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

AGENDA

Date: January 16, 2025

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/89891215757?pwd=L0sneNl533DRCliNKnh0OwEMeEMXRy.1

Phone: (669) 900-6833

Meeting ID: 898 9121 5757

Passcode: 188646

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. December 12, 2024, Open Session Meeting Minutes

   B. December 12, 2024, Executive 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. 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. James John Teet, D.O.

b. Michael Maruska, D.O.

c. Ikshvanku Amrutlal Barot, M.D.

d. Raymon Kevin Nelson, M.D.

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

a. Johnson Kevin Lay, M.D.

b. Tochi Ajiwe, M.D.

B. Ratification List (See attached list)

(i) January 16, 2025, Ratification List

4. 2025 Legislative Session:

A. Proposed Legislation Relating to Foreign Medical Graduates

The Board will consider draft legislation to amend HRS section 453-4.5. The amendments would authorize the Hawaii Medical Board provide graduates of foreign medical schools with alternate methods of qualifying for a Hawaii medical license.

B. S.B. 107 RELATING TO MEDICAL INFORMED CONSENT

Requires the Hawaii Medical Board to establish standards for health care providers to ensure that a patient's consent to treatment is an informed consent. Requires that informed consent for a proposed medical or surgical treatment or a diagnostic or therapeutic procedure shall be obtained before the day of that treatment or procedure. Specifies that if the treatment or procedure is to occur on the same day it is scheduled, the informed consent shall be obtained at the time the decision is made to schedule that treatment or procedure.

5. Executive Officer Report

   A. Implementation of Interstate Medical Licensure Compact Commission (IMLCC)

      On January 1, 2025, the Interstate Medical Licensure Compact went into effect, implementing a process that complements the existing licensing and regulatory authority of state medical boards and provides a streamlined process that allows physicians to become licensed in the State.

6. Interstate Medical Licensure Compact Commission (IMLCC)

   A. Appointment of Commissioner

      The Board will appointment one voting representative who will serve as Commissioners on the IMLCC. A Commissioner shall be a(n); allopathic or osteopathic physician appointed to a member board, executive director, executive secretary, or similar executive of a member board; or a member of the public appointed to a member board.

7. Federation of State Medical Boards

   A. Reentry to Practice: Report of the FSMB Workgroup on Reentry to Practice, Draft, January 2025

      Physicians may take a leave from practice for a variety of reasons, necessitating reentry. The following document contains guidance for state medical boards when considering potential reentry to practice requirements for physicians seeking to resume active practice following a significant absence. Recommendations offered in the document reflect an appreciation that unique situations exit for physicians (hereinafter understood to include physician assistants/associates (PAs)) seeking to reenter practice, and flexibility is therefore encouraged, as is the need to consider reentry decisions on a case-by-case basis.

      The Board will discuss and consider providing feedback and comments to this Report.

   B. Invitation to USMLE Workshop for State Board Members

      The USMLE program is working to increase its database of potential candidates to serve on USMLE test development committees and/or other USMLE committees and activities. In particular, FSMB is striving to increase the number of physicians in their database who have experience as current or former members of a state medical board. This meeting will be held on March 14, 2025, at FSMB offices in Euless, Texas.

      The Board will discuss and consider selecting Board member(s) to participate in this meeting.

8. Next Meeting: February 13, 2025

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

9. Adjournment

If you need an auxiliary aid/service or other accommodation due to a disability, contact Chelsea Fukunaga 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 January 14, 2025, 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.

01/7/2025

Hawaii Medical Board
January 16, 2025, Ratification List

AMD-1419-0	AMY Q TRAN
AMD-1420-0	MARIA EXCELLSIS L DELA CRUZ
AMD-1421-0	EVAN S JOHNSON
AMD-1422-0	KEVIN T OSBORNE
AMD-1423-0	DEVIN E A EAGAN
AMD-1424-0	NIKKI S L KUNITOMO
AMD-1425-0	MALIA K RUSSO
DOS-2645-0	NATHAN I PRAY
DOS-2646-0	KATHERINE L M DIETRICH
DOS-2647-0	JAMES CARNELL SIBBETT
DOS-2648-0	VANESSA K ANTONIO-IGNACIO
DOS-2649-0	SAM ZAND
DOS-2650-0	MICHAL KOZDRONKIEWICZ
DOS-2651-0	JOY RATHOD
DOS-2652-0	AVE M SPENCER
DOS-2653-0	JASON T LANNING
DOS-2654-0	ROBIN R ARMENIA
DOS-2655-0	DEPEN J PATEL
DOS-2656-0	ZACHARY F VERES
DOS-2657-0	MOHSIN A SIDDIQUI
DOS-2658-0	ERIN M MEYER
DOS-994-0	CHAD J CLARK
EMT-3448-0	MICHAEL JAMES GORMAN
EMT-3449-0	ZIGGY C. MURAMOTO
EMT-3450-0	JUSTIN K. KANOHO
EMTP-2500-0	CAMRON JAMES LINGENFELTER
MD-14387-0	MARK K TU
MD-19798-0	JENNIFER A ARMSTRONG
MD-24914-0	MAYUMI OKA
MD-24915-0	JOSHUA MICAH COLVIN
MD-24916-0	EVAN SIRC
MD-24917-0	STEVEN LEO ROSONKE
MD-24918-0	LEON ANIJAR
MD-24919-0	BRANDON JUDE ABEYTA
MD-24920-0	NICHOLAS PROVATAS SPANOS
MD-24921-0	SEAN ARORA
MD-24922-0	RONALD CHAN

Hawaii Medical Board
January 16, 2025, Ratification List

MD-24923-0	CARL RYDELL JENSON
MD-24924-0	JANET MANSOOR
MD-24925-0	SHAUN SETTY
MD-24926-0	BRITTANY KIRSCH
MD-24927-0	BRIAN JOHN GOLDSMITH
MD-24928-0	DMITRY SUKENIK
MD-24929-0	GERALD ROWLAND
MD-24930-0	SANJEEV RAVIPUDI
MD-24931-0	JENNIFER L NADEL
MD-24932-0	PRAKASH VALIVETI
MD-24933-0	SAMUEL EDWARD ADAMS
MD-24934-0	DAWN RENE CLARK
MD-24935-0	LINDEN DOSS
MD-24936-0	TIN TRUNG NGUYEN
MD-24937-0	DAON HA
MD-24938-0	MEGAN LINDSAY BRENNER
MD-24939-0	ANTONIO FARGIANO
MD-24940-0	BOBBY AMIR MALIK
MD-24941-0	CONCEPCION SANTILLAN
MD-24942-0	VISHAL PANCHAL
MD-24943-0	SUSAN LAYNE LEWIS
MD-24944-0	ELISABETH ANNE HOYER
MD-24945-0	SAMIR GAUTAM
MD-24946-0	ROBERT ARI LOWENSTEIN
MD-24947-0	ELISA MARIE DANNEMILLER
MD-24948-0	JOSEPH N MORGAN
MD-24949-0	SOO CHON KIM
MD-24950-0	GREGORY BLASE FRANZ
MD-24951-0	DANIEL J MCCONNELL
MD-24952-0	RUSSELL HAL MCUNE
MD-24953-0	JEFFREY BLAKE CAZIER
MD-24954-0	BOBBY KAPIL DESAI
MD-24955-0	ROSHAWNDA BROWN
MD-24956-0	KRISTINE DIANA DEMAIO

__.B. NO._____

A BILL FOR AN ACT

RELATING TO FOREIGN MEDICAL GRADUATES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. Section 453-4.5, Hawaii Revised Statutes, is amended to read as follows:

"**§453-4.5 foreign medical graduates; alternative qualifications.** Notwithstanding section 453-4(b)(2)(B), a graduate of a foreign medical school:

(a) Who has passed the Federation Licensing Examination (FLEX) or the United States Medical Licensing Examination (USMLE), or a combination of these examinations as approved by the board, with scores deemed satisfactory to the board, passed the qualifying examination of the Educational Commission for Foreign Medical Graduates [~~prior to 1984~~], and has at least three years of medical training or experience in a hospital approved by the Council on Medical Education and Hospitals of the American Medical Association for internship or residency may be licensed by the Hawaii medical board under section 453-4(c); or

(b) Who has passed the Federation Licensing Examination (FLEX) or the United States Medical Licensing Examination (USMLE), or a combination of these examinations as approved by the board, with scores deemed satisfactory to the board, possesses an Educational Commission for Foreign Medical Graduates certificate, and has successfully completed two years of post-graduate medical training in an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved or Canadian program that has been accredited for resident training by the Royal College of Physicians and Surgeons of Canada, or by the College of Family Physicians of Canada. If the post-graduate medical training involves a subspecialty clinical fellowship program, the board may accept post-graduate medical training in a hospital that has an Accreditation Council for Graduate Medical Education or American Osteopathic Association or accredited Canadian post graduate medical training program in the parent specialty."

SECTION 2. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 3. This Act shall take effect upon its approval.

INTRODUCED BY: _____

__.B. NO._____

BY REQUEST

__.B. NO._____

Report Title:

DCCA; Hawaii Medical Board; Foreign medical graduates; alternate qualifications; examination

Description:

Authorizes the Hawaii Medical Board to provide graduates of foreign medical schools with alternate methods of qualifying for a Hawaii medical license.

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.

ACT 133

S.B. NO. 2870

A Bill for an Act Relating to Medicine and Surgery.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Chapter 453, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§453- Foreign medical graduates; alternative qualifications.** Notwithstanding section 453-4(b)(2)(B), a graduate of a foreign medical school who has passed the federation licensing examination (FLEX) with scores deemed satisfactory to the board, passed the qualifying examination of the Educational Commission for Foreign Medical Graduates prior to 1984, and has at least three years of medical training or experience in a hospital approved by the Council on Medical Education and Hospitals of the American Medical Association for internship or residency may be licensed by the board of medical examiners under section 453-4(c)."

SECTION 2. New statutory material is underscored.[1]

SECTION 3. This Act shall take effect upon its approval.

(Approved May 27, 1988.)

Note

1. Edited pursuant to HRS §23G-16.5.

SCR 1945 1526-88

Your Committee finds that the "sunset" law provided for in Chapter 26H has led to significant improvements in regulatory programs and that expanding the law to include the programs as provided in this bill will promote efficient and responsive regulation or termination of unwarranted regulation.

Your Committee on Consumer Protection and Commerce is in accord with the intent and purpose of S.B. No. 2114 and recommends that it pass Second Reading and be placed on the calendar for Third Reading.

Signed by all members of the Committee except Senators Fernandes Salling and Tungpalan.

SCRep. 1945 Consumer Protection and Commerce on S.B. No. 2870

The purpose of this bill is to provide graduates of foreign medical schools with an alternate method of qualifying for a Hawaii medical license.

Under current law, in order to obtain a license to practice medicine in Hawaii, a graduate of a foreign medical school must (1) have at least two years of residency in an approved program; (2) hold the national certificate of the Educational Commission for Foreign Medical Graduates (ECFMG); or the Certificate of the Fifth Pathway Program; and (3) pass the Federation Licensing Examination (FLEX).

This bill would allow licensure to foreign medical graduates who have (1) passed the FLEX; (2) passed the qualifying examination of the ECFMG prior to 1984; and (3) have at least three years of training or experience in an approved hospital. The major difference in qualifications proposed by this bill is that the applicant need not have the certificate of the ECFMG but instead must only present evidence of passing the ECFMG examination.

Testimony presented by the Hawaii Medical Association indicated that in order to obtain an ECFMG certificate, a person must, in addition to passing the appropriate examinations, document the completion of all educational requirements to practice medicine in the country in which the medical education was completed, or if the person is a national of the country in which the education was completed, obtain an unrestricted license to practice medicine in that country. The testimony further indicated that there may be good reason for a foreign trained physician not to be eligible for, or not to have obtained, a license in the country where the person was trained. However, under the current law, whatever the reason, the person would be ineligible to obtain an ECFMG certificate, and therefore, ineligible for Hawaii licensure. This bill would allow such a person, who is otherwise qualified as provided in the bill, to obtain a license to practice medicine in Hawaii.

Your Committee received supporting testimony from the Director of Health, who noted that the bill does not lessen the qualifications for licensure but merely eliminates the requirement for the ECFMG certificate for applicants who have passed all examinations required for the certificate. The Department of Health strongly supported the bill because it has the potential to increase the number of trained physicians available for recruitment for Department of Health vacant positions.

Favorable testimony was also received from the Board of Medical Examiners and the Hawaii Medical Association with the reservation that the Board of Medical Examiners should be given the discretion to examine all circumstances surrounding the failure to obtain an ECFMG certificate before granting a license. Your Committee is in agreement that the Board should be given discretion in granting exceptions to the normal requirements and, therefore, has amended the bill appropriately. The bill has been further amended to add the word "of" between the words "years" and "medical" on line 10 of the bill.

Your Committee on Consumer Protection and Commerce is in accord with the intent and purpose of S.B. No. 2870, as amended herein, and recommends that it pass Second Reading in the form attached hereto as S.B. No. 2870, S.D. 1, and be placed on the calendar for Third Reading.

Signed by all members of the Committee except Senators Fernandes Salling and Tungpalan.

SCRep. 1946 Consumer Protection and Commerce on S.B. No. 2789

The purpose of this bill is to require applicants for a license to practice chiropractic to pass the National Board of Chiropractic Examiners' Written Examination and Written Clinical Competency Examination (WCCE).

Currently, Section 442-6, Hawaii Revised Statutes, requires applicants to pass parts I and II of the National Board of Chiropractic Examiners' examination in order to qualify for the state chiropractic examination. This bill will specify that applicants must pass both the Written Examination and the WCCE.

Your Committee heard supporting testimony from the Board of Chiropractic Examiners stating that the WCCE is designed to assess clinical competence and skills that are nationally accepted as necessary in light of common practice requirements. It is an objective examination which will be administered and defended by a national agency. Furthermore, it will reduce the scope of the practical examination now administered by the State since some test areas overlap; thus it will reduce potential liability for the State. Moreover, the WCCE has been accepted by over fifty percent of the state boards in the nation.

Your Committee finds that it is in the best interest of the public welfare that applicants be required to pass both the Written Examination and the WCCE, in order to ensure that they are qualified to practice chiropractic.

Your Committee has amended the bill by specifying the effective date to be November 1, 1988, and by making non-substantive technical changes for the purpose of clarity and style.

Your Committee on Consumer Protection and Commerce is in accord with the intent and purpose of S.B. No. 2461, S.D. 1, and recommends that it pass Second Reading and be placed on the calendar for Third Reading.

Signed by all members of the Committee.

SCRep. 1523-88 Consumer Protection and Commerce on S.B. No. 2793

The purpose of this bill is to permit the Director of Commerce and Consumer Affairs (Director) to set fees by rules adopted pursuant to Chapter 91, Hawaii Revised Statutes.

Under Section 26-9(k), the Director is authorized to adopt rules to establish, amend, or repeal registration renewal and late renewal fees; to increase or decrease fees charged by boards and commissions; and to maintain a reasonable relation between the revenues derived from fees and the cost or fair value of services rendered. This bill would grant the Director similar authority under Chapter 514A, the Horizontal Property Regime law, to set fees, including filing fees, issuance fees for public reports, related reimbursement fee amounts, and managing agents' registration fees.

Your Committee received testimony in favor of this administration bill from the Real Estate Commission.

Your Committee on Consumer Protection and Commerce is in accord with the intent and purpose of S.B. No. 2793, S.D. 1, and recommends that it pass Second Reading and be placed on the calendar for Third Reading.

Signed by all members of the Committee.

SCRep. 1524-88 Consumer Protection and Commerce on S.B. No. 2322

The purpose of this bill is to allow industrial loan companies to use recent real property tax assessments for the purpose of valuing residential properties if certain conditions are met.

Your Committee received favorable testimony from the Hawaii Financial Services Association that this bill would, in some cases, reduce the costs which a consumer would incur in trying to get a loan by saving on the cost of appraisals. Your Committee also received testimony that county tax assessors are qualified appraisers and that in the vast majority of cases the tax assessed values are less than appraisals. This conservative valuation would provide an adequate safeguard for sound lending.

Your Committee on Consumer Protection and Commerce is in accord with the intent and purpose of S.B. No. 2322 and recommends that it pass Second Reading and be placed on the calendar for Third Reading.

Signed by all members of the Committee.

SCRep. 1525-88 Consumer Protection and Commerce on S.B. No. 3000

The purpose of this bill is to allow resorts to serve liquor to guests on non-motor vehicles such as gondolas or horse-drawn carriages.

Your Committee received testimony that some of the newer resorts desire to serve liquor in horse-drawn carriages and other non-motorized vehicles on their premises. The bill would not affect the status of liquor service in vehicles permitted in section 291-3.4 of the Hawaii Revised Statutes.

Your Committee received testimony in favor of this bill from the Hawaii Hotel Association and the Hawaii Transportation Association.

Your Committee on Consumer Protection and Commerce is in accord with the intent and purpose of S.B. No. 3000, S.D. 1, and recommends that it pass Second Reading and be placed on the calendar for Third Reading.

Signed by all members of the Committee.

SCRep. 1526-88 Consumer Protection and Commerce on S.B. No. 2870

The purpose of this bill is to provide graduates of foreign medical schools with an alternate method of qualifying for a Hawaii medical license.

Under current law, in order to obtain a license to practice medicine in Hawaii, a graduate of a foreign medical school must:

(1) Have at least two years of residence in an approved program;

(2) Hold the national certificate of the Educational Commission for Foreign Medical Graduates (ECFMG), or the Certificate of the Fifth Pathway Program; and

(3) Pass the Federation Licensing Examination (FLEX).

This bill would allow licensure to foreign medical graduates who have:

(1) Passed the FLEX;

(2) Passed the qualifying examination of the ECFMG prior to 1984; and

(3) Have at least three years of training or experience in an approved hospital.

The major difference in qualifications proposed by this bill is that the applicant need not have the certificate of the ECFMG but instead must only present evidence of passing the ECFMG examination.

Your Committee received supporting testimony from the Department of Health, who noted that the bill does not lessen the qualifications for licensure but merely eliminates the requirement for the ECFMG certificate for applicants who have passed all examinations required for the certificate. The Department of Health strongly supported the bill because it has the potential to increase the number of trained physicians available for recruitment for Department of Health vacant positions.

Your Committee also received favorable testimony from the Board of Medical Examiners.

Your Committee on Consumer Protection and Commerce is in accord with the intent and purpose of S.B. No. 2870, S.D. 1, and recommends that it pass Second Reading and be placed on the calendar for Third Reading.

Signed by all members of the Committee.

SCRep. 1527-88 Consumer Protection and Commerce on S.B. No. 3011

The purpose of this bill is to exclude non-residential condominium apartments from the parking stall requirements of section 514A-14.5, Hawaii Revised Statutes.

Your Committee received favorable testimony on this bill from the Real Estate Commission, the Hawaii State Bar Association, and the Horizontal Property Regime Blue Ribbon Panel.

Your Committee on Consumer Protection and Commerce is in accord with the intent and purpose of S.B. No. 3011, S.D. 1, and recommends that it pass Second Reading and be placed on the calendar for Third Reading.

Signed by all members of the Committee.

SCRep. 1528-88 Consumer Protection and Commerce and Judiciary on S.B. No. 2784

The purpose of this bill is to provide that an unlicensed person is guilty of a misdemeanor for advertising as a contractor in a paid listing in any directory.

This administration bill would clarify an ambiguity in Section 444-9.2, Hawaii Revised Statutes, which has resulted in litigation, by creating a standard of advertising for contractors which would be easily understood and applied.

The original form of this bill was previously amended by the Senate to include the following provisions:

(1) Clarified Section 444-9.2(a) to firmly establish that the prohibited practice of an unlicensed contractor advertising is not limited, and that advertising includes any listing or heading which includes the word contractor;

(2) Amended Section 444-9.2(b) by providing that a publisher or producer who obtains a signed statement from the contractor to the effect that the contractor has read the advertisement or listing, is licensed as advertised, has included all applicable license numbers in the advertisement or listing, and knows of the law against false advertising, has a rebuttable presumption of compliance with the law;

(3) Added subsection (c) to Section 444-9.2 to provide that a contractor who has advertised falsely shall have the telephone number contained in the advertisement or listing disconnected; and

(4) Provided in new subsection (d) of Section 444-9.2, previously subsection (c), that good faith compliance by a public utility with subsection (c) is a complete defense to any civil or criminal action brought against it arising from the termination of telephone service.

Your Committees received testimony basically in favor of this bill, including the above amendments previously made by the Senate, from the Department of Commerce and Consumer Affairs, the Hawaii Business League and Hawaiian Telephone Company. Your Committees also received testimony that Hawaiian Telephone and the Department have reached a separate agreement between themselves to avoid any possible confusion or conflict, as a result of this bill, similar to the litigation which arose between them under the previous law. The terms of this agreement are:

1. Hawaiian Telephone/GTE Directories will provide educational messages under certain directory headings for the purpose of advising consumers of the contractors licensing laws. The placement and content of the messages will be agreed to by Hawaiian Telephone/GTE Directories and the Department/Contractors License Board annually;

THE SENATE
THIRTY-THIRD LEGISLATURE, 2025
STATE OF HAWAII

S.B. NO. 107

JAN 15 2025

A BILL FOR AN ACT

RELATING TO MEDICAL INFORMED CONSENT.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. Section 671-3, Hawaii Revised Statutes, is amended to read as follows:

"**§671-3 Informed consent.** (a) The Hawaii medical board [~~may~~] shall establish standards for health care providers to follow in giving information to a patient, or to a patient's guardian or legal surrogate if the patient lacks the capacity to give an informed consent, to ensure that the patient's consent to treatment is an informed consent. The standards shall be consistent with [~~subsection~~] subsections (b) and (c) and may include:

(1) The substantive content of the information to be given;

(2) The manner in which the information is to be given by the health care provider; and

(3) The manner in which consent is to be given by the patient or the patient's guardian or legal surrogate.

(b) The following information shall be supplied to the patient or the patient's guardian or legal surrogate [~~prior to~~] before obtaining consent to a proposed medical or surgical treatment or a diagnostic or therapeutic procedure:

(1) The condition to be treated;

(2) A description of the proposed treatment or procedure;

(3) The intended and anticipated results of the proposed treatment or procedure;

(4) The recognized alternative treatments or procedures, including the option of not providing these treatments or procedures;

(5) The recognized material risks of serious complications or mortality associated with:

(A) The proposed treatment or procedure;

(B) The recognized alternative treatments or procedures; and

(C) Not undergoing any treatment or procedure; and

(6) The recognized benefits of the recognized alternative treatments or procedures.

(c) Informed consent to a proposed medical or surgical treatment or a diagnostic or therapeutic procedure shall be

obtained from the patient or the patient's guardian or legal surrogate before the date that the treatment or procedure is to take place; provided that if the proposed procedure or treatment is to take place on the same day on which it is scheduled, the informed consent shall be obtained at the time the decision is made to schedule that procedure or treatment. A confirmation of the informed consent that was previously acquired may be obtained by the treating health care provider from the patient or patient's guardian or legal surrogate on the day of the treatment or procedure.

[~~(c)~~] (d) On or before January 1, 1984, the Hawaii medical board shall establish standards for health care providers to follow in giving information to a patient or a patient's guardian, to ensure that the patient's consent to the performance of a mastectomy is an informed consent. The standards shall include the substantive content of the information to be given, the manner in which the information is to be given by the health care provider and the manner in which consent is to be given by the patient or the patient's guardian. The substantive content of the information to be given shall

include information on the recognized alternative forms of treatment.

[~~(d)~~] (e) Nothing in this section shall require informed consent from a patient or a patient's guardian or legal surrogate when emergency treatment or an emergency procedure is rendered by a health care provider and the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of the patient's health.

[~~(e)~~] (f) For purposes of this section, "legal surrogate" means an agent designated in a power of attorney for health care or surrogate designated or selected in accordance with chapter 327E."

SECTION 2. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 3. This Act shall take effect upon its approval.

INTRODUCED BY: _____

Report Title:
Medical Informed Consent; Timing; Hawaii Medical Board; Standards

Description:
Requires the Hawaii Medical Board to establish standards for health care providers to ensure that a patient's consent to treatment is an informed consent. Requires that informed consent for a proposed medical or surgical treatment or a diagnostic or therapeutic procedure shall be obtained before the day of that treatment or procedure. Specifies that if the treatment or procedure is to occur on the same day it is scheduled, the informed consent shall be obtained at the time the decision is made to schedule that treatment or procedure.

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.

that has been delivered unintentionally alive at 20-weeks old. He clarified that an abortion is also a pre-term delivery and went on to state that the survivability of a 22-week delivery has 20% chance of survivability with today's technology, at 23-weeks and above, the survivability rate is 55% and above.

Dr. Dao went on to say that certain hospitals have rules regarding the matter where a physician is expected to do everything within their power to ensure the survivability of a 23-week-old and older infant. He went on to say that if the bill were to pass, it would conflict with the hospital's rules and standards of care.

Mr. Belcher thanked Dr. Dao for his elucidation on the matter.

Dr. Sawai commented that this bill limits the rights to an abortion, which she thinks should be a discussion between the provider and the patient and does not support this bill.

Dr. Fong agreed with Dr. Dao, and stated that the law would be setting the standard of care.

Mr. Belcher reminded the Board members that the bill criminalizes physicians for murder in the second degree if found guilty.

By consensus, the Board opposes the bill.

E. H.B. 516 RELATING TO HEALTH

The Board discussed this bill.

The purposes of this bill are to: authorize naturopathic physicians to provide written certification to qualifying patients for the medical use of cannabis; and clarify provisions regarding the establishment of bona fide physician-patient, naturopathic physician-patient, and advanced practice registered nurse-patient relationships via telehealth.

Ms. Quiogue informed the Board that this measure was deferred indefinitely, and will not be moving through the legislative process.

F. H.B. 518 / S.B. 17

The Board discussed these bills.

The purposes of these bills are to: require the Hawaii Medical Board to establish standards for health care providers to ensure that a patient's consent to treatment is an informed consent; require that informed consent for a proposed medical or surgical treatment or a diagnostic or therapeutic procedure shall be obtained prior to the day of that treatment or procedure; and

specify that if the treatment or procedure is to occur on the same day it is scheduled, the informed consent shall be obtained at the time the decision is made to schedule that treatment or procedure.

By consensus, the Board opposes these bills as outlined in prior years where similar measures were introduced.

G. H.B. 664 / S.B. 599 RELATING TO HEALTH

The Board discussed these bills.

The purpose of these bills is to expand the class of health care providers under whom respiratory therapists may practice respiratory care to include physician assistants and advanced practice registered nurses.

By consensus, the Board supports these measures.

H. H.B. 666 / S.B. 674 RELATING TO THE INTERSTATE MEDICAL LICENSURE COMPACT

The Board discussed its support of the Interstate Medical Licensure Compact at its January 19, 2023 meeting.

The purpose of these bills is to adopt the Interstate Medical Licensure Compact to create a comprehensive process that complements the existing licensing and regulatory authority of state medical boards and provides a streamlined process that allows physicians to become licensed in multiple states, thereby enhancing the portability of a medical license and ensuring the safety of patients.

By consensus, the Board will support these measures.

I. H.B. 685 RELATING TO ABORTION

The Board discussed this bill.

The purposes of this bill are to: prohibits the abortion of a fetus that contains a fetal heartbeat; provide certain exceptions; and establish penalties.

By consensus, the Board opposes this bill.

J. H.B. 884 RELATING TO TRAVELING TEAM PHYSICIANS

The Board discussed this bill.

SB17/HB518 RELATING TO MEDICAL INFORMED CONSENT.

The Board discussed these bills.

The purposes of these bills are to: require the Hawaii Medical Board to establish standards for health care providers to ensure that a patient's consent to treatment is an informed consent; require that informed consent for a proposed medical or surgical treatment or a diagnostic or therapeutic procedure shall be obtained prior to the day of that treatment or procedure; and specify that if the treatment or procedure is to occur on the same day it is scheduled, the informed consent shall be obtained at the time the decision is made to schedule that treatment or procedure.

Ms. Quiogue reminded the Board members that at its February 11, 2021, meeting the Board opposed similar measures, HB138 and SB203. She went on to add that at its February 2023, meeting, the Board opposed this measure because Subchapter 4 of Hawaii Administrative Rules chapter 16-85, address the purpose of informed consent, general standards of categories of information, manner of disclosure, refusal of information, etc. This was mandated by Act 114, Session Laws of Hawaii 2003.

The Board opposes this measure.

SB60 RELATING TO HEALTH

The Board discussed this bill.

The purposes of this bill are to: authorize state-licensed and credentialed physicians, advanced practice registered nurses, and physician assistants, who are not physically in the State, to issue prescriptions for certain controlled substances under a limited circumstance; and authorize pharmacies to dispense the prescriptions.

Ms. Quiogue reminded the Board members that at its February 2023 and January 2024, meetings, the Board voted to track this measure.

The Board will track this measure.

SB61 RELATING TO ASSOCIATE PHYSICIANS.

The Board discussed this bill.

The purposes of this bill are to: create a new category of professional licensure for associate physicians, which are recent medical school graduates who have passed certain medical exams but have not been placed into a residency program and

Implementation of Interstate Medical Licensure Compact Commission (IMLCC)

Implementation

On January 1, 2025, the Interstate Medical Licensure Compact went into effect.

Number of Non-State of Principal License(s) (SPL)

As of January 9, 2025, 16 Non-State of Principal Licenses were issued.

- 6 Osteopathic Physician (DOS) Licenses
- 10 Physician (MD) Licenses

Processing Time

The average processing time of 4 business days

Issues

There have been no reported issues at this time.

Updates to HMB Website

The Board's staff is currently working to add information to the HMB website that will provide information regarding the IMLCC and direct interested applicant's to the IMLCC's website.

It was moved by Mr. Belcher, seconded by Dr. Dao to reply to the inquirer citing the Board's defined scope of practice, and should they seek to pursue the opening of the clinic, it should provide more information to the Board.

B. Email inquiry from Krupa Patel, Compliance Analyst, nirvanaHealth RAdvance, regarding Hawaii Regulation on adverse determination related to prior authorization.

After due consideration, it was moved by Dr. Ignacio, seconded by Dr. Dao to forward the request to the Board of Pharmacy to provide a response.

C. Email inquiry from Jarrod Rainey, Partner, Goldsand Friedberg, regarding the Board's position on prescribing controlled substances via telehealth.

After due consideration, it was moved by Dr. Jaffe, seconded by Dr. Pratt, and unanimously carried to reply to Mr. Rainey, that controlled substances may only be prescribed after an initial in-person consultation.

For clarity, Chair Takanishi stated that under Hawaii Revised Statutes, the inquirer should be minimally informed that a Hawaii-licensed physician be in State to prescribe controlled substances. This is consistent with HRS chapter 329.

Chair Takanishi noted DAG Wong appeared to want to provide comment.

DAG Wong asked members whether they would like to address Mr. Rainey's questions point by point. For instance, for questions 1 and 3, the Board may advise Mr. Rainey that the Board does not interpret HRS chapter 329.

Chair Takanishi asked whether the Board should vacate its motion.

DAG Wong advised the Board that its motion was fine, and asked whether it would allow she and Ms. Quiogue to provide more detailed responses to Mr. Rainey's questions.

The Board answered in the affirmative.

Discussion on Limiting Attempts for the USMLE Step 3:

The Board will be defer the discussion on this matter to a later meeting.

Interstate Medical

A. Appointment of Commissioner

Licensure Compact Commission (IMLCC): The Board must appoint an additional commissioner to the IMLCC. Ms. Quiogue reminded members that the second commission member can be an executive officer of the Board.

It was moved by Mr. Belcher, seconded by Dr. Young, that one of its Executive Officers be appointed as the second commissioner to serve on the IMLCC.

Next Meeting: Thursday, March 7, 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 4:26 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
2/1/2024

( ) Minutes approved as is.
(X) Minutes approved with changes: March 7, 2024, meeting minutes.

REENTRY TO PRACTICE

Report of the FSMB Workgroup on Reentry to Practice
Draft, January 2025

Executive Summary

Physicians may take a leave from practice for a variety of reasons, necessitating reentry. The following document contains guidance for state medical boards when considering potential reentry to practice requirements for physicians seeking to resume active practice following a significant absence. Recommendations offered in the document reflect an appreciation that unique situations exist for physicians (hereinafter understood to include physician assistants/associates (PAs)) seeking to reenter practice, and flexibility is therefore encouraged, as is the need to consider reentry decisions on a case-by-case basis.

Key considerations for state medical boards in reentry decisions include:

- time out of practice;
- clinical and other relevant activities engaged in by the physician while out of practice;
- the need for assessment of a physician's competence prior to reentry to practice;
- reentry during public health emergencies;
- collection of data about licensee clinical activity;
- the variety of challenges faced by physicians seeking to reenter practice;
- instances where absence from practice occurs to manage potentially impairing illness;
- mentoring and supervision for reentering physicians; and
- differing requirements when retraining is required due to a change in scope of practice or a lack of training or experience in the physician's intended scope of practice.

The following recommendations are included for state medical boards:

1) State medical boards should proactively communicate with and educate licensees/applicants about the issues associated with reentering clinical practice and ways to be considered in clinically active practice.
2) Reentry to practice decisions should be made on a case-by-case basis.
3) All licensees/applicants returning to clinical practice after a period of inactivity should be required to provide a detailed description of their future scope of practice plans.
4) State medical boards and licensees/applicants who have been clinically inactive should collaborate when developing a reentry to practice plan. Applicants should provide proof of completion of the plan prior to reentry.
5) State medical boards should foster collaborative relationships with academic institutions, community hospital training centers, medical specialty certifying boards, state medical societies, state physician health programs, and state chapters of specialty societies, to develop and ensure the availability of assessment, educational and other interventions and resources for the various types of practices.
6) Supervisory arrangements for reentering physicians should be approved by state medical boards. Where formal supervision is not required, mentorship may be arranged by reentering physicians. State medical boards should make efforts, in collaboration with

relevant partners, to ensure a sufficient pool of supervisors and mentors is available to reentering physicians.

7) State medical boards should require licensees to report information about their practice as part of the license renewal process, including type of practice, status, whether they are actively seeing patients, specialty board certification status, and what activities they are engaged in if they are not engaged in clinical practice.
8) Licensees who are clinically inactive should be allowed to maintain their licensure status provided they meet the requirements set forth by the state medical board. Depending on a licensee's engagement in activities designed to maintain clinical competence, should the licensee choose to return to active clinical practice, the board may require participation in a reentry program.
9) State medical boards should be consistent in the creation and execution of reentry programs.

Introduction

In April 2012, the Federation of State Medical Boards (FSMB) adopted the *Report of the Special Committee on Reentry to Practice (2012).* The following year, the FSMB adopted the *Report of the Special Committee on Reentry for the Ill Physician (2013).* At the times of their adoption, the two reports addressed current regulatory challenges associated with physician reentry to practice, while recognizing that there was a paucity of research surrounding the issue. Despite minimal advances in research, widespread recognition has since developed that physicians may take a temporary absence from clinical practice for a variety of reasons, and physician reentry can be a common part of a physician's continuing practice of medicine. Organizations such as the American Medical Association (AMA), Federation of State Physician Health Programs (FSPHP), and others have developed policy documents, recommendations and guidelines to assist physicians with addressing these challenges and to explore and clarify the issues surrounding physician illness and its impact (see Appendix B for a list of resources).

Jeffrey D. Carter, MD, Chair of the FSMB, appointed the Workgroup on Reentry to Practice in May 2023 to update FSMB policies related to reentry to practice for state medical and osteopathic boards (hereinafter referred to as "state medical boards" and/or "medical boards"). The Workgroup was charged with conducting a comprehensive review of state medical and osteopathic board rules, regulations and policies related to reentry to practice; conducting a review and evaluation of FSMB policies, including *Reentry to Practice (HOD 2012)* and *Reentry for the Ill Physician (HOD 2013),* and specifically the recommendations regarding time out of practice, based on current evidence; conducting a literature review of related research, guidelines and other publications and the impact of demographic changes in the physician workforce on licensure and practice; identifying available educational resources and activities for physicians to positively impact their ability to demonstrate their fitness to reenter practice; and identifying options for competency assessment tools for state medical boards to evaluate physicians' fitness to reenter practice.

In meeting its charge, the Workgroup also surveyed medical boards to better understand the current priorities and procedures related to the departure and reentry to practice. Survey results indicated that reentry to practice is a high priority for medical boards. Results also indicated that 57 percent of responding medical boards ask licensees, whether during license renewal or another mechanism, if they are actively clinically practicing. However, a greater number of medical boards (69 percent of respondents) reported not collecting data on the number of medical professionals who left clinical practice and applied for reentry.

The results of the survey helped guide Workgroup discussions, as did the involvement of a subject matter expert with extensive experience working in assessment and training of physicians (hereinafter understood to include physician assistants/associates (PAs)) reentering practice. These also helped inform the Workgroup's decision that *Reentry to Practice* and *Reentry for the Ill Physician* should be combined into one document, as did FSMB's recent experience working with state medical boards on the issue of physician well-being. This report, and recommendations, are intended to serve as a framework for common reentry standards and processes. These recommendations are also intended to provide flexibility for state medical boards and physician and PA licensees/applicants.

The recommendations provided in this report are organized as follows:

- Education and Communication
- Determining Competence to Reenter Practice
- Supervision and Mentoring for Practitioners Who Want to Reenter the Workforce
- Improving Regulation of Licensed Practitioners Who are Clinically Inactive

Section One. Glossary

The Workgroup presents the following glossary to support a common interpretation of key terms related to reentry to practice.

"Absence from Practice" means any duration of time that a physician voluntarily takes an absence from providing direct, consultative, or supervisory patient care. Some absences from practice may require a medical board-approved reentry process, whereas absences of shorter duration or absences that include activities aimed at maintaining competence may not. Unless otherwise specified, an absence from practice does not include absences that result from medical board disciplinary action.

"Clinically Active Practice" means engagement in direct, consultative, or supervisory patient care. Further details and activities, including frequency and intensity of engagement in such activities, may be defined by the state medical board.

"Mentoring" means a dynamic, reciprocal relationship in a work environment between two individuals where, often but not always, one is an experienced physician in active practice and the other is a physician reentering practice. The peer-relationship is aimed at providing the physician reentering practice with knowledge and resources to support safe reentry. This relationship is distinct from a supervisory relationship in that the mentor plays a supportive role but does not have a specific reporting responsibility to the medical board beyond that which would exist in any clinical context.

"Physician Reentry" means a return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity. Physician reentry is distinct from remediation or retraining.

"Physician Return to Work" means a return to clinical practice after a period of medical leave the duration of which would not be expected to negatively impact practice performance or require reentry interventions. Return to work planning typically occurs under the supervision of a physician health program.

"Physician Reentry Program" means a formal, structured curriculum including clinical experience which prepares a physician to return to clinically active practice following an extended period of clinical inactivity. Physician Reentry Programs follow and are informed by a comprehensive assessment of the physician's competence to determine educational needs.

"Physician Retraining" means the process of learning the necessary skills to move into a new clinical area that is distinct from the area of one's primary medical training. Physician retraining is distinct from physician reentry and may require a new residency.

"Specialty Board Certification" means a process for defining specialty-specific standards for knowledge and skills that includes an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty.[1]

"Supervision" means a medical board-mandated process whereby a supervisor physician, who has been actively practicing for at least the five prior consecutive years, is ABMS or AOA BOS board certified, has no prior disciplinary history during the previous five years and practices in the same clinical area as the licensee/applicant seeking reentry, observes a physician reentering practice for a defined period and provides feedback, education, and clinical support aimed at ensuring safe reentry to practice. This relationship is distinct from a mentoring relationship in that the supervisor has a defined responsibility to the medical board for assessing the reentering physician's competence and ability to practice independently. For physician assistants, the role of supervisor may be fulfilled by a supervising physician or a supervising PA who has been actively practicing for at least five consecutive years prior, is NCCPA board certified, has no disciplinary history during the last five years, and practices in the same clinical area as the licensee/applicant seeking reentry.

Section Two. Key Issues

The Workgroup identified several key issues relevant to state medical board decisions about reentry to practice.

Timeframe

More than two years away from practice is commonly accepted as the timeframe for when physicians should go through a reentry process. The two-year timeframe is based on extensive state medical board experience and subject matter expertise in physician assessment and remediation. The Workgroup recognizes the need for flexibility when applying the two-years-absent-from-practice timeframe to an individual physician, as there is great variability in specialty, type of practice, and clinical and educational engagement while absent from practice.

When determining whether a physician requires a reentry to practice program, a medical board may choose to consider the following factors:

- administrative or consultative activity during the time out of practice (e.g., chart reviews);
- concordance of prior and intended scopes of practice upon proposed reentry;
- educational, supervisory or mentoring responsibilities during the time out of practice;
- intention to perform procedures upon reentry and types of procedures proposed;
- length of time in practice prior to departure;
- participation in accredited continuing medical education and/or volunteer activities during the time out of practice;

[1] American Medical Association, *Medical Specialty Board Certification Standards H-275.926*, 2023, available at: https://policysearch.ama-assn.org/policyfinder/detail/certification?uri=%2FAMADoc%2FHOD.xml-0-1904.xml.

- participation in continuing certification[2] prior to departure from practice;
- prior disciplinary history;
- time since completion of post-graduate training; and
- whether the absence from practice was caused or exacerbated by illness or impairment (with or without board action)

Assessment of Competence to Reenter Practice

It is the responsibility of state medical boards to determine whether a licensee/applicant who has had an absence from practice should demonstrate whether they are competent to reenter practice. The assessment, as well as the assessment modality or modalities may be tailored to the individual. If it is not immediately clear how best to assess the licensee's competence, state medical boards are encouraged to seek the expertise of assessment organizations with experience in this area.[3] Boards may recommend that clinically inactive physicians proactively complete a self-assessment prior to reentering practice to identify any clinical deficiencies as this may be valuable in determining board-mandated reentry requirements.

Responsibility for assessment may take place through an assessment and remediation program. It may also take place through a formal supervisory relationship. In either case, the party responsible for supervision and assessment should provide ongoing assessment feedback to the reentering physician and updates to the state medical board about the physician's progress. See Appendix C for a sample assessment form that can be shared with the reentering physician and state medical board and should be adapted according to the needs of either party.

Public Health Emergencies

During public health emergencies, state medical boards may recognize the need to, and choose to, implement temporary licensure modifications and waivers allowing clinically inactive physicians to reenter practice. When doing so, medical boards should utilize mechanisms that can quickly identify and verify credentials of health professionals to ensure patient safety and maintain oversight of licensure waivers that fall outside medical board control. If a clinically inactive physician chooses to practice beyond the public health emergency, they must complete the appropriate reentry program determined by the state medical board. Boards are encouraged to make licensees aware of Provider Bridge[4] so they may choose to register as potential volunteers in advance of future public health emergencies.

State Medical Board Data Collection on Clinical Activity

State medical boards should consider means of collecting information from licensees about their clinical activity to understand workforce demographics. This data should be stratified by race, gender, ethnicity, language, and underserved practice areas to understand the equity impact of workforce demographics and determine what is needed to promote an equitable workforce that meets population health needs. While some state medical boards will be limited in their capacity to collect data on licensee clinical activity, they may wish to consider alternative means to

[2] The Workgroup recognizes that at the time of drafting, some specialty certifying boards continue to use the term "Maintenance of Certification" to describe this process.
[3] FSMB, Directory of Physician Assessment and Remedial Education Programs. September 2024, available at: https://www.fsmb.org/siteassets/spex/pdfs/remedprog.pdf.
[4] https://www.providerbridge.org/

collecting this on licensing applications such as optional surveys to licensees. This can be particularly important for understanding the degree to which active licensees are not clinically active and may inform reentry decisions for this population.

Challenges to Reentry

There are difficulties associated with identifying entities that provide reentry services to physicians. These include cost, geographic considerations, eligibility requirements, licensure status, malpractice issues and lack of uniformity among entities available to physicians seeking reentry. While some of these challenges are outside the purview of state medical boards, others can be mitigated by boards, including requirements for mentors, rather than supervisors, and the ability to obtain a training license. State medical boards may choose to review their current practices to avoid undue burdens or barriers to reentry, while being mindful of patient safety considerations. Boards may proactively choose to communicate these challenges to licensees so that they can plan accordingly when an absence from practice is anticipated. This can help avoid possible inequities with certain populations, as well as those in difficult socioeconomic circumstances that may present additional challenges to accessing reentry processes.

Common challenges to consider may include:

- *Reentry planning for extended absences due to illness or impairment:* When illness or impairment result in an extended absence from practice, medical boards have the additional challenge of considering medical fitness for practice in addition to competence. Board actions related to impairment can also present reentry challenges, especially when the board action (such as license suspension) does not address the additional reentry requirements that may be needed should the physician remain under suspension or restriction for an extended period. Physician health programs are a valuable resource to assist state medical boards with reentry planning when concerns of illness or impairment are present.
- *Cost and duration of reentry programs*: Due to the time and resources required to effectively assess and support a physician through a reentry process, reentry programs are, of necessity, costly. However, they are an essential mechanism to inform state medical board decisions about reentry requirements in the interest of patient safety. State medical boards and others involved in supporting physician reentry should familiarize themselves with their state Vocational Rehabilitation programs which are often able (and required by law) to assist with the costs of reentry programs for physicians.
- *Accessibility of reentry programs*: There is a wide range of entities[5] that offer reentry services, ranging in remediation programs to mini residencies. Accessibility may vary depending on the needs of the reentering physician and the geographic location of reentry programs. However, as some services are being offered online, accessibility is improving.
- *Availability of mentors and supervisors*: It may be challenging for medical boards to identify and select mentors and supervisors based on the needs of the reentering physician, due to various reasons, including geographical location or specialty. Boards may develop a roster of mentors and supervisors that would serve in these roles for reentering physicians. Recruitment may occur through questions on renewal applications or through advertising in board publications.

[5] FSMB, Directory of Physician Assessment and Remedial Education Programs. September 2024, available at: https://www.fsmb.org/siteassets/spex/pdfs/remedprog.pdf.

- *Ability to obtain a training license (and engage in clinical activity without a full and unrestricted license)*: As many medical board-approved programs necessitate clinical training which includes direct patient care, a training license is required. However, this license type is not offered in all states. Boards may choose to evaluate whether their existing license types include a license that permits reentering physicians to practice within their reentry program. Possible license types may include a limited or special purpose license, temporary license, or a resident license.
- *Medical Liability Insurance and Hospital Credentialing/Privileging*: In many jurisdictions it is not possible to obtain liability insurance without first obtaining a medical license. As mentioned previously, because of this requirement, medical boards may again choose to evaluate whether their existing license types include a license that permits reentering physicians to obtain liability insurance required for practice. It is also not possible to obtain hospital privileges without first obtaining a license and liability insurance.

Impairment

Physicians with board action caused or exacerbated by illness or impairment can pose unique challenges for reentry after an extended absence from practice. In addition to this report, state medical boards should familiarize themselves with the FSMB's *Policy on Physician Illness and Impairment* (HOD, 2021) when considering illness and impairment as it presents in the regulatory context.

Ideally, physicians with impairing health conditions will receive appropriate assistance before circumstances necessitate reporting to the state medical board. This is more likely when there are opportunities for physicians to confidentially participate in state physician health programs. When concerns for impairment are reported to the state medical board, it is often possible for the board to refer the matter to the state physician health program without the need for disciplinary action. However, in some cases, impairing illness leads to behaviors or circumstances where discipline is appropriate and necessary. Such disciplinary actions can present unique challenges for return to work and reentry of the ill physician that may not always be anticipated in the disciplinary process. Often, physician health programs are best equipped to help program participants effectively navigate these challenges. As such, the value of state medical board and physician health program collaboration cannot be overstated.

For state medical boards *with* access to a state physician health program, the following are important considerations when an extended absence from practice was caused or exacerbated by illness:

1. State medical boards should weigh endorsement of fitness for practice from the PHP and/or facilitated by the PHP as part of its consideration of a reentry plan when extended practice leave was caused or exacerbated by illness.
2. State medical boards should avoid requiring disclosure of protected health information in developing reentry plans for PHP endorsed physicians.
3. State medical boards should consult with their state physician health program before finalizing orders for PHP involved physicians. This can help avoid orders that include specific monitoring requirements that might be difficult or impractical for the PHP to

implement, impose arbitrary time out of practice that can impede rehabilitation and reentry efforts, or create circumstances that can delay return to work or reentry for physicians who are otherwise fit for practice.

4. License restriction or suspension in cases of impairment may result in extended absences from practice that were not anticipated at the time of the board action. Such orders may stipulate the conditions for reinstatement or termination of restrictions but not include a discernable pathway for reentry when fitness has been restored. State medical boards should consider adding language to orders, in general terms, that address the possibility of additional reentry requirements should there be an extended absence from practice related to board action.

State medical boards that do not have access to a physician health program may have greater difficulty when consideration of illness or impairment is part of reentry planning. Such planning requires careful review of complex and often sensitive health information often pertaining to stigmatized health conditions. The potential for stigma, actual or perceived bias and discrimination in regulatory processes add further complexity to regulatory decisions by state medical boards. Additionally, the possibility of disclosure of medical records to state medical boards as a condition of reentry can undermine trust in the care provider-patient relationship. This can result in reluctance to divulge critical health information in the assessment and treatment process, thereby putting the physician as patient, in additional to that physicians future patients, at increased risk of harm.

For state medical boards *without* access to a state physician health program, the following are important considerations when an extended absence from practice was caused or exacerbated by illness:

1. State medical boards should utilize qualified, board-approved evaluators and treatment providers to determine fitness for reentry when extended practice leave was caused or exacerbated by illness. The *2019 FSPHP Physician Health Program Guidelines* and the *FSPHP Evaluation and Treatment Accreditation™ (FSPHP-ETA™) Standards for Accreditation of Evaluation and Treatment Services for Healthcare Workers in Safety-Sensitive Occupational Roles* can help state medical boards identify and approve qualified evaluators.
2. State medical boards should ensure that physicians with board action related to illness or impairment have decisions about reentry considered on a case-by-case basis. Once fitness to return has been established, these physicians should have access to the same set of reentry requirements, programs, and support as other physicians.
3. State medical boards should consider opportunities to reduce the risk of bias and discrimination in situations where they hold potentially stigmatizing health information. Redaction of records, blinding procedures, and case summaries that replace specific diagnoses with general terms such as “health condition” can help mitigate these risks.
4. State medical boards should refer to the FSPHP *2019 Physician Health Program Guidelines* and FSMB *Policy on Physician Illness and Impairment* when there is need to develop an ongoing program of health monitoring as part of a physician reentry plan.
5. State medical boards should critically evaluate their ability to understand and interpret data in mental health, neurocognitive, and substance use disorder evaluation and

treatment reports as it pertains to reentry planning. Consultation with physicians who have expertise in mental health, substance use disorders, and/or occupational medicine may be necessary.

Mentoring and Supervision of Reentry Physicians

Academic Medical Centers (AMCs) and Community Hospital Training Centers (CHTCs) have a role in physician reentry as they already have the facilities, faculty, and resources to effectively perform assessment and training. AMCs and CHTCs can provide a complete reentry package from initial assessment of the reentry physician to final evaluation of competence and performance in practice. AMCs can provide selected services on an as-needed basis such as assessment testing, focused practice-based learning, procedure labs and identifying and vetting mentors and supervisors. Acknowledging that assessments for reentry can involve costs that may not be borne solely by the reentering physician, potential incentives to stimulate AMC involvement in reentry include research opportunities and revenue generation.

To help state medical boards evaluate a reentering physician's competence and understand the scope of their reentry program, AMCs and CHTCs should collaborate on the completion of an assessment form. This form could summarize key aspects such as the reentering physician's activities, strengths identified, areas for improvement, a plan for addressing these areas, and any other relevant comments from the assessment (See Appendix C for a suggested template Assessment Form).

Maintaining Licensure if Not in Active Clinical Practice

Some states consider the work done and decisions made by medical directors of health care programs to be the practice of medicine and therefore they are required to have an active license. Other states issue administrative medicine licenses as a distinct area of practice, which includes consultations and other educational functions that are non-clinical in nature. These types of licenses do not include the authority to practice clinical medicine, examine, care for, or treat patients, prescribe medications including controlled substances, or delegate medical acts or prescriptive authority to others.[6]

Retraining When Practice Differs or is Modified from Area of Primary Training

Some physicians who seek reentry want to practice in a specialty or area that differs from their area of primary training. In such cases, it is considered retraining, not reentry, and would require the physician to complete the necessary educational and training requirements for the new specialty, likely to include a residency. An obstetrician/gynecologist wishing to practice family medicine would fall into this category and require retraining. A physician seeking to narrow their primary area of practice, however, would not necessarily need to complete retraining, such as when an obstetrician/gynecologist wishes to limit their practice to only gynecology.

[6] Iowa Code Ann. § 148.11A.

Section Three. Recommendations

The following recommendations are intended to provide state medical boards, licensees, health insurers, physician health programs, health care organizations, and state government agencies with a framework for developing common standards and terminology around the reentry process.

Education and Communication

Recommendation 1: Proactive communications

State medical boards should have materials that proactively educate licensees/applicants about ways to maintain competence while absent from practice and ways to be considered in clinically active practice. Such materials and education will prepare and inform licensees and applicants who are thinking about taking extended leave from active practice or are considering returning to clinical practice by:

- clarifying issues associated with reentering clinical practice (e.g., continued participation in CME activities while out of practice), and
- preventing unintended consequences of taking an extended leave from active practice such as impact on certification status, malpractice costs and future employment.

State medical boards could develop written guidance on issues such as the importance of engaging in clinical practice, if even on a limited, part-time basis, or seeking counsel from their insurance carriers prior to withdrawal from practice and when they are ready to reenter practice. They might also suggest that the licensee/applicant review the FSMB Roadmap for Those Considering Temporarily Leaving Practice (See Appendix A). State medical boards could include such information with the initial license, with the license renewal application, in the board's newsletter, and on the board's website. This may also help physicians who are contemplating retirement but are unaware that a reentry process may be required by their state medical board if they change their mind.

Determining Competence to Reenter Practice

Recommendation 2: Review on a case-by-case basis

Because competence is maintained in part through continuous engagement in patient care activities, licensees/applicants seeking to return to clinical work after an absence from practice should be considered on a case-by-case basis. Absences from practice of two years or greater are generally accepted as the minimum timeframe for when physicians should be required to engage in a reentry process. However, decisions about whether the licensee/applicant should demonstrate readiness to reenter practice should be based on a global review of the licensee/applicant's situation, including:

- administrative or consultative activity (e.g., chart reviews);
- concordance of prior and intended scopes of practice;
- educational, supervisory or mentoring responsibilities;
- intention to perform procedures upon reentry;
- length of time in practice prior to departure;
- participation in accredited continuing medical education and/or volunteer activities during the time out of practice;

- participation in ABMS or AOA continuing board certification prior to departure from practice;
- prior disciplinary history; and
- time since completion of post-graduate training;
- whether the absence from practice was caused or exacerbated by illness or impairment (with or without board action)

Licensees/applicants who wish to take some time away from clinical practice should be encouraged to remain clinically active in some, even if limited, capacity, and urged to participate in continuing medical education and continuous certification.

Recommendation 3: Documentation

All licensees/applicants returning to clinical practice after a period of inactivity should be required to provide a detailed description of their future scope of practice plans. The degree of documentation required may vary depending on the length of time away from clinical practice and whether the licensee/applicant's scope of practice is consistent with their medical education and training. For example, documented evidence might include CME certificates and verification of volunteer activities.

A physician returning to a scope or area of practice in which they previously trained or certified, or in which they previously had an extensive work history may need reentry. A physician returning to clinical work in an area or scope of practice in which they have not previously trained or certified or in which they have not had an extensive work history needs retraining and, for the purposes of this report, is not considered a reentry physician. The reentering licensee/applicant should also be required to provide information regarding the environment within which they will be practicing, the types of patients they anticipate seeing, and the types of clinical activities in which they will be engaged.

Recommendation 4: Reentry plan after extended time out of practice

State medical boards and licensees/applicants who have been clinically inactive should agree upon a reentry to practice plan based on various considerations, which may include a self-assessment by the licensee/applicant, assessment of the licensee/applicant's knowledge and skills, and any activities completed during the absence from practice. The state medical board has final approval of the reentry plan, and the licensee/applicant should be required to present proof of completion of the plan to the state medical board. (See Appendix D for a template reentry plan)

State medical boards should consider consultation or referral to the state physician health program[7] when a health condition may have caused or contributed to time out of practice. The physician health program can provide verification of health and fitness for duty and develop ongoing health support and monitoring when needed to support a reentry.

In instances where reentry plans require activities involving direct patient care, state medical boards may consider whether their existing license types allow for the reentering physician to participate in required reentry training programs. Such licenses permit the licensee/applicant to

[7] A list of state physician health programs is available through the Federation of State Physician Health Programs at the following link: https://www.fsphp.org/state-programs

participate in activities necessary to regain the knowledge and skills needed to provide safe patient care, such as participation in a mini residency.

Recommendation 5: State medical board collaborative relationships

State medical boards should foster collaborative relationships with academic institutions, community hospital training centers, specialty certifying boards, state medical societies, state physician health programs, and state chapters of specialty societies to develop assessment, educational and other interventions and resources for the various types of practices and reentry circumstances. The Accreditation Council for Continuing Medical Education, accredited CME community, American Board of Medical Specialties, American Medical Association, American Osteopathic Association Bureau of Osteopathic Specialties, National Board of Medical Examiners, and National Board of Osteopathic Medical Examiners and Federation of State Physician Health Programs may likewise serve in a supportive role to state medical boards in this regard. These institutions and organizations may have readily adaptable recommendations, programs or simulation centers that meet the individual needs of reentering physicians.

State physician heath programs often have considerable experience with physician reentry and return to work planning and may be a helpful resource to assist state medical boards develop plans and identify resources to assist with reentry.

<u>Supervision and Mentoring for Practitioners Who Want to Reenter the Workforce</u>

Recommendation 6: State medical board-approved supervisors and mentors

Supervisors may be selected by either the state medical board or the licensee/applicant, but in all cases should be approved by the state medical board. At a minimum, the supervisor should be actively practicing for at least the five prior consecutive years, be ABMS or AOA board certified, have no disciplinary history during the previous five years and practice in the same clinical area as the licensee/applicant seeking reentry.

The state medical board should set forth in writing its expectations of the supervisor, including what aspects of the reentering licensee/applicant's practice are to be supervised, frequency and content of reports by the supervisor to the state medical board, and how long the practice is to be supervised. The board's expectations should be communicated both to the supervisor and the licensee/applicant being supervised. For physician assistants, the role of supervisor may be fulfilled by the supervising physician or the supervising PA, who is NCCPA board certified, have no prior disciplinary history during the previous five years, and practice in the same clinical area as the licensee/applicant seeking reentry.

The supervisor should be required to demonstrate to the medical board's satisfaction that they have the capacity to serve as a supervisor, for example, sufficient time for supervising, lack of disciplinary history, proof of an active, unrestricted medical license, and demonstration of having actively practiced for at least the prior five consecutive years. The supervisor may be permitted to receive financial compensation or incentives for work associated with supervision. Potential sources of bias should be identified, and in some cases may disqualify a potential supervisor from acting in that capacity.

Separate from a supervisor, the licensee/applicant reentering practice should establish a peer-mentorship with an actively practicing physician who meets the requirements of a supervising physician. The mentor does not require medical board approval, nor would they take on additional mandatory reporting requirements beyond those which would typically exist in any clinical context. In certain circumstances the supervisor and mentor may be the same individual; in those situations, the supervisory requirements supersede the peer-mentorship role.

State medical boards should work with state medical and osteopathic societies and associations and the medical education community, including physician health programs, to identify and increase the pool of potential supervisors and mentors. To protect the pool of supervisors from liability, boards may make supervisors agents of the board.

Improving Regulation of Licensed Practitioners Who Are Clinically Inactive

Recommendation 7: Identifying clinically inactive licensees

State medical boards should require licensees to report information about their practice as part of the license renewal process, including type of practice, status (e.g., full-time, part-time, number of hours worked per week), whether they are actively seeing patients, specialty board certification status, and what activities they are engaged in if they are not engaged in clinical practice (e.g., research, non-medical work, retired, etc.). Such information will enable state medical boards to identify licensees who are not clinically active and to intervene and guide, as needed, if a licensee chooses to return to patient care duties. State medical boards should advise licensees who are clinically inactive of their responsibility to participate in an individualized, diagnostic reentry plan prior to resuming patient care duties.

Recommendation 8: Licensure status

Licensees who are clinically inactive should be allowed to maintain their licensure status if they pay the required fees and complete any required continuing medical education or other requirements as set forth by the medical board. Depending on a licensee's engagement in activities designed to maintain clinical competence including continuous participation in ABMS or AOA continuing board certification, should the licensee choose to return to active clinical practice, the board may require participation in a reentry program.

Recommendation 9: Consistency of reentry across jurisdictions

State medical boards should be consistent in the creation and execution of reentry programs. In recognition of the differences in resources, statutes, and operations across states, and acknowledging that implementation of physician reentry should be within the discretion and purview of each board, these guidelines are designed to be flexible to meet local considerations. However, physicians may reasonably be concerned about an overly burdensome reentry process where they might have to meet varying criteria to obtain licensure in different states. For purposes of license portability, FSMB will continue to track the implementation of these guidelines to facilitate transparency for licensees and encourage consistency among boards.

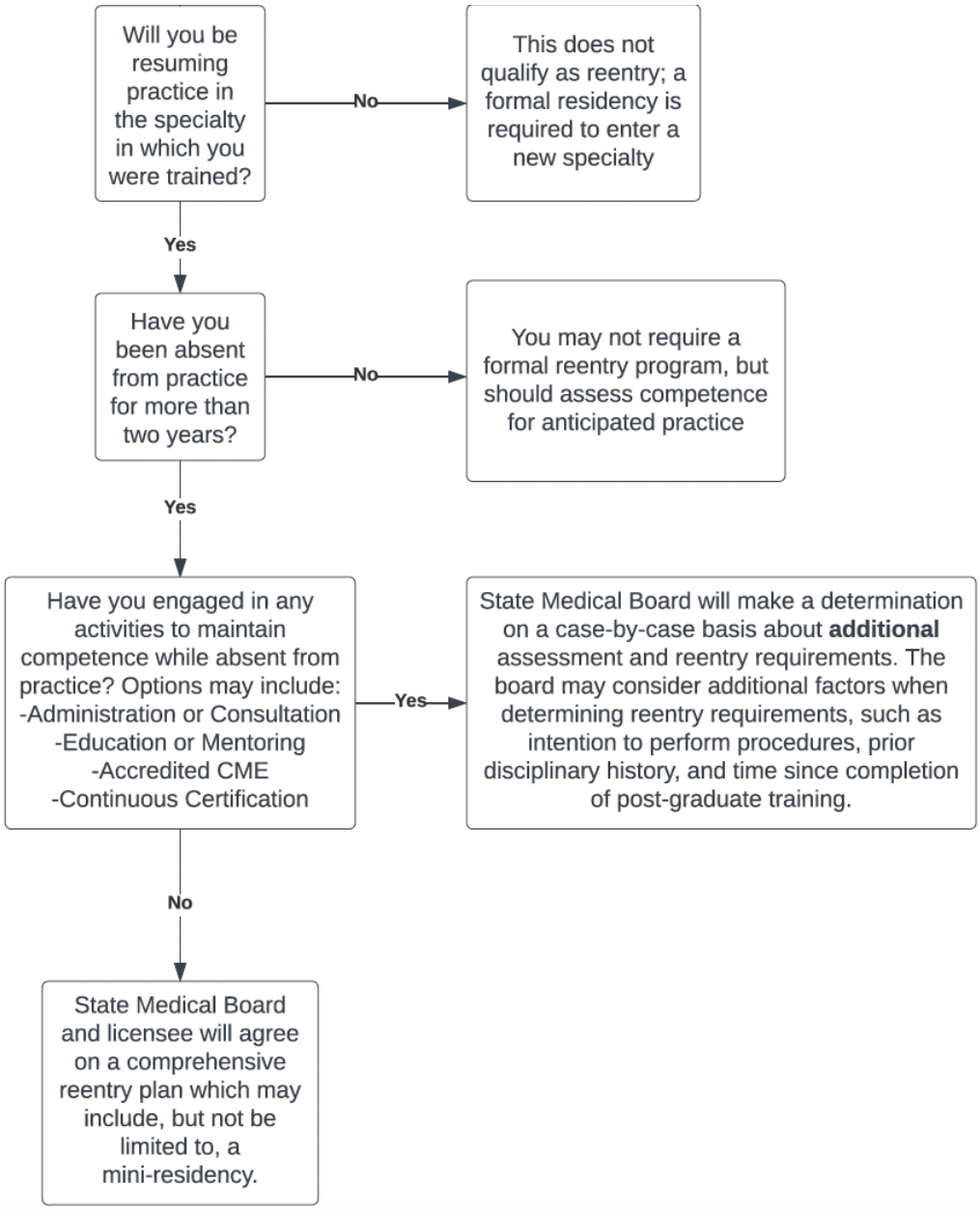
Recommendation 10: Evaluating effectiveness of reentry programs

State medical boards should monitor and evaluate the effectiveness of their reentry programs (i.e. percentage successfully completed the process, subsequent complaints and discipline, time in practice following reentry, etc.).

Conclusion

Since the FSMB's *Reentry to Practice (2012),* there has been widespread recognition that physicians may need or want to take a temporary absence from clinical practice for a variety of reasons, and physician reentry can be a normal part of a physician's continuing practice of medicine. State medical boards should create standardized processes for reentry to practice that allow flexibility for the board and for the licensee/applicant, while also ensuring patient safety. In creating reentry programs, state medical boards should rely on, and collaborate with, the broader medical system for education, training, and supervision and mentorship.

Appendix A. FSMB Roadmap for Those Considering Temporarily Leaving Practice



Appendix B. Additional policy resources related to physician health, illness and impairment, and physician reentry to practice

1. AMA: Resources for physicians returning to clinical practice, definition of physician impairment, Resources for Physician Health
2. AOA: Resources for Physician Wellness
3. CMSS/Specialty Society: CMSS Position on Physician Reentry (11/11)
4. FSPHP: Public Policy Statement : Physician Illness vs. Impairment
5. ACOG: Re-entering the Practice of Obstetrics and Gynecology
6. ACCME: Find a CME Provider

Appendix C. Sample Supervision Assessment Feedback Form for Reentry to Practice[8]

Physician Being Evaluated: _____

Date: _____

Supervising Physician/PA: _____

This form is intended to capture feedback provided by a supervisor to a physician or Physician Assistant (PA) who is working to reenter the active practice of medicine. Areas for feedback could be drawn from self-assessment of the reentering physician/PA and direct observation by the supervisor. In completing this form, it may be helpful to structure feedback according to one or more of the Core Competencies of medical practice:

- Medical Knowledge
- Patient Care
- Interpersonal and Communication Skills
- Professionalism
- Systems-Based Practice
- Practice-Based Learning and Improvement

1. Strengths identified:
   _____
   _____
   _____
   _____

2. Areas for improvement:
   _____
   _____
   _____
   _____

3. Agreed interim plan:
   _____
   _____
   _____
   _____

4. Other comments:
   _____
   _____
   _____
   _____

[8] Adapted with permission from Texas A&M Rural and Community Health Institute KSTAR Program.

Appendix D. Template Reentry to Practice Plan (To be completed by physician applicant)

Physician Name:
License Number:
Date of Plan:

1. Background Information
    - Date last engaged in active clinical practice:
    - Reason for absence from practice:
    - Brief description of prior clinical practice and specialty/practice area:
2. Assessment of Current Knowledge and Skills
    - Results of formal assessment (if completed):
    - Self-assessment of strengths and areas needing improvement:
    - Plan for addressing any identified gaps:
3. Proposed Scope of Practice Upon Reentry
    - Specialty/practice area:
    - Is this the same as your prior specialty/practice area? (Y/N):
    - Types of procedures to be performed:
    - Patient population:
    - Practice setting:
4. Continuing Medical Education Plan
    - Number and type of CME hours completed in past 2 years:
    - Planned CME activities prior to reentry:
5. Clinical Skills Refresher Activities
    - Observerships/shadowing planned:
    - Simulation training planned:
    - Other clinical skills activities:
6. Supervision Plan
    - Name and credentials of proposed supervisor:
    - Frequency and nature of supervision:
    - Plan for supervisor's reporting to [medical board]:
7. Mentorship Arrangement (if applicable)
    - Name and credentials of proposed mentor:
    - Frequency and nature of mentorship:
8. Timeline
    - Proposed start date for supervised practice:
    - Estimated duration of supervision period:
    - Proposed date for return to practice:
9. Additional Information
    - Malpractice insurance status:
    - Hospital privileges status:
    - Any other relevant information:

Physician/PA Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

[Medical Board] Approval: _____ Date: _____

FSMB WORKGROUP ON REENTRY TO PRACTICE[9]

Members

George M. Abraham, MD, MPH, Workgroup Chair
FSMB Board of Directors
Former Chair, Massachusetts Board of Registration in Medicine

John S. Antalis, MD
Former Chair, Georgia Composite Medical Board

Nathaniel B. Berg, MD
Chair, Guam Board of Medical Examiners

Kevin Bohnenblust, JD, CMBE
Executive Director, Wyoming Board of Medicine

Erin Cramer, PA-C
Secretary, Oregon Medical Board

Lawrence J. Epstein, MD
Chair, New York State Board for Medicine

Rebecca Fishman, DO
Vice President and Fellow, American Osteopathic College of Physical Medicine and Rehabilitation
Fellow, American Academy of Physical Medicine and Rehabilitation

Allen Friedland, MD, FAAP, MACP
American Academy of Pediatrics

Maroulla S. Gleaton, MD
FSMB Board of Directors
Chair, Maine Board of Licensure in Medicine

Dawn Morton-Rias, EdD, PA-C, ICE-CCP, FACHE
President and CEO, National Commission on Certification of Physician Assistants

Shawn P. Parker, JD, MPA
FSMB Board of Directors
Former Member, North Carolina Medical Board

Naveed Razzaque, MD
President, Missouri Board of Registration for the Healing Arts

Robert S. Steele, MD
Medical Director, KSTAR Programs, Texas A&M Health Science Center

[9] State Medical Board or organizational affiliations are presented for purposes of identification and do not imply endorsement of any draft or final version of this report

Sanjay Desai, MD
Chief Academic Officer and Group Vice President of Education, American Medical Association

Geraldine T. O'Shea, DO
Trustee, American Osteopathic Association

Ex Officio

Jeffrey D. Carter, MD
Chair, FSMB

Katie L. Templeton, JD
Chair-elect, FSMB

Humayun J. Chaudhry, DO, MACP
President and CEO, FSMB

Staff Support

John P. Bremer
Director, State Legislation & Policy, FSMB

Andrew Smith, MPP
Manager, Legislation and Policy, FSMB

Mark Staz, MA
Chief Learning Officer, FSMB

Chelsea L. Fukunaga

From: Dawn R. Lee
Sent: Friday, January 10, 2025 7:18 AM
To: Chelsea L. Fukunaga
Subject: Fw: Invitation to USMLE workshop for state board members - March 14, 2025

Fyi

Dawn Lee
Administrative Assistant
Department of Commerce & Consumer Affairs
Professional & Vocational Licensing Division
P.O. Box 3469
Honolulu, Hawaii 96801

From: Frances Cain (FSMB) [redacted]
Sent: Friday, January 10, 2025 7:05 AM
To: Frances Cain (FSMB) [redacted]
Cc: Andrea Ciccone [redacted]
Subject: [EXTERNAL] Invitation to USMLE workshop for state board members - March 14, 2025

Dear State Board Executive Directors,

Happy New Year! I hope you are well!

On behalf of the United States Medical Licensing Examination (USMLE) program, I would like to invite your board members to attend a workshop on the USMLE. The USMLE program is working to increase its database of potential candidates to serve on USMLE test development committees and/or other USMLE committees and activities. In particular, we are striving to increase the number of physicians in our database who have **experience as *current or former members* of a state medical board.**

The meeting will be held on March 14, 2025, at FSMB offices in Euless, Texas.

In addition to providing an overview and updates on USMLE from program staff, we will also have time allotted for attendees to discuss any issues that state medical boards are seeing or addressing.

All travel expenses (i.e., airfare, lodging, food) will be covered by the USMLE program.

Interested board members can contact me directly to confirm their interest, and I will then provide them with details about attending in person or virtually.

Thank you in advance for your assistance. We look forward to hopefully seeing a member of your board on March 14!

Take care,
Frances

Frances Cain, MPA
Director, Assessment Services

Federation of State Medical Boards
400 Fuller Wiser Road | Euless, TX 76039
o. 817-868-4022 | fcain@fsmb.org | www.fsmb.org