician is someone who "confidently and unfailingly gives care, not one who needs care – especially mental health

[5] Rethans JJ, Norcini JJ, Barón-Maldonado M, et al. The relationship between competence and performance: implications for assessing practice performance. *Med Educ* 2002;36:901–9.

services."[6] This view of physicians as invulnerable and not susceptible to the same ailments or conditions as the general public has contributed to a "culture of silence"[7] throughout medicine where it is seen as inappropriate and unacceptable to admit weakness, let alone illness or impairment, or to seek help or treatment. This culture that pervades the medical profession impacts not only the availability of supportive resources for physicians, but also the willingness of physicians to seek help through those resources that are available. Cultural change must be a priority in order for risk to be effectively mitigated, physicians to be supported, and patients to receive safe care.

Burnout and Wellness

The above tables and graphics attempt to simplify and provide order to a very complex picture of multiple different but interrelated factors that impact physician performance. Regardless of the categorization of factors, there is significant overlap with respect to those risk factors that negatively impact a physician's health and well-being and lead to, or exacerbate, burnout. This demonstrates the important role played by health and well-being for the provision of safe patient care.

State medical boards seeking to impact medical culture could examine their own regulatory processes to identify ones that contribute to stigma surrounding illness and create barriers to treatment seeking. Such processes might include licensing applications that inquire about any previous history of illness or treatment, use of punitive approaches in response to impairment, a lack of confidentiality in regulatory processes related to impairment, and insufficient transparency regarding boards' approaches to working with licensees experiencing impairing illnesses.

State medical boards can also look to their key partners in physician health, especially those in the physician health program (PHP) community. The goals of PHPs and state medical boards are closely aligned, especially insofar as they relate to ensuring patient protection by supporting licensees in their efforts to remain healthy or to safely transition through difficult or high-risk periods in their lives and careers. Relationships between state medical boards and PHPs merit ongoing attention and nurture to ensure that the most effective supports are in place for the licensee population.

State medical board engagement in this type of effort also presents an opportunity to start conversations about the importance of self-care and treatment seeking among licensees and engaging in support through communication. Open communication about these issues with licensees and the public (e.g., through editorials published in state or local newspapers) helps to reduce stigma and chip away at the culture of silence, thereby encouraging the licensees themselves to engage in their own conversations, share their experiences, ask others how they

[6] Kirch D, Physician Mental Health: My Personal Journey and Professional Plea. *Acad Med* 2021.
[7] Hengerer, A., and S. P. Kishore. 2017. Breaking a culture of silence: The role of state medical boards. *NAM Perspectives.* Commentary, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/201708b

are doing in a meaningful way and, most importantly, feel comfortable seeking help when necessary.

Operational Use of Risk and Support Factors

As noted, state medical boards already create and provide a significant number of resources to help support physician performance in several areas. However, information about risk and support factors can also inform the work of state medical boards themselves.

Educational resources can be disseminated proactively to licensees who fall into particular risk categories, rather than retroactively as part of disciplinary actions. Where board resources allow for the creation of new educational or other supportive materials, assessments of educational need can be informed by data about which risk factors are most prominent in the licensee population.

State medical boards may also wish to use information about risk factors to help with decisions about financial and human resource allocation. Triage of complaints can also be facilitated by prioritizing investigation of those complaints against practitioners with the most significant or a greater number of risk factors. This is currently being done in Australia where the Australian Health Practitioner Regulation Agency cross-references information from complaints received against characteristics of a practitioner and their practice context.[8]

Progress in the Era of COVID-19

Positive change with respect to providing support to licensees has occurred as a result of greater recognition of the widespread nature of health worker burnout and the need for self-care during the COVID-19 pandemic. This has led to new and expanded availability of counselling resources for clinicians, even in rural and remote settings through telehealth models, that can be promoted by state medical boards and others in an effort to ensure their permanence so that licensees can continue to benefit from their availability.

The value of “lifelong self-care” can be espoused by state boards alongside, and as a parallel to, statements about lifelong learning. Boards can encourage self-care as part of a professional culture that identifies risk early and takes mitigating action before it results in impairment or related patient safety concerns. This can take the form of encouraging routine health screening from a personal physician, counselling-related resources, especially during training, and opportunities to engage with mentors, coaches, or peer groups in practice or non-practice settings. The goal of such strategies is not to identify and remove from practice those physicians at risk of poor performance. Rather, it involves providing support to those who need it most in order to help keep them practicing safely and longer.

[8] Australian Health Practitioner Regulation Agency, 2017-18 Annual Report, available at http://www.ahpra.gov.au/annualreport/2018/notifications.html

FSMB Resources

The FSMB has given significant focus in recent years to the issues of physician health, burnout, and impairment. This has included development of a policy on Physician Wellness and Burnout, ongoing work with state medical boards focusing on regulatory processes that impact treatment-seeking among licensees, revisions to the FSMB's policy on Physician Impairment, and collaboration with partner organizations to address burnout and support physician wellness, including the FSMB's sponsorship of, and collaboration in, the National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience.

The key themes and recommendations arising from this work are relevant in the context of risk and support factors. Given the ways in which the current practice environment has been affected by the COVID-19 pandemic and the associated stress and trauma it brings for physicians, action on the part of state medical boards that supports physician health and mitigates the risk of burnout is especially timely.

The FSMB can harness the momentum that has come from its work in these areas and continue to play a supporting role in this endeavor by promoting and facilitating positive developments in the areas of stigma reduction and support of physician health by state medical boards and others. The FSMB's "State Board Connect," a Policy Clearing House containing resources for state medical boards can also be leveraged as an additional means of sharing resources and approaches to addressing risk and providing support.

Section 8: Conclusion

This report provides introductory information for state medical boards about risk and support factors affecting physician performance. An understanding of why these factors are relevant to medical practice and how they may impact the quality of care patients receive can influence medical board processes and approaches to more effectively and efficiently support safe medical practice and ensure patient safety.

State medical boards and the FSMB are encouraged to collaborate with partners in patient safety, medical education, and clinician health to develop resources, based on an understanding of risk and support factors, that help licensees to continue practicing safely throughout their careers. Effectively mitigating risk will require attention to the health and wellness of licensees, important transitions in their lives and careers, and their practice environment. Moreover, a sustained dialogue about the realities of risk and importance of support is necessary in order to bring the medical profession out of a culture of silence and into one of lifelong self-care. This is a responsibility of the medical profession to its members and to their patients.

Resolution 21-1

Federation of State Medical Boards
House of Delegates Meeting
May 1, 2021

Subject:	Incorporating the Care of Persons with Intellectual and Developmental Disabilities into the Medical School Curriculum
Introduced by:	The New York State Board for Medicine of the New York State Education Department's Office of Professions and the New York State Board of Regents
Approved:	December 2020

Whereas, Intellectual and/or Developmental Disability (IDD) is a lifelong condition that exists across every race, ethnicity, and age group; and

Whereas, Individuals with IDD include those with cognitive limitations, cerebral palsy, vision or hearing impairment, genetic disorders such as Down Syndrome and Fragile X Syndrome, as well as those on the autism spectrum; and

Whereas, More than seven million people in the United States have a diagnosis of IDD, which includes the entire population of individuals with developmental disabilities and intellectual disabilities; and

Whereas According to the Centers for Disease Control and Prevention, approximately 17 percent of children, aged 3-17, have one or more developmental disabilities;[1] and

Whereas, Individuals with IDD generally have less access to physical, mental, and dental health services and experience worse health outcomes than the general population; and

Whereas, These differences in access and outcomes are often the result of systemic barriers to quality care for this population; and

Whereas, Individuals with disabilities are more likely to use hospitals' emergency departments more often, have higher hospitalization rates, die of preventable causes, and die at an earlier age than the general population; and

[1] www.cdc.gov/ncbddd/developmentaldisabilities/about.html; accessed Nov. 16, 2020.

Whereas, The *New York Times* recently reported that, "People with intellectual disabilities and developmental disorders are three times more likely to die if they have Covid-19, the illness caused by the coronavirus, compared with others with the diagnosis…";[2] and

Whereas, All persons with IDD are unique, and providing for their care requires an ability to understand the many complex factors and challenges involved in their individual treatment; and

Whereas, The great majority of persons with IDD obtain healthcare across their lifespans in their home communities, where physicians are expected to play a critical role in their care; and

Whereas, An estimated 72% of people in the United States with IDD live at home with their parents, who play an invaluable role in their lives at all ages; and

Whereas, Parents are called upon to carry out treatment plans and provide consent for treatment, so building rapport with parents is essential to the doctor-patient relationship and can significantly influence health outcomes for children with IDD; and

Whereas, According to the Surgeon General of the United States, most medical students and practitioners receive insufficient education and training on critical aspects of care for persons with IDD, leading to poorer health outcomes and compromised care;[3] and

Whereas, Further, according to the Surgeon General, community-based support services are insufficiently integrated to meet the needs of the 'whole person'; and

Whereas, Further, according to the Surgeon General, the healthcare system does not sufficiently address the prevention of unhealthy behaviors in people with disabilities, including those at risk of secondary conditions such as obesity, type II diabetes, depression, and substance abuse; and

Whereas, To prepare students to provide appropriate care for patients with IDD, schools of medicine must integrate curricula and clinical experiences into their programs; and

Whereas, The Federation of State Medical Boards has considerable influence with the Liaison Committee of Medical Education, the Commission on Osteopathic College Accreditation, the Association of American Medical Colleges and the

[2] *The New York Times*, https://www.nytimes.com/2020/11/10/health/covid-developmental-disabilities.html?searchResultPosition=2 , accessed Nov. 16, 2020.

[3] The Surgeon General's "Call to Action to Improve the Health and Wellness of Persons with Disabilities," 2005.

American Association of Colleges of Osteopathic Medicine and other influential organizations in the national House of Medicine; now, therefore, be it

Resolved, That the Federation of State Medical Boards supports and advocates for changes to the medical education curricula at accredited medical schools in the United States to formally integrate into such curricula a better understanding of the care, treatment, and management of patients with IDD; and be it further

Resolved, That such curricula should include entrustable professional activities and clinical experiences specific to the care, treatment, and management of patients with IDD; and be it further

Resolved, That such curricula should emphasize the need for medical students to develop skills in patient-centered care that is delivered with dignity; and be it further

Resolved, That such curricula should emphasize the need for medical students to understand how quality-of-life experiences are perceived by patients and their families; and, finally, be it

Resolved, That such curricula serve to promote evidence-based best practices to be utilized across the lifespan of patients with IDD, including the prevention of secondary conditions.

MANAGEMENT FISCAL NOTE:
No additional financial impact beyond proposed FY2022 budget.

Federation of State Medical Boards

Report of the Nominating Committee

January 20, 2021

The Nominating Committee met on Wednesday, January 20, 2021 via videoconference at 3:00 pm CST. FSMB Immediate Past Chair Scott Steingard, DO serves as Chair of the Committee. Other members of the Committee include Nathaniel Berg, MD; Maroulla Gleaton, MD; Alexander Gross, MD; John "Jake" Manahan, JD; Joy Neyhart, DO; and Michael Wieting, DO. Providing staff support were FSMB President and CEO Humayun Chaudhry, DO, MACP; Chief Legal Officer Eric Fish, JD; Director of Leadership Services Patricia McCarty, MM; and Governance Support Associate Pamela Huffman.

Dr. Steingard expressed his deep gratitude for the Committee's dedication and emphasized the significance of their work in selecting highly qualified candidates for the elected office positions in the midst of a global pandemic.

The Committee reviewed all nomination materials submitted; provided verbal reports of their one-on-one nominee interviews; and focused on the importance of selecting candidates who fulfill the qualifications for FSMB leadership positions as defined in the Committee's charge. The Committee addressed methods to enhance the process of soliciting quality candidates in the future. Following thoughtful and prudent deliberation throughout the vetting process, the Nominating Committee unanimously approved the following roster of candidates:

Chair-elect – 1 Board Member Fellow, to be elected for three years: a one-year term as Chair-elect; a one-year term as Chair; and a one-year term as Immediate Past Chair

Assists the Chair in the discharge of the Chair's duties and performs the duties of the Chair at the Chair's request or, in the event of the Chair's temporary absence or incapacitation, at the request of the Board of Directors.

Sarvam P. TerKonda, MD – Florida Medical

Running unopposed for Chair-elect, Dr. TerKonda will be elected by acclamation. His current term on the Board of Directors expires on May 1, 2021.

Treasurer – 1 Board Member Fellow, to be elected for a three-year term

Performs the duties customary to that office and such other duties as the Bylaws and custom and parliamentary usage may require or as the Board of Directors shall deem appropriate; serves as an ex officio member of the Audit Committee and as chair of the Finance Committee.

Jone C. Geimer-Flanders, DO – Hawaii

Running unopposed for Treasurer, Dr. Geimer-Flanders will be elected by acclamation. Her current term on the Board of Directors will not expire until April 30, 2022; therefore, it will be necessary to elect a candidate to complete the remainder of her term (a partial term of 1 year).

Board of Directors – 4 Board Member Fellows, three (3) to be elected for a three-year term and one (1) to be elected for a one-year term*

Control and administration of the corporation is vested in the Board of Directors, which is the fiscal agent of the corporation; the Board acts for the FSMB between Annual Meetings.

Andrea A. Anderson, MD – District of Columbia
Mohammed A. Arsiwala, MD – Michigan Medical
William K. Hoser, MS, PA-C – Vermont Medical
Denise Pines, MBA – California Medical
Sandra L. Schwemmer, DO – Florida Osteopathic
Sherif Z. Zaafran, MD – Texas

*In accordance with the FSMB Bylaws, *"At least three members of the Board, who are not Staff Fellows, shall be non-physicians, at least two of whom shall be a Member Medical Board public member."* Currently, there are two non-physicians on the FSMB board, who are Member Medical Board public members, who will continue serving through FY 2022 (May 2021-April 2022). Accordingly, **it is *required* that one non-physician be elected in 2021; additional non-physicians also may be elected.**

Nominating Committee – 3 Board Member Fellows**,** each to be elected for a two-year term** / ***

Nominating Committee members select a roster of nominees for each of the elected positions to be filled at the annual business meeting of the House of Delegates.

Alexios G. Carayannopoulos, DO, MPH – Rhode Island
Amy J. Derick, MD – Illinois
Rup K. Nagala, MD – North Dakota
Ramanathan Raju, MD, MBA – New York

In accordance with the FSMB Bylaws, *"At least one elected member of the Nominating Committee shall be a public member."* Currently, there is one public member on the Nominating Committee who will continue to serve through April 2022. Accordingly, **it is *not required* that a public member be elected in 2021.

***No two Nominating Committee members shall be from the same Member Medical Board. Continuing members of the Committee are from **Georgia, Minnesota and Tennessee Osteopathic; therefore, no Nominating Committee candidates shall be from those Member Medical Boards.**

Respectfully submitted,

Scott A. Steingard, DO
Chair, Nominating Committee

GUIDE TO THE FSMB HOUSE OF DELEGATES MEETING

TABLE OF CONTENTS

Preface

The House of Delegates is the official public policy-making body of the FSMB. A “public policy” is defined in the FSMB Bylaws as *the official public position of the FSMB on a matter that may be reasonably expected to affect Member Boards when dealing with their licensees, other health care providers, health-related special interest groups, governmental bodies or the public.* At its Annual Meeting each spring, the House acts on numerous reports and resolutions and establishes policy to guide the organization and its members.

This *Guide* provides information about the House’s policy development process and is designed to help those attending the annual business meeting of the House of Delegates better understand and/or participate in that process.

Chapter 1: FSMB's Governance Structure

Two characteristics distinguish the FSMB from most other nonprofit organizations: it is a membership association, and it has a national scope. The FSMB Bylaws distribute the authority to govern across six levels. The organizational elements that participate in the FSMB's system of governance and policymaking process include: Member Medical Boards, House of Delegates, Board of Directors, Executive Committee, Standing and Special Committees/Workgroups, and the Executive Office. (see FSMB's Organizational Chart on page 4)

The roles and responsibilities of each of these components of the FSMB's governance structure are described below.

I. Member Medical Boards

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

A Member Medical Board's participation in the policymaking process of the FSMB takes place at the corporation's annual business meeting of the House of Delegates. The right to vote at meetings of the House of Delegates is vested in, and restricted to, Member Medical Boards. All classes of FSMB membership (Fellows, Honorary Fellows, Associate Members, Courtesy Members, Affiliate Member Boards and Official Observers) shall have the right of the floor at meetings of the House upon request of a delegate and approval of the presiding officer; however, the right to introduce resolutions for the House of Delegates to act upon is restricted to Member Medical Boards and the Board of Directors. Except as otherwise noted in the FSMB Bylaws, rights, duties, privileges and obligations of a member of the FSMB may be exercised only by a Member Medical Board.

II. House of Delegates

A delegate is the president/chair of a Member Medical Board or his/her designated alternate (Board Member Fellow, Staff Fellow or Associate Member). Each Member Medical Board is entitled to one vote at the meetings of the House of Delegates, which is to be cast by the delegate of the Member Medical Board.

III. Board of Directors

As the body responsible for the control and administration of the FSMB, the Board of Directors reports to the House of Delegates. The Board represents the interests of the House of Delegates and FSMB membership between Annual Meetings. The responsibilities of the Board include: providing leadership in the development and implementation of the FSMB's Strategic Plan; governing and conducting the business of the corporation, including supervising the President/Chief Executive Officer (President/CEO); and, under the leadership of the FSMB's Chair and President/CEO, representing the FSMB to the leadership of other organizations and speaking on behalf of the FSMB to promote recognition of the FSMB as the premier organization concerned with medical licensure and discipline.

IV. Executive Committee

Under the leadership of the Chair, the Executive Committee, which also includes the Chair-elect, Treasurer, Immediate Past Chair and three Directors-at-Large, represents the Board of Directors between Board meetings. The members of the Executive Committee, either collectively or individually, provide leadership on behalf of the Chair in scheduling and conducting Board committee meetings; provide leadership on behalf of the Chair to the Directors-at-Large and Staff Fellows serving on the Board in the fulfillment of their responsibilities, including governing and conducting the business of the corporation and supervising the President/CEO; and, at the direction of the Chair, represent the FSMB to the leadership of other organizations, promoting recognition of the FSMB as the premier organization concerned with medical licensure and discipline.

V. Standing and Special Committees/Workgroups/Task Forces

The Board of Directors governs by making decisions about goals and objectives, programs and services, personnel, finances, facilities and equipment and then seeing to it that those decisions are carried out. To assure that the Board conducts its business efficiently and democratically, assistance is provided through the FSMB's committee and workgroup structure. The Board oversees the work of two types of committees: standing and special.

Standing committees are permanent and assist the House of Delegates and Board of Directors with overseeing a specific aspect of governance such as finance. All standing committees are either specifically mentioned in the Bylaws or must be created by resolution of the FSMB and/or amendment to the Bylaws. Membership on standing committees is determined by the Bylaws (as approved by the House of Delegates) or Chair.

The FSMB standing committees include:

Audit Committee
Bylaws Committee
Editorial Committee
Education Committee
Ethics and Professionalism Committee
Finance Committee
Nominating Committee

Special committees, workgroups and task forces are temporary and are created for some special purpose such as overseeing the development of a program or conducting research on a specific subject. The Chair determines the membership of these groups. Those for FY 2021 include:

Ad Hoc Health Equity and Medical Regulation Task Force
Artificial Intelligence Task Force
Workgroup on Board Action Content Evaluation (BACE)
Workgroup on Board Education, Service and Training (BEST)
Workgroup on Emergency Preparedness and Response
Workgroup on Physician Impairment
Workgroup to Study Risk and Support Factors Affecting Physician Performance

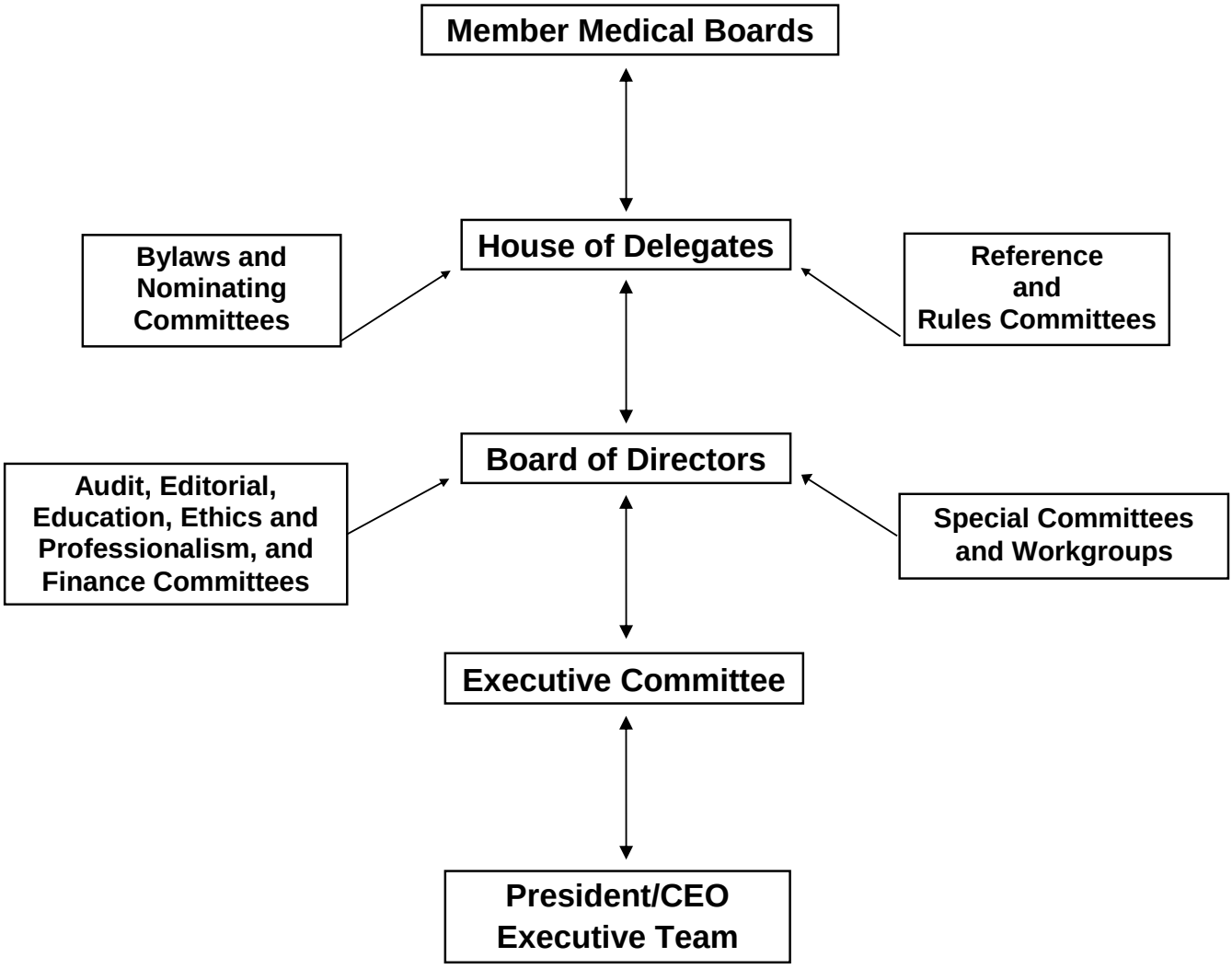
In addition to the existence of standing and special committees, workgroups and task forces, a Rules Committee and Reference Committee(s) meet for each Annual Meeting to help facilitate the progress of business at the House of Delegates meeting.

VI. Executive Office

The President/CEO reports to the Board of Directors. The President/CEO supports and assists the Board and its committees in the conduct of its corporate business and apprises the Board of the internal operations of the organization. Additionally, the President/CEO acts as the primary spokesperson for the FSMB to outside organizations, government authorities, special interest groups, the media and the public promoting recognition of the FSMB as the premier organization concerned with medical licensure and discipline.

Assisting the President/CEO are members of the Executive Team including the Chief Advocacy Officer, Chief Assessment Officer, Chief Financial Officer, Chief Legal Officer, and Chief Operating Officer.

FSMB Organizational Chart



Chapter 2: The House of Delegates Policy Development Process

I. Reports and Proposals

Reports of the FSMB Board of Directors, Executive Office, committees, workgroups, task forces and representatives to other organizations are transmitted to the House of Delegates for information or action. Informational reports provide highlights or an update on activities or projects that have been completed or are in progress, and do not require any decision-making on the part of the House. Action reports recommend a new or modified policy or that a particular action be carried out by the FSMB.

While the full text of reports and proposals is published, only the recommendations are subject to amendment, and only the recommendations adopted by the House become FSMB policy.

II. Resolutions

Member Medical Boards may wish to submit resolutions for consideration at the annual business meeting of the House of Delegates. A resolution is a way to express an idea or to identify a problem or opportunity. Although resolutions may deal with complex issues, most resolutions begin simply when a problem is recognized, and a solution is suggested. Resolutions are structured to express the background of the problem and to lay out a course of action in a logical way so that the need for action on the issue is clear. To set the tone for discussion, each *Whereas* clause should carry a message and develop statements that require a solution. *Resolved* clauses should reflect what has just been stated and then go on to address what the FSMB should do or what position the FSMB should take on the identified topic.

Member Medical Boards wishing to submit resolutions are requested to forward all proposed resolutions to the FSMB's Executive Office. In order to streamline the processing of business for the meeting and increase the efficiency with which the House of Delegates agenda materials are produced, resolutions must be submitted in writing or via e-mail to the FSMB at least 60 days prior to the meeting. **The FSMB cannot accept resolutions after the published deadline.**

When drafting resolutions for submission:

- The title of the resolution should appropriately and concisely reflect the action for which it calls.

- The date on which the resolution was approved by the Member Medical Board should appear beneath the title.
- Information contained in the resolution should be checked for accuracy.
- The *Resolved* portions should stand alone since the House adopts only the *Resolved* portions and the *Whereas* portions are not subject to adoption.

III. Reference Committees [in 2021, the Reference Committee(s) will meet virtually on April 20 in place of a Reference Committee(s) hearing – written testimony may be submitted by the Member Medical Boards for the Committee's consideration by April 15. The report(s) of the Reference Committee(s) will be posted on the Member Portal no later than April 1.]

One or more Reference Committee hearings are scheduled prior to the House of Delegates annual business meeting. An agenda for the items to be heard by each Committee is posted with the Annual Meeting materials on the FSMB Member Portal, as well as on the Annual Meeting app.

All interested Annual Meeting participants may attend Reference Committee hearings and make statements on items being considered. Agenda items can include resolutions, Board reports, Bylaws amendments or other proposals that require a vote by the House of Delegates. All items heard in Reference Committee hearings will be voted upon by the full House of Delegates at the annual business meeting. Reference Committees are not empowered to take any action on items of business. Their role is to make recommendations to the House of Delegates. Only those items acted upon by the House of Delegates are considered official.

Each Reference Committee will be appointed by the Chair of the FSMB Board of Directors and will be composed of three to five members. However, the Chair may appoint additional members as needed. The Chair(s) of the Reference Committee(s) introduces each item of business, opens the floor for comment and recognizes individuals from the floor. While the purpose of the Reference Committee(s) is to hear as much testimony as necessary for a full discussion of each item, the Committee Chair(s) may set time limits on the testimony, as deemed necessary.

Members of the FSMB's Board of Directors, standing committees, special committees, workgroups, task forces and staff are present at Reference Committee hearings to provide any requested resources or information. The Reference Committee(s) is to listen and, if necessary, seek out any appropriate information and/or viewpoints on each item under discussion. Members of the Reference Committee(s) are not allowed to engage in debate or express their own opinions during the hearing(s), and they are not empowered to entertain motions or make decisions on items of business.

At the close of the hearing(s), Reference Committee members meet in Executive Session to formulate their recommendations on each item. These recommendations are based on what is in the best interest of the FSMB, and not on the amount of testimony for or against a particular proposal.

During the House of Delegates business meeting, the Chair(s) of each Reference Committee(s) presents the Committee's report. The Reference Committee(s) may recommend that a proposal be adopted, rejected, amended or otherwise disposed of, and give reasons, therefore. It may also recommend amendments to proposals that have been referred and/or make substitute proposals of its own. The Reference Committee(s) must forward a recommendation to the House of Delegates on each item of business, and the House must take action on these recommendations. Any "whereas" portions or preambles of resolutions before the Committee(s) are informational and explanatory, and only the "resolve" portions are considered by the House of Delegates. Recommendations of the Reference Committee(s) are advisory, and it is important that the House of Delegates has the opportunity to consider all proposals submitted to it and make the final decision on each.

The use of Reference Committee hearings allows for a more detailed and thorough discussion of items of business to come before the House of Delegates, thereby facilitating the progress of the annual House of Delegates business meeting.

IV. Setting Policy

A simple majority vote of the House is required for most items of business. Some actions, such as changes to the Bylaws, require a two-thirds majority vote of those voting.

The House of Delegates may act on items before it in one of the following ways:

- The House may **adopt** the recommendations of reports and resolves of resolutions or **not adopt** if a majority of the House votes against them.
- The House may **amend and then adopt** the amended recommendations of reports and resolves of resolutions.
- The House may **propose amendments by substitution and then adopt** the substitute amendments to recommendations of reports and resolves of resolutions.
- The House may **refer the items back to the Board** (or through the Board to the appropriate committee) **for further review**. If an item is referred for further study, then all pending information (i.e., amendments) relating to that item is referred as well. A specific time for reporting back to the House should be indicated.
- The House may **refer the items back to the Board for decision**, which gives the Board the authority and responsibility for making a determination on the matter.

- The House may **file an informational report** (acknowledging that a report has been received and considered, but that no action has been necessary or taken).
- The House may **table** a recommendation, which sets aside the recommendation for the current meeting unless the House votes to resume its consideration. A tabled recommendation is postponed to an undetermined time and may be proposed again, as a new recommendation at any future meeting; however, if a recommendation is tabled as a means of closing debate indefinitely, it would require a two-thirds majority vote.

V. Elections

Elections for filling vacancies within the Board of Directors and Nominating Committee are conducted at the annual business meeting of the House of Delegates in accordance with the Bylaws of the FSMB, the process of which is described in Section VII of this chapter (Rules Committee). **Only individuals who are Board Member Fellows of the FSMB at the time of the election may run for elective office**. A Board Member Fellow is an individual member who as a result of appointment or confirmation is designated to be a member of a Member Medical Board. A Board Member Fellow shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of thirty-six months thereafter.

a. Officers:

The Chair and Chair-elect may serve for terms of one (1) year or until their successors assume office. The Chair then serves one year as Immediate Past Chair, and the Chair-elect serves one year as Chair. The Treasurer may serve for a single term of three (3) years or until his/her successor assumes office. At each annual business meeting of the House of Delegates the Chair-elect will be elected and every third year at the Annual Meeting the Treasurer will be elected. (The position of Secretary is an ex-officio office, without vote, and the President/CEO serves as Secretary.) Officers assume office upon final adjournment of the Annual Meeting at which they were elected.

b. Directors-at-Large and Staff Fellows serving on the Board:

In addition to the Officers, the Board of Directors is comprised of nine (9) Directors-at-Large who are elected by the House of Delegates, and two Staff Fellows who are appointed by the Board of Directors. At least three members of the Board, who are not Staff Fellows, shall be non-physicians, at least two of whom shall be a Member Medical Board public member. Directors-at-Large shall serve for a term of three (3) years and are eligible to be re-elected for one additional term. A partial term of one-and-a-half years or more counts as a full term. At least three (3) of the Directors-at-Large are to be elected each year at the Annual Meeting. Staff Fellows

shall serve for a term of two years and shall be eligible to be reappointed to one additional term. A partial term of one-and-a-half years or more counts as a full term.

c. Nominating and Other Standing Committee Members:

At least three Board Member Fellows are elected at each Annual Meeting to serve on the Nominating Committee, each for a two-year term. Consecutive terms are not permitted. At least one elected member of the Committee shall be a public member. With the exception of the Immediate Past Chair, who chairs the Committee without vote except in the event of a tie, no two Committee members shall be from the same Member Medical Board and no officer or member of the Board of Directors shall serve on the Committee. Committee members are not eligible for inclusion on the roster of candidates for offices and positions to be filled by election at the Annual Meeting of the House of Delegates.

With the exception of the Nominating Committee, chairs and members of all standing committees are appointed by the FSMB Chair, with the approval of the Board of Directors, for a term of one (1) year, unless otherwise provided for in the Bylaws. Reappointment, unless specifically prohibited, is permissible. Members of the Editorial Committee serve staggered three-year terms and are limited to two full terms. The Chair appoints the chair of the Audit, Bylaws, and Ethics and Professionalism Committees. The FSMB Treasurer serves as chair of the Finance Committee. The FSMB Chair serves as the chair of the Education Committee. The Immediate Past Chair serves as the chair of the Nominating Committee. The Editorial Committee elects its own chair, who serves as the Editor-in-Chief of the *Journal of Medical Regulation.* No officer or member of the Board of Directors shall serve on the Editorial Committee.

VI. House of Delegates Meeting Materials

The House of Delegates business meeting materials include the agenda, minutes of the previous meeting, reports and resolutions, management notes (summaries of agenda items with any recommendations by FSMB management on appropriate actions to be taken by the House of Delegates), and reference information. **The House of Delegates business meeting materials will be posted on the FSMB Member Portal approximately one month prior to the Annual Meeting.**

VII. Rules Committee

The role of the Rules Committee is to develop the rules for conducting business during the virtual House of Delegates annual business meeting and to develop a Report of the Rules Committee for ratification by the House of Delegates.

The 2020 Report of the Rules Committee as ratified virtually by the House of Delegates states the following:

I. House Security:

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

II. Credentials:

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

III. Order of Business:

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

IV. Privilege of the Floor:

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

V. Procedures of the Annual Business Meeting:

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

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

All issues not decided by voice vote shall be decided by electronic balloting. In the event electronic balloting is not possible because of technical or other reasons, voting

representatives participating using the remote electronic platform shall communicate their vote through an electronic communication to a teller.

VI. Nominations:

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

VII. Elections:

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

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

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

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

When it is necessary to meet the minimum Bylaws requirement for election of a non-physician director, election of a non-physician director from the field of non-physicians shall precede election of other at-large candidates to the Board of Directors. Non-physician candidates not elected to the required seat shall join the slate of physician candidates for the remaining at-large positions on the Board of Directors. The same procedures shall be used for election of the Nominating Committee.

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

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

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

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

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

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

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

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

Chapter 3: Designated Annual Meeting Attendees [In 2021, due to COVID-19, a virtual Annual Meeting of the House of Delegates is to be held.]

I. Designation of Member Medical Board Voting Delegates and Alternates

In early January prior to the Annual Meeting, the presidents/chairs (Board Member Fellows) and executive directors (Staff Fellows) of each Member Medical Board are sent an email communication requesting they begin the process of identifying the individuals who will participate in the virtual FSMB House of Delegates meeting as their board's voting delegate (president/chair/another board member) and alternate delegate (executive director/another staff member). In the event the board president/chair cannot participate as voting delegate, an alternate delegate representing the medical board may be identified by the board president/chair to serve as the designated voting delegate. In the event the chair/president nor alternate delegate representing the medical board cannot participate, a Staff Fellow or Associate Member may be identified by the board chair/president to serve as their designated voting delegate. The designated delegate's name must be communicated to FSMB prior to the start of the Annual Meeting. Only board members, Staff Fellows or Associate Members of the FSMB may be designated as an alternate voting delegate. If the Staff Fellow cannot participate, another senior staff member may be identified by the board president/chair to serve in lieu of the Staff Fellow.

Scholarship and related Annual Meeting information is forwarded to the presidents/chairs (Board Member Fellows) and executive directors (Staff Fellows) of each Member Medical Board in January to assist when identifying designated attendees.

II. Registration and Program Information

Upon notification of a designated voting delegate and/or alternate delegate, the FSMB will forward a confirmation email and Scholarship Registration Link to the selected individual(s). The Annual Meeting registration fee is waived for scholarship recipients. Attendees of in-person meetings also receive reimbursement policy and travel information.

2020 FSMB BYLAWS

ARTICLE I. NAME

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

ARTICLE II. CLASSES OF MEMBERSHIP, ELECTION AND MEMBERSHIP RIGHTS

SECTION A. MEMBER MEDICAL BOARDS

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

SECTION B. FELLOWS

There shall be two categories of Fellow of the FSMB:

1. BOARD MEMBER FELLOW. A Board Member Fellow is an individual member who as a result of appointment or confirmation is designated to be a member of a Member Medical Board. A Board Member Fellow shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of thirty-six months thereafter, and
2. STAFF FELLOW. A Staff Fellow is an individual hired or appointed and who is responsible for the day-to-day supervision and performance of the administrative duties and functions for which a medical board is responsible. Each member board may denote only one individual to serve as a Staff Fellow of the FSMB. No individual shall continue as a Staff Fellow upon termination of employment by or service to the Member Medical Board.

SECTION C. HONORARY FELLOWS

A Board Member Fellow as defined in Section B, paragraph 1 shall become an Honorary Fellow of the FSMB thirty-six months after completion of service on a Member Medical Board. A Staff Fellow as defined in Section B, paragraph 2 shall become an Honorary Fellow of the FSMB upon

termination of employment by or service to the Member Medical Board. An Honorary Fellow of the FSMB may be appointed by the Chair to serve as a member of any committee or in any other appointive capacity.

SECTION D. ASSOCIATE MEMBERS

A Member Medical Board may designate one or more employees or staff members, other than an individual designated as a Staff Fellow, to be an Associate Member of the FSMB. No individual shall continue as an Associate Member upon termination of employment by or service to the Member Medical Board.

SECTION E. COURTESY MEMBERS

Any physician or physician assistant licensed by a Member Medical Board or an Affiliate Member Board and not eligible for any other type of membership may become a Courtesy Member of the FSMB upon approval of the candidate's application. A Courtesy Member may serve as a member of a committee and in any other capacity upon appointment by the Chair.

SECTION F. AFFILIATE MEMBERS BOARDS

A board or authority that is not otherwise eligible for membership may become an Affiliate Member Board of the FSMB upon approval of its application by the Board of Directors if the board or authority licenses either:

1. Allopathic or osteopathic physicians or physician assistants in the United States; or
2. Allopathic or osteopathic physicians if the board or authority is located in another country.

SECTION G. OFFICIAL OBSERVERS

An organization may apply for Official Observer status at meetings of the House of Delegates. The Board of Directors shall prescribe rules and procedures to govern the application for, the granting of and the exercise of Official Observer status.

SECTION H. RIGHTS OF MEMBERS

Except as otherwise provided in these Bylaws, rights, duties, privileges and obligations of a member of the FSMB may be exercised only by a Member Medical Board.

SECTION I. METHODS OF NOMINATION TO ELECTED OFFICE

Nomination by the Nominating Committee or Nomination by Petition pursuant to Articles III, IV, V and VIII shall be the sole methods of nomination to an elected office of the FSMB. A candidate

who runs for and is not elected to an elected office shall be ineligible to be nominated for any other elected office during the same election cycle.

ARTICLE III. OFFICERS: ELECTION AND DUTIES

SECTION A. OFFICERS OF THE FSMB

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

SECTION B. ELECTION OF OFFICERS

1. The Chair-elect shall ascend to the position of Chair at the Annual Meeting following the meeting in which the Chair-elect was elected.
2. The Chair-elect shall be elected at each Annual Meeting of the House of Delegates.
3. The Immediate Past Chair assumes that position upon the Chair-elect ascending to the position of Chair.
4. The Treasurer shall be elected every third year at the Annual Meeting of the House of Delegates.
5. Officers shall be elected by a majority of the members of the House of Delegates present and voting.
6. In any election, should no candidate receive a majority of the votes cast, a runoff election shall be held between the two candidates who receive the most votes for that office on the first ballot. Up to two additional runoff elections shall be held.
7. Prior to each election, the presiding officer shall cast a sealed vote that shall be counted only to resolve a tie that cannot be decided by the process set forth in this section.

SECTION C. DUTIES OF OFFICERS

1. The duties of the Chair shall be as follows:

a. Preside at all meetings and sessions of the House of Delegates and the Board of Directors;

b. Perform the duties customary to the office of the Chair;

c. Make appointments to committees and define duties of committee members in accordance with these Bylaws, except as otherwise provided herein;

d. Serve, ex officio, on all committees except as otherwise provided herein; and

e. Exercise such other rights and customs as the Bylaws and parliamentary usage may require or as the FSMB or the Board of Directors shall deem appropriate.

2. The duties of the Chair-elect shall be as follows:

a. Assist the Chair in the discharge of the Chair's duties; and

b. Perform the duties of the Chair at the Chair's request or, in the event of the Chair's temporary absence or incapacitation, at the request of the Board of Directors.

3. The duties of the Immediate Past Chair shall be as follows:

a. Assist the Chair in the transition from Chair-elect to Chair;

b. Serve as chair of the Nominating Committee; and

c. Perform such other duties and responsibilities as the Chair shall determine.

4. The duties of the Treasurer shall be as follows:

a. Perform the duties customary to that office;

b. Perform such other duties as the Bylaws and custom and parliamentary usage may require or as the Board of Directors shall deem appropriate;

c. Serve as an ex officio member of the Audit Committee; and

d. Serve as chair of the Finance Committee.

5. The duties of the Secretary shall be as follows:

a. Administer the affairs of the FSMB; and

b. Such duties and responsibilities as the FSMB and the Board of Directors shall determine.

SECTION D. TERMS OF OFFICE AND SUCCESSION

1. The Chair and Chair-elect shall serve for single terms of one year or until their successors assume office.

2. The Immediate Past Chair shall serve until a successor to the current Chair assumes office.
3. The Treasurer shall serve for a single term of three years or until the Treasurer's successor assumes the office.
4. Officers shall assume office upon final adjournment of the Annual Meeting of the House of Delegates at which they were elected.
5. The term of the Secretary is co-terminus with that of the President.

SECTION E. VACANCIES

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

ARTICLE IV. BOARD OF DIRECTORS

SECTION A. MEMBERSHIP AND TERMS

1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, nine Directors-at-Large and two Staff Fellows. At least three members of the Board, who are not Staff Fellows, shall be non-physicians, at least two of whom shall be a Member Medical Board public member.
2. NOMINATION OF STAFF FELLOWS: Nominations for Staff Fellow positions shall be accepted from Member Boards, the Board of Directors and the Administrators in Medicine. Staff Fellows shall be appointed by the Board of Directors in staggered terms in accordance with policies and procedures established by the Board of Directors.

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

SECTION B. NOMINATIONS

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

SECTION C. ELECTION OF DIRECTORS-AT-LARGE

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

SECTION D. DUTIES OF THE BOARD OF DIRECTORS

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

SECTION E. REMOVAL FROM OFFICE

1. REMOVAL: Any officer or member of the Board of Directors may be removed for any cause deemed sufficient by an affirmative vote of two-thirds of the total members of the Board of Directors entitled to vote and who are not subject to removal from office.
2. PROCEDURE: The procedure for removal shall be as follows:
    a. The Board shall file with the Secretary of the Board and deliver a written statement of the cause for removal to the officer or board member in sufficient detail as to state the grounds

for the removal. Delivery to the officer or board member shall be by certified mail, return receipt requested, to the last address known to the Board.

b. The officer or board member shall deliver a sworn written response to the Board no later than thirty calendar days after the written statement of the cause for removal is delivered to the officer or board member in question. Delivery to the Board shall be by certified mail, return receipt requested, directed to the Secretary of the Board at the FSMB corporate office.

c. At the Board meeting following the date the response is due, the Board shall determine whether or not to proceed with removal. Notice of the Board's action shall be delivered to the officer or board member by certified mail, return receipt requested. If the officer or board member does not file a written response, the Board shall proceed with a determination.

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

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

4. DELIVERY: For the purposes of this section, "Delivery" is effective upon mailing.

SECTION F. VACANCIES

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

2. STAFF FELLOWS: In the event of a vacancy of a Staff Fellow, the Board of Directors may appoint a substitute to complete the Staff Fellow's term in accordance with the policies established by the Board of Directors.

SECTION G. EXECUTIVE COMMITTEE OF THE BOARD

1. MEMBERSHIP: The Board of Directors shall establish an Executive Committee of the Board, which shall consist of the Chair as Chair, Chair-elect, Treasurer, Immediate Past Chair and three Directors-at-Large. The Directors-at-Large shall be elected for a one-year term by majority vote of the Directors-at-Large and the Staff Fellows serving on the Board of Directors at the first regular meeting of the Board following the annual meeting of the House of Delegates. In the event of a vacancy in a Director-at-Large position, the Directors-at-Large and the Staff Fellows serving on the Board, by majority vote~~,~~ shall choose another Director-at-Large to serve the remainder of the one-year term. A Staff Fellow may serve in one of the Director-at-Large positions. No more than one Staff Fellow may serve on the Executive Committee at any one time. In the event of vacancy in the position of Immediate Past Chair, this position shall remain vacant until the next annual meeting of the House of Delegates.
2. DUTIES: In intervals between Board meetings, the Executive Committee shall act for and on behalf of the Board in any matters that require prompt attention. It shall not modify actions previously taken by the Board unless additional information or a change of circumstances is presented and warrants additional action.
3. MEETINGS: The Executive Committee may meet as often as it deems necessary or appropriate, either in person, telephonically, electronically or by unanimous written consent, and at such times and places and manner as the Chair may determine. Minutes must be kept of all meetings.
4. REPORTING: The Executive Committee shall report in writing all formal actions taken by it to the Board of Directors within five working days of taking those actions. At each meeting of the Board, the Executive Committee shall present to the Board a written report of all its formal actions since the previous meeting of the Board.

SECTION H. PUBLIC POLICY STATEMENTS

A “public policy” is defined as the official public position of the FSMB on a matter that may be reasonably expected to affect Member Boards when dealing with their licensees, other health care providers, health-related special interest groups, governmental bodies or the public. The House of Delegates is the official public policy-making body of the FSMB. When the interests of the FSMB require more immediate action, the Board of Directors, or the President in consultation with the Chair, if feasible, is authorized to issue statements on matters of public policy between Annual Meetings.

ARTICLE V. NOMINATION BY PETITION FOR BOARD OF DIRECTORS AND NOMINATING COMMITTEE

SECTION A. SUBMISSION OF A PETITION

1. At the time the Nominating Committee's roster of candidates is distributed to the Member Boards, the Boards will be informed that a Fellow who is qualified for nomination, but not otherwise nominated by the Nominating Committee, may seek to run for a position on the Board of Directors as an Officer or Director-at-Large, or for a position on the Nominating Committee.
2. In order to be placed on the ballot, the Fellow seeking nomination is required to present a petition to Administrative Staff that is signed by at least one Fellow from at least four Member Boards as well as a fellow from the Board of the member seeking nomination.
3. The deadline to submit petitions to the Administrative Staff is twenty-one days prior to the Annual Meeting.

SECTION B. VALIDATION AND PLACEMENT ON BALLOT

1. The Administrative Staff shall verify that all signatures on the petition are valid. "Valid" is defined as the person who is seeking nomination and the persons who signed the petition are Fellows as defined in the FSMB Bylaws.
2. Once verified, the petitions are deemed valid and the candidate is placed on the ballot.
3. The names of those seeking to run by petition whose petitions are deemed valid shall be distributed to the Voting Delegates not fewer than fourteen days prior to the Annual Meeting.
4. Once a candidate seeking to run by petition is added to the ballot, the candidate shall be afforded the same privileges and be bound by the same rules in the campaign process as candidates who were nominated by the Nominating Committee.

ARTICLE VI. PRESIDENT

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

ARTICLE VII. MEETINGS

SECTION A. ANNUAL MEETING OF THE HOUSE OF DELEGATES

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

SECTION B. SPECIAL MEETINGS OF THE HOUSE OF DELEGATES

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

SECTION C. RIGHT TO VOTE

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

SECTION D. QUORUM

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

SECTION E. RULES OF ORDER

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

ARTICLE VIII. STANDING AND SPECIAL COMMITTEES

SECTION A. STANDING COMMITTEES

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

Board of Directors, shall appoint a Fellow to serve on the committee for the remainder of the unexpired term. In the event the Chairmanship of the Nominating Committee becomes vacant, the FSMB Chair, with the approval of the FSMB Board of Directors, shall appoint a Past Chair of the FSMB Board of Directors to serve in that capacity for the remainder of the unexpired term.

SECTION B. AUDIT COMMITTEE

The Audit Committee shall:

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

SECTION C. BYLAWS COMMITTEE

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

SECTION D. EDITORIAL COMMITTEE

1. An Editorial Committee, not to exceed twelve Fellows and three non-Fellows, at least two of whom shall be subject matter experts, shall advise the Editor-in-Chief on editorial policy for the FSMB's official publication, and shall serve as the editorial board of that publication and otherwise assist the Editor-in-Chief in the performance of duties as appropriate and necessary. No officer or member of the Board of Directors shall serve on this Committee.
2. Service on the Editorial Committee is by nomination and appointment by the FSMB Chair, subject to approval of the Board of Directors, immediately following the Annual Meeting of the House of Delegates. Candidates are allowed to express their interest in serving on the Committee through self-nomination. Committee members shall serve staggered three-year terms and shall be limited to two full terms.
3. The Editor-in-Chief shall be elected by the Editorial Committee to a three-year term beginning on the date of the annual Editorial Committee meeting, with the Editor-in-Chief's term on the Editorial Committee being automatically extended to allow the Editor-in-chief to serve for three years. A member of the Editorial Committee whose term is expiring shall continue to serve until the member's replacement meets at the next annual Editorial Committee meeting.
4. The Editorial Committee will elect its Chair, who will serve as the Editor-in-Chief of the *Journal of Medical Regulation.* The Editor-in-Chief will serve without compensation and will coordinate decisions on the *Journal* content, among other duties to be determined by the Bylaws Committee.

SECTION E. EDUCATION COMMITTEE

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

SECTION F. ETHICS AND PROFESSIONALISM COMMITTEE

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

SECTION G. FINANCE COMMITTEE

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

SECTION H. NOMINATING COMMITTEE: PROCESS FOR ELECTION

1. MEMBERSHIP: The Nominating Committee shall be composed of six Fellows and the Immediate Past Chair, who shall chair the Committee and serve without vote except in the event of a tie. At least one elected member of the Nominating Committee shall be a public member. With the exception of the Immediate Past Chair, no two Committee members shall be from the same member board and no officer or member of the Board of Directors shall serve on the Committee. A member of the Nominating Committee may not serve consecutive terms.
2. ELECTION: At least three Fellows shall be elected at each Annual Meeting of the House of Delegates by a plurality of votes cast, each to serve for a term of two years. Only an individual who is a Board Member Fellow at the time of the individual's election shall be eligible for election as a member of the Nominating Committee. In the event of a tie vote in a runoff election, up to two additional runoff elections shall be held. Prior to the election, the presiding officer shall cast a sealed vote, ranking each candidate in a list. The presiding officer's vote is counted for the candidate in the runoff election who is highest on the list. The presiding officer's vote is counted only to resolve a tie that cannot be decided by the process set forth in this section.
3. Members of the Nominating Committee are not eligible for inclusion on the roster of candidates for offices and positions to be filled by election at the Annual Meeting of the House of Delegates.

SECTION I. SPECIAL COMMITTEES

Special committees may be appointed by the Chair, from time to time, as may be necessary for a specific purpose.

SECTION J. REPRESENTATIVES TO OTHER ORGANIZATIONS AND ENTITIES

Appointment of all representatives of the FSMB to other official organizations or entities shall be made or nominated by the Chair, with the approval of the Board of Directors, as applicable, and shall serve for a term of three years unless the other organization shall specify some other term of appointment. Representatives to these organizations shall be Fellows, Honorary Fellows, Associate Members or Courtesy Members at the time of their appointment or nomination.

ARTICLE IX. UNITED STATES MEDICAL LICENSING EXAMINATION (USMLE)

SECTION A. Except as otherwise set forth in this Article, the composition of committees and subcommittees for the USMLE are subject to agreements with and the advice and consent of the National Board of Medical Examiners (NBME) and/or the USMLE Composite Committee. The Chair, with the approval of the Board of Directors, shall make appointments to the following USMLE committees in appropriate numbers and at appropriate times as required by the FSMB/NBME Agreement establishing the USMLE and by other agreements as may apply:

1. USMLE Composite Committee, which shall be responsible for the development, operation and maintenance of policies governing the three-step USMLE. The President shall be one of the FSMB's representatives on this Committee.
2. USMLE Budget Committee, which shall be responsible for the development and monitoring of USMLE revenues and expenses, including the establishment of fees. FSMB representatives on the Committee will be the Chair, Chair-elect, Treasurer, President and the senior FSMB financial staff member.
3. The USMLE Management Committee shall be responsible for overseeing the design, development, scoring and standard setting for the USMLE Step examinations, subject to policies established by and reporting to the USMLE Composite Committee. Appointments to the Management Committee shall be made consistent with the FSMB/NBME Agreement Establishing the USMLE.

SECTION B. The President shall provide FSMB advice and consent to the NBME for NBME's appointments to the USMLE Management Committee and/or any appointments made jointly under the FSMB/NBME Agreement Establishing the USMLE.

ARTICLE X. POST-LICENSURE ASSESSMENT SYSTEM

The Post-Licensure Assessment Governing Committee shall be responsible for the development, operation and maintenance of policies governing the Post-Licensure Assessment System (PLAS) established by joint agreement between FSMB and NBME. The Chair, with the approval of the Board of Directors, shall make appointments to the Post-Licensure Assessment Governing Committee and its program committees in appropriate numbers and at appropriate times as required by the FSMB/NBME joint agreement establishing the Post-Licensure Assessment System and by other agreements as may apply.

ARTICLE XI. FINANCES AND DUES

SECTION A. SOURCES OF FUNDS

Funds necessary for the conduct of the affairs of the FSMB shall be derived from but not be limited to:

1. Annual dues imposed on the Member Medical Boards, Affiliate Members, Courtesy Members and Official Observers;
2. Special assessments established by the House of Delegates;
3. Voluntary contributions, devices, bequests and other gifts;
4. Fees charged for examination services, data base services, credentials verification services and publications.

SECTION B. ANNUAL DUES, ELIGIBILITY TO SERVE AS A DELEGATE

The annual dues for Member Medical Boards shall be established, from time to time, by a majority vote of the House of Delegates.

1. Annual dues for Member Medical Boards shall be the same for all Members regardless of their physician populations. Annual dues are due and payable not later than January 1.
2. Any Member Medical Board whose dues are in default at the time of the Annual Meeting of the House of Delegates shall be ineligible to have a seated delegate.

ARTICLE XII. DISCIPLINARY ACTION

SECTION A. MEMBER

For the purposes of this Article, a member shall be defined as a Member Medical Board, a Fellow, an Honorary Fellow, an Associate Member, an Affiliate Member, Courtesy Member or Official Observer.

SECTION B. AUTHORIZATION

The Board of Directors, on behalf of the House of Delegates, may enforce disciplinary measures, including expulsion, suspension, censure and reprimand, and impose terms and conditions of probation or such sanctions as it may deem appropriate, for any of the following reasons:

1. Failure of the member to comply or act in accordance with these Bylaws, the Articles of Incorporation of the FSMB, or other duly adopted rules or regulations of the FSMB;
2. Failure of the member to comply with any contract or agreement between the FSMB and such member or with any contract or agreement of the FSMB that binds such member;
3. Failure of the member to maintain confidentiality or security, or the permitting of conditions that allow a breach of confidentiality or security, in any manner dealing with the licensing examination process or the confidentiality of FSMB records, including the storage, administration, grading or reporting of examinations and information relating to the examination process; or
4. The imposition of a sanction, judgment, disciplinary penalty or other similar action by a Member Medical Board that licenses the member or by a state or federal court, or other competent tribunal, whether or not related to the practice of medicine and including conduct as a member of a Member Medical Board.

SECTION C. PROCEDURE

Any member alleged to have acted in such manner as to be subject to disciplinary action shall be accorded, at a minimum, the procedural protection set forth in the Manual for Disciplinary Procedures, which is available from the FSMB upon the written request of any member.

SECTION D. REINSTATEMENT

In the event a member is suspended or expelled from the FSMB, the member may apply to the President for reinstatement after one year following final action on expulsion. The President shall review the application and the reason for the suspension or expulsion and forward a report to the

Board. The Board may accept application for reinstatement under such terms and conditions as it may deem appropriate, reject the application or request further information from the President. The Board's decision to accept or reject an application is final.

ARTICLE XIII. CORPORATE SEAL

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

ARTICLE XIV. ADOPTION AND AMENDMENT OF BYLAWS, EFFECTIVE DATE

SECTION A. AMENDMENT

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

SECTION B. EFFECTIVE DATE

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

Bylaws last amended in May 2020