AMENDED

HAWAII MEDICAL BOARD

Professional and Vocational Licensing Division
Department of Commerce and Consumer Affairs
State of Hawaii

AGENDA

Date: November 14, 2024

Time: 1:00 p.m.

In-Person Meeting Location: Queen Liliuokalani Conference Room
HRH King Kalakaua Building
335 Merchant Street, First Floor
Honolulu, Hawaii 96813

Agenda: The agenda was posted to the State electronic calendar as required by Hawaii Revised Statutes ("HRS") section 92-7(b).

Virtual Participation: Virtual Videoconference Meeting – Zoom Meeting (use link below)

https://dcca-hawaii-gov.zoom.us/j/81639607524?pwd=RNIagUQfc5m0DgMo2daybDVp2ZKg3p.1

Phone: (669) 900-6833

Meeting ID: 816 3960 7524

Passcode: 437740

If you wish to submit written testimony on any agenda item, please email your testimony to medical@dcca.hawaii.gov or by hard copy mail to: Attn: Hawaii Medical Board, P.O. Box 3469, Honolulu, HI 96801. We request submission of testimony at least 24 hours prior to the meeting to ensure that it can be distributed to the Board members.

INTERNET ACCESS:

To view the meeting and provide live oral testimony, please use the link at the top of the agenda. You will be asked to enter your name. The Board requests that you enter your full name, but you may use a pseudonym or other identifier if you wish to remain anonymous. You will also be asked for an email address. You may fill in this field with any entry in an email format, e.g., *****@***mail.com.

Your microphone will be automatically muted. When the Chairperson asks for public testimony, you may click the Raise Hand button found on your Zoom screen to indicate that you wish to testify about that agenda item. The Chairperson will individually enable each testifier to unmute their microphone.

When recognized by the Chairperson, please unmute your microphone before speaking and mute your microphone after you finish speaking.

PHONE ACCESS:

If you cannot get internet access, you may get audio-only access by calling the Zoom Phone Number listed at the top on the agenda.
Upon dialing the number, you will be prompted to enter the Meeting ID which is also listed at the top of the agenda. After entering the Meeting ID, you will be asked to either enter your panelist number or wait to be admitted into the meeting. You will not have a panelist number. So, please wait until you are admitted into the meeting.

When the Chairperson asks for public testimony, you may indicate you want to testify by entering "*" and then "9" on your phone's keypad. After entering "*" and then "9", a voice prompt will let you know that the host of the meeting has been notified. When recognized by the Chairperson, you may unmute yourself by pressing "*" and then "6" on your phone. A voice prompt will let you know that you are unmuted. Once you are finished speaking, please enter "*" and then "6" again to mute yourself.

For both internet and phone access, when testifying, you will be asked to identify yourself and the organization, if any, that you represent. Each testifier will be limited to five minutes of testimony per agenda item.

If connection to the meeting is lost for more than 30 minutes, the meeting will be continued on a specified date and time. This information will be provided on the Board's website at http://cca.hawaii.gov/pvl/boards/medical/board-meeting-schedule/.

Instructions to attend State of Hawaii virtual board meetings may be found online at https://cca.hawaii.gov/pvl/files/2020/08/State-of-Hawaii-Virtual-Board-Attendee-Instructions.pdf

1. Call to Order

2. Approval of Minutes:

   A. October 10, 2024, Open Session Meeting Minutes

The Board may enter into Executive Session to consult with the Board's attorney on questions and issues pertaining to the Board's powers, duties, privileges, immunities, and liabilities in accordance with HRS section 92-5(a)(4) to review the executive session minutes.

3. Adjudicatory, HRS Chapter 91

   A. In the Matter of the Physician's License of Curtis R. Bekkum, M.D.; Hearings Officer's Findings of Fact, Conclusions of Law, and Recommended Order; MED-2018-85-L.

   B. In the Matter of the Physician's Licensing of Thomas K.S. Noh, M.D.; Settlement Agreement Prior to Filing of Petition for Disciplinary Action and Board's Final Order; MED-2023-88-L.

   C. In the Matter of the License to Practice Osteopathy of Shannon P. Calhoun, D.O.; Settlement Agreement Prior to Filing of Petition for Disciplinary Action and Board's Final Order; Exhibits "1" and "2"; MED-2022-158-L.

4. Applications for License/Certification:

   The Board will enter into Executive Session pursuant to Hawaii Revised Statutes §§ 92-5(a)(1) and 92-5(a)(4) to consider and evaluate personal information relating to individuals applying for professional or vocational licenses cited in section 26-9 or both and to consult with the board's attorney on questions and issues pertaining to the board's powers, duties, privileges, immunities, and liabilities.

   A. Applications:

      (i) Physician (Permanent/Endorsement):

         a. Catherine Samuels Uram, M.D.

         b. John Paul Burns, M.D.

      (ii) Podiatrist (Permanent):

         a. Neil Patel, D.P.M.

   B. Ratification List (See attached list)

      (i) November 14, 2024, Ratification List

5. Unfinished Business:

   A. Scope of Practice

      Does the administration of vitamin injections/shots (e.g., B12), to the public fall under the practice of medicine as defined by Hawaii Revised Statutes §453-1, and is the provider required to be licensed as a physician or physician assistant.

   B. Interstate Medical Licensure Compact (IMLCC)

      (i) Update Regarding Implementation of the IMLCC

Mr. Randy Ho, Executive Officer, will provide the Board a summary of his recent training with IMLCC staff to ensure proper implementation of the IMLCC in the State of Hawaii.

C. Federation of State Medical Boards, Inc. (FSMB)

(i) Advisory Commission on Additional Licensing Models

The Advisory Commission on Additional Licensing Models has released draft preliminary recommendations for public comment. The recommendations, once finalized, are intended for state medical boards, state legislators, policymakers and interested stakeholders to help inform those jurisdictions interested in developing or modifying additional licensing pathways for physicians who have completed training internationally.

(ii) Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health (Policy).

The Board will consider FSMB's Policy and the working group's recommended amendments to its questions on its initial and renewal applications regarding addiction, dependency, or habituation to alcohol and other substances.

D. United States Medical Licensing Examination (USMLE)

(i) The USMLE is seeking current and former physician board members to volunteer for its panels/committees, including test development and non-test development committees.

6. Next Meeting: December 12, 2024

Virtual Videoconference Meeting – Zoom Meeting

and

In-Person Meeting Location: Queen Liliuokalani Conference Room
HRH King Kalakaua Building
335 Merchant Street, First Floor
Honolulu, HI 96813

7. Adjournment

If you need an auxiliary aid/service or other accommodation due to a disability, contact Randy Ho at (808) 586-2699, between the hours of 7:45 a.m. – 4:30 p.m. or by email at medical@dcca.hawaii.gov preferably by November 12, 2024, or as soon as possible. Requests made as early as possible have a greater likelihood of being fulfilled. Upon request, this notice is available in alternate/accessible formats.

11/4/2024

HAWAII MEDICAL BOARD
Professional and Vocational Licensing Division
Department of Commerce and Consumer Affairs
State of Hawaii

MINUTES OF MEETING

Date:	October 10, 2024
Time:	1:00 p.m.
In-Person Meeting Location:	Queen Liliuokalani Conference Room HRH King Kalakaua Building 335 Merchant Street, Third Floor Honolulu, Hawaii 96813
Virtual Participation:	Virtual Videoconference Meeting – Zoom Webinar https://dcca-hawaii-gov.zoom.us/j/83429784345?pwd=5L4mzGgajSRPVmKMKUCNhMdKkLhqha.1
Zoom Recoding Link:	https://youtu.be/6dOqC2PMg3o
Present:	Danny M. Takanishi, M.D., Chairperson, Honolulu Member Gary Belcher, Vice Chairperson, Public Member Andrew R. Fong, MD, Hawaii County Member Michael Jaffe, D.O., Honolulu, Osteopathic Member Elizabeth “Lisa Ann” Ignacio, M.D., Maui Member Wesley Mun, Public Member Angela Pratt, M.D., Honolulu Member Rebecca Sawai, M.D., Honolulu Member Geri Young, M.D., Kauai Member William Brian Hatten, D.O., Osteopathic Member Shari J. Wong, Deputy Attorney General (“DAG”) Ahlani K. Quiogue, Licensing Administrator Randy Ho, Executive Officer Chelsea Fukunaga, Executive Officer Dawn Lee, Administrative Assistant Johnny Li (Technical Support)
Zoom Guests:	Alexander White dr.richardpaltenghi Autumn Conde Kozue Shimabukuro yen Ricky Patel
In-Person Guest(s):	Rebecca Yanashiro

Agenda: The agenda for this meeting was posted to the State electronic calendar as required by Hawaii Revised Statutes ("HRS") section 92-7(b).

A short video was played to explain the meeting procedures and how members of the public could participate in the virtual meeting.

Call to Order: The meeting was called to order at 1:06 p.m., at which time quorum was established.

Chair Takanishi welcomed everyone to the meeting and proceeded with a roll call of the Board members. All Board members confirmed that they were present and alone.

Approval of the August 8, 2024, Open Session and Executive Minutes: It was moved by Dr. Pratt, seconded by Dr. Jaffe, and carried by a majority, with the exception of Dr. Fong and Dr. Hatten, who abstained from the discussion and vote on this matter, to approve the meeting minutes of the open session and executive session of the August 8, 2024, meeting, as follows:

> Chair Takanishi, Mr. Belcher, Dr. Jaffe, Dr. Ignacio, Dr. Munn, Dr. Pratt, Dr. Sawai, and Dr. Young voted in favor of the motion.
>
> Dr. Fong and Dr. Hatten abstained from the vote.

Chair Takanishi informed meeting attendees that applicants whose applications were on the agenda would be invited to join the executive session to provide their testimony.

Chair Takanishi asked if anyone from the public would like to provide oral testimony on this agenda item. There was none.

Ch. 91, HRS, Adjudicatory Matters: Chair Takanishi called for a recess from the meeting at 1:20 p.m., to discuss and deliberate on the following adjudicatory matters pursuant to Chapter 91, HRS (Note: Board members and staff entered the Zoom Breakout Room).

Chair Takanishi proceeded with a roll call of the Board members in the Zoom Breakout Room. All Board members confirmed that they were present and alone.

A. In the Matter of the Physician's License of Curtis R. Bekkum, M.D.; Hearings Officer's Findings of Fact, Conclusions of Law, and Recommended Order; MED-2018-85-L.

Chair Takanishi announced that on October 9, 2024, the Board, through the Licensing Administrator, issued an Order Granting Respondent's Motion for Order Continuing Hearing. The hearing on Oral Argument in the matter is tentatively rescheduled to Thursday, November 14, 2024, at 1:00 p.m.

B. In the Matter of the Physician's License of Chris A. Boulange, M.D.; Settlement Agreement Prior to Filing of a Petition for Disciplinary Action and Board's Final Order; Exhibits "1" and "2"; MED-2023-0044-L.

After due consideration of the information received, it was moved by Dr. Jaffe, seconded by Dr. Pratt, and unanimously carried, to approve the aforementioned Settlement Agreement Prior to Filing of Petition for Disciplinary Action and Board's Final Order.

Chair Takanishi's Zoom video froze, and he exited the Zoom breakout room at 1:25 p.m.

C. In the Matter of the License to Practice Osteopathy of Shannon P. Calhoun, D.O.; Settlement Agreement Prior to Filing of Petition for Disciplinary Action and Board's Final Order; Exhibits "1" - "2"; MED 2022-158-L.

After due consideration of the information received, it was moved by Mr. Belcher, seconded by Dr. Young, and unanimously carried, to defer the request for early termination of probation until additional information is received.

D. In the Matter of the Physician's License of Kyle K. Chong, M.D.; Settlement Agreement Prior to Filing of Petitioner for Disciplinary Action and Board's Final Order; MED-2024-0064-L.

After due consideration of the information received, it was moved by Dr. Jaffe, seconded by Dr. Young, and unanimously carried, to approve the aforementioned Settlement Agreement to Filing of Petition for Disciplinary Action and Board's Final Order.

E. In the Matter of the Physician's License of Sinikka Liisa Green, M.D.; Settlement Agreement Prior to Filing of Petition for Disciplinary Action and Board's Final Order; Exhibits 1-4; MED-2023-251-L.

Chair Takanishi re-entered the Zoom Adjudicatory Matters Breakout Room at 1:32 p.m.

After due consideration of the information received, it was moved by Dr. Pratt, seconded by Mr. Mun, and unanimously carried, to approve the aforementioned Settlement Agreement Prior to Filing of Petition for Disciplinary Action and Board's Final Order.

Following the Board's review, deliberation, and decision on these matters pursuant to Chapter 91, HRS, Chair Takanishi announced that the Board reconvenes to its Chapter 92, HRS, meeting at 1:43 p.m. Board members and staff returned to the open session

Zoom meeting. All Board members confirmed that they were present and alone.

Chair Takanishi asked if anyone from the public would like to provide oral testimony on these agenda items. There was none.

Applications for License/ Certification:

A. Applications:

It was moved by Dr. Jaffe, seconded by Mr. Belcher, and unanimously carried to enter into executive session at 1:47 p.m., pursuant to HRS §92-5(a)(1), to consider and evaluate personal information relating to individuals applying for professional licenses cited in HRS §26-9 and, pursuant to HRS §92-5 (a)(4), to consult with the Board's attorney on questions and issues pertaining to the Board's powers, duties, privileges, immunities and liabilities. (Note: Board members and staff entered the Zoom Breakout Room).

Chair Takanishi proceeded with a roll call of the Board members in the Zoom Breakout Room. All members confirmed that they were present and alone.

Dr. Ignacio's Zoom feed was dropped and she exited the Zoom Breakout Room at 2:04 p.m.

(i) Physician (Permanent/Endorsement):

a. Alexander Raymond White, M.D.

Alexander Raymond White, M.D. entered the Zoom Breakout Room at 2:05 p.m.

Alexander Raymond White, M.D. exited the Zoom Breakout Room at 2:15 p.m.

b. Kozue Shimabukuro, M.D.

Dr. Ignacio re-entered Zoom Executive Session Breakout Room at 2:23 p.m.

Kozue Shimabukuro, M.D. entered the Zoom Breakout Room at 2:31 p.m.

Kozue Shimabukuro, M.D. exited the Zoom Breakout Room at 2:39 p.m.

The Board took a brief recess from 2:42 p.m. to 2:47 p.m.

c. Yen-Trang Xuan Vo, D.O.

Yen-Trang Xuan Vo, D.O. entered the Zoom Breakout Room at 2:52 p.m.

Yen-Trang Xuan Vo, D.O. exited the Zoom Breakout Room at 3:01 p.m.

d. Autumn Dawn Conde, D.O.

Autumn Dawn Conde, D.O. entered the Zoom Breakout Room at 3:08 p.m.

Autumn Dawn Conde, D.O. exited the Zoom Breakout Room at 3:20 p.m.

(ii) Physician (Permanent/Non-Endorsement):

a. Richard Neil Paltenghi, M.D.

Richard Neil Paltenghi, M.D. entered the Zoom Breakout Room at 3:25 p.m.

Richard Neil Paltenghi, M.D. exited the Zoom Breakout Room at 3:40 p.m.

b. Ricky Patel, D.O.

Ricky Patel, D.O. entered the Zoom Breakout Room at 3:56 p.m.

Ricky Patel, D.O exited the Zoom Breakout Room at 4:03 p.m.

Scope of Practice: A. Does the administration of vitamin injections/shots (e.g., B12), fall under the practice of medicine as defined by Hawaii Revised Statutes §453-1

2025 Legislation: Licensure Compact
A. Relating to the Interstate Medical
B. Relating to Medical Records

It was moved by Dr. Pratt, seconded by Dr. Sawai, and unanimously carried to return to the open session meeting at 4:16 p.m. Board members and staff returned to the main Zoom meeting. All Board members confirmed that they were present and alone.

(i) Physician (Permanent/Endorsement):

a. Alexander Raymond White, M.D.

After due consideration of the information received, it was moved by Dr. Young, seconded by Dr. Pratt, and unanimously carried to approve Dr. White's application for licensure.

b. Kozue Shimabukuro, M.D.

After due consideration of the information received, it was moved by Chair Takanishi, seconded by Mr. Belcher, and unanimously carried to approve Dr. Shimabukuro's application for licensure.

c. Yen-Trang Xuan Vo, D.O.

After due consideration of the information received, it was moved by Chair Takanishi, seconded by Dr. Pratt, and unanimously carried to approve Dr. Vo's application for licensure.

d. Autumn Dawn Conde, D.O.

After due consideration of the information received, it was moved by Dr. Pratt, seconded by Dr. Hatten, and unanimously carried to approve Dr. Conde's application for licensure.

(ii) Physician (Permanent/Non-Endorsement):

a. Richard Neil Paltenghi, M.D.

After due consideration of the information received, it was moved by Dr. Fong, seconded by Mr. Mun, and unanimously carried to approve Dr. Paltenghi's application for licensure.

b. Ricky Patel, D.O.

After due consideration of the information received, it was moved by Dr. Jaffe, seconded by Dr. Pratt, and unanimously carried to approve Dr. Patel's application.

B. Ratification List (See attached list)

(i) October 10, 2024, Ratification List

It was moved Dr. Jaffe, seconded by Dr. Young, and unanimously carried to ratify the attached lists of individuals for licensure or certification from October 10, 2024.

Scope of Practice: A. Does the administration of vitamin injections/shots (e.g., B12), fall under the practice of medicine as defined by Hawaii Revised Statutes §453-1

Due to time limitations, the Board will defer its discussion on this matter to a later meeting. In the meantime, the Executive Officer was instructed to perform additional research on the matter of delegating medical procedures to licensed/unlicensed providers by way of the Board's issuance of past informal opinions.

2025 Legislation:

A. Relating to the Interstate Medical Licensure Compact

The purpose of this bill authorizes the Hawaii Medical Board as the State of Principal License to investigate and request criminal history record checks of qualified physicians seeking licensure through the Interstate Medical Licensure Compact. This bill also appropriates funds.

Chair Takanishi asked for a motion of support for this bill. It was moved by Dr. Pratt, seconded by Dr. Sawai, and unanimously carried to support this bill.

B. Relating to Medical Records

The purpose of this bill is to repeal requirements for healthcare providers leaving their practices to receive approval from the Department of Health for the disposition of their medical records.

Chair Takanishi made a motion that the Board track this measure if is formally introduced during the 2025 legislative session. This motion was seconded by Dr. Jaffe, and carried unanimously carried by the Board to track this measure.

Due to time limitations, the Board deferred its discussion on these matters to a later meeting:

Interstate Medical Licensure Compact:

A. Update Regarding Implementation of the IMLCC

Federation of State Medical Boards:

A. FSMB Advisory Commission on Additional Licensing Models

Unfinished Business:

A. Federation of State Medical Boards, Inc. (FSMB)

(i) Policy on Physician Illness and Impairment:

United States Medical Licensing Examination:

A. USMLE is seeking current and former physician board members to volunteer for its panels/committees

Next Meeting: Thursday, November 14, 2024

In-Person Meeting Location:	Queen Liliuokalani Conference Room King Kalakaua Building, 1st Floor 335 Merchant Street Honolulu, Hawaii 96813

Virtual Videoconference Meeting – Zoom Webinar

Adjournment: The meeting adjourned at 4:27 p.m.

Reviewed and Approved by:	Taken and Recorded by:
/s/ Randy Ho	/s/ Dawn Lee
Mr. Randy Ho Executive Officer	Ms. Dawn Lee Administrative Assistant

( ) Minutes approved as is.
( ) Minutes approved with changes:

HAWAII MEDICAL BOARD
November 14, 2024, Ratification List

AMD-1401-0	KELSEY J CAIN
AMD-1402-0	SEAN T MICKELSEN
AMD-1403-0	TANISHA MONIQUE HENRY
AMD-1404-0	JULIA GROH
AMD-1405-0	AKANE M DUNN
AMD-1406-0	JEFFREY A POKUTA
AMD-1407-0	KAITLIN TONER
AMD-1408-0	JULIANE DIONNE
AMD-1409-0	CHASTYN B CABATU
AMD-1410-0	JASMINE D KALILI
AMD-1411-0	KACEY DAYTON
AMD-1412-0	JOSEPH H BABBEL
AMD-1413-0	DARCY L MULLIGAN
DOS-2617-0	BRENT A NEDELLA
DOS-2618-0	KASSANDRA IVA MARIE COOPER
DOS-2619-0	BLAKE W JOHNSON
DOS-2620-0	JINEANE Y SHIBUYA
DOS-2621-0	YEN-TRANG VO
DOS-2622-0	AUTUMN D CONDE
DOS-2623-0	RICKY PATEL
DOS-2624-0	DONNA WOODS
DOS-2625-0	WENDY SONG
DOS-2626-0	MADISON R PERINGTON
DOS-2627-0	RICHARD ARRIVIELLO
DOS-2628-0	JARAD A SCHWARTZ
DOS-2629-0	JENNIFER FOESS BEATTY
DOS-2630-0	SETH LEWIS KOSTER
DOS-2631-0	SREE REDDY
DOS-2632-0	MARY ELLEN PARMAN
DOS-2633-0	JUSTIN M MEDLOCK
DOS-2634-0	CHRISTOPHER JOSEPH RENDINA
EMT1-34-0	HAYLEY MAE WEST
EMT-3426-0	DENNIS KALANI WALSH
EMT-3427-0	TAYLOR JAMES DEGUERRA
EMT-3428-0	KUMU KEVIN BENDER
EMT-3429-0	JASON GALBRAITH POLOA

HAWAII MEDICAL BOARD
November 14, 2024, Ratification List

EMTP-2496-0	STANLEY CARL ABLER
EMTP-2497-0	JORGE ROGELIO VELASQUEZ
EMTP-2498-0	CHRISTOPHER ASKEW
MD-11667-0	DEBORAH A STRELETZ
MD-11828-0	HEIDI U FERGUSON
MD-14853-0	CHRISTOPHER C FINDLEY
MD-16189-0	ALEXANDER R WHITE
MD-24781-0	CHASE WARASHINA
MD-24782-0	USHA THAPALIA ARYAL
MD-24783-0	BRITTA RAMSETH REIERSON
MD-24784-0	FARAH BRASFIELD
MD-24785-0	KAITLYN MEI ANN YIM
MD-24786-0	JAMAL FAROOQ KHATTAK
MD-24787-0	LEE T WOLFE
MD-24788-0	POOJA BUDHIRAJA
MD-24789-0	BASHIR AHMED
MD-24790-0	EDWARD J HEPWORTH
MD-24791-0	MARK MURROW
MD-24792-0	CYNTHIA YUKIE OHATA
MD-24793-0	MARITE ALEXIS CAMPOS
MD-24794-0	ABIGALE T COX
MD-24795-0	JOHN HUGH GRANVILLE WARD
MD-24796-0	RICHARD NEIL PALTENGHI
MD-24797-0	DAVID SUSUMU NARITA
MD-24798-0	SENDHIL KRISHNAN
MD-24799-0	ORLANDO J URBANO FARJE
MD-24800-0	DOMINICK ANDREW RUIZ
MD-24801-0	MEHRBOD SOM JAVADI
MD-24802-0	WALEED MOURAD
MD-24803-0	PARTH SHAH
MD-24804-0	KOZUE SHIMABUKURO
MD-24805-0	ROBERT LONG
MD-24806-0	IRFAN FAUQ
MD-24807-0	LAURA KILOFLISKI
MD-24808-0	CAROLYN EUNBEE KWON
MD-24809-0	SARAH ELIZABETH LIGON
MD-24810-0	TAMMY LEFEBVRE
MD-24811-0	BRENDA OIYEMHONLAN

HAWAII MEDICAL BOARD
November 14, 2024, Ratification List

MD-24812-0	SCOTT KEVIN ROSS MD
MD-24813-0	ROWENA ARLENE CHUA
MD-24814-0	JOSEPH MERSOL
MD-24815-0	EMILIO LUIS GONZALEZ
MD-24816-0	SIVA RAMAN
MD-24817-0	GARY ZIMMER
MD-24818-0	ERIC M CHEN
MD-24819-0	MINA FOROOHAR
MD-24820-0	ELISE BURGER
MD-24821-0	SUNIL N GANDHI
MD-24822-0	JOEL KOCHANSKI
MD-24823-0	CUNG BRYAN PHAM
MD-24824-0	SASHA PAVLOVICH
MD-24825-0	ROBERT K SIMS IV
MD-24826-0	JANET MARIE LEGARE
MD-24827-0	PATRICK GONZALES
MD-24828-0	RUSSELL DEAN PI'IMAUNA KACKLEY
MD-24829-0	ANTHONY JOHN DINA
MD-24830-0	MARIA GUADALUPE RAMOS MENDEZ
MD-24831-0	RUBEN ALBERTO QUINTERO
MD-24832-0	BLAKE CHRISTOPHER POLEYNARD
MD-24833-0	MARK ALLEN OSBORNE MD
MD-24834-0	MARCUS SCHMITZ
MD-24835-0	RAYMOND SUMMERS
MD-24836-0	MICHAEL MICHNO
MD-24837-0	GALEN CASTILLO LOUGHREY
MD-24838-0	SAURABH PATEL
MD-24839-0	MATTHEW TRAN
MD-24840-0	TAYLOR CHEN
MD-24841-0	BRIANNA NORMA AUKLAND
MD-24842-0	MICHAEL JOSEPH BOYD
MD-24843-0	CHIH-WEI CHANG
MD-24844-0	NUTAN J VAZ
MD-24845-0	JENNIFER MITCHELL VEACO
MD-24846-0	SHAHROKH IGANEJ
MD-24847-0	KEVIN JOHN BLOUNT
MD-24848-0	VISHESH KOTHARY
MD-5079-0	PETER STUART ROBBINS

Question: ***Does the administration of vitamin injections/shots (e.g., B12), to the public fall under the practice of medicine as defined by Hawaii Revised Statutes §453-1, and is the provider required to be licensed as a physician or physician assistant?***

Hawaii Revised Statutes section 453-1, practice of medicine defined, states that:

> For the purposes of this chapter, the practice of medicine by a physician or an osteopathic physician includes the use of drugs and medicines; surgery; manual medicine; water; electricity; hypnotism; telehealth; the interpretation of tests, including primary diagnosis of pathology specimens, medical imaging, or any physical; osteopathic medicine; any means, method, or agent, either tangible or intangible, to diagnose, treat, prescribe for, palliate, or correct disease, or prevent any human disease, condition, ailment, pain, injury, deformity, illness, infirmity, defect, physical or mental condition in the human subject.
>
> This section shall not amend or repeal the law respecting the treatment of those affected with Hansen's disease.

Note: At the October 10, 2024, meeting, the Board requested that its Executive Officers perform additional research on the matter of delegating medical procedures to licensed and unlicensed providers.

Attached:

1. 12/12/2003 Open Session Meeting Minutes, page 5, d. Physician Delegation to Ancillary Personnel;
2. 8/14/2014 Open Session Meeting Minutes, page 7, New Business: Scope of Practice: Clarification Regarding the Use of Laser;
3. 10/8/2015 Open Session Meeting Minutes, pages 9-11, Scope: b., Inquiry from Board of Barbering and Cosmetology;
4. 7/14/2016 Open Session Meeting Minutes, pages 9-11, Correspondence: a. and b.;
5. 1/12/2017 Open Session Meeting Minutes, pages 6-7, Unfinished Business: b. Email Inquires dated November 18, 2016 and December 29, 2016, from Michael Pasquale, DO, Regarding the Use of Laser and Intense Pulse Light Devices (IPL); and
6. 5/11/2017 Open Session Meeting Minutes, pages 6-8, Correspondence: a. and b.

b. Emergency Contraceptive Drug Therapy Collaborative Agreement Protocol

The Board of Pharmacy approved a prototype Emergency Contraception Drug Therapy collaborative agreement. According to the collaborative agreement, the pharmacist may prescribe the emergency contraceptive and use their discretion in notifying physicians.

Although the pharmacist determines when a prescription should be filled, the Board believed that physicians should always be notified. The Board also discussed that all requests for emergency contraception should be noted in the charts. The Board believed that it is the physician's responsibility to chart.

After much discussion, it was moved by Dr. McDonnell, seconded by Dr. Netzer and unanimously carried to refer the collaborative agreement to the OBGYN Association and the Hawaii Chapter of ACOG for review and recommendations.

c. Foreign Medical Graduates of Oceania University of Medicine

This matter was discussed and voted upon at it's last meeting on November 14, 2003.

d. Physician Delegation to Ancillary Personnel

The Board received a letter requesting whether physicians are allowed to delegate the administration of medications to their personnel. It was discussed that this was brought before the Board's attention once before and it was determined that a physician is not allowed to delegate the administration of medications to unlicensed persons.

A physician or pharmacist is allowed to dispense medication; however, a registered nurse is unable to, unless under the supervision of a physician.

After discussion, it was moved by Dr. Patten, seconded by Dr. Kienitz and unanimously carried that a physician cannot delegate an act to an unlicensed person if that requires a license in the State of Hawaii.

e. Scope of Practice: Physician Orders

The Board received an inquiry from Dr. Frank M. Houser of The Healthcare Company ("HCA"). Dr. Houser states that HCA is a

Request for Reconsideration: Valerie Gironda, M.D.

After due consideration of Dr. Gironda's request and new information, it was moved by Dr. Kosasa, seconded by Mr. Puletasi and unanimously carried to approve her application for medical licensure.

New Business: Scope of Practice: Clarification Regarding the Use of Laser

Members reviewed emails from Michael Pasquale, D.O. dated July 17, 2014 and July 31, 2014, regarding the use of lasers. The Board also reviewed its prior informal opinion regarding the use of lasers issued in 1999. That informal opinion states that "except as otherwise provided by law, the use of lasers is considered to be the practice of medicine."

Discussion followed. After due consideration of the information received, the Board informally opined that unless authority is granted by a statute or administrative rule beyond Chapter 453, Hawaii Revised Statutes, and Chapter 16-85, Hawaii Administrative Rules (the laws which governs the practice of medicine in Hawaii), the use of lasers to cut, shape, burn, vaporize, or otherwise structurally alter human tissue constitutes the practice of medicine. The Board further informally opined that the delegation of the use of any lasers may only be made to those professions which are regulated by the State of Hawaii. Therefore, medical assistants and laser technicians who are not regulated by the State of Hawaii may not use lasers, nor may a licensed professional (e.g., physician or nurse) delegate the use of lasers to such unregulated personnel.

In accordance with the Hawaii Administrative Rules § 16-201-90, the above interpretation is for informational and explanatory purposes only. It is not an official opinion or decision, and therefore is not to be viewed as binding on the Board or the Department of Commerce and Consumer Affairs ("DCCA").

Advisory Committees:

a. Physician Assistants

b. Emergency Medical Service Personnel

c. Podiatrists

b. RICO Medical Advisory Committee and Addendum

It was moved by Dr. Bintliff, seconded by Dr. Halford, and unanimously carried to approve the Regulated Industries Complaints Office ("RICO") Medical Advisory Committee list and the Addendum language – Effective January 1, 2016.

Scope:

a. Podiatrists Performing Ablation Therapy

The Board reviewed and discussed emails from Dr. Kuhn dated September 24, 2015, and September 25, 2015, regarding whether a Hawaii-licensed podiatrist may perform ablation therapy for varicose veins.

After due consideration of the information provided, the Board informally opined that a Hawaii-licensed podiatrist may provide services as defined in HRS §463E-1. HRS 463E-1 defines podiatric medicine as the "medical, surgical, mechanical, manipulative, and electrical diagnosis and treatment of the human foot, malleoli, and ankle, including the surgical treatment of the muscles and tendons of the leg governing the functions of the foot, but does not include amputation above the ankle, treatment of systemic conditions, or the use of any anesthetic except local anesthetic."

As such, ablation therapy may only be provided if it is for the purpose of treating the human foot, malleoli, and ankle, including the surgical treatment of the muscles and tendons of the leg governing the functions of the foot.

Lastly, in accordance with Hawaii Administrative Rules ("HAR") §16-201-90, the above interpretation is for informational and explanatory purposes only. It is not an official opinion or decision, and therefore is not be viewed as binding on the Board or the Department of Commerce and Consumer Affairs ("DCCA").

b. Inquiry from Board of Barbering and Cosmetology:

The Board considered the Hawaii Board of Barbering and Cosmetology's inquiry regarding:

1. High Intensity Focused Ultrasound Technology for Facial Treatment;
2. Fractional Radio Frequency Thermagic for Face Lift Treatment;
3. Vacuum Cavitation Cryolipolysis Slimming Machine; and
4. Ultrasonic or Microcurrent Technologies for Slimming and/or Spot Removal Purposes (no laser).

Specifically, the Board was asked to comment on whether the above procedures fall within practice of medicine as defined by HRS Chapter 453. In consideration of this request, the Board also considered an

Industry Bulletin issued by the California Board of Barbering and Cosmetology, which states that:

> If the machine produces any of the following, you are working out of your scope of practice:
>
> - Bleeding
> - Bruising
> - Edema
> - Inflammation
> - Oozing
> - Excoriation
> - Scabbing
> - Removal of skin below the epidermis
> - Piercing of skin
> - Heating or burning of the skin.

Dr. Halford stated, and members agreed, that the California Board of Barbering and Cosmetology's industry bulletin reflects a safe and prudent position.

Discussion followed. After due consideration of this information, the Board determined that it will not issue approvals of specific procedures or devices. However, it is the Board's informal opinion that anyone engaged in the practice of medicine, as defined by HRS §453-1, requires a medical or osteopathic medical license in the State. HRS §453-1 defines the practice of medicine as:

> For the purposes of this chapter the practice of medicine by a physician or an osteopathic physician includes the use of drugs and medicines, water, electricity, hypnotism, osteopathic medicine, or any means or method, or any agent, either tangible or intangible, for the treatment of disease in the human subject; provided that when a duly licensed physician or osteopathic physician pronounces a person affected with any disease hopeless and beyond recovery and gives a written certificate to that effect to the person affected or the person's attendant nothing herein shall forbid any person from giving or furnishing any remedial agent or measure when so requested by or on behalf of the affected person.
>
> This section shall not amend or repeal the law respecting the treatment of those affected with Hansen's disease.
>
> For purposes of this chapter, "osteopathic medicine" means the utilization of full methods of diagnosis and treatment in physical and mental health and disease, including the prescribing and administration of drugs and biologicals of all kinds, operative surgery, obstetrics, radiological, and other electromagnetic

emissions, and placing special emphasis on the interrelation of the neuro-musculoskeletal system to all other body systems, and the amelioration of disturbed structure-function relationships by the clinical application of the osteopathic diagnosis and therapeutic skills for the maintenance of health and treatment of disease.

Lastly, in accordance with HAR §16-201-90, the above interpretation is for informational and explanatory purposes only. It is not an official opinion or decision, and therefore is not to be viewed as binding on the Board or the DCCA.

Correspondence:

a. American College of Emergency Physicians: Anonymous Expert Physician Testimony for a State Medical Licensing Board / Anonymous Complaints

Executive Officer Quiogue informed members that the correspondence provided is for informational purposes only, and that she had also provided this information to RICO.

As the September 4, 2015 letter states, the American College of Emergency Physicians ("ACEP") recently adopted policy statements regarding "Anonymous Expert Physician Testimony for a State Medical Licensing Board" and "Anonymous Complaints to State Licensing Boards by Third Parties".

b. Inquiry from Amy Littlefield, Independent Journalist, Producer at Democracy Now!, regarding Hawaii Revised Statutes §453-18, Pelvic Examinations on Anesthetized or Unconscious Female Patients

The Board reviewed Ms. Littlefield's email dated September 30, 2015, regarding HRS §453-18. In particular, Ms. Littlefield inquired whether the Board would consider it a violation of HRS §453-18, if the patient "wouldn't necessarily be told specifically that a [medical] student would perform a pelvic exam, in addition to the [Hawaii-licensed physician, osteopathic physician, or surgeon's] exam, while the patient is under anesthesia."

Discussion followed. Dr. Egami expressed his concerns regarding this matter, and asked Executive Officer Quiogue why the Board is being asked to interpret this particular statutory section. Dr. Egami questioned whether there is an ongoing trial.

Chair Desai stated, and members agreed, that a patient must give informed consent for any procedure.

Correspondence: a. Email from Elisa Hester, MBA/HCM, Regarding Delegation of Medical Tasks: Allergy Testing Percutaneous / Allergy Testing Intradermal / Immunotherapy Mixing / Immunotherapy Injections / RAST (Blood Testing).

The Board reviewed and discussed Ms. Hester's email dated June 27, 2016, regarding the delegation of certain medical tasks to allergy technicians, including: allergy testing percutaneous; allergy testing intradermal; immunotherapy mixing; immunotherapy injections; and RAST (blood testing).

After due consideration of Ms. Hester's email, the Board informally opined that anyone engaged in the practice of medicine, as defined by HRS §453-1, requires a license in the state of Hawaii. HRS §453-1, defines the practice of medicine as:

> For the purposes of this chapter the practice of medicine by a physician or an osteopathic physician includes the use of drugs and medicines, water, electricity, hypnotism, osteopathic medicine, or any means or method, or any agent, either tangible or intangible, for the treatment of disease in the human subject; provided that when a duly licensed physician or osteopathic physician pronounces a person affected with any disease hopeless and beyond recovery and gives a written certificate to that effect to the person affected or the person's attendant nothing herein shall forbid any person from giving or furnishing any remedial agent or measure when so requested by or on behalf of the affected person.
>
> This section shall not amend or repeal the law respecting the treatment of those affected with Hansen's disease.
>
> For purposes of this chapter, "osteopathic medicine" means the utilization of full methods of diagnosis and treatment in physical and mental health and disease, including the prescribing and administration of drugs and biologicals of all kinds, operative surgery, obstetrics, radiological, and other electromagnetic emissions, and placing special emphasis on the interrelation of the neuromusculoskeletal system to all other body systems, and the amelioration of disturbed structure-function relationships by the clinical application of the osteopathic diagnosis and therapeutic skills for the maintenance of health and treatment of disease.

Discussion followed. The Board determined that the above medical tasks appear to fall within the definition of the practice of medicine. Furthermore, the Board informally opined that the delegation of such medical tasks shall only be delegated to those professions which are regulated by the State of Hawaii and whose scopes of practice allow that professional to perform such tasks.

Lastly, in accordance with HAR §16-201-90, the above interpretation is for informational and explanatory purposes only. It is not an official opinion or decision, and therefore is not to be viewed as binding on the Board or the Department of Commerce and Consumer Affairs.

b. Email from Angela Gagliardi, M.D., Regarding State Regulations on Writing Prescriptions/Orders for Biomedical Devices – Neuromuscular Electronic Stimulation.

The Board reviewed Ms. Gagliardi's email dated July 3, 2016, regarding State regulations on writing prescriptions/orders and who may provide the treatment for biomedical devices – neuromuscular electronic stimulation.

After due consideration of Ms. Gagliardi's email, the Board informally opined that anyone engaged in the practice of medicine, as defined by HRS §453-1, requires a license in the state of Hawaii. HRS §453-1, defines the practice of medicine as:

> For the purposes of this chapter the practice of medicine by a physician or an osteopathic physician includes the use of drugs and medicines, water, electricity, hypnotism, osteopathic medicine, or any means or method, or any agent, either tangible or intangible, for the treatment of disease in the human subject; provided that when a duly licensed physician or osteopathic physician pronounces a person affected with any disease hopeless and beyond recovery and gives a written certificate to that effect to the person affected or the person's attendant nothing herein shall forbid any person from giving or furnishing any remedial agent or measure when so requested by or on behalf of the affected person.
>
> This section shall not amend or repeal the law respecting the treatment of those affected with Hansen's disease.
>
> For purposes of this chapter, "osteopathic medicine" means the utilization of full methods of diagnosis and treatment in physical and mental health and disease, including the prescribing and administration of drugs and biologicals of all kinds, operative surgery, obstetrics, radiological, and other electromagnetic emissions, and placing special emphasis on the interrelation of the neuro-musculoskeletal system to all other body systems, and the amelioration of disturbed structure-function relationships by the clinical application of the osteopathic diagnosis and therapeutic skills for the maintenance of health and treatment of disease.

Discussion followed. The Board determined that the above medical task appears to fall within the definition of the practice of medicine. As such, a physician may write prescriptions or orders for this device and provide ~~the~~ treatment using such device. Furthermore, the Board informally opined that the delegation of such medical task shall only be delegated to those professions which are regulated by the State of Hawaii and whose scopes of practice allow that professional to perform such task.

Lastly, in accordance with HAR §16-201-90, the above interpretation is for informational and explanatory purposes only. It is not an official opinion or decision, and therefore is not to be viewed as binding on the Board or the Department of Commerce and Consumer Affairs.

Advisory Committees:

a. Physician Assistants

b. Emergency Medical Service Personnel

c. Podiatrists

Chairperson's Report: None.

Executive Officer's Report: None.

Next Meeting: Thursday, August 11, 2016
King Kalakaua Conference Room, First Floor
335 Merchant Street
Honolulu, HI 96813

Adjournment: It was moved by Dr. Egami, seconded by Mr. Puletasi, and unanimously carried to adjourn the meeting at 4:01 p.m.

Reviewed and approved by:

/s/Ahlani K. Quiogue
(Ms.) Ahlani K. Quiogue
Executive Officer

Taken and recorded by:

/s/Wilma Balon
Wilma Balon
Secretary

AKQ:wb
07/28/16

(X) Minutes approved as is.
( ) Minutes approved with changes; see minutes of _____.

increasing medical school and graduate medical education class sizes. She went on to say that there is proven data that physicians' remain where they complete their residency/fellowship training.

It was moved by Chair Desai, seconded by Dr. Halford and unanimously carried to request that the physician workforce assessment fee be repealed on June 30, 2017. Further, members stated that the comments above regarding the quality of the data and the focus of the study be relayed in the Board's testimony when the Legislature hears the bill(s).

Unfinished Business: a. Physician Workforce Assessment Report

This matter was deferred to the February 9, 2017 meeting.

b. Email Inquiries dated November 18, 2016 and December 29, 2016, from Michael Pasquale, D.O., Regarding the Use of Laser and Intense Pulse Light Devices (IPL)

The Board reviewed and discussed Dr. Pasquale's November 18, 2016 email; meeting minutes of the Board of Nursing, Board of Barbering and Cosmetology, and Medical Board; and letter from the American Association of Medical Assistants ("AAMA").

Discussion followed. Regarding Dr. Pasquale's specific questions, the Board provided the following responses:

1. *A completely unlicensed individual does LASER or IPL treatments with no physician supervisor.*

Unlicensed individuals shall not use lasers or IPL treatments to cut, shape, burn, vaporize or otherwise structurally alter human tissue, whether delegated or not.

2. *A completely unlicensed individual does LASER or IPL treatments with a physician supervisor, but not in house but in some communication.*

See response to question 1.

3. *A completely unlicensed individual does LASER or IPL treatments with a physician supervisor as in house medical director.*

See response to question 1.

4. *A license nurse performs a laser/IPL treatment with no supervision on their own.*

Licensed nurses may use lasers and other similar devices to cut, shape, burn, or otherwise structurally alter human tissue provided their practice act (HRS Chapter 457) allows them to

perform such tasks, and such tasks are delegated and under the direction of a physician. Further, the supervision and delegation of such tasks and/or treatments by the physician must ensure the safety of the patient and must also adhere to the generally accepted principles of professionalism as set forth in the AMA's Code of Medical Ethics and the AOA's Code of Ethics.

5. *A license nurse performs a laser/IPL treatment with a medical director on paper only but does not show evidence of supervision.*

See response to question 4.

6. *A license nurse performs a laser/IPL treatment with a medical director who is out of house supervisor.*

See response to question 4.

7. *A license nurse performs a laser/IPL treatment with an in-house medical director supervisor.*

See response to question 4.

Members recommended that any cases of suspected violations should be referred to the Regulated Industries Complaints Office for investigation.

With regard to the letter from the AAMA, the AAMA's interpretation of Hawaii law, specifically Hawaii Revised Statutes § 453-5.3, is incorrect. This statutory section applies to physician assistants only, and not medical assistants. Therefore, physician assistants are a regulated profession in this State, and must meet specific requirements in order to be issued a license by the Board. The Board noted that Mr. Balasa's letter reflects a significant misunderstanding of the role of medical assistants in Hawaii. As opposed to physician assistants, medical assistants are not regulated in Hawaii and have considerably less qualifications and, accordingly, less authority to perform certain tasks.

Discussion followed. After due consideration of the information received, it was moved by Chair Desai, seconded by Dr. Geimer-Flanders, and unanimously carried to affirm its informal opinion of August 2014, and determined that it will assess situations based on their individual characteristics.

Lastly, in accordance with Hawaii Admin. Rule § 16-201-90, the above interpretation is for informational and explanatory purposes only. It is not an official opinion or decision, and therefore is not to be viewed as binding on the Medical Board or the Dept. of Commerce and Consumer Affairs.

to nonpayment of fees, retirement, or change to initial inactive status), or otherwise.'

45 CFR §60.9(a)(3) mandates States to report, to the NPDB, 'any other loss of the license of the health care practitioner, physician, dentist, or entity, whether by operation of law, voluntary surrender (excluding those due to non-payment of licensure renewal fees, retirement, or change to inactive status), or otherwise.' Contrary to 45 CFR §61.7(a)(2), there is no specific to a loss of the right to apply for a license.

(iv) Request for Sponsorship to Retake United States Medical Licensure Examination (USMLE) Step 3:

a) Bassam Jwaida, M.D.

The Board reviewed Dr. Jwaida's letter dated April 18, 2017, requesting that it sponsor him to retake the United States Medical Licensure Examination ("USMLE") Step 3 because he has reached the maximum examination attempts.

The Board noted that it has only sponsored an applicant to retake any Step or Step Component of the USMLE if that Step or Step Component was previously passed and exceeds this jurisdiction's previously established time limit for completion of all Steps of the USMLE, and has met all other license requirements in place (i.e. graduation from medical school, completion of at least two years of accredited graduate medical education for foreign medical school graduates, etc.).

After due consideration of the information received, it was moved by Chair Desai, seconded by Dr. Bintliff, and unanimously carried to deny Dr. Jwaida's request because, although the Board has repealed its 7-year time limit, it appears that he has not met all other license requirements in place to obtain a medical license in this jurisdiction.

Correspondence:

a. Email dated April 27, 2017, from Leah Tinney, Esq., Quarles & Brady, LLP, regarding whether a physician may delegate their duty to order and/or receive prescription drugs from a pharmacy wholesaler

The Board reviewed Ms. Tinney's email dated April 27, 2017, regarding whether a physician may delegate their duty to order and/or receive prescription drugs from a pharmacy wholesaler pursuant to Hawaii Administrative Rules ("HAR") §16-85-49.1.

The Board discussed, HAR §16-85-49.1, which states:

(a) A physician assistant shall be considered the agents of the physician assistant's supervising physician in the performance of all practice-related activities as established in writing by the employer.

(b) Medical services rendered by the physician assistants may include, but are not limited to:
(2) **Ordering**, interpreting, or performing diagnostic and therapeutic procedures.

Chair Desai stated the term "ordering" as referred to in HAR §16-85-49.1, refers to ordering diagnostic or therapeutic procedures for a specific patient in the context of a provider-patient relationship, and not ordering and/or receiving prescription drugs from a pharmacy wholesaler as Ms. Tinney suggests in her email.

Given the above discussion, it was moved by Chair Desai, seconded by Dr. Geimer-Flanders, and unanimously carried to advised Ms. Tinney of the Board's discussion above.

In accordance with HAR §16-201-90, the above interpretation is for informational and explanatory purposes only. It is not an official opinion or decision, and therefore is not to be viewed as binding on the Board or the Department of Commerce and Consumer Affairs ("DCCA").

b. Email dated April 26, 2017, from the Board of Optometry, regarding whether ophthalmic technicians may perform procedures using a Picosure Laser

The Board reviewed an email dated April 26, 2017 from the Board of Optometry, regarding whether ophthalmic technicians may perform procedures using a Picosure Laser.

Discussion followed. The Board determined that it will not issue approvals of specific procedures or devices. However, it is the Board's informal opinion that anyone engaged in the practice of medicine as defined by HRS §453-1, requires a medical license or an osteopathic medical license in the State. HRS §453-1, states:

> For the purposes of this chapter the practice of medicine by a physician or an osteopathic physician includes the use of drugs and medicines, water, electricity, hypnotism, osteopathic medicine, or any means or method, or any agent, either tangible or intangible, for the treatment of disease in the human subject; provided that when a duly licensed physician or osteopathic physician pronounces a person affected with any disease hopeless and beyond recovery and gives a written certificate to that effect to the person affected or the person's attendant nothing herein

shall forbid any person from giving or furnishing any remedial agent or measure when so requested by or on behalf of the affected person.

This section shall not amend or repeal the law respecting the treatment of those affected with Hansen's disease.

For purposes of this chapter, "osteopathic medicine" means the utilization of full methods of diagnosis and treatment in physical and mental health and disease, including the prescribing and administration of drugs and biologicals of all kinds, operative surgery, obstetrics, radiological, and other electromagnetic emissions, and placing special emphasis on the interrelation of the neuro-musculoskeletal system to all other body systems, and the amelioration of disturbed structure-function relationships by the clinical application of the osteopathic diagnosis and therapeutic skills for the maintenance of health and treatment of disease.

Further, the Board recommends that the inquirer of the initial email submitted to the Board of Optometry obtain legal counsel to ensure that they are adhering to all federal and state laws.

In accordance with HAR §16-201-90, the above interpretation is for informational and explanatory purposes only. It is not an official opinion or decision, and therefore is not to be viewed as binding on the Board or the DCCA.

Legislation: (i) HB 428, HD 1, SD 1, CD 1 Relating to Physician Workforce Assessment

The Board discussed the above bill.

The purpose of the bill is to allow the John A. Burns School of Medicine ("JABSOM") to continue to receive a portion of the physician workforce assessment fee for ongoing physician workforce assessment and planning to support the recruitment and retention of physicians in the State, particularly those in rural and medically underserved areas.

Executive Officer Quiogue informed the Board that the bill was passed with a permanent assessment fee, deleting the existing assessment fee repeal date of June 30, 2017.

Discussion followed. The Board noted that since 2010, Hawaii physicians have been assessed $2,025,600.00. Members noted that these monies have been used by JABSOM to fund, among other things, an annual Workforce Summit.

Members expressed the same concerns that they have provided throughout the legislative session, including:

UPDATE REGARDING IMPLEMENTATION OF THE IMLCC

From 20 to 22 August, Interstate Medical Licensure Compact Commission (IMLCC) Operations Manager Dave Clark provided in-person training to nine DCCA PVL staff members involved with medical board work and support.

August 20:

Mr. Clark introduced the IMLCC's mission of providing streamlined and expedited licensure for a population of specialty board certified physicians with no current or pending disciplinary actions and no significant criminal background history. Currently there are 40 states and Guam participating. Many physicians seeking compact licensure are operating in telemedicine roles or are providing medical services to neighboring state rural communities where specializations or services are more limited.

Mr. Clark clarified that the IMLCC "as a governmental instrumentality, is a middleman, a business office, and is not concerned with the qualitative aspects of applications." These qualitative aspects remain the responsibility of state medical boards. Furthermore, he added that the medical compact differs from the nursing compact, because in the IMLC each state issues the licenses and has the authority to take disciplinary action. Conversely, nursing compact licenses would behave more similarly to drivers' licenses, where providers can move around to practice more freely, with little direct recourse for enforcement of sanctions.

Mr. Clark then gave a visual overview of the IMLCC's internal working interface through Microsoft Dynamics. He demonstrated how to navigate through their interface and key data sets of relevance for application processing such as the application and letter of qualification (LOQ). He then created test accounts for each PVL participant to practice navigating, while he walked around to troubleshoot and answer questions.

August 21:

Mr. Clark discussed the renewal process. Processes vary from state to state, for example the time allowed to complete a late renewal after a license expires varies broadly. For this reason, IMLCC staff must manually edit renewal options, timeframes, and fees.

Test accounts were generated for participants to review renewal applications. Mr. Clark guided applications through the user interface to identify relevant data fields. Staff practiced finding information and signing off on application approved for renewal.

August 22:

IT Manager Matt Robison and Controller Keyla Blanco presented virtually on their respective areas of expertise.

Mr. Robison discussed the application programming interface (API) and system and security compatibility requirements with David Shak and Charlene Oshiro. Mr. Shak asked if there would be compatibility or login issues with Microsoft Azure. Mr. Robison said that there would not be

issues, and that he would be willing to meet again with our IT personnel and Salesforce vendor separately to continue the working dialogue to ensure database connectivity and assist in the dataflow setup.

Ms. Blanco presented the remittance process to participants. Physician applicants complete their payment process directly through the IMLCC via ACH or credit card. The IMLCC remittance week spans from Friday to Thursday of the subsequent week, and these remittances are sent to the boards via email every Friday afternoon. The IMLCC fiscal year spans from July 1st to June 30th. Adjustments can be made with member board authorization for duplicate renewals, ineligible LOQ's, etc. Adjustments are made to the following week's remit. For return of funds, the Operations Manager will email the state board with options to keep the fee, return directly to applicant, or authorize the IMLCC to return the fee to applicant.

The IMLCC training concluded, and we thanked Dave Clark for traveling to personally train our PVL staff.

ADVISORY COMMISSION ON ADDITIONAL LICENSING MODELS

Advisory Commission on Additional Licensing Models Releases Draft Preliminary Recommendations for Public Comment

Public comment period runs through December 6

WASHINGTON, D.C.- The Advisory Commission on Additional Licensing Models has released draft preliminary recommendations for public comment. The recommendations, once finalized, are intended for state medical boards, state legislators, policymakers and interested stakeholders to help inform those jurisdictions interested in developing or modifying additional licensing pathways for physicians who have completed training internationally.

The draft guidance with preliminary recommendations is available for viewing **here**.

The Advisory Commission encourages interested parties to **submit comments about the draft recommendations through December 6, 2024 at the survey link here**.

The Advisory Commission compiled the draft preliminary recommendations in response to a growing number of U.S. state and territorial legislatures interested in modifying traditional post-graduate training requirements for medical licensure of physicians who have completed training internationally by eliminating the traditional requirement for completion of ACGME-accredited graduate medical education (GME) in the U.S. The draft preliminary recommendations, outlined in nine specific areas and largely focused

alignment of existing and future policies and statutes.

Upon completion of the public comment period, the Advisory Commission will review the feedback and comments received and release its preliminary guidance for formal consideration in early 2025.

Additional recommendations from the Advisory Commission, which will be essential to supplement the initial recommendations being shared today for feedback, are anticipated later in 2025 to address other important areas, such as the criteria or assurances that should be required for a physician to transition from provisional to full and unrestricted licensure.

About the Advisory Commission on Additional Licensing Models

The Advisory Commission on Additional Licensing Models was established in December 2023 by the Federation of State Medical Boards (FSMB), Intealth™, and the Accreditation Council for Graduate Medical Education (ACGME). The Advisory Commission was principally formed to provide guidance about additional pathways for the state licensure of physicians who have completed training and practiced outside of the United States.

About FSMB

The Federation of State Medical Boards (FSMB) is a national non-profit organization representing the medical boards within the United States and its territories that license and discipline allopathic and osteopathic physicians and, in some jurisdictions, other health care professionals. The FSMB serves as the voice for state medical boards, supporting them through education, assessment, research and advocacy while providing services and initiatives that promote patient safety, quality health care and regulatory best practices. The FSMB serves the public through Docinfo.org, a free physician search tool which provides background information on the more than 1 million doctors in the United States. To learn more about the FSMB, visit **www.fsmb.org**.

About Intealth

Intealth is a private, nonprofit organization that brings together the expertise and resources for advancing quality in health care education worldwide in order to improve health care for all. Through strategic integration of its divisions, ECFMG® and

verify their qualifications required to practice, and inform the development of health workforce policies around the world. By leveraging these combined competencies, Intealth powers innovation in areas critical to the health professions. Learn more at **www.intealth.org**.

About ACGME

The Accreditation Council for Graduate Medical Education (**ACGME**) is an independent, 501(c)(3), not-for-profit organization that sets and monitors voluntary professional educational standards essential in preparing physicians to deliver safe, high-quality medical care to all Americans. Graduate medical education (GME) refers to the period of education in a particular specialty (residency) or subspecialty (fellowship) following medical school; the ACGME oversees the accreditation of residency and fellowship programs in the US.

Advisory Commission on Additional Licensing Models
DRAFT GUIDANCE DOCUMENT

There are currently two primary pathways by which internationally trained physicians may become eligible for medical licensure from a state medical board in the United States and its territories:

1. Completion of one to three years, depending on the state or territory,[1] of U.S.-based graduate medical education (GME) accredited by the Accreditation Council for Graduate Medical Education (ACGME), accompanied by certification by ECFMG®, a division of Intealth™, and successful passage of all three Steps of the United States Medical Licensing Examination® (USMLE®), is the most common current pathway to medical licensure for international medical graduates (IMGs) in the United States. In addition to expanding a physician's knowledge and skills in one or more medical or surgical specialties, U.S.-based GME affords time for participants to acclimate to the U.S. health care system, culture and social norms, and the medical illnesses and conditions that are most prevalent (e.g., heart disease, cancer, accidents) among those residing in the United States.
2. "Eminence" pathways (usually sought by prominent mid-career physicians from abroad) have long existed in many states and typically do not require ECFMG Certification or successful passage of any Step of the USMLE. It is likely that such pathways will continue to be an option for highly qualified and fully trained internationally trained physicians. These pathways are most often used for those deemed to have "extraordinary ability," and include "eminent specialist" or "university faculty" pathways for physicians pursuing academic or research activities, and they typically align with the O-1 (extraordinary ability) visa issued by the U.S. State Department.[2] Of note, most state medical boards also have existing statutes or regulations allowing the licensing of IMGs at their discretion, though in practice these are not easy to achieve or available commonly. A few medical boards explicitly allow postgraduate training (PGT) – also known as postgraduate medical education (PGME) – outside of the United States or Canada, from countries such as England, Scotland, Ireland, Australia, New Zealand and the Philippines.

Beginning in 2023, eight (8) states have enacted legislation creating additional licensing pathways for internationally trained physicians that does <u>not</u> require completion of ACGME-accredited GME training in the United States.

[1] International Medical Graduates GME Requirements, Board-by-Board Overview, FSMB
[2] https://www.uscis.gov/working-in-the-united-states/temporary-workers/o-1-visa-individuals-with-extraordinary-ability-or-achievement

These newly established additional licensing pathways are designed principally for internationally-trained and internationally-practicing physicians who wish to enter the U.S. health care workforce. A primary goal of these pathways in many jurisdictions, according to testimony and statements by sponsors and supporters, is to address U.S. health care workforce shortages, especially in rural and underserved areas.

It must be noted that U.S. federal immigration and visa requirements will impact the practical ability of those who are not U.S. citizens or permanent U.S. residents (green card holders) to utilize any additional pathway. Additionally, the ubiquity of specialty-board certification as a key factor in employment and privileging decisions is likely to impact the efficacy of non-traditional licensing pathways. States may, therefore, wish to consider other health care workforce levers, such as advocating for increased state and Medicare/Medicaid funding to expand U.S. GME training slots, offering some means of transition assistance to IMGs, and expanding the availability and utilization of enduring immigration programs like the Conrad 30 waiver program, Health and Human Services (HHS) waivers, regional commission waivers, and the United States Citizenship and Immigration Service (USCIS) Physician National Interest Waiver.

While the additional pathway legislation introduced and enacted since 2023 varies from state to state, this consensus-based guidance highlights areas of similarities among them and suggests considerations and resources related to each, where such may exist. Areas of concordance among most, if not all, state laws advancing additional licensure pathways – as addressed in more detail later in this document – include the following:

1. **Rulemaking authority should be delegated, and resources allocated, to the state medical board for implementing additional licensure pathways**
2. **An offer of employment prior to application for an additional pathway**
3. **ECFMG Certification and graduation from a recognized medical school**
4. **Completion of post-graduate training (PGT) outside the United States**
5. **Possession of a license/registration/authorization to practice medicine in another country or jurisdiction and medical practice experience**
6. **A limit on "time out of practice" before becoming eligible to apply for an additional pathway**
7. **A requirement for a period of temporary provisional licensure prior to eligibility to apply for a full and unrestricted license to practice medicine**
8. **Eligibility for a full and unrestricted license to practice medicine**
9. **Standard data collection requirements**

The Advisory Commission on Additional Licensing Models, established in December 2023 and convened on four separate occasions in 2024, would like to offer the following set of initial recommendations for consideration by state medical boards, state legislators, policymakers, and other relevant stakeholders, specific to the above nine areas of concordance. The purpose of these recommendations is to support alignment of policies, regulations and statutes, where possible, and to add clarity and specificity to statutory and

procedural language to better protect the public – the principal mission of all state medical boards – and to advance the delivery of quality health care to all citizens and residents of the United States.

These initial recommendations focus on eligibility requirements and related considerations for entry into an additional licensure pathway. To ensure that physicians entering these pathways are prepared to safely practice in the United States, these pathways should optimally include assessment and supervisory components for which additional guidance is under development by the advisory commission and will be forthcoming in 2025.

1. **Rulemaking authority should be delegated, and resources allocated, to the state medical board for implementing additional licensure pathways.**

Many states that have enacted additional pathway legislation have explicitly included state medical boards in the implementation process to assure the ability of the state to support safe medical practice.

Additional licensure pathways will likely incur increased processes, time and resources for state medical boards. State legislatures should consider additional funding and resources that may need to be allocated through state appropriations to fully implement, operationalize, and evaluate an additional new pathway for medical licensure.

States evaluating how to proceed may wish to consider first authorizing their state medical boards to establish a smaller pilot program with primary care specialties that typically require a shorter period of post-graduate training, which may be more comparable internationally, and which may serve to increase access to care in rural and underserved areas. This may enable state medical boards and private partners to build the necessary infrastructure and trust for adoption of additional licensure pathways and evaluate the programs before a substantial increase in applicants or expansion to other specialties is welcomed.

***Recommendation 1a*: States should empower their medical boards to promulgate rules and regulations should they choose to enact additional licensure pathway requirements for qualified, internationally trained physicians.**

***Recommendation 1b:* State legislatures should ensure state medical boards have the necessary resources to fully implement, operationalize, and evaluate any new, additional licensure pathways including the ability to hire or assign staff with knowledge and understanding of licensing international medical graduates.**

2. An offer of employment prior to application for an additional pathway.

Internationally trained physicians applying for a license to practice medicine under these new additional licensure pathways have typically required in statute to have an offer of employment from a medical facility that can assure supervision and assessment of the IMG's proficiency. All states that have enacted additional pathway legislation at the time of this document's publication have included such a requirement, whether it is employment with an associated ACGME-accredited program, a Federally Qualified Health Center (FQHC), a Community Health Center (CHC), a Rural Health Clinic (RHC), or other state-licensed medical facility that has capacity and experience with medical education and assessment. The employer should be an entity with sufficient infrastructure that allows for supportive education and training resources for the IMG, as well as supervisory and assessment resources, including peer-review.

Recommendation 2a: **States should require internationally trained physicians applying under an additional licensure pathway to have an offer of employment from a medical facility, as defined by the state medical board.**

Recommendation 2b: **State medical boards should have the authority to determine which medical facilities are able to supervise and assess the IMG's proficiency and capabilities (e.g., an ACGME-accredited program, an FQHC, a CHC, an RHC or other state-licensed medical facility that has capacity and experience with medical education and assessment).**

3. ECFMG Certification and graduation from a recognized medical school.

Internationally trained physicians applying under an additional licensure pathway should be graduates of a recognized medical school. All states that have enacted pathway legislation at the time of this document's publication have included this requirement.

Recognition or inclusion in directories from organizations such as the World Health Organization (WHO) or the *World Directory of Medical Schools* (*World Directory*)[3] may serve as a helpful proxy for this requirement. The latter directory is the product of a collaboration between the World Federation for Medical Education (WFME) and FAIMER®, a division of Intealth.

Traditionally, IMGs have been required to obtain ECFMG Certification, a qualification that includes verification of their graduation from a *World Directory* recognized medical school, passage of USMLE Steps 1 and 2, and demonstration of English language proficiency via the Occupational English Test (OET) Medicine.

[3] https://www.wdoms.org/

Recommendation 3: **States should require ECFMG Certification for internationally trained physicians to enter an additional licensure pathway.**

State medical boards may also wish to require IMGs to provide additional supporting materials of the medical education they have undertaken outside the United States. In such instances, primary source verification and review of credentials that utilizes resources such as Intealth's Electronic Portfolio of International Credentials (EPIC℠)[4] may be useful.

4. Completion of post-graduate training (PGT) outside the United States.

States that have introduced or enacted additional pathway legislation have generally included a requirement that applicants should have completed PGT that is "substantially similar" to a residency program accredited by the ACGME in the United States.

There is significant variability, however, in the structure and quality of international PGT. The degree of clinical exposure may be uncertain and inconsistent across programs. Too, there is not currently an established and accepted accreditation system or authority that is able to deem international PGT programs to be "substantially similar" to ACGME-accredited PGT programs available in the United States, nor do many state medical boards have the capacity, resources, or expertise to assess international programs for this purpose on their own. Until such a formal accreditation system exists, the term "substantially similar" may need to be defined and determined by the state medical board.[5] Arriving at definitions and determinations of substantial similarity will have significant implications for state medical boards to plan for and obtain additional resources and support, and expertise to evaluate international training programs that have significant variability in structure, content and quality.

Recommendation 4a: **Completion of formal, accredited PGT outside the United States should be a requirement for entry into an additional licensure pathway.**

Formal postgraduate training and accreditation is not available in all countries and jurisdictions. In its absence, medical boards may be inclined to consider alternative forms of training on a case-by-case basis. These circumstances and experiences – including apprenticeship, clerkship, or observership models – may differ widely in objective measures of quality that do not involve fellowship training or involve quasi-residency arrangements that may or may not support an international physician's education and experience for additional pathway eligibility.

[4] https://www.ecfmg.org/psv/

[5] Development of a program for recognition of international systems of accreditation of PGT is currently being led by the Word Federation for Medical Education, with anticipated launch in mid-2025.

Recommendation 4b: **State medical boards may make use of a variety of existing proxies for determining that a PGT program completed outside the United States is "substantively similar" for purposes of additional licensure pathway eligibility for internationally trained physicians, including whether the IMG's program has been accredited by ACGME International (ACGME-I) and/or whether the IMG has completed an ACGME-accredited fellowship training program in the United States. Boards may also wish to ask the IMG to produce their training program's curriculum (and case requirements, for surgical specialties) for review.**

A "number of years in-practice" threshold in a given specialty in place of formal PGT may also be used on a case-by-case basis by the state medical board as an alternative metric, as long as it also includes additional requirements, such as ECFMG Certification and passage of all three Steps of the USMLE program. Where boards have access to, or can partner with, organizations with relevant experience and expertise, they may seek to determine the nature of such practice, including degree of clinical exposure, interaction with patients and performance of procedures; where applicable, this information is likely to be valuable in making determinations of competency and practice readiness.

5. **Possession of a license/registration/authorization to practice medicine in another country or jurisdiction and medical practice experience.**

Most states that have enacted additional pathway legislation have included a requirement that applicants be licensed or authorized to practice medicine in another country. Practice experience requirements in current statutes vary from three to five years. Additional pathway legislation commonly also includes a requirement that the license obtained overseas be "in good standing" and that attempt be made to verify the physician's discipline and criminal background history. State medical boards should consider primary source verification of any documentation from applicants related to licensure, employment and practice history.

Recommendation 5: **States should require internationally trained physicians applying for a license under an additional licensure pathway to be fully licensed, registered, or authorized to practice medicine in another country or jurisdiction and to provide evidence of medical practice experience of at least three years.**

6. **A limit on "time out of practice" before becoming eligible to apply for an additional licensure pathway.**

An international physician's time out of active practice before applying for an additional licensing pathway is typically and explicitly limited in currently enacted legislation, in line with extant guidelines required for medical licensure renewal of most physicians licensed in the United States. Time out of practice is a major challenge and concern for state medical boards in terms of assuring patient safety and public protection, regardless of where the training or initial licensure occurred, given that the practice of medicine changes

so rapidly. Many state medical boards, and this is often included in their respective Medical Practice Acts, already recommend a formal re-entry process when a licensed physician has been out of practice for more than a certain number of years (the most often cited period of time in most statutes is two years).[6]

Recommendation 6: **States should consider limits on time out of practice for physicians entering additional licensing pathways that are consistent with re-entry to practice guidelines for other physician applicants within their jurisdiction.**

States that have enacted additional licensing pathway legislation have listed varying ranges for the number of years of IMG practice, from continuous practice preceding application to within the preceding five years. States should be cognizant that requiring continuous practice may be difficult for many applicants to manage and/or demonstrate, especially if they have to navigate the U.S. immigration system, adjust to displacement, or face any number of non-immigration barriers faced by domestic physicians that require time away from active practice, including, but not limited to, sickness, caregiving or raising children.

7. **A requirement for a period of temporary provisional licensure prior to eligibility to apply for a full and unrestricted license to practice medicine.**

All states that have enacted additional pathway legislation as of the date of publication of this guidance have explicitly included a provision that applicants for additional pathways to a full and unrestricted medical license first begin with a temporary provisional license to practice medicine.

"Supervision" is mentioned as a part of this provision by some states in their enacted legislation. For example, a few states have enacted legislation that allows internationally trained physicians to practice under the "supervision of a licensed physician for two years" as part of their pathway. Supervision and support for internationally trained physicians are crucial to navigate and bridge cultural and boundary differences, and to enable qualified internationally trained physicians to learn the technical and operational side of the U.S. health care system, including the process of billing and the use of electronic health records. Such supervision and support are also essential for public protection. Examples of supervisory structures that could be helpful include a collaborative practice arrangement, preceptorships and/or more formalized training models that include opportunities for progressive assessment of the international physician's caseload and practice. States may also choose to require a "declaration of fitness" made by supervising physicians or verification of compliance with a state's continuing medical education (CME) requirements in order to progress to full and unrestricted licensure.[7]

[6] board-requirements-on-re-entry-to-practice.pdf (fsmb.org)
[7] Continuing Medical Education, Board-by-Board Overview, FSMB

The Advisory Commission on Additional Licensing Models is exploring resources available to assist state medical boards with the potential structure of an assessment program and provisional supervised licensure, and anticipates proposing recommendations on this matter sometime in 2025.

***Recommendation 7a*: States should require a period of temporary provisional licensure for qualified internationally trained physicians under an additional licensure pathway before they become eligible to apply for a full and unrestricted license.**

***Recommendation 7b*: During their period of temporary provisional licensure, applicants should be supervised by licensed physicians within the same specialty as the applicant's intended practice.**

***Recommendation 7c*: During this period of temporary provisional licensure, applicants should receive progressive assessment (as defined by the state medical boards and suggested in this section) and adequate support by the employer to help the international physician navigate and bridge cultural and boundary differences, including understanding billing, coding and electronic health records.**

States have taken a variety of approaches in specifying the duration of provisional licensure, with two or three years being the most common time periods cited in legislation. However, there have been some legislative proposals for a two-step progression, by which an IMG first becomes eligible for a restricted or limited license after at least two years of provisional licensure, but still practices in areas or specialties with the greatest medical need, with or without ongoing supervision; provisional, restricted, and limited licensees under this arrangement are *required* in order to practice at these facilities for the entire duration of their time prior to full licensure.

8. Eligibility for a full and unrestricted license to practice medicine.

All states that have enacted additional pathway legislation have included a provision that at the conclusion of the provisional or restricted licensure period, the qualified international physician should become eligible to apply for a full and unrestricted license to practice medicine. There is a small but meaningful linguistic divergence in enacted legislation thus far, however, with wording indicating that state medical boards *may* or *shall* grant a full and unrestricted license to the IMG applicant.

State medical boards ordinarily and typically retain the authority to make licensure decisions for all licensees, even after a period of provisional licensure. Automatic transition to full and unrestricted licensure, by contrast, is neither ordinary nor typical. State medical boards may wish to consider working with their legislatures to retain the ability to exercise their due diligence and assess each applicant on their merits before determining whether they meet the state's criteria for full licensure.

States may also consider explicit requirements for provisional licensees before being granted eligibility for full licensure, such as passing USMLE Step 3 (already a requirement for all other IMGs for licensure), passing the employer's (or facility's) assessment and evaluation program, and having neither any disciplinary actions nor investigations pending over the course of their provisional licensure. Most states that have enacted pathway legislation have required a combination of these steps and there have been some proposals to include a letter of recommendation from the applicant's supervising physician as well.

***Recommendation 8a*: State medical boards in states that have enacted legislation to create additional licensing pathways for internationally trained physicians should work with their legislatures, where permitted, to retain their historic and statutory ability to exercise their due diligence and assess each applicant on their merits before they progress from provisional to full and unrestricted licensure.**

***Recommendation 8b:* State medical boards should add a requirement for passing USMLE Step 3 (as already required of all IMGs) for a full and unrestricted license and a proviso that the applicant not have any disciplinary actions or investigations pending from their provisional licensure period.**

9. Standard data collection requirements.

Data collection and dissemination is critical for state medical boards, state legislators, and state medical boards to better understand the impact of these types of additional licensure pathways. Significant questions remain about the efficacy of these additional pathways to address U.S. health care workforce shortages. Much of the legislation introduced thus far does not address what will likely be significant barriers to employment and the ability to practice with a full license in many states. These questions include whether physicians entering a pathway will be eligible for board certification, whether malpractice insurers will cover their practice, and whether payors will reimburse for the services provided by these physicians.

***Recommendation 9*: State medical boards, assisted by partner organizations as may be necessary, should collect information that will facilitate evaluation of these additional licensure pathways to make sure they are meeting their intended purpose. This information should include:**

- **the number of applicants**
- **the number of internationally trained physicians receiving provisional licensure under the pathway and the number denied provisional licensure under the pathway**
- **the number of individuals achieving full and unrestricted licensure,**
- **the percentage of individuals that stay and practice in their specialty of training and in rural or underserved areas**

- **the number of complaints received and disciplinary actions taken (if any)**
- **the practice setting and specialty of applicants**
- **the number of IMGs licensed through additional licensure pathways who ultimately remain in the United States versus returning to their home countries**
- **the number of individuals achieving specialty board certification**
- **the costs to the board of operating an additional licensing pathway**

5.C.(ii) FSMB: Policy on Physician Illness and Impairment

Agenda Item 5.C.(ii), Federation of State Medical Boards, Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health.

The Board will consider the Policy and whether it will amend its questions on its initial and renewal applications regarding addiction, habituation, etc. The Board's application currently asks:

> In the past five years, have you been addicted to, dependent on, or a habitual user of alcohol or a narcotic, barbiturate, amphetamine, hallucinogen, or other drug having similar effects?

For your consideration of this matter are the following documents:

1. 7/14/22 HMB Open Session Meeting Minutes (pages 6 - 11);
2. 11/10/22 HMB Open Session Meeting Minutes (pages 4 and 5);
3. Federation of State Medical Boards, Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health;
4. Board Examples of Questions;
5. Pu`ulu Lapa`au Brochure;
6. Claire Zilber, MD, Safe Haven Article;
7. A Toolkit for State Medical Boards;
8. American College of Emergency Physicians Joint Statement; and
9. APA Position Statement.

After due consideration of the information received, it was moved by Dr. Takanishi, seconded by Dr. Egami, and unanimously carried to approve Dr. Feeney's application.

b. Mark M. Fukuda, M.D.

After due consideration of the information received, it was moved by Dr. Egami, seconded by Chair Geimer-Flanders, and unanimously carried to approve Dr. Fukuda's application.

B. Request to have Conditions Removed from Conditional License:

(i) Physician:

a. John Ellis, M.D.

After due consideration of the information received, it was moved by Dr. Jaffe, seconded by Mr. Belcher, and carried by a majority, with the exception of Chair Geimer-Flanders who recused herself from discussion and vote on this matter, to approve Dr. Ellis's request to have the conditions removed from his conditional license.

C. Ratifications List (See attached list)

(i) List

It was moved by Chair Geimer-Flanders, seconded by Dr. Egami, and unanimously carried to ratify the attached list of individuals for licensure or certification.

Federation of State Medical Boards, Inc. (FSMB):

Chair Geimer-Flanders asked if any members of the public wished to provide oral testimony at this time. There were none.

a. Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health (Policy).

The Board considered the FSMB's Policy and other materials to determine whether it will amend its questions on its initial and renewal applications regarding addiction, dependency, or habituation to alcohol and other substances.

For members and guest's information, Chair Geimer-Flanders referred to the Board's initial application question, which asks:

> In the past 5 years, have you been addicted to, dependent on, or a habitual user of alcohol or of a narcotic, barbiturate, amphetamine, hallucinogen, or other drug having similar effect?

The Board's renewal application asks a similar question. These types of questions require physicians to disclose personal health information on their applications to practice medicine in this State.

Chair Geimer-Flanders introduced the matter by reminding members and guests of Lorna Breen, M.D., an emergency room physician in New York, who was unwilling to seek mental health treatment for fear that she would have to disclose it to the New York Board of Medicine; potentially jeopardizing her ability to practice medicine. Dr. Breen died by suicide.

Chair Geimer-Flanders informed the Board that the Lorna Breen Health Care Provider Protection Act was signed into law, which provides federal funding for mental health education and awareness aimed at protecting the well-being of health care workers.

The FSMB initially encouraged boards to adopt an attestation that covered physical and mental health questions.

Chair Geimer-Flanders reminded the Board that it had previously considered amending its questions regarding habituation and addiction, but at that time, it could not circumvent the fact that a "YES" answer would be required by the applicant. Based on the FSMB's Policy and support by several other organizations, there is now a movement to support physicians by destigmatizing the questions posed on board applications.

Dr. Jaffe stressed the importance of this discussion underlining that substance abuse is one of the primary reasons that physicians lose their license. He emphasized the importance of updating the Board's applications, both initial and renewal applications. It is also important to offer clinicians treatment programs, but also balancing that with appropriate action by the Board if they are unfit to treat patients.

The guest speakers were introduced as follows:

- Esther Brown, Complaints and Enforcement Officer, Regulated Industries Complaints Office ("RICO")
- John Hassler, Supervising Attorney, RICO
- Mark Staz, Consultant Medical Regulation and International Collaboration, FSMB
- Theodore Sakai, Executive Director, Pu`ulu Lapa`au, Hawaii Program for Healthcare Professionals
- Kristopher Bjornson, M.D., Medical Director, Pu`ulu Lapa`au

Esther Brown and John Hassler were promoted to panelists at

2:21 p.m.

Mark Staz was promoted to a panelist at 2:22 p.m.

Theodore Sakai and Kris Bjornson were promoted to panelists at 2:25 p.m.

Ms. Brown introduced herself and Mr. Hassler. Ms. Brown stated that providing clarity to the Board's questions is important to avoid confusion.

Mr. Hassler stated that questions on the initial application and renewal application are broad as new laws have posed gradual restrictions on what licensing boards can discipline regarding conduct and substance abuse. The Americans with Disabilities Act ("ADA") have narrowed the scope of what is disciplinable conduct. Mr. Hassler stressed that the issues are complicated and important, and thanked the Board for this very important discussion.

Chair Geimer-Flanders emphasized the importance of the Board's mandate, which is to protect the health and safety of Hawaii patients. She also acknowledged the importance of protecting physicians' wellbeing.

Dr. Bjornson illustrated how burnout is a topic the FSMB, as well as many organizations, have addressed. He suggested that the Board's questions only refer to current impairments and eliminate past problems.

Ms. Quiogue reminded Board members that their packets included the following documents:

1. Federation of State Medical Boards, Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health;
2. Board Examples of Questions;
3. Pu`ulu Lapa`au Brochure;
4. Claire Zilber, M.D., Safe Haven Article;
5. A Toolkit for State Medical Boards;
6. American College of Emergency Physicians Joint Statement; and
7. APA Position Statement.

Dr. Bjornson brought to the Board's attention the concept of 'Safe-Haven', and the importance of it to physician wellness. The intent of which is to allow a physician, who is currently engaged in a monitoring treatment, to answer "NO" to the question of whether they were suffering from any condition or impairment. He posed the example of Colorado who introduced the concept in 1990.

Within five (5) years of implementation, their volunteer referrals increased by 195%. He believes the concept of a 'safe-haven' is as important as rephrasing a substance use question. Dr. Bjornson referred to the information included in the Board's packet, which provides that the idea of an attestation versus a "YES" or "NO" response is addressed.

Chair Geimer-Flanders stressed that she was keen on the concept of a safe-haven. She also referred to the North Carolina Medical Board's application, which provides that if an applicant is engaged in a physician healthcare program, they may answer "NO" to the substance use question.

Chair Geimer-Flanders introduced Mr. Mark Staz from the FSMB.

Mr. Staz stated that the FSMB has been looking into physician burnout since 2015. Dr. Takanishi chaired the workgroup for the FSMB that developed the policy recommendations in 2018.

Mr. Staz delineated the primary goals of the policies, which aim to allow treatment to those that need it by removing barriers in seeking treatment. He emphasized that physicians' well-being is as important as patient well-being. An attestation shows the importance of seeking help. Informationally, seventeen (17) states have adopted the 'safe-haven' concept.

Mr. Staz mentioned that West Virginia implemented a safe haven program that garnered an increase in its referral programs. Some states have eliminated questions regarding substance use, but have added attestations to its applications. This change conveys the importance of well-being.

Dr. Jaffe reiterated the importance of safeguarding the wellbeing of healthcare professionals and patients by asking appropriate questions.

Chair Geimer-Flanders asked Dr. Takanishi for his input on the matter having chaired the workgroup for the FSMB.

Dr. Takanishi illustrated the findings of a two-year project. What emerged is that there is known stigma towards substance use, but a willingness to come forward if there is a 'safe haven' program. He brought forth the example of North Carolina, which allows applicants to answer "NO" to the question of substance use if they are participating and complying with a health care program's recommendation.

Dr. Takanishi added that there would be no stigma if there were no questions regarding substance use, and physicians would be more likely to seek help.

Dr. Halford stated that the ensuing problem was the phrasing of the new questions and recommended creating a working group to develop said questions.

Chair Geimer-Flanders proposed a meeting with representatives from the Board, RICO, and Pu`ulu Lapa`au to propose appropriate verbiage.

Dr. Takanishi recommended attestations and proceeded to state that fourteen (14) states have included health statements and seventeen (17) states have adopted the 'safe-haven' concept. He reiterated the importance of not precluding the opportunity to seek help, and thanked the Board for embarking on this task.

Dr. Jaffe stated that the Board's duty is to protect the community and it would be arduous to screen applicants without asking questions.

Dr. Takanishi stated that doctors can operate safely under supervised medication. It is important to allow doctors the appropriate health care they need so that they can perform safely.

Dr. Jaffe agreed with Dr. Takanishi's statements, and recommended that the Board's questions on its initial and renewal applications be revised to encourage healthcare professionals to seek help by offering services whilst allowing the Board to perform its duty of safeguarding consumers.

Chair Geimer-Flanders asked Mr. Hassler for his input regarding the Board's discussion.

Mr. Hassler shared that, historically, most cases that have involved impairment were reported by a third party, and not triggered by an affirmative response to a particular question. He went on to say that even the ADA recognizes that there are cases where substance use that are appropriately monitored so to ensure the safety of patient, and other instances where substance use is not appropriately monitored and can affect the care offered to patients.

Chair Geimer-Flanders thanked members and guests for their input regarding this very important matter.

A motion was requested to be made to establish a working group consisting of two (2) physician members of the Board, a public member of the Board, and a representative of Pu`ulu Lapa`au. The working group would separately seek input from RICO and the FSMB. The working group shall, at a minimum, research and recommend for the Board's consideration, new language for the questions posed on its initial and renewal applications regarding

addiction, dependency, and habituation. It was noted that the Board's questions do not currently ask about mental illness.

Discussion followed. It was moved by Dr. Takanishi, seconded by Chair Geimer-Flanders, and unanimously carried to have Dr. Takanishi, Dr. Jaffe, Mr. Belcher, and Dr. Bjornson, with input provided by RICO and the FSMB, to research and recommend for the Board's consideration, new language for the questions posed on its initial and renewal applications regarding addiction, dependency, and habituation. Chair Geimer-Flanders offered to assist with this group due to Ms. Quiogue's schedule.

Esther Brown, John Hassler, Theodore Sakai, Kris Bjornson, and Mark Staz returned to attendees at 2:21 p.m.

Chairperson Report: Chair Geimer-Flanders announced that the August meeting would be her and Dr. Halford's last meetings.

She requested that the August agenda include consideration of the Board holding meetings every other month after the completion of the legislative session. She emphasized that with the established applications review committee, applications that do not include adverse, derogatory, or questionable information are processed.

Ms. Quiogue acknowledged this request and confirmed that it would be placed on the August agenda.

Next Meeting: Thursday, August 11, 2022
1:00 p.m.

In-Person Location: Queen Liliuokalani Conference Room
King Kalakaua Building, 1st Floor
335 Merchant Street
Honolulu, HI 96813

Virtual Videoconference Meeting – Zoom Webinar

Adjournment: The meeting adjourned at 3:00 p.m.

Reviewed and approved by:

/s/ Ahlani K. Quiogue

(Ms.) Ahlani K. Quiogue
Executive Officer

Taken and recorded by:

/s/ Chiara Latini

(Ms.) Chiara Latini
Secretary

AKQ:cl
7/22/22

licensure or certification.

Unfinished Business:

A. Federation of State Medical Boards, Inc. (FSMB):

(i) Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Healthy (Policy).

Chair Takanishi reminded the Board members that this matter was discussed at its July 14, 2022, meeting. At that meeting, the Board considered whether it would amend its initial and renewal applications question regarding addiction, dependency, or habituation to alcohol and/or drugs. In particular, the Board's initial application asks:

> In the past five years, have you been addicted to, dependent on, or a habitual user of alcohol or of a narcotic, barbiturate, amphetamine, hallucinogen, or other drug having similar effects?

The Board's renewal application asks a similar question. These types of questions require physicians to disclose personal health information on their applications to practice medicine in this State.

Chair Takanishi invited the Board members to provide comments regarding this matter.

Dr. Jaffe expressed his opinion that these questions need to be updated. Based on his recollection of the discussion that occurred at the July 14, 2022, meeting, there was much discussion regarding the safe haven concept, which develops a framework to support health information while complying with legal and regulatory requirements. It is his understanding that this concept mostly refers to mental health disorders, and not alcohol or substance use disorders. He added that the questions should emphasize the importance of provider health and encourage those to seek help if needed; however, he does not believe that it is appropriate for a licensed provider to answer "NO" to a question because they are under treatment.

Chair Takanishi suggested forming a task force to discuss the question and formulate a better alternative.

Dr. Jaffe agreed with Chair Takanishi, and queried whether any amendments to the questions should also include mental health disorders.

Dr. Dao agreed with Dr. Jaffe's suggestion that the question also include mental health disorders, and asked why the Board's questions are limited to alcohol or substance use disorders.

Ms. Quiogue referred to HRS §453-8(a)(4), which states:

> (a) In addition to any other actions authorized by law, any license to practice medicine and surgery may be revoked, limited, or suspended by the board at any time in a proceeding before the board, or may be denied, for any cause authorized by law, including but not limited to the following:
>
> (4) Being habituated to the excessive use of drugs or alcohol; or being addicted to, dependent on, or a habitual user of a narcotic, barbiturate, amphetamine, hallucinogen, or other drug having similar effects.

She stated that this citation could be the reason for the question being limited to alcohol/substance disorders. She went on to say that the Board must be mindful of other laws in place (i.e., American Disabilities Act) when amending its questions.

Ms. Quiogue reminded members that a group had been established at its July 14, 2022 meeting, which includes Chair Takanishi, Mr. Belcher, Dr. Jaffe, and Dr. Bjornson, to research and recommend for the Board's consideration, new language for the questions asked on its initial and renewal applications regarding addiction, dependency, and habituation to alcohol/drugs.

DAG Wong explained that if a new explorative group were to be established, such as a permitted interaction group, then the matter would need to be properly noticed on a future agenda.

Chair Takanishi asked the Board members if they were in accord with allowing the previously established group to proceed with their research.

Dr. Fong stated that he would like for the same group to proceed with their research on the matter.

Chair Takanishi recommended reaching out to the Federation of State Medical Boards for support and advice considering that other states had revised their applications to address this matter.

New Business:

A. Executive Order 22-05

Ms. Quiogue provided a copy of Governor David Y. Ige's Executive Order "Providing Access to Reproductive Healthcare Services" issued on October 11, 2022, for the Board members

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

[1] A PHP (Physician Health Program) is a confidential program of prevention, detection, intervention, rehabilitation and monitoring of licensees or those in training with impairing conditions, 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.

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 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.

6. PHP arrangement for emergency interventions and evaluations, where possible.

[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.

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 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.

[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

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.

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

[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
[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.

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 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,

[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

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 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

[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

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 potentially 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 a medical condition that impairs the ability to practice medicine with reasonable skill and safety.

2. Information or documentation of excessive use of alcohol or other potentially impairing drugs, regardless of addictive potential (e.g., antipsychotics, anticholinergics, anticonvulsants, hallucinogens, stimulants)

3. 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.

[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.

4. Behavioral, affective, cognitive, or other mental problems that raise reasonable concern for public safety.

5. 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 for a 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

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

[16] Federation of Physician Health Programs, Physician Health Program Guidelines, 2019.
[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.

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 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

[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.
[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

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 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 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 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 on licensing applications of treatment sought either through the PHP model or a 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*.

[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.
[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.

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.

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 or at risk of 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 who 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 an 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]

Abstinence
Abstinence is defined as the complete avoidance of potentially impairing drugs that are not legitimately prescribed.

[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.

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.

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Tennessee Board:

Do you currently have any condition that is causing impairment that affects your ability to practice medicine with reasonable skill and safety in a competent, ethical and professional manner? (You may answer no if you are being appropriately treated and not impaired.)

Have you engaged in the excessive use of alcohol, controlled substances or prescription drugs, or in the use of illegal drugs, or received any therapy or treatment for alcohol or drug use? (If you are an anonymous participant in the Tennessee Medical Foundation Physicians Health Program and are in compliance with your contract, you may answer "No" to this question)

New Hampshire Board of Medicine:

15. Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, which has not been annulled by a court, but not including traffic offenses not classified as misdemeanors or felonies? Yes ☐ No ☐

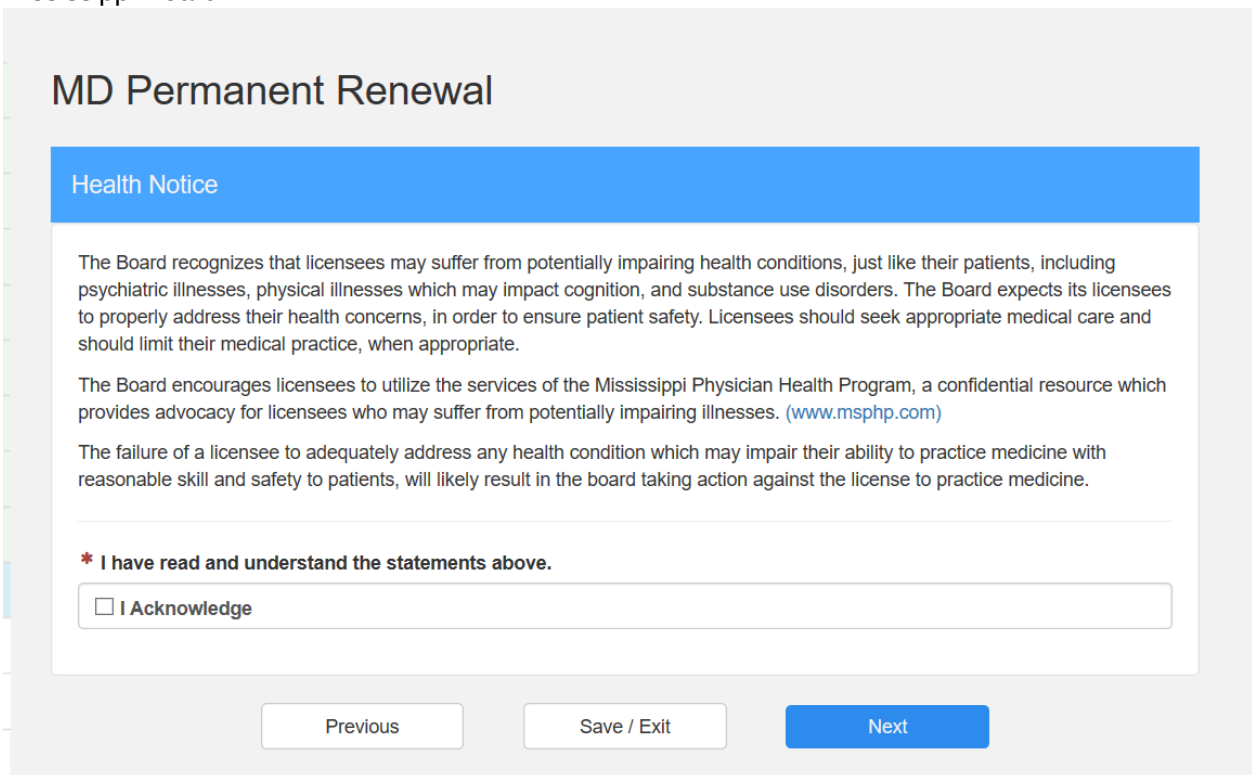
16. Has your privilege to possess, dispense, or prescribe controlled substances ever been suspended, revoked, denied, restricted, or surrendered, or have you ever been charged, investigated, or warned by a state or federal agency based on controlled substance issues? Yes ☐ No ☐

17. The NH Board of Medicine ("Board") acknowledges that it is not only normal but anticipated and acceptable for a physician or a physician assistant to feel overwhelmed from time to time and to seek help when appropriate. The Board emphasizes the importance of provider health, self-care, and appropriate treatment for all health conditions. The Board supports the NH Professionals Health Program ("NHPHP"). The NHPHP provides free-of-charge, confidential and "safe-haven non-reporting" intake assessments, referrals and monitoring (when appropriate) for all NH physicians and physician assistants who have potentially impairing or troubling conditions such as substance use, mental health conditions, burnout, physical illness or disruptive behavior. The Board encourages all providers to read about the NHPHP, provider wellness and resources found at www.nhphp.org.

    Are you currently suffering from any condition, mental or physical that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? Yes ☐ No ☐

18. Are you currently or have you in the past been monitored or treated by a private, state, medical society or hospital physician health program, other than through the NH board approved physician health program? Yes ☐ No ☐

Mississippi Board:



Massachusetts:

CONFIDENTIAL INFORMATION QUESTIONS			
For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one's functioning as a licensee, or within the past two years. You must answer "yes" or "no" to questions #50 - 52. **NOTE: A "yes" response to questions # 50 - 52 requires a detailed explanation. Please use the *Explanation for Confidential Information Questions.***		**YES**	**NO**
50.	Do you have a medical or physical condition that currently impairs your ability to practice medicine? (You may answer "**NO**" if the behavior or condition is known to the *Massachusetts Medical Society's Physician Health Services* (PHS) and you are complying with all PHS requirements for evaluation, treatment and/or monitoring as recommended.)	☐	☐
51.	Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?	☐	☐
52.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?	☐	☐

**** IMPORTANT NOTE REGARDING PHYSICIAN WELLNESS ****

If you have a substance use disorder or mental or physical health diagnosis that impacts your ability to practice medicine, the Board encourages you to seek assistance voluntarily and to abide by any recommendations of your health care provider.

When the Board receives notice of a substance use disorder, its primary mission is to protect the public; however, the Board also seeks to ensure successful rehabilitation through the physician's participation in approved treatment programs and supervised structured aftercare. Similarly, when the Board receives notice of a mental health or physical health diagnosis that impacts a physician's ability to practice, the Board needs to ensure that the physician can practice medicine safely.

In regard to issues of physician impairment, whether the impairment is caused by a substance use disorder, or a mental or physical health diagnosis, the Board works cooperatively with the Massachusetts Medical Society's Physician Health Services (PHS) and encourages physicians to contact PHS to determine what services may be available to them in order to ensure their safe practice of medicine.

PHS is a nationally recognized physician health program designed to assist physicians with a variety of health related challenges, including but not limited to alcohol and substance use disorders, behavioral or mental health challenges, and/or physical health concerns that could impact the ability to practice medicine. PHS is also available for consultation and resources around stress and burnout, work-family balance, and other health related challenges. PHS is not a direct care provider but can help assess and identify health related challenges, refer for evaluation and treatment when needed, and provide ongoing supportive monitoring when indicated. PHS is a voluntary program available to all physicians in Massachusetts, whether or not they belong to the Massachusetts Medical Society. For more information, please see https://www.massmed.org/phshome/, or reach out for a confidential consultation at (781) 434-7404.

North Carolina:

3. In the past five (5) years, have you used or consumed any controlled substance or other prescription drug that you obtained through illegal or improper means? (If you are an anonymous participant in the NC Professionals Health Program and are in compliance with your agreement, you may answer "no" to this question.)
Yes No

4. In the past five (5) years, have you used or consumed any illicit or illegal drugs including, but not limited to cocaine, heroin, ecstasy, LSD, mescaline, psilocybin, PCP and/or marijuana? (If you are an anonymous participant in the NC Professionals Health Program and are in compliance with your agreement, you may answer "no" to this question.)
Yes No

5. In the past five (5) years, have you used alcohol or other substances in a manner that could in any way impair or limit your ability to practice medicine with reasonable skill and safety or have you been told you were impaired by your use of alcohol or other substances in a manner that could impair or limit your ability to practice medicine with reasonable skill and safety? (If you are an anonymous participant in the NC Professionals Health Program and are in compliance with your agreement, you may answer "no" to this question.)
Yes No

Hawai`i Program for Healthcare Professionals: Pu`ulu Lapa`au

We are Hawai`i's premier independent program for licensed health care professionals with conditions or behaviors that may interfere with their ability to work productively and safely. We started as the Physician Wellness Committee of the Hawai`i Medical Association and became an independent non-profit corporation in 2006. Our services are now available to other licensed health care professionals.

Our ultimate goals are professional well-being and patient safety! Healthcare workers have a profound impact on the community, and the profession must do all it can to maintain their trust.

Unless the conditions are addressed effectively, health professionals may eventually face serious consequences, such as loss of employment and license to practice. The community may lose a valuable, highly trained professional.

Our model works! National evidenced-based research shows that strict monitoring, following established guidelines, provides an alternative path for physicians, so they can continue to serve our community.

How we are supported

- We have contracts with hospitals which may refer professionals to us for services.
- Participants are assessed a monitoring fee to assure that they have a tangible investment in their own success.
- As a non-profit organization with 501(c)3 status we are able to receive donations from those who support our work.

Data shows:

- Three hundred to four hundred physicians die by suicide every year, a rate more than double the general population.
- Over 50% of physicians exhibit symptoms of burnout. If these indications are not addressed, they may lead to problems, including inappropriate workplace behaviors, job dissatisfaction, substance abuse, early withdrawal from practice, and sometimes, suicide.
- 8 to 10% of healthcare workers suffer from substance use disorders.
- The cost to the community includes reduced number of available healthcare providers.
- The cost to employers can be very high, in terms of inefficiencies, increased error rates, and replacing experienced professionals.

Call today: (808) 593-7444

Pu'ulu Lapa'au

Pu'ulu Lapa'au

The Hawai`i Program for Healthcare Professionals

Pu`ulu Lapa`au is an independent, non-profit organization dedicated to assisting our healthcare provider colleagues in their journey of life and medicine.

200 N. Vineyard Blvd, Bldg. B Ste 271
Honolulu, Hawai`i 96817

Visit our website: www.hawaiiphp.org

5.C.(ii) FSMB: Policy on Physician Illness and Impairment

We Serve:
Most licensed healthcare providers in Hawai`i.

We Provide:
Education, Prevention, Referral, Monitoring and Advocacy for conditions that may interfere with a healthcare professional's ability to practice effectively and safely, and issues that may lead to disruption in the workplace.

Our Work
Healthcare professionals have a profound impact on the safety of patients and families, co-workers, and the public. Yet, like others in our community, their performance can be compromised by factors like high levels of stress and they sometimes suffer from conditions such as substance use disorder and symptoms of burnout.

Pu`ulu Lapa`au provides alternate paths to wellness, so professionals can continue to contribute to the community. Standard Monitoring utilizes guidelines established by the Federation of State Physician Health Programs, the American Society of Addiction Medicine, and the Federation of State Medical Boards. Not all participants require Standard Monitoring. Some may benefit from Supportive Case Management.

Why We Do It
- Unless the condition is addressed effectively, healthcare professionals may face serious consequences, such as potential loss of employment and their license to practice. The community may lose a valuable, highly trained professional.
- Our model works! Multiple evidence-based studies clearly demonstrate professionals were able to restore their careers when they adhere to these requirements.

Our Services:
We provide respectful and confidential support and advocacy

We focus on long-term recovery through rigorous, sustained monitoring and abstinence.

We continuously support participants with individualized plans designed to mitigate issues, promote wellness and assure safe practice.

We monitor the following conditions:
- Stress management, including burnout
- Substance abuse disorders
- Mental and physical conditions, including cognitive disorders
- Behavior issues, including disruptive behaviors
- Sexual misconduct or other boundary violations

Supportive Case Management
- Develop short term monitoring plans, if indicated.
- Referral to services such as counseling and professional coaching.
- Referral to support groups, such as Mindfulness Based Stress Reduction (MBSR)
- Advocacy with employers and licensing boards

Standard Monitoring
- Monitoring plans of up to five years
- Referral to assessments and treatment, and services such as professional coaching
- Referral to support groups
- Advocacy with employers and licensing boards

Physician Health Program Model endorsed by the American Medical Association

Essential elements of the model:
- Confidentiality
- Independent Governing Board
- Evidence-based Methods
- Peer-to-Peer interaction
- Qualified staff
- Mutual immunity

Essential activities of the model:
- Appropriate advocacy for the professional
- Referrals to qualified professionals for evaluation and/or treatment
- Behavioral and toxicologic monitoring
- Compliance documentation
- Documentation of well-being
- Facilitated reentry to practice

For hospitals, clinics and insurers:
- Presentations to our contract partners and others on issues of relevance to the well-being of health professionals.
- Regular reports on compliance
- Fulfillment of Joint Commission requirement MS.11.01.01

Benefits include:
- Help achieve and sustain wellness
- Rigorous independent monitoring
- Professionals are held accountable
- Professionals can continue to practice safely
- Employers and licensing boards receive independent reports
- Hospitals meet Joint Commission requirements

‘Safe Haven’ Integral to Physician Wellness

CLAIRE ZILBER, M.D.
Published Online:14 May 2019https://doi.org/10.1176/appi.pn.2019.5b22

A psychiatry resident is treated for anorexia nervosa in a state that doesn’t offer “safe haven.” She discloses her illness to the licensing board, which publishes details about her illness on its website. What she thought was her private, protected health information is now available to the Googling public.

Claire Zilber, M.D., is a psychiatrist in private practice in Denver, a faculty member of the PROBE (Professional Problem Based Ethics) Program, and chair of the Ethics Committee of the Colorado Psychiatric Society. She is the co-author of *Living in Limbo: Creating Structure and Peace When Someone You Love Is Ill.*

A growing number of medical licensing boards (MLBs) are forging agreements with their corresponding physician health programs (PHPs) to provide “safe haven” to licensees who are in psychiatric or substance abuse treatment and whose treatment is monitored by the PHP. This column details the history of safe haven agreements, explains their importance for physician wellness, and describes the experience with safe haven in one of the first states to implement this innovation.

Following the 1990 passage of the Americans With Disabilities Act (ADA), MLBs have been encouraged to modify their broad questions on licensure applications, such as, “Are you now, or have you ever been, diagnosed with or treated for mental illness?” The Department of Justice has deemed that questions about history of mental illness, rather than impairment, are a form of discrimination because they foster assumptions about a person’s functioning based on a diagnosis—similar to categorizing people based on race or gender.

In 1997, APA proposed guidelines to help MLBs comply with the ADA by narrowing their questions to reflect current functional impairment. Despite the ADA’s and APA’s guidelines, a study by Sarah Polfliet, M.D., reviewing MLB questions from 1993, 1996, 1998, and 2006 application forms found that licensing boards asked more questions about past diagnoses and treatment of mental illness in 2006 than in the 1990s.

Equally concerning were the results of a survey by the Federation of State Medical Boards (FSMB) in 2007, in which MLBs were asked about licensing applications.

Thirteen of the 35 (37%) responding boards indicated that a mental health diagnosis by itself was sufficient to sanction physicians, regardless of occupational functioning. Over one-third of responding state boards admitted that they treat physicians receiving psychiatric care differently from those receiving other forms of medical care.

Given societal stigma about psychiatric illness and some MLBs' apparent discriminatory practices, it is no surprise that medical students and physicians often avoid seeking mental health treatment. This likely exacerbates the high suicide rate among physicians and the epidemic rates of burnout.

In the 1990s, some PHPs negotiated safe haven agreements with MLBs to encourage physicians to proactively seek assistance for mental or physical illness by ensuring confidentiality from the medical board. This was an attempt to preserve physicians' ability to receive confidential treatment while honoring the duty of the licensing boards to protect the public from impaired physicians. Under safe haven agreements, applicants for licensure are allowed to answer "no" to questions about mental illness as long as they are being treated under the supervision of their state PHP. The PHP reports physicians to the MLB only when they are deemed dangerous or are not following the program's recommendations.

A direct, linear relationship exists between the extent to which the clients of a PHP must be reported to the licensing board and the number of clients in that PHP: The less confidentiality exists for treatment, the fewer physicians enrolled in a PHP. Amid growing concern about physician burnout and its impact on patient care, the AMA in 2016 and the Federation of State Medical Boards in 2018 each advanced a policy that discourages probing questions about psychiatric illness or substance abuse on licensing applications and promotes safe haven for physicians who seek treatment as long as they are not impaired in their ability to treat patients competently.

Colorado was one of the first states to adopt a safe haven agreement. Under the agreement, which has been in effect since 1990, a physician or physician assistant applying or reapplying for licensure can reply "no" to application questions about psychiatric illnesses as long as the applicant has had a voluntary evaluation by the Colorado Physician Health Program (CPHP). Prior to safe haven, referrals to CPHP came primarily through the MLB and were complaint driven, usually after something bad had happened. After safe haven, the majority of CPHP encounters were voluntary referrals, unknown to the board; and interventions were early, before impairment occurred. Within five years of implementing safe haven, voluntary referrals increased by 195%. In 2019, the Colorado Medical Board took a further positive step to reduce stigma by changing its application questions to ask only about impairment by a medical or psychiatric condition.

As MLB policies adapt to changing societal expectations, organized medicine and PHPs must remain vigilant to inadvertent erosion of protections that afford physicians and trainees confidential health treatment. Nobody deserves to have his or her psychiatric history available to the public simply for choosing to seek treatment.

Without safe haven, rather than voluntarily presenting to a PHP for evaluation and referral to treatment, depressed, anxious, suicidal, or otherwise suffering colleagues may try to tough it out on their own with no treatment. Or they may attempt to self-medicate, a solution fraught with medical and ethical risks. Their illness may become known to the

PHP and the licensing board only after a bad outcome, such as poor work performance, behavioral problems, adverse patient care, or a suicide attempt.

APA district branches and state PHPs can work with their state MLBs to ensure that safe haven is available to physicians in their state. ■

"AMA Adopts Policies to Support Physician Wellness, Mental Health" can be accessed here. "Report and Recommendations of the Workgroup on Physician Wellness and Burnout" by the Federation of State Medical Boards is available here. APA's policy on the diagnosis and treatment of mental disorders in connection with professional credentialing and licensing is posted here.

How to Improve Licensure Questions & Better Support Your Health Workforce

A Toolkit for State Medical Boards

THE EFFECT OF INVASIVE LICENSURE QUESTIONS ON PHYSICIANS

THE PROBLEM

Clinicians aren't seeking mental health care, despite the traumatic, exhausting experience of the past two years. They fear losing their license, stigma, discrimination, or privacy violations in the workplace.

A recent Medscape survey of 13,000 physicians found that 43 percent said the reason they had not sought help for burnout or depression was because they "don't want to risk disclosure to the medical board."

WHAT DOCTORS SAY

"I'm afraid that if I spoke to a therapist, I'd have to report receiving psychiatric treatment to credentialing or licensing boards."

"Physicians cannot seek help for these issues because if we do that, these temporary issues will follow us for the rest of our careers."

"I feel I should know how to deal with this myself, even though I wish I didn't have to."

Why Physicians Kept Their Suicidal Thoughts Secret, Medscape 2022

ARE THESE QUESTIONS PROTECTING THE PUBLIC?

In short, NO.

While these invasive questions were originally developed with good intent, it is a misconception that they are protecting the public. In many cases, it actually has the opposite effect.

Though there is no data demonstrating that these questions protect the public, it is well-documented that they often lead to physicians not seeking care. This, in turn, negatively impacts patients, as the margin of error in medical situations is significantly reduced when doctors and nurses are not burnt out or suffering from untreated mental health strains.

Burnout Among Health Care Professionals: A Call to Explore and Address This Underrecognized Threat to Safe, High-Quality Care, National Academy of Medicine

THREE STEPS TO MENTAL HEALTH SUPPORT & REFORM

There are many State Medical Boards that have eliminated invasive language, just as there are still many that have invasive language on their applications. In this toolkit, you will find three actionable steps that every board must take to ensure that they are adequately supporting the health workforce in their state.

AUDIT

Review all licensure applications, addendums, and peer review forms (if applicable).

CHANGE

Remove invasive or stigmatizing language around mental health and substance abuse.

COMMUNICATE

Disclose these changes and assure physicians that it is safe for them to seek care.

1. AUDIT

Review every application your board issues, including training, renewal, initial, educational, supplemental / addendum, and peer review forms (where applicable).

You should look for the following:

- Questions that contain invasive or stigmatizing language and disclosure requests around a physician's health, well-being, or substance use.
- Questions that ask about a physician's history of "time off" or "breaks in practice."
- Questions prying into substance use at all, beyond illegal usage and penalties.
- Language that references mental health explicitly in any way that's not supportive (see next page for recommended language). There is no reason to separate mental and physical health unless you're encouraging physicians to seek treatment if and as needed.
- Questions that ask about past usage or experiences.
- Unnecessary asterisks or fine print (i.e., "current impairment can be any time in the last 5 years").

2. CHANGE

Remove any invasive or stigmatizing language around mental health and substance abuse.

Option 1: Ask one question consistent with FSMB's Recommended Language that addresses all mental and physical health conditions as one, with no added explanations, asterisks, or fine print:

> "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)"

Option 2: Refrain from asking probing questions about an applicant's health altogether.

Option 3: Implement an Attestation Model, like that used in North Carolina (see their language below) and Mississippi. This uses supportive language around mental health from the Board and holds physicians accountable to their well-being, making it clear that their self-care is patient care. Offer "safe haven" non-reporting options to physicians who are under treatment and in good standing with a recognized physician health program (PHP) or other appropriate care provider.

> "Important: The Board recognizes that licensees encounter health conditions, including those involving mental health and substance use disorders, just as their patients and other health care providers do. The Board expects its licensees to address their health concerns and ensure patient safety. Options include seeking medical care, self-limiting the licensee's medical practice, and anonymously self-referring to the NC Physicians Health Program (www.ncphp.org), a physician advocacy organization dedicated to improving the health and wellness of medical professionals in a confidential manner. The failure to adequately address a health condition, where the licensee is unable to practice medicine within reasonable skill and safety to patients, can result in the Board taking action against the license to practice medicine."

3. COMMUNICATE

Disclose these changes and assure physicians that it is safe for them to seek care.

Identify the appropriate channel(s) of communication and trusted messenger(s) for each key audience (licensees, health systems, and the FSMB).

Craft your message and ensure that in communicating these changes, licensure applicants are first met with supportive language so they know it is safe to seek mental health care. Sample language in reaching out to licensees is below.

> "Your State Medical Board recognizes the hardships of the last several years of the pandemic and urges you to seek the mental health care and support that you need. It is in the best interest of yourself, your patients, and your colleagues to take care of your physical and mental well-being, and we want to assure you that it is safe and encouraged to seek this care. As a protective and supportive measure, we have recently removed all unnecessary questions about mental health from all of our licensure applications."

Begin direct, specific, and transparent communications (via text, mail, or email) with your audiences.

- Establish a designated communications channel for licensees in-state to update them in real-time on the new licensure language.
- Make applications available and easily accessible to the public on the medical board's website. ***Applications that are only behind online portals inhibit transparency***, so it's important to ensure that applications are also accessible in full directly on your site.
- Reach out and encourage state health systems to follow your lead in changing invasive questions on credentialing applications and communicating to their workforces their and the state's changes.
- Once your board has adopted the changes, we recommend that you communicate back to FSMB so that they can help share your successes and positive changes with other boards and promote best practices nationally.

Contact us: We will provide you with a full social media toolkit to help you share out your support of physicians' well-being and any updated language you may have to share via Facebook and/or Twitter. Reach out to us at social@participant.com.

JOINT STATEMENT

Supporting Clinician Health in the Post-COVID Pandemic Era

- The COVID-19 global pandemic is an unprecedented modern public health crisis. The extent and nature of lingering health effects of the pandemic on providers, whether or not they themselves have been infected, are not yet known. In order to minimize the loss of life from COVID-19 and its sequelae, and from other current and future public health threats, and to ensure future patient access to medically necessary care, it is vital that we work to preserve and protect the health of our medical workforce.
- Optimal physical and mental health of physicians and other clinicians is conducive to the optimal health and safety of patients. The wellness of our medical workforce, physical and mental health, is necessary to ensure patient care.
- Physicians and other clinicians must be able to safely secure treatment for mental or other health issues, just as any other individual. A provider's history of mental illness or substance use disorder (SUD) should not be used as any indication of their current or future ability to practice competently and without impairment.
- Discrimination based on disability, as defined by the Americans with Disabilities Act (ADA), is prohibited under federal law and applies to professional licensing bodies1. We therefore support states that ask questions that do not violate the intent of the ADA not to discriminate against individuals. We strongly urge states that ask inappropriate questions to immediately modify them to be consistent with the principles of the ADA. Specifically, see recommendations and position statements of the American Medical Association (AMA), the Federation of State Medical Boards (FSMB), American Psychiatric Association (APA), American College of Physicians (ACP) and the American College of Emergency Physicians (ACEP).
    - Licensing and credentialing applications by covered entities should only employ narrowly focused questions that address current functional impairment.
- Additionally, we strongly support The Joint Commission (TJC) statement on Removing Barriers to Mental Health Care for Clinicians and Health Care Staff. TJC, "supports the removal of any barriers that inhibit clinicians and health care staff from accessing mental health care services." TJC also encourages organizations not to inquire about previous history of mental health conditions or treatment.
- For most physicians and other clinicians, seeking treatment for mental health triggers legitimate fear of resultant loss of licensure, loss of income or other career setbacks. Such fears are known to deter physicians from accessing necessary mental health care. Seeking care should be strongly encouraged, not penalized.
- Additionally, we support the use of non-clinical mental health support, such as social or peer support. Social and peer support provide a sense of belonging to those with shared experiences. Individuals who are able to express frustrations and share coping strategies to address mutual challenges and provide hope to one another are invariably healthier than those without such support. Social support systems of all types are useful adjuncts that associations can provide to their members.
- Additionally, credentialing agencies should support and expand access to treatment programs, such as including the ability of a physician to self-refer, without fear of reprisal.

[1] Americans with Disability Act, 28 Code Fed. Reg. § 35.130

Co-signers

American College of Emergency Physicians (ACEP)
American Academy of Allergy, Asthma & Immunology (AAAAI)
American Academy of Child and Adolescent Psychiatry (AACAP)
American Academy of Family Physicians (AAFP)
American Academy of Hospice and Palliative Medicine (AAHPM)
American Academy of Neurology (AAN)
American Academy of Ophthalmology (AAO)
American Academy of Physical Medicine and Rehabilitation (AAPMR)
American Association for Emergency Psychiatry (AAEP)
American Association of Suicidology (AAS)
American College of Obstetricians and Gynecologists (ACOG)
American College of Physicians (ACP)
American College of Preventive Medicine (ACPM)
American College of Radiology (ACR)
American College of Surgeons (ACS)
American Epilepsy Society (AES)
American Foundation for Suicide Prevention (AFSP)
American Geriatric Society (AGS)
American Medical Association (AMA)
American Psychiatric Association (APA)
American Society for Clinical Pathology (ASCP)
American Society of Anesthesiologists (ASA)
American Society of Colon and Rectal Surgeons (ASCRS)
American Society of Hematology (ASH)
American Society of Nephrology (ASN)
American Society of Plastic Surgeons (ASPS)
American Thoracic Society (ATS)
American Urological Association (AUA)
Coalition on Psychiatric Emergencies (CPE)
Council of Residency Directors in Emergency Medicine (CORD)
Council for Medical Specialty Societies (CMSS)
Depression and Bipolar Support Alliance (DBSA)
Dr. Lorna Breen Heroes' Foundation
Emergency Medicine Residents' Association (EMRA)
Emergency Nurses Association (ENA)
Federation of State Medical Boards (FSMB)
Infectious Diseases Society of America (IDSA)
National Alliance on Mental Illness (NAMI)
North American Spine Society (NASS)
Society for Academic Emergency Medicine (SAEM)
Society of Emergency Medicine Physician Assistants (SEMPA) Society of Hospital Medicine (SHM)
Society of Interventional Radiology (SIR)
Society of Thoracic Surgeons (STS)
The Physicians Foundation

APA Official Actions

Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing

Approved by the Board of Trustees, July 2018
Approved by the Assembly, May 2018

"Policy documents are approved by the APA Assembly and Board of Trustees. . . . These are . . . position statements that define APA official policy on specific subjects. . ." – *APA Operations Manual*

Issue:
The APA recognizes the important role served by licensing boards, institutional privileging committees, insurance credentialing panels, and other entities charged with protecting the public from impaired physicians, attorneys, and other licensees. In discharging their responsibilities, these entities legitimately may inquire about current functional impairment in professional conduct and, when relevant, current general medical or mental disorders that may be associated with such impairment. However, the APA believes that prior diagnosis and treatment of a mental disorder are, *per se*, not relevant to the question of current impairment and that oversight entities should not include questions about past diagnosis and treatment of a mental disorder as a component of a general screening inquiry.

APA Position Statement:
The APA recommends the following principles to guide licensing boards and other regulatory agencies, and training programs.

1. **General screening inquiries about past diagnosis and treatment of mental disorders are overbroad and discriminatory and should be avoided altogether. A past history of work impairment, but not a report of past treatment or leaves of absence, may be requested.**
2. **The salient concern for licensing entities is always the professional's current capacity to function and/or current functional impairment. Questions on application forms should inquire only about the conditions that currently impair the applicant's capacity to function as a licensee, and that are relevant to present practice. As examples of questions that might be asked, the following are suggested:**
   Question: Are you currently using narcotics, drugs, or intoxicating liquors to such an extent that your ability to practice [law / medicine / other profession] in a competent, ethical and professional manner would be impaired? (Yes/No)
   Question: Are you currently suffering from a condition that impairs your judgment or that would otherwise adversely affect your ability to practice [law / medicine / other profession] in a competent, ethical, and professional manner? (Yes/No)

3. **If a relevant impairment of functioning has been acknowledged by the applicant or documented by other sources, inquiries about mental health treatment may be appropriate for the sole purpose of understanding current functioning and future performance.**
4. **If conduct that would otherwise provide grounds for denial or revocation of a professional license or privileges has been documented or acknowledged by the applicant, it would also be appropriate to ask the applicant whether a disorder or condition was raised to explain that conduct.**
5. **Applicants must be informed of the potential for public disclosure of any information they provide on applications.**
6. **If the applicant raises a mental health diagnosis or treatment as an explanation for conduct or behavior that may otherwise warrant denial of credentials or licensure, the licensing board may inquire into such diagnosis or treatment. Such inquiry shall be narrowly, reasonably, and individually tailored. Medical or hospital records requested shall be by way of narrowly tailored requests and releases that provide access only to information that is reasonably needed to assess the applicant's fitness to practice. All personal or health-related information shall be kept strictly confidential and shall be accessed only by individuals with a legitimate need for such access.**[1]
7. **Personal health information collected by the board should be kept confidential and should be destroyed after a reasonable period of time.**

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[1] Language adapted from Settlement Agreement Between the United States of America and the Louisiana Supreme Court under the Americans with Disabilities Act, August 13, 2014, http://www.ada.gov/louisiana-supreme-court_sa.htm, Terms and Conditions, § (A) (13) (c).

United States Medical Licensing Examination (USMLE)

The USMLE is seeking current and former physician board members to volunteer for its panels/committees, including test development and non-test development committees.

- Varying levels of commitment:
    - Standard setting panel: one time meeting, with prep work;
    - Advisory panels: 1-2 meetings per year, some prep work; and
    - Test development meetings: 3-days in Philly, 40-50 hours, 2-yr term, annual extensions up to 4 years.
- 40-50 openings annually, seeking physicians from different or specific specialties, demographics, and institutions.
- Non-test development types of committees may be eligible for executive staff.

Why volunteer? Opportunities to professionally network across the nation, affect the medical field by ensuring patient safety, professional development, and CME credit.