Wisconsin Department of Safety and Professional Services
Division of Policy Development
4822 Madison Yards Way, 2nd Floor
PO Box 8366
Madison WI 53708-8366

Phone: 608-266-2112
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Tony Evers, Governor
Dan Hereth, Secretary

HYBRID (IN-PERSON/VIRTUAL)
MEDICAL EXAMINING BOARD
Room N208, 4822 Madison Yards Way, 2nd Floor, Madison
Contact: Tom Ryan (608) 266-2112
May 21, 2025

The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Board. Be advised that board members may attend meetings designated as "Hybrid" in-person or virtually.

AGENDA

8:00 A.M.

OPEN SESSION – CALL TO ORDER – ROLL CALL

A. Adoption of Agenda (1-5)

B. Approval of Minutes of April 16, 2025 (6-10)

C. Introductions, Announcements and Recognition

D. Reminders: Conflicts of Interest, Scheduling Concerns
1) Medical Examining Board and Affiliated Credentialing Boards joint meeting – September 17, 2025

E. Administrative Matters – Discussion and Consideration
1) Department, Staff and Board Updates
2) Board Members – Term Expiration Dates
   a. Bond, Jr., Milton – 7/1/2027
   b. Chou, Clarence P. – 7/1/2027
   c. Clarke, Callisia N. – 7/1/2028
   d. Ferguson, Kris – 7/1/2025
   e. Gerlach, Diane M. – 7/1/2028
   f. Goel, Sumeet K. – 7/1/2027
   g. Hilton, Stephanie – 7/1/2028
   h. Lerma, Carmen – 7/1/2024
   i. Leuthner, Steven R. – 7/1/2027
   j. Majeed-Haqqi, Lubna – 7/1/2027
   k. Schmeling, Gregory J. – 7/1/2025
   l. Siebert, Derrick R. – 7/1/2025
   m. Yu, Emily S. – 7/1/2028

3) **Wis. Stat. § 15.085 (3)(b) – Affiliated Credentialing Boards' Biannual Meeting with the Medical Examining Board to Consider Matters of Joint Interest**
   a. Physician Assistant Affiliated Credentialing Board – Jennifer Jarrett, Chairperson

F. 8:00 A.M. Preliminary Hearing on Statement of Scope – SS 025-25 on Med 21, Relating to Patient Health Care Records (11-14)
1) Review Preliminary Hearing Comments

G. Administrative Rules Matters – Discussion and Consideration (15-18)
1) Pending or Possible Rulemaking Projects
   a. Rule Projects Charts **(16-17)**
   b. Affiliated Credentialing Board Rule Summaries **(18)**

H. **Credentialing Matters – Discussion and Consideration (19-22)**
1) Physician Application language updates

I. Legislative and Policy Matters – Discussion and Consideration

J. Federation of State Medical Boards (FSMB) Matters – Discussion and Consideration
1) 2025 FSMB Annual Meeting Report **(23-57)**

K. Newsletter Matters – Discussion and Consideration

L. Interdisciplinary Advisory Committee Liaison Report – Discussion and Consideration

M. Professional Assistance Procedure (PAP) Discussion of Expansion to Include Mental Health Disorders

N. Controlled Substances Board Report – Discussion and Consideration

O. Interstate Medical Licensure Compact Commission (IMLCC) – Report from Wisconsin's Commissioners – Discussion and Consideration

P. Screening Panel Report

Q. Future Agenda Items

R. Discussion and Consideration of Items Added After Preparation of Agenda:
1) Introductions, Announcements and Recognition
2) Elections, Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments
3) Administrative Matters
4) Election of Officers
5) Appointment of Liaisons and Alternates
6) Delegation of Authorities
7) Education and Examination Matters
8) Credentialing Matters
9) Practice Matters
10) Public Health Emergencies
11) Legislative and Policy Matters
12) Administrative Rule Matters
13) Liaison Reports

14) Board Liaison Training and Appointment of Mentors
15) Informational Items
16) Division of Legal Services and Compliance (DLSC) Matters
17) Presentations of Petitions for Summary Suspension
18) Petitions for Designation of Hearing Examiner
19) Presentation of Stipulations, Final Decisions and Orders
20) Presentation of Proposed Final Decisions and Orders
21) Presentation of Interim Orders
22) Petitions for Re-Hearing
23) Petitions for Assessments
24) Petitions to Vacate Orders
25) Requests for Disciplinary Proceeding Presentations
26) Motions
27) Petitions
28) Appearances from Requests Received or Renewed
29) Speaking Engagements, Travel, or Public Relation Requests, and Reports

S. Public Comments

CONVENE TO CLOSED SESSION to deliberate on cases following hearing (s. 19.85(1)(a), Stats.); to consider licensure or certification of individuals (s. 19.85(1)(b), Stats.); to consider closing disciplinary investigations with administrative warnings (ss. 19.85(1)(b), and 448.02(8), Stats.); to consider individual histories or disciplinary data (s. 19.85(1)(f), Stats.); and to confer with legal counsel (s. 19.85(1)(g), Stats.).

T. Credentialing Matters

1) Application Review

a. F.V. – Visiting Physician Temporary Permit (IA-590672) **(58-86)**
b. H.I. – Visiting Physician Temporary Permit (IA-598435) **(87-119)**
c. J.K. – Predetermination Physician - MD (IA-571690) **(120-164)**

U. Proposed Stipulations and Interim Orders

1) 24 MED 0493 – Keith G. Hickey **(165-169)**

V. Deliberation on DLSC Matters

1) Proposed Stipulations, Final Decisions and Orders

a. 22 MED 308 and 24 MED 0105 – Kathryn A. Lilley **(170-177)**
b. 24 MED 0095 – Bashar E. Kiami **(178-183)**
c. 24 MED 0189 – Nathan T. Zwagerman **(184-190)**
d. 24 MED 0248 – Shankar M. Sundaram **(191-196)**
e. 24 MED 0379 – Geoffrey Roelant **(197-209)**

2) Administrative Warnings

a. 23 MED 177 – D.L.A. **(210-211)**
b. 24 MED 0216 – F.X.R. **(212-213)**
c. 24 MED 0342 – S.R.S. **(214-215)**
d. 24 MED 0440 – M.G.T. **(216-217)**
e. 25 MED 0017 – J.W.S. **(218-219)**
f. 25 MED 0066 – E.A.M.W. **(220-222)**

3) Case Closings

a. 22 MED 133 – M.M.M. **(223-234)**
b. 23 MED 347 – L.N.H. **(235-245)**
c. 23 MED 444 – H.R.B. **(246-254)**
d. 24 MED 0263 – G.A.C. & N.C.R. **(255-269)**
e. 24 MED 0368 & 24 MED 0373 – S.K.K. **(270-283)**
f. 24 MED 0487 – M.A.H. **(284-292)**
g. 24 MED 0490 – J.D.A. **(293-298)**
h. 25 MED 0037 – J.R.K. **(299-304)**
i. 25 MED 0038 – R.R.R. **(305-311)**
j. 25 MED 0044 – B.S.R. **(312-328)**
k. 25 MED 0106 – K.A.B. **(329-333)**

W. Deliberation of Items Added After Preparation of the Agenda

1) Education and Examination Matters
2) Credentialing Matters
3) DLSC Matters
4) Monitoring Matters
5) Professional Assistance Procedure (PAP) Matters
6) Petitions for Summary Suspensions
7) Petitions for Designation of Hearing Examiner
8) Proposed Stipulations, Final Decisions and Order
9) Proposed Interim Orders
10) Administrative Warnings
11) Review of Administrative Warnings
12) Proposed Final Decisions and Orders
13) Matters Relating to Costs/Orders Fixing Costs
14) Complaints
15) Case Closings
16) Board Liaison Training
17) Petitions for Extension of Time
18) Petitions for Assessments and Evaluations
19) Petitions to Vacate Orders
20) Remedial Education Cases
21) Motions
22) Petitions for Re-Hearing
23) Appearances from Requests Received or Renewed

X. Open Cases

Y. Consulting with Legal Counsel

RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

Z. Vote on Items Considered or Deliberated Upon in Closed Session if Voting is Appropriate

AA. Open Session Items Noticed Above Not Completed in the Initial Open Session

BB. Delegation of Ratification of Examination Results and Ratification of Licenses and Certificates

ADJOURNMENT

ORAL INTERVIEWS OF CANDIDATES FOR LICENSURE

VIRTUAL/TELECONFERENCE

9:00 A.M. OR IMMEDIATELY FOLLOWING THE FULL BOARD MEETING

CLOSED SESSION – Reviewing Applications and Conducting Oral Interviews of **two (2)** (at time of agenda publication) Candidates for Licensure – **Dr. Goel** and **Dr. Leuthner**

NEXT MEETING: JUNE 18, 2025

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MEETINGS AND HEARINGS ARE OPEN TO THE PUBLIC, AND MAY BE CANCELLED WITHOUT NOTICE.

Times listed for meeting items are approximate and depend on the length of discussion and voting. All meetings are held virtually unless otherwise indicated. In-person meetings are typically conducted at 4822 Madison Yards Way, Madison, Wisconsin, unless an alternative location is listed on the meeting notice. In order to confirm a meeting or to request a complete copy of the board's agenda, please visit the Department website at https:\\dsps.wi.gov. The board may also consider materials or items filed after the transmission of this notice. Times listed for the commencement of any agenda item may be changed by the board for the convenience of the parties. The person credentialed by the board has the right to demand that the meeting at which final action may be taken against the credential be held in open session. Requests for interpreters for the hard of hearing, or other accommodations, are considered upon request by contacting the Affirmative Action Officer or reach the Meeting Staff by calling 608-267-7213.

VIRTUAL/TELECONFERENCE
MEDICAL EXAMINING BOARD
MEETING MINUTES
APRIL 16, 2025

PRESENT: Milton Bond, Jr.; Clarence Chou, M.D. *(excused at 10:19 a.m.)*; Sumeet Goel, D.O.; Diane Gerlach, D.O.; Stephanie Hilton; Steven Leuthner, M.D.; Lubna Majeed-Haqqi, M.D.; Gregory Schmeling, M.D.; Derrick Siebert, M.D.; Emily Yu, M.D.

ABSENT: Callisia Clarke, M.D.; Kris Ferguson, M.D.; Carmen Lerma

STAFF: Will Johnson, Executive Director; Renee Parton, Legal Counsel; Nilajah Hardin, Administrative Rules Coordinator; Brenda Taylor, Board Services Supervisor; and other Department staff

CALL TO ORDER

Gregory Schmeling, Chairperson, called the meeting to order at 8:00 a.m. A quorum was confirmed with ten (10) members present.

ADOPTION OF AGENDA

MOTION: Diane Gerlach moved, seconded by Lubna Majeed-Haqqi, to adopt the Agenda as published. Motion carried unanimously.

APPROVAL OF MINUTES OF MARCH 19, 2025

MOTION: Sumeet Goel moved, seconded by Lubna Majeed-Haqqi, to approve the Minutes of March 19, 2025 as published. Motion carried unanimously.

ADMINISTRATIVE RULE MATTERS

Final Rule Draft: Med 27, Relating to Provisional Licensure for International Physicians

MOTION: Sumeet Goel moved, seconded by Steven Leuthner, to approve the Legislative Report and Draft for Clearinghouse Rule 24-099 on Med 27, Relating to Provisional Licensure for International Physicians for submission to the Governor's Office and Legislature. Motion carried unanimously.

Preliminary Rule Draft: Med 1, Relating to Licensure Requirements

MOTION: Emily Yu moved, seconded by Sumeet Goel, to approve the preliminary rule draft of Med 1, relating to Licensure Requirements, for posting for economic impact comments and submission to the Clearinghouse. Motion carried unanimously.

Adoption Order: Med 24, Telemedicine and Telehealth

MOTION: Steven Leuthner moved, seconded by Clarence Chou, to approve the Adoption Order for Clearinghouse Rule 24-039 (Med 24), relating to Telemedicine and Telehealth. Motion carried unanimously.

CONSIDER APPLICATION TO RESPIRATORY CARE PRACTITIONERS EXAMINING COUNCIL

Kristine Ostrander, MA, RRT – Respiratory Care Practitioner Member

MOTION: Sumeet Goel moved, seconded by Emily Yu, to approve Kristine Ostrander as a Medical Examining Board appointed member of the Respiratory Care Practitioners Examining Council. Motion carried unanimously.

CLOSED SESSION

MOTION: Clarence Chou moved, seconded by Steven Leuthner, to convene to Closed Session to deliberate on cases following hearing (§ 19.85(1)(a), Stats.); to consider licensure or certification of individuals (§ 19.85(1)(b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85(1)(b), Stats. and § 448.02(8), Stats.); to consider individual histories or disciplinary data (§ 19.85(1)(f), Stats.); and to confer with legal counsel (§ 19.85(1)(g), Stats.). Gregory Schmeling, Chairperson, read the language of the motion aloud for the record. The vote of each member was ascertained by voice vote. Roll Call Vote: Milton Bond, Jr.-yes; Clarence Chou-yes; Diane Gerlach-yes; Sumeet Goel-yes; Stephanie Hilton-yes; Steven Leuthner-yes; Lubna Majeed-Haqqi-yes; Gregory Schmeling-yes; Derrick Siebert-yes; and Emily Yu-yes. Motion carried unanimously.

The Board convened into Closed Session at 8:45 a.m.

CREDENTIALING MATTERS

Application Review

A.P. – Waiver of 24 Months of ACGME/AOA Accredited Post-Graduate Training (IA-529675)

MOTION: Sumeet Goel moved, seconded by Clarence Chou, to deny the Waiver of 24 Months of ACGME/AOA Accredited Post-Graduate Training application of A.P. (IA-529675). **Reason for Denial**: Wis. Stat. § 448.06(2) and Wis. Admin. Code § Med 1.02(3)(a) and (b). Motion carried unanimously.

Full Board Oral Interview

APPEARANCE: J.A.P. – Medicine and Surgery Applicant (IA-447687)

MOTION: Lubna Majeed-Haqqi moved, seconded by Sumeet Goel, to find that J.A.P. (IA-447687) achieved a passing score on the Full Board Oral Examination pursuant to Wis. Admin. Code § Med 1.06(4)(b). Motion carried unanimously.

MOTION: Steven Leuthner moved, seconded by Clarence Chou, to notify the Division of Professional Credential Processing that J.A.P. (IA-447687) achieved a passing score on the Full Board Oral Examination and that a license may be issued once all requirements are met. Motion carried unanimously.

DELIBERATION ON PROPOSED FINAL DECISION AND ORDERS

Benjamin S. Gozon, III, Respondent (DHA Case Number SPS-23-0074/ DLSC Case Number 22 MED 260)

MOTION: Clarence Chou moved, seconded by Steven Leuthner, to adopt with variance the Proposed Decision and Order of Default in the matter of disciplinary proceedings against Benjamin S. Gozon, III, DLSC Case Number DHA Case Number SPS-23-0074/ DLSC Case Number 22 MED 260. Motion carried unanimously.

DELIBERATION ON DIVISION OF LEGAL SERVICES AND COMPLIANCE (DLSC) MATTERS

Proposed Stipulations, Final Decisions and Orders

22 MED 185 – Gordon L. Mortensen

MOTION: Sumeet Goel moved, seconded by Clarence Chou, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Gordon L. Mortensen, DLSC Case Number 22 MED 185. Motion carried unanimously.

23 MED 343 – Wycliffe O. Okumu

MOTION: Steven Leuthner moved, seconded by Lubna Majeed-Haqqi, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Wycliffe O. Okumu, DLSC Case Number 23 MED 343 with correction. Motion carried unanimously.

24 MED 0229 – Luann Moraski

MOTION: Sumeet Goel moved, seconded by Clarence Chou, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Luann Moraski, DLSC Case Number 24 MED 0229. Motion carried unanimously.

24 MED 0379 – Geoffrey Roelant

MOTION: Clarence Chou moved, seconded by Sumeet Goel, to table the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Geoffrey Roelant, DLSC Case Number 24 MED 0379. Motion carried unanimously.

Complaints

22 MED 400 – O.V.A.

MOTION: Clarence Chou moved, seconded by Lubna Majeed-Haqqi, to find probable cause in DLSC Case Number 22 MED 400, to believe that O.V.A. has committed unprofessional conduct, and therefore, to issue the Complaint and hold a hearing on such conduct pursuant to Wis. Stat. § 448.02(3)(b). Motion carried unanimously.

(Gregory Schmeling recused themself and left the room for deliberation and voting in the matter concerning O.V.A., DLSC Case Number 22 MED 400.)

Administrative Warnings

Clarence Chou excused 10:19 a.m.

MOTION: Steven Leuthner moved, seconded by Sumeet Goel, to issue Administrative Warnings in the following DLSC Cases:
23 MED 336 – P.G.C.
24 MED 0276 – M.A.S.
25 MED 0016 – C.M.M.
Motion carried unanimously.

23 MED 312 – P.L.L.

MOTION: Lubna Majeed-Haqqi moved, seconded by Sumeet Goel, to refer back DLSC Case Number 23 MED 312, to DLSC for further investigation regarding the collaborative agreement and delineation of duties and to refer a complaint to the Board of Nursing against the APNP associated with this matter. Motion carried unanimously.

Case Closings

MOTION: Sumeet Goel moved, seconded by Stephanie Hilton, to close the following DLSC Cases for the reasons outlined below:
23 MED 201 – M.J.M. – No Violation
23 MED 298 – K.M.O. – No Violation
23 MED 360 – A.S.H. – Insufficient Evidence
23 MED 454 – H.R.A. – Insufficient Evidence
23 MED 563 – B.H.L. – No Violation
23 MED 567 – M.T.A. – No Violation
24 MED 0090 – J.T.J. – Insufficient Evidence
24 MED 0169 – C.L.L.M. – No Violation
24 MED 0302 – J.W.G. – No Violation
24 MED 0385 – T.R.R. – No Violation
24 MED 0475 – M.W.W. – No Violation
24 MED 0504 – K.E.M. – No Violation
24 MED 0519 – A.K.P. – No Violation
Motion carried unanimously.

RECONVENE TO OPEN SESSION

MOTION: Milton Bond moved, seconded by Emily Yu, to reconvene to Open Session. Motion carried unanimously.

The Board reconvened to Open Session at 10:38 a.m.

VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION

MOTION: Sumeet Goel moved, seconded by Stephanie Hilton, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

(Be advised that any recusals or abstentions reflected in the closed session motions stand for the purposes of the affirmation vote.)

DELEGATION OF RATIFICATION OF EXAMINATION RESULTS AND RATIFICATION OF LICENSES AND CERTIFICATES

MOTION: Lubna Majeed-Haqqi moved, seconded by Milton Bond, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

ADJOURNMENT

MOTION: Lubna Majeed-Haqqi moved, seconded by Diane Gerlach, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 10:40 a.m.

State of Wisconsin
Department of Safety & Professional Services

AGENDA REQUEST FORM

1) Name and title of person submitting the request:	2) Date when request submitted:
Nilajah Hardin **Administrative Rules Coordinator**	**05/08/25** Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting

3) Name of Board, Committee, Council, Sections:

Pharmacy Examining Board

4) Meeting Date:	5) Attachments:	6) How should the item be titled on the agenda page?
05/21/25	☒ Yes ☐ No	**8:00 A.M. Preliminary Hearing on Statement of Scope – SS 025-25 on Med 21, Relating to Patient Health Care Records** **1. Review Preliminary Hearing Comments**

7) Place Item in:	8) Is an appearance before the Board being scheduled? *(If yes, please complete Appearance Request for Non-DSPS Staff)*	9) Name of Case Advisor(s), if required:
☒ Open Session ☐ Closed Session	☐ Yes ☒ No	**N/A**

10) Describe the issue and action that should be addressed:

The Board will hold a Preliminary Hearing on this scope statement as directed by the Joint Committee for Review of Administrative Rules.

11) Authorization

Nilajah D. Hardin — 05/08/25

Signature of person making this request — **Date**

Supervisor (if required) — **Date**

Executive Director signature (indicates approval to add post agenda deadline item to agenda) — **Date**

Directions for including supporting documents:
1. This form should be attached to any documents submitted to the agenda.
2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.
3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

From:	Sen.Nass
To:	Hereth, Daniel - DSPS; DSPS; DSPS Admin Rules
Cc:	Tierney, Michael - DSPS; Sen.Nass - LEGIS; Rep.Neylon - LEGIS; Grosz, Scott A - LEGIS; Kauffman, Jill - LEGIS; Duchek, Mike - LEGIS
Subject:	JCRAR Directive to Hold Preliminary Hearing on Scope Statements SS-025-25
Date:	Thursday, April 17, 2025 12:18:16 PM

April 17, 2025

Gregory J. Schmeling, Chairperson
Medical Examining Board
Department of Safety & Professional Services
P.O. Box 8366
Madison, WI 53708-8366

RE: SS 025-25 – Patient health care records

Dear Chairperson Schmeling:

As co-chairperson of the Joint Committee for Review of Administrative Rules (JCRAR) and pursuant to s. 227.136 (1), Stats., I write to direct the Medical Examining Board (MEB) to hold a preliminary public hearing and comment period on Scope Statement SS 025-25, which was published in the Wisconsin Administrative Register on April 14, 2025.

Additionally, pursuant to s. 227.135 (2), Stats., please note that a scope statement may not be approved by the Secretary, the Department of Safety & Professional Services (DSPS), or any of the agencies under DSPS until after the preliminary public hearing and comment period is held by the agency, and accordingly, no activity may be conducted in connection with the drafting of a proposed rule until after such hearing and approval have occurred.

Please confirm receipt of this letter directing a preliminary hearing and comment period on the above scope statement.

Sincerely,

Steve Nass

Senator Steve Nass
Co-Chair, JCRAR

Cc: Dan Hereth, Secretary-designee, DSPS

STATEMENT OF SCOPE

MEDICAL EXAMINING BOARD

Rule No.: Med 21

Relating to: Patient Health Care Records

Rule Type: Permanent

1. Finding/nature of emergency (Emergency Rule only): N/A

2. Detailed description of the objective of the proposed rule:
The objective of the proposed rule is to revise chapter Med 21 to remove references to "physician assistant," as the Physician Assistant Affiliated Credentialing Board has their own chapters in the Wisconsin Administrative Code that govern their profession. The Board may make other updates as needed to align the Chapter with current medical practice standards.

3. Description of the existing policies relevant to the rule, new policies proposed to be included in the rule, and an analysis of policy alternatives:
The Board intends to update Wisconsin Administrative Code chapter Med 21 to reflect the current relationship between the Medical Examining Board and the Physician Assistant Affiliated Credentialing Board. Both Boards now have their own parts of the Administrative Code for their professions. Therefore, Med 21 should be updated to reflect this. While the chapter is open, the Board will review areas that need to be updated to meet current practice standards as well. An alternative would be to not revise the administrative code to accurately reflect requirements for Physicians and Physician Assistants. This would create confusion and a lack of clarity for stakeholders and licensees on what the rules are for patient health care records in Wisconsin.

4. Detailed explanation of statutory authority for the rule (including the statutory citation and language):
Section 15.08 (5) (b), Stats. states that "The Board shall promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains, and define and enforce professional conduct and unethical practices not inconsistent with the law relating to the particular trade or profession."

Section 448.40 (1), Stats., provides that "[t]he board may promulgate rules to carry out the purposes of this subchapter, including rules requiring the completion of continuing education, professional development, and maintenance of certification or performance improvement or continuing medical education programs for renewal of a license to practice medicine and surgery."

5. Estimate of amount of time that state employees will spend developing the rule and of other resources necessary to develop the rule:
Approximately 80 hours

6. List with description of all entities that may be affected by the proposed rule:
Wisconsin licensed physicians and physician assistants, and their respective employers

7. Summary and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule: None.

8. Anticipated economic impact of implementing the rule (note if the rule is likely to have a significant economic impact on small businesses):

The proposed rule will have minimal to no economic impact on small businesses and the state's economy as a whole.

Contact Person: Nilajah Hardin, Administrative Rules Coordinator, DSPSAdminRules@wisconsin.gov, (608) 267-7139.

Approved for publication:

Gregory Schmeling, M.D. Digitally signed by Gregory Schmeling, M.D. Date: 2025.03.07 12:56:41 -06'00'

Authorized Signature

3/7/25

Date Submitted

Approved for implementation:

Authorized Signature

Date Submitted

State of Wisconsin
Department of Safety & Professional Services

AGENDA REQUEST FORM

1) Name and title of person submitting the request:	2) Date when request submitted:
Nilajah Hardin, Administrative Rules Coordinator	05/08/25 Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting

3) Name of Board, Committee, Council, Sections:

Medical Examining Board

4) Meeting Date:	5) Attachments:	6) How should the item be titled on the agenda page?
05/21/25	☒ Yes ☐ No	Administrative Rule Matters – Discussion and Consideration 1. Pending or Possible Rulemaking Projects a. Rule Projects Charts b. Affiliated Credentialing Board Rule Summaries

7) Place Item in:	8) Is an appearance before the Board being scheduled? *(If yes, please complete Appearance Request for Non-DSPS Staff)*	9) Name of Case Advisor(s), if required:
☒ Open Session ☐ Closed Session	☐ Yes ☒ No	N/A

10) Describe the issue and action that should be addressed:

Attachments:
Rule Project Charts
Affiliated Credentialing Board Rule Summaries

(Board Rule projects can be Viewed Here if Needed: https://dsps.wi.gov/Pages/RulesStatutes/PendingRules.aspx)

11) Authorization

Nilajah D. Hardin — 05/08/25

Signature of person making this request **Date**

Supervisor (if required) **Date**

Executive Director signature (indicates approval to add post agenda deadline item to agenda) **Date**

Directions for including supporting documents:
1. This form should be attached to any documents submitted to the agenda.
2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.
3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

Medical Examining Board
Rule Projects (updated 05/08/25)

Clearinghouse Rule Number	Scope #	Scope Expiration	Code Chapter Affected	Relating clause	Current Stage	Next Step
Not Assigned Yet	099-24	03/23/2027	Med 1	Licensure Requirements	Preliminary Rule Draft Under EIA Comment, Fiscal Estimate, and Clearinghouse Review	Public Hearing Anticipated for Future Meeting
Not Assigned Yet	025-25	10/14/2027	Med 21	Patient Health Care Records	Preliminary Hearing on Statement of Scope held at 05/21/25 Meeting	Scope Implementation
24-039	117-23	06/26/2026	Med 24	Telemedicine and Telehealth	Rule Effective 6/1/2025	N/A
24-099	055-24	11/28/2026	Med 27	Provisional Licensure for International Physicians	Final Rule Draft and Legislative Report Approved by Governor's Office on 05/08/25	Submission for Legislative Review

Medical Examining Board
Affiliated Credentialing Board (ACB) Rule Projects

Clearinghouse Rule Number	Scope #	Scope Expiration	ACB Name	Code Chapter Affected	Relating clause	Current Stage	Next Step
25-020	097-22	06/12/2025	Athletic Trainers	AT 4	Protocol Requirements	Drafting Final Rule and Legislative Report	Submission for Governor's Office Approval and Legislative Review
24-098	064-24	12/03/2026	Dietitians	DI 1	Definitions	Drafting Final Rule and Legislative Report	Submission for Governor's Office Approval and Legislative Review
Not Assigned Yet	009-25	02/17/2027	Massage Therapy and Bodywork Therapy	MTBT 3	Education	Preliminary Hearing on Statement of Scope Ordered by JCRAR	Preliminary Hearing Anticipated at 05/19/25 Meeting
24-054	080-23	04/23/2026	Massage Therapy and Bodywork Therapy	MTBT 6	Temporary License	Legislative Review	Adoption Order Review at a Future Meeting
24-050	072-22	02/22/2025	Occupational Therapists	OT 1 to 5	Implementation of the Occupational Therapy Licensure Compact	Adoption Order ready for 06/10/25 Meeting	Submission for Publication and Effective Date
25-029	091-24	02/12/2027	Physician Assistant	PA 1 to 4	Implementation of the Physician Assistant Licensure Compact	Public Hearing Scheduled for 06/26/25 Meeting	Drafting Final Rule and Legislative Report
25-002	065-24	12/03/2026	Physician Assistant	PA 4	Physical Examinations	Drafting Final Rule and Legislative Report	Submission for Governor's Office Approval and Legislative Review
Not Assigned Yet	024-25	10/14/2027	Podiatry	Pod 1 and 9	Supervision of Physician Assistants	Preliminary Hearing on Statement of Scope Ordered by JCRAR	Preliminary Hearing Anticipated at 06/11/25 Meeting
Not Assigned Yet	023-25	10/14/2027	Podiatry	Pod 1 and 10	Podiatrists and Telehealth	Scope Statement Pending Chairperson Approval for Implementation	Drafting

Affiliated Credentialing Board (ACB) Rule Summaries

Athletic Trainers:

- AT 4, Relating to Protocol Requirements
    - Updates the Athletic Trainer Protocol to include already existing statutory practice exceptions and adds manual therapy as a service

Dietitians:

- DI 1, Relating to Definitions
    - Updates the definition of "regionally accredited college or university" to mean a college or university recognized by the US Department of Education as being accredited, instead of listing individual institutions by name

Massage Therapy and Bodywork Therapy:

- MTBT 3, Relating to Education (Scope Statement not implemented yet)
    - The ACB plans to change the initial licensure requirement of 600 education hours to match the standard recommended by the Federation of State Massage Therapy Boards.
    - Other updates may be made to the chapter to align with current practice if needed
- MTBT 6, Relating to Temporary Licenses
    - Updates to allow applicants to practice while waiting for their examination results.
    - Each temporary license expires after 6 months or when the applicant successfully passes their examination, whichever comes first.

Occupational Therapists:

- OT 1 to 5, Relating to Implementation of the Occupational Therapy Licensure Compact
    - 2021 WI Act 123 outlines all compact requirements in the statute.
    - This rule project adds compact privilege as a license option to the rules.

Physician Assistant:

- PA 1 to 4, Relating to Implementation of the Physician Assistant Licensure Compact
    - 2023 WI Act 81 outlines all compact requirements in the statute.
    - This rule project adds compact privilege as a license option to the rules.
- PA 4, Relating to Physical Examinations
    - Similar to the recent rule that amended Med 10, this rule requires that each licensee have a policy on chaperones for sensitive examinations, and that such a policy be made available to all patients.

Podiatry:

- Pod 1 and 9, Relating to Supervision of Physician Assistants (Scope Statement not implemented yet)
    - Due to 2021 WI Act 23, the ACB plans to create requirements for supervision of Physician Assistants by a Podiatrist.
- Pod 1 and 10, Relating to Podiatrists and Telehealth (Scope Statement not implemented yet)
    - The ACB plans to create requirements on Telehealth in line with 2021 WI Act 121.

State of Wisconsin
Department of Safety & Professional Services

AGENDA REQUEST FORM

1) Name and title of person submitting the request: Richanda Turner, Paralegal, on behalf of Renee Parton, Board Counsel		**2) Date when request submitted:** 05/08/2025 **Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting**
3) Name of Board, Committee, Council, Sections: Medical Examining Board		
4) Meeting Date: 05/21/25	**5) Attachments:** ☒ Yes ☐ No	**6) How should the item be titled on the agenda page?** Credentialing Matters – Discussion and Consideration A. Physician Application language updates
7) Place Item in: ☒ Open Session ☐ Closed Session	**8) Is an appearance before the Board being scheduled?** *(If yes, please complete Appearance Request for Non-DSPS Staff)* ☐ Yes <Appearance Name(s)> ☒ No	**9) Name of Case Advisor(s), if applicable:** N/A
10) Describe the issue and action that should be addressed: Board should consider updating language utilized in the Physician applications to conform with best practices as it relates to mental health disclosures and licensure.		
11)	**Authorization**	
Richanda Turner		*05/08/25*
Signature of person making this request		**Date**
Supervisor (Only required for post agenda deadline items)		**Date**
Executive Director signature (Indicates approval for post agenda deadline items)		**Date**

Directions for including supporting documents:

1. **This form should be saved with any other documents submitted to the Agenda Items folders.**
2. **Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.**
3. **If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.**

Additional Declarations

For the purposes of these questions, the following phrases or words have the following meanings:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned judgments and to learn and keep abreast of developments; and
2. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disability, emotional or mental illness, specific learning disabilites, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical Substances" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.
"Illegal use of Controlled Dangerous Substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances, which are not obtained pursuant to a valid prescription, or not taken in accordance with the directions of a licensed health care practitioner

12. Do you have a medical, physical, or mental condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If no, you may skip Question 13.
○ Yes ◉ No

13. If yes to Question 12, are the limitations or inpairments caused by your medical, physical, or mental condition reduced or ameliorated because you receive ongoing treatment (with or without medications), participate in a monitoring program, or reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?
○ Yes ◉ No

14. Do you use chemical substance(s), as defined above, that in any way impair or limit your ability to practice medicine with reasonable skill and safety?
○ Yes ◉ No

15. Are you currently (within the last two years) engaged in the illegal use of controlled dangerous substances?
○ Yes ◉ No

16. If yes to Question 15, are you participating in a supervised rehabilitation program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?
○ Yes ◉ No

17. Have you ever been diagnosed as having, or have you ever been treated for, pedophilia exhibitionism, or voyeurism?
○ Yes ◉ No

Previous

Physician Initial Application – Updates To Consider May 2025

For the purposes of these questions, the following phrases or words have the following meanings:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned judgments and to learn and keep abreast of developments; and
2. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disability, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, ~~drug addiction and alcoholism~~ substance use disorder, alcohol use disorder, or other substance use disorders.

"Chemical Substances" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of Controlled Dangerous Substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances, which are not obtained pursuant to a valid prescription, or not taken in accordance with the directions of a licensed health care practitioner

12. Do you have a medical, physical, or mental condition which ~~in any way~~ currently impairs or limits your ability to practice medicine with reasonable skill and safety? If no, you may skip Question 13.
Yes
No
13. If yes to Question 12, please describe the limitation and/or impairment, including whether you require an accommodation to ensure safe, competent practice. ~~are the limitations or impairments caused by your medical, physical, or mental condition reduced or ameliorated because you receive ongoing treatment (with or without medications), participate in a~~

~~**monitoring program, or reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?**~~

Yes

No

14. Do you use chemical substance(s), as defined above, that ~~in any way~~ currently impairs or limits your ability to practice medicine with reasonable skill and safety?

Yes

No

~~**15. Are you currently (within the last two years) engaged in the illegal use of controlled dangerous substances?**~~

~~Yes~~

~~No~~

~~**16. If yes to Question 15, are you participating in a supervised rehabilitation program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?**~~

~~Yes~~

~~No~~

17. Have you ever been diagnosed as having, or have you ever been treated for, pedophilia exhibitionism, or voyeurism?

Yes

No

State of Wisconsin
Department of Safety & Professional Services

AGENDA REQUEST FORM

1) Name and title of person submitting the request:		**2) Date when request submitted:** **4/30/2025** **Items will be consider4/30/ed late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting**
3) Name of Board, Committee, Council, Sections: **Medical Examining Board**		
4) Meeting Date: **5/21/2025**	**5) Attachments:** ☒ **Yes** ☐ **No**	**6) How should the item be titled on the agenda page?** **Federation of State Medical Boards (FSMB) Matters – Discussion and Consideration** • **2025 FSMB Annual Meeting Report**
7) Place Item in: ☒ **Open Session** ☐ **Closed Session**	**8) Is an appearance before the Board being scheduled?** *(If yes, please complete Appearance Request for Non-DSPS Staff)* ☐ **Yes** ☒ **No**	**9) Name of Case Advisor(s), if applicable:** **N/A**
10) Describe the issue and action that should be addressed: **Board members will deliver a report from the 2025 FSMB Annual Meeting.** **Attachments:** • **Report on Reentry to Practice** • **Report on Professionalism in the Context of Assessment for Licensure**		
11) Authorization **Signature of person making this request**		**Date**
Supervisor (Only required for post agenda deadline items)		**Date**
Executive Director signature (Indicates approval for post agenda deadline items)		**Date**
Directions for including supporting documents: **1. This form should be saved with any other documents submitted to the Agenda Items folders.** **2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.** **3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.**		

REENTRY TO PRACTICE

Report of the FSMB Workgroup on Reentry to Practice
Adopted by the FSMB House of Delegates, April 2025

Executive Summary

Physicians may take a leave from practice for a variety of reasons that later necessitate 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 sometimes exist for physicians – as well as physician assistants/associates (PAs), for whom many of the policy recommendations in this guidance may also apply[1] – 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 of 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 specialty-specific 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 in which the individual may demonstrate engagement in clinically active practice.

[1] Physicians and PAs are held to different standards of practice, reflecting differences in their training, experience, and expertise. Additionally, the degree of practice independence for PAs varies by state, with some requiring physician supervision and others allowing greater autonomy depending on regulatory frameworks.

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 (PHPs), 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 occurred that physicians may take a temporary absence from clinical practice for a variety of reasons, and physician reentry can be a common part of any 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 at the time, 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 licensure 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 (and physician assistants/associates (PAs). 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 its

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 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.

"Clinically Active Practice" means engagement in direct, consultative, or supervisory patient care, whether in-person or via telemedicine. 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 (PHP).

"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.[2]

"Supervision" means a medical board-mandated process whereby a supervisor physician, who has ideally been actively practicing for five prior consecutive years, is American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS) specialty 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 to provide 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 National Commission on Certification of Physician Assistants (NCCPA) 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, however, as there is great variability in specialty, type of practice, and clinical and educational engagement while absent from practice.

[2] 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.

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;
- participation in continuing certification[3] 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.[4] 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 may be shared with the reentering physician and state medical board and can 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 any licensure waivers that fall outside

[3] 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.

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

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,[5] a means by which they may choose to register in advance as potential volunteers for 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 collect this information 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 sometimes associated with identifying entities that provide reentry services to physicians. These relate to 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 (PHPs) 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 often required to effectively assess and support a physician through a reentry process, reentry programs are, of necessity, costly. However, they are an essential

[5] https://www.providerbridge.org/

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[6] that offer reentry services, ranging from 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. A need exists for accessible assessments for physician assistants. While options are available through NCCPA's certification and recertification examinations and various other sources, specialty-specific assessment needs remain, particularly in clinical skills and procedure-based assessment.
- *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 wish to develop a roster of mentors and supervisors who could serve in these roles for reentering physicians. Recruitment may be facilitated with questions on renewal applications or through advertising in board publications.
- *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 that includes direct patient care, a training license may be 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 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.

<u>Impairment</u>

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.

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

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 discernible 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 of the 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 addition to that physician's 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" may 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.

<u>Mentoring and Supervision of Reentry Physicians</u>

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 usually 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.[7]

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 should be 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, for example, would fall into this category and require retraining. A physician seeking to narrow their primary area of practice, such as when an obstetrician/gynecologist wishes to limit their practice to only gynecology, would not necessarily need to complete retraining,

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 an 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

[7] Iowa Code Ann. § 148.11A.

- preventing unintended consequences of taking an extended leave from active practice such as impact on specialty 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 BOS 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[8] 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 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, established reentry programs, 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 (ACCME), accredited CME community, ABMS, American Medical Association, AOA BOS, National Board of Medical Examiners, National Board of Osteopathic Medical Examiners, National Commission on Certification of Physician Assistants, and FSPHP may likewise serve in a supportive role to state medical boards in this regard. These institutions and organizations may have readily adaptable

[8] 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

recommendations and criteria to establish reasonable levels of competence, as well as programs or simulation centers that meet the individual needs of reentering physicians and physician assistants.

With respect to the assessment of physician assistants/associates for reentry purposes, ongoing collaboration with NCCPA on the development of specialty specific resources is recommended.

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.

Supervision and Mentoring for Practitioners Who Want to Reenter the Workforce

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. Ideally, the supervisor should be actively practicing for five prior consecutive years, be ABMS or AOA BOS 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 active practice for a period as defined by the board. 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 wish to 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 BOS 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.

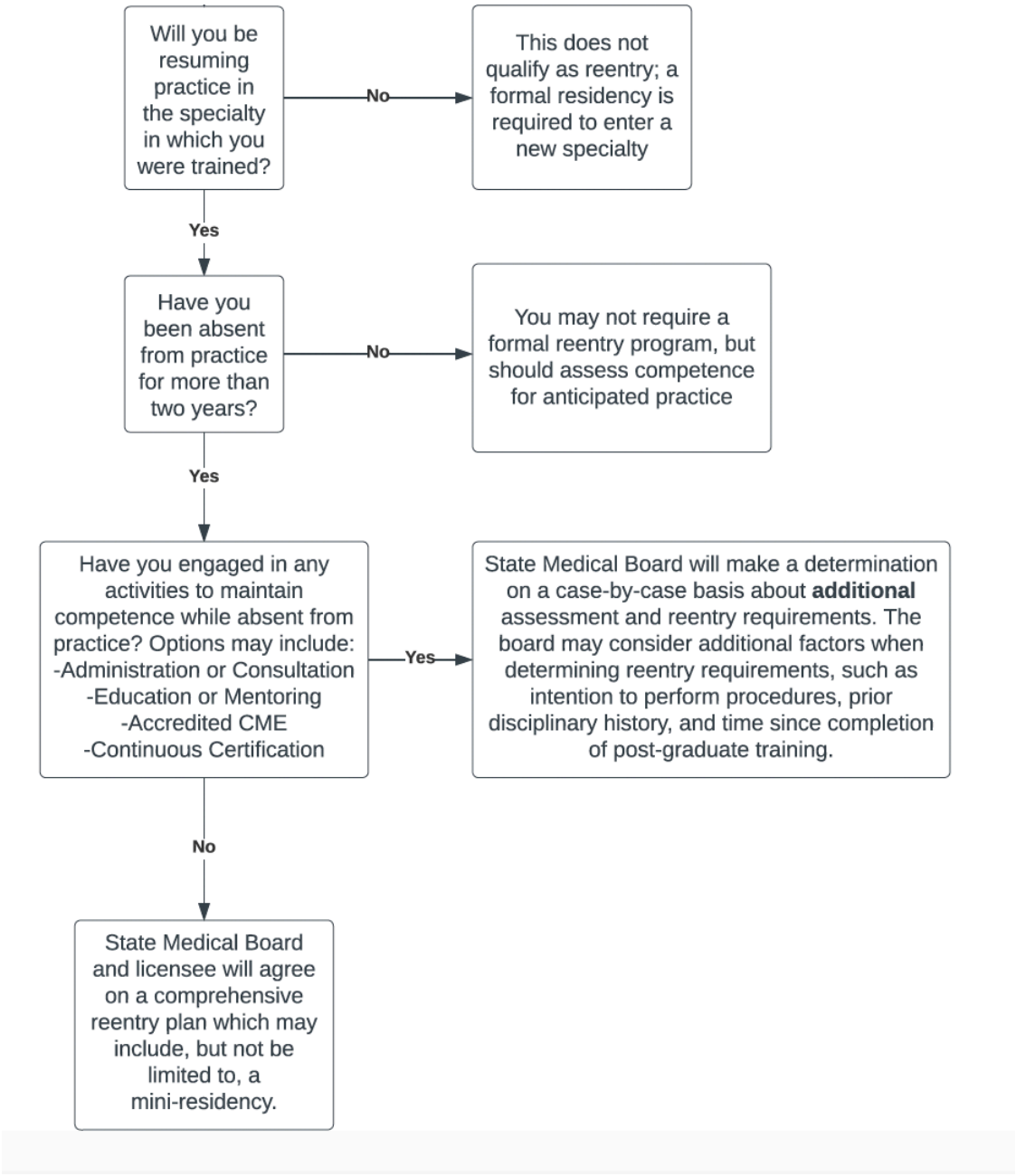
Recommendation 10: Evaluating effectiveness of reentry programs

State medical boards should monitor and evaluate the effectiveness of their reentry programs (i.e. percentage who have 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[9]

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:
   _____
   _____
   _____

[9] 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: _____

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PROFESSIONALISM IN THE CONTEXT OF ASSESSMENT FOR LICENSURE

Report of the FSMB Ethics and Professionalism Committee
Adopted by the FSMB House of Delegates, April 2025

Executive Summary

Professionalism is essential to the practice of medicine. New technologies and cultural shifts in response are causing medicine to evolve, but it is important that standards of professionalism remain consistent. Professionalism must be fostered and enforced from the beginning of medical education and training and throughout the licensing process, especially during licensing examinations. This report of the Federation of State Medical Boards (FSMB) Ethics and Professionalism Committee primarily focuses on professionalism related to examinations, due to their importance in the licensing process, however, academic dishonesty of any kind is generally considered unprofessional behavior, across all academic settings at every level of education. The report also explores the importance of the social contract, environmental factors, and new challenges to professionalism in the context of academic dishonesty. The report includes several recommendations directed to state medical boards, medical educators, and future physicians.

Section One. Background

Professionalism in medicine is not always easy to define. It encompasses a complex set of behaviors, values and attitudes that are subjective and can vary depending on context. Most definitions share a common root, however, when they describe a commitment by a physician or other health care professional to provide competent care with integrity, to uphold the best interests of the patient, and to be accountable to society. Professionalism also helps distinguish medicine as a highly skilled and trusted science and art – more of a calling than an occupation, even as more physicians are increasingly employed – with members who agree to adhere to high ethical standards such as truthfulness and honesty, and a commitment to safeguarding and promoting the public good.

We live in an extraordinary time as we enter the second quarter of this century, when advances in diagnostics and treatment are fundamentally changing how medicine is practiced. Generative artificial intelligence (A.I.) is beginning to revolutionize medical imaging, as one big example, while CRISPR gene-editing therapies are now able to successfully treat most patients with sickle cell disease, as one specific example. Recent concepts in health care delivery such as “value-based care” and “patient-centered, team-based care” are helping advance cost-effective health care and prevent disease, providing benefit to individual patients. And novel learning methodologies are improving

ways in which medical students and physicians-in-training are taught to provide safe and competent care, helping them keep up with rapid changes in the medical profession's knowledge and understanding of a myriad of conditions and illnesses. As advances like these become more mainstream and common, however, it is important to appreciate the unchanging nature of the principles that underlie the foundations of professionalism.

Particularly as technology enables newer learning strategies to train the next generation of physicians – everything from the "flipped classroom model" in medical school to "simulation-based learning" in residency-training – newer instances and types of lapses in judgment and professionalism are beginning to be observed among individuals pursuing a license to practice medicine.[1] It is these lapses that prompted Katie Templeton, JD, Chair of the Federation of State Medical Boards (FSMB), to task the FSMB's Ethics and Professionalism Committee in May of 2024 with providing updated guidance to state medical boards about professional expectations across the continuum of a physician's medical education (from medical school through residency training and practice). The Committee was tasked with balancing the real need for individuals to collaborate and share resources during training and practice with the independence required during their academic progression and professional assessment.

Gray areas in how professionalism in medicine is judged have long existed and state medical boards have gained experience over the years in grappling with how best to process, manage, investigate and adjudicate complaints about professionalism and professional misconduct. This document helps complement that experience, summarizing the foundations of professionalism, highlighting key features in the context of assessment for the purposes of determining licensure eligibility, and offering general recommendations for how professional expectations may be better conveyed, fulfilled, and enforced in today's context among learners and licensees.

Section Two. The Social Contract

Upholding the standards of professionalism is essential during all stages – and across all aspects – of a medical career. This typically begins in medical school with what has come to be known as the White Coat ceremony, which symbolically signifies entrance into the medical profession and/or the beginning of clinical care interactions, and almost always includes a recitation of the Hippocratic Oath or its equivalent. During this ceremony, future physicians pledge to abide by and fulfill a critically important *social contract*, an implicit agreement between physicians and society by which a physician pledges to provide competent, altruistic care to the public in exchange for professional autonomy and latitude within a self-regulatory framework.[2] Abiding by and exhibiting moral virtues, including competence, transparency, integrity, honesty, altruism and accountability, is an avenue

[1] "USMLE Program Statement on Notification of Invalidated Exam Scores," USMLE, January 31, 2024, https://www.usmle.org/usmle-program-statement-notification-invalidated-exam-scores.
[2] Cruess, Sylvia R., and Richard L. Cruess. "Professionalism and Medicine's Social Contract With Society." Journal of Ethics | American Medical Association, April 1, 2004. https://journalofethics.ama-assn.org/article/professionalism-and-medicines-social-contract-society/2004-04.

for health care professionals to exhibit professional behavior and adhere to the requirements of the social contract.

The social contract requires the physician to be competent in their profession. In the United States, physician competence is typically measured by an individual's performance on the United States Medical Licensing Examination (USMLE) and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) series of licensure examinations, administered at various points along the continuum of undergraduate and graduate medical education. Misconduct related to licensing exams—though relatively infrequent—has persisted over time.[3] While some physicians may question the value of licensing exams as an eligibility tool, it is helpful to recognize the compelling evidence of a direct connection between lack of competency, as measured by licensing exams, and increased risk of harm to patients.[4]

Fulfilling the social contract also requires that healthcare professionals uphold the pillars of transparency, integrity, and honesty. Physicians remain among the most highly respected professionals because of their adherence to these pillars.[5] Honesty and cooperation with state medical boards during the application process and any investigative efforts are also important for maintaining the integrity of the profession and the effectiveness of self-regulation.

There are gray areas to this component of the social contract, especially when it comes to exam preparation and education. Common practices such as group study, study banks of questions, and giving advice as an older student can sometimes straddle the lines (intentionally or otherwise) of what is appropriate and not when it comes to ethical preparation practices. Medical boards and medical educators have a unique opportunity to offer guidance in the face of these ethical challenges, and should set clear expectations for academic conduct, both for in-school exams as well as national licensing exams.[6]

USMLE and COMLEX-USA both have detailed guidance and directives in their policies that explicitly set forth expectations for professional conduct before, during, and after an

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[3] David Alan Johnson, "An Assessment of USMLE Examinees Found to Have Engaged in Irregular Behavior, 1992–2006," Journal of Medical Regulation 95, no. 4 (December 1, 2009): 26–35, https://doi.org/10.30770/2572-1852-95.4.26., Frances E. Cain et al., "Characteristics and Outcomes of Individuals Engaging in USMLE Irregular Behavior, 2006–2015," *Journal of Medical Regulation* 106, no. 4 (December 1, 2020): 8–16, https://doi.org/10.30770/2572-1852-106.4.8.

[4] Monica M. Cuddy et al., "Exploring the Relationships between USMLE Performance and Disciplinary Action in Practice: A Validity Study of Score Inferences from a Licensure Examination," *Academic Medicine* 92, no. 12 (December 2017): 1780–85, https://doi.org/10.1097/acm.0000000000001747., John Norcini et al., "The Associations between United States Medical Licensing Examination Performance and Outcomes of Patient Care," Academic Medicine 99, no. 3 (October 9, 2023): 325–30, https://doi.org/10.1097/acm.0000000000005480.

[5] Megan Brenan and Jeffrey M. Jones, "Ethics Ratings of Nearly All Professions down in U.S.," Gallup.com, October 16, 2024, https://news.gallup.com/poll/608903/ethics-ratings-nearly-professions-down.aspx.

[6] Module 2: Understanding medical licensure, accessed January 14, 2025, https://www.fsmb.org/siteassets/education/pdf/best-module-2-script-understanding-medical-licensure-transcript.pdf.

examination.[7] These agreements lay out what constitutes unprofessional conduct, including behaviors such as reproducing exam content, bringing unauthorized materials into the exam room, and having someone else take the exam in one's place.[8] Both examinations also include content that assesses knowledge about ethics and professionalism, highlighting the importance of the topics to the medical profession.[9]

Altruistic service to patients is another expectation for physicians in fulfilment of the social contract. Physicians should fulfill this expectation by placing patients' best interests ahead of their own, while also acting to safeguard the reputation of the medical profession. For example, abiding by ethical norms related to study and assessment and avoiding opportunities to engage in academic dishonesty, despite the possibility of achieving better assessment results for oneself, is a means for maintaining high ethical standards.

Lastly, accountability ties the social contract together. Health professionals must be held accountable not only for providing competent care to patients, but also for upholding the social contract itself. State medical boards have a key role in enforcing the values required by the social contract through their licensure and disciplinary efforts.[10] Although state medical boards cannot directly prevent academic dishonesty, they are positioned to act in the name of the profession when candidates with prior exam misconduct history present themselves for licensure. There is compelling evidence suggesting a correlation between individuals found to have engaged in misconduct related to their licensing exam and subsequent disciplinary action by state regulatory agencies.[11] It is essential that medical educators and others hold medical students and trainees accountable for adherence to ethical and professional standards early in their careers, as previous research has also suggested a strong correlation between problematic behaviors in medical school and later disciplinary action by medical boards.[12] Optimizing professionalism education within a trainee environment can be made difficult with

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[7] "Examination Day & Testing," Bulletin of Information | Exam Day & Testing, accessed January 14, 2025, https://www.usmle.org/bulletin-information/examination-day-testing., "Terms and Conditions," NBOME, October 8, 2024, https://www.nbome.org/assessments/comlex-usa/bulletin-of-information/terms-and-conditions/.

[8] "Examination Day & Testing," Bulletin of Information | Exam Day & Testing, accessed January 14, 2025, https://www.usmle.org/bulletin-information/examination-day-testing., "Terms and Conditions," NBOME, October 8, 2024, https://www.nbome.org/assessments/comlex-usa/bulletin-of-information/terms-and-conditions/.

[9] USMLE content outline, accessed January 14, 2025, https://www.usmle.org/sites/default/files/2021-08/USMLE_Content_Outline.pdf., "Comlex-USA Blueprint," NBOME, accessed January 14, 2025, https://www.nbome.org/assessments/comlex-usa/comlex-usa-blueprint/.

[10] Humayun J. Chaudhry, J. Daniel Gifford, and Arthur S. Hengerer, "Ensuring Competency and Professionalism through State Medical Licensing," *JAMA* 313, no. 18 (May 12, 2015): 1791, https://doi.org/10.1001/jama.2015.4017.

[11] Patient Note Fabrication and Consequences of Unprofessional Behavior in a High-Stakes Clinical Skills Licensing Examination, Johnson JC, Kim H, Johnson PA. Pedagogy in Perspective: Ethical Erosion and Effects on Empathy Levels in Healthcare Education. Med Sci Educ. 2021 Mar 22;31(3):1173-1175. doi: 10.1007/s40670-021-01273-3. PMID: 34457960; PMCID: PMC8368147.

[12] Margaret M Plack, "Unprofessional Behavior in Medical School Is Associated with Subsequent Disciplinary Action by a State Medical Board.," *Journal of Physical Therapy Education* 18, no. 2 (March 2004): 93, https://doi.org/10.1097/00001416-200407000-00018.

environmental factors prevalent in medical education and practice, some of which will be explored in the next section.

Section Three. Environmental Influences on Professionalism During Pathway to Licensure

There are environmental influences on professionalism along the pathway to licensure that can present challenges for students and trainees to uphold the values of the social contract. Ethical values do not exist in a vacuum, and there are many factors that influence decision-making, steering young professionals away from the core virtues of medical professionalism. One study found that medical students, when entering medical school, often have an adequate perception and appreciation of medical professionalism, yet something happens to erode that sense in some students.[13] Medical educators and other health professionals, particularly those who serve as mentors and role models, are already making great efforts to foster self-reflection on professionalism and reduce environmental factors that encourage unethical behavior, such as academic dishonesty.

Ethics and professionalism are widely taught in U.S. medical schools, although they can be difficult to connect to real-life ethical and professional dilemmas.[14] Common curricula include bioethics courses, common ethical scenarios, and emphasis on values such as honesty, integrity, respect for other professions, and altruism.[15] Educators should also continue to prioritize creating an equitable learning environment by fostering dialogue about these key curricular areas in ethics and professionalism, and ensuring a consistent understanding of what is and is not acceptable for test preparation. This is especially important as learning and practice environments evolve through technology, team-based learning, and team-based provision of care. This could occur by clarifying expectations around information sharing among learners and should be informed by the knowledge that materials and resources are more widely shared now than ever before, given the technological means for doing so. As such, education and expectations that support teamwork and collaboration while emphasizing honesty and integrity will offer learners guidance that better equips them to navigate new dilemmas in evolving educational and practice environments.

Many different types of motivations give rise to cheating behaviors, research shows, such as individual fear of failure, family expectations, stress around residency applications,

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[13] Sandra Vilagra et al., "Professional Values at the Beginning of Medical School: A Quasi-Experimental Study," *BMC Medical Education* 24, no. 1 (March 8, 2024), https://doi.org/10.1186/s12909-024-05186-8.
[14] Eve Glicksman, "'what Do I Do?' Teaching Tomorrow's Doctors How to Navigate the Tough Ethical Questions Ahead," AAMC, September 27, 2016, https://www.aamc.org/news/what-do-i-do-teaching-tomorrows-doctors-how-navigate-tough-ethical-questions-ahead., Osteopathic Medical Education and accreditation, accessed January 14, 2025, https://www.aacom.org/become-a-doctor/about-osteopathic-medicine/overview-of-osteopathic-medical-education-and-accreditation., Alberto Giubilini, Sharyn Milnes, and Julian Savulescu, "The Medical Ethics Curriculum in Medical Schools: Present and Future," The Journal of Clinical Ethics 27, no. 2 (Summer 2016): 129-45., Association of American Medical Colleges (AAMC), "Learning Objectives for Medical Student Education— Guidelines for Medical Schools: Report 1 of the Medical School Objectives Project," Academic Medicine 74 (1999): 13-8.
[15] Ibid.

monetary gain, pressure to help peers succeed, or the view that examinations are unnecessary hurdles that bar entry into the profession.[16] One study found that cheating is often influenced by goal setting, self-efficacy, and cost-benefit analysis.[17] Specifically, it found that cheating is most likely when goals center around extrinsic motivators, such as ego and performance, rather than learning and mastery, when students do not believe that they can achieve their goals, and they believe there is a low risk of consequences (i.e., getting caught) associated with engaging in dishonest behaviors.[18]

Many of these motivations may be influenced by the so-called hidden curriculum in medical education, defined as "learning that occurs by means of informal interactions among students, faculty, and others and/or learning that occurs through organizational, structural, and cultural influences intrinsic to training institutions."[19] Although educators of ethics and professionalism in medicine may emphasize the importance of integrity and upholding the social contract, the broader environment surrounding medical education and the hidden curriculum can undermine these values.

One example of this is seen in the use of USMLE performance related to screening and selection of medical students for residency training programs. With USMLE Step 1 converting to a pass/fail reporting system, residency programs and peers have placed a higher emphasis upon Step 2 scores, a significantly different purpose than USMLE's principal role in supporting state medical boards' decision-making to ensure a minimum competence standard for entry into the medical profession.[20] The same may be said of COMLEX-USA Level 1 scores when they converted to pass/fail reporting. The residency selection process and hidden curriculum can add an additional pressure to licensure exams by collapsing the measure of a prospective medical trainee to an examination score. Holistic evaluation of medical trainees can lead to a more professional and productive learning environment. While a holistic review of applicants should be the standard, current screening practices utilizing Step 2 threaten the holistic approach. An acknowledgement of the additional pressure placed on medical students to score highly on this examination is one step towards mitigating its effects.[21]

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[16] Tamera B. Murdock and Eric M. Anderman, "Motivational Perspectives on Student Cheating: Toward an Integrated Model of Academic Dishonesty," *Educational Psychologist* 41, no. 3 (September 2006): 129–45, https://doi.org/10.1207/s15326985ep4103_1.
[17] Tamera B. Murdock and Eric M. Anderman, "Motivational Perspectives on Student Cheating: Toward an Integrated Model of Academic Dishonesty," *Educational Psychologist* 41, no. 3 (September 2006): 129–45, https://doi.org/10.1207/s15326985ep4103_1.
[18] Tamera B. Murdock and Eric M. Anderman, "Motivational Perspectives on Student Cheating: Toward an Integrated Model of Academic Dishonesty," *Educational Psychologist* 41, no. 3 (September 2006): 129–45, https://doi.org/10.1207/s15326985ep4103_1.
[19] Carlton Lawrence et al., "The Hidden Curricula of Medical Education: A Scoping Review," *Academic Medicine* 93, no. 4 (April 2018): 648–56, https://doi.org/10.1097/acm.0000000000002004.
[20] Brendan Murphy, "How the Switch to Pass-Fail Scoring for USMLE Step 1 Is Going," American Medical Association, April 5, 2023, https://www.ama-assn.org/medical-students/usmle-step-1-2/how-switch-pass-fail-scoring-usmle-step-1-going.
[21] Andrea N. Belovich et al., "USMLE Step-1 Is Going to Pass/Fail, Now What Do We Do?," *Medical Science Educator* 31, no. 4 (June 4, 2021): 1551–56, https://doi.org/10.1007/s40670-021-01337-4. https://pmc.ncbi.nlm.nih.gov/articles/PMC8177252/

Role models are an essential aspect of promoting a professional environment that upholds ethical principles and values. One study found that medical students exposed to unprofessional behaviors of other physicians may be more likely to repeat those behaviors during their own careers.[22] Many medical students may not report unprofessional behaviors they encounter among peers or those to whom they report for a wide variety of reasons, including fear of retribution or a desire to fit in.[23] Medical trainees may be driven to lie or cheat to prevent backlash for lack of knowledge or missing a task. This can cause moral distress in medical students and takes away from the value of discussing errors as a way of learning.[24] In contrast, fostering a growth mindset among medical trainees, creating an environment where they feel safe to learn from mistakes, and reinforcing professional values like honesty and integrity will equip trainees to combat these ethical pitfalls throughout the path to licensure.

Section Four. New Challenges in Academic Integrity

Although violations of academic integrity are not new, there are many new challenges, such as artificial intelligence (AI), social media and internet chats, as well as predatory practices of rogue test preparation services.[25] AI offers students novel methods of cheating, highlighting the importance of vigilance and proactivity on the part of test administrators to mitigate any cheating efforts.[26] Some suggestions include using retrospective tools (including AI itself) to detect AI use once the quality improves, incorporating AI into assignments, and clear communication of assignment expectations.[27] Online activity occurring within closed messaging rooms and secure online applications make cheating behaviors conducted as part of an online social interaction difficult to track. Informal third-party efforts targeting examinees who recall test materials to aid in creating study guides also present challenges, as these behaviors directly cross an ethical line violating professional norms for physicians, fundamentally subverting the examination process.[28] Many of these forms of cheating arise within a highly competitive system that places the need for individual progress through that system above professional values of altruism and integrity. Medical educators and regulators

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[22] Galit Neufeld-Kroszynski, Keren Michael, and Orit Karnieli-Miller, "Associations between Medical Students' Stress, Academic Burnout and Moral Courage Efficacy," *BMC Psychology* 12, no. 1 (May 27, 2024), https://doi.org/10.1186/s40359-024-01787-6.
[23] Ibid. (associations)
[24] Ibid. (associations)
[25] Social Media and Electronic Communications, April 2019, https://www.fsmb.org/siteassets/advocacy/policies/social-media-and-electronic-communications.pdf.,
[26] Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice, April 2024, https://www.fsmb.org/siteassets/advocacy/policies/incorporation-of-ai-into-practice.pdf., Daniel Birks and Joe Clare, "Linking Artificial Intelligence Facilitated Academic Misconduct to Existing Prevention Frameworks," *International Journal for Educational Integrity* 1, no. 19 (June 27, 2023), https://doi.org/10.31235/osf.io/5cvs7.
[27] "AI & Academic Integrity: Center for Teaching Innovation," AI & Academic Integrity | Center for Teaching Innovation, accessed January 14, 2025, https://teaching.cornell.edu/generative-artificial-intelligence/ai-academic-integrity.
[28] "Optima University Owners Charged with Stealing Test Questions from Medical Licensing Exam," FBI, July 7, 2011, https://archives.fbi.gov/archives/newark/press-releases/2011/optima-university-owners-charged-with-stealing-test-questions-from-medical-licensing-exam.

should remain aware of how systems of dishonesty are evolving and continue to innovate preventive methods. Everyone in the medical community has a role in ensuring that the social contract is upheld, and it is important to work collaboratively in this space.

Section Five. Recommendations

State Medical Boards

1) Given the continued evolution and advancement of technology, state medical boards should remain familiar with current and novel challenges threatening professionalism across the continuum of medical education and practice. Resources such as this report and FSMB's report on *Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice* should be reviewed and considered to maintain current policies and procedures that uphold the ethical responsibilities of medical practitioners.
2) State medical boards should ensure that their laws, processes, and systems allow for disciplinary consideration of professional misconduct in all forms (including misconduct related to licensing examinations), with pathways for professional remediation available to contribute to further development of medical professionals.
3) State medical boards should connect with administrators of the USMLE or COMLEX-USA if there are questions regarding exam performance or irregular behavior. These assessment programs should continue to provide communications on pertinent issues.

Medical Educators

1) Test scores on licensing exams, which are not intended to stratify knowledge and skills beyond competence, should be weighted appropriately as a part of holistic assessments of a medical student's expertise in one or more basic or clinical science subjects. Educators should remain mindful that secondary uses of licensing examination scores place additional pressures upon examinees.
2) Medical educators should continue to foster an environment where honesty and integrity are rewarded, working to shift dialogue towards what matters most: learner development, and the delivery of quality health care and patient safety.
3) Medical educators should continue to be proactive in addressing changes in both learning and professional environments.
4) Medical schools should teach students and faculty alike about responsible use of AI, stay up to date about new uses of AI for unethical behavior, and refer to FSMB's report on *Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice.*
5) Required lectures and presentations in the principles and practices of ethics and professionalism should continue to be central components at all stages of the continuum of medical education.
6) Medical educators should continue to strive to create an equitable learning environment by encouraging collaboration, teamwork, and honesty. This includes being aware of how technology shapes test preparation practices and making appropriate adjustments.

Medical Trainees

1) Medical trainees should seek to understand the social contract between the medical profession and society and become aware of their professional responsibilities and how they should be fulfilled.
2) Medical trainees should become aware of unethical practices perpetuated by inappropriate and sometimes highly organized efforts that actively seek, and then disseminate, illicit test materials from recent examinees. Sharing and reproduction of examination content is, and always has been, against USMLE and COMLEX-USA examinee agreements to ensure all candidates have a fair and valid opportunity for licensure.

Section 6. Conclusion

State medical boards must have the ability to uphold the social contract by keeping medical professionals accountable for unprofessional actions. It is important that standards of professionalism are enforced and upheld at all stages of training and practice as a physician.

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