

# **Maintaining State-based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession**

## **The Federation of State Medical Boards of the United States, Inc.**

The recommendations contained herein were adopted as policy by the House of Delegates of the Federation of State Medical Boards of the United States, Inc., May 1998.

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### **Preface: A Perfect World**

Suppose the president asked you to devise a comprehensive system for effective regulation of the medical profession. You are given total discretion over the components of such a system; however, the president informs you that certain issues must be addressed.

- Standards for medical licensure must be maintained at the highest possible level.
- A medical license must be easily portable from one jurisdiction to another, yet mechanisms must be put in place to ensure that bad physicians cannot easily move to another jurisdiction to avoid prosecution for inappropriate behavior or poor medical care.
- Your new system must accommodate the rapidly-evolving technologies associated with telemedicine, and extend access to health care to the broadest possible segment of the American public.
- The various jurisdictions within the system must recognize standard definitions for their most-used terms.
- There must be standardized formats for applying for a license and reporting disciplinary actions taken against physicians.
- The jurisdictions must agree that "x" physician behavior, having been defined as substandard or inappropriate by the majority, shall be recognized as such by all.
- The system must be designed so that an appropriate balance is struck in the disciplinary area: The public must be protected from bad doctors, yet good doctors must be protected from wrongful, misguided, or overzealous prosecution.
- And, finally, the system must continually adapt to the changing environment of health care delivery in the United States.

The president of the Federation has made such a request.

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## **The Special Committee on Uniform Standards and Procedures**

### **Introduction and Charge**

The Special Committee on Uniform Standards and Procedures was formed in April 1996 by then-President James E. West, MD. The changing environment of health care delivery has led to the development of several issues that threaten the current state-based system of medical licensure and discipline. Of particular concern is managed care—with its needs for flexibility and demands for cost-effectiveness, licensure

portability in an increasingly mobile society, and telemedicine—with all its promise and yet-uncharted territory. As the practice of medicine undergoes these and other changes, the absence of uniformity and consistency in the licensing and disciplinary arenas exposes medical boards to criticism that the state-based system is not effectively adapting to the changes that have been brought about by new technology and the ever-increasing demand for instant health care. This criticism often includes a call for national licensing and disciplinary mechanisms. The Federation strongly believes that the state-based system retains a flexibility and sensitivity to local concerns that would inevitably be lost in a national system, and allows for the evolution and testing of a range of new approaches to improve the regulation of the medical profession in a number of jurisdictions at once.

The Federation, however, also recognizes that administrative inconsistency and the general lack of medical board autonomy in key operational areas pose grave threats to the future of state-based medical regulation. It was with a profound sense of urgency, then, that the Federation's leadership appointed the Special Committee on Uniform Standards and Procedures to craft recommendations to improve consistency and promote uniform standards for the effective regulation of the medical profession.

The Special Committee was charged with the following tasks:

1. Identify current standards utilized by state medical boards for the evaluation of physicians.
2. Evaluate the effectiveness of current standards in meeting desired objectives.
3. Determine what standards are common to all boards and draft uniform requirements/ language that could be recommended to state medical boards.
4. Identify outdated, inappropriate, or ineffective standards that should be eliminated, and identify the need for any new standards.
5. Draft recommendations to state medical boards which will improve uniform standards.
6. Identify current terms and language utilized by state medical boards.
7. Recommend uniform terms/language for adoption and use by state medical boards.
8. Analyze current procedures/processes used by state medical boards to license, regulate and discipline physicians, and identify such procedures/processes common to all state medical boards.
9. Develop recommended procedures/processes which will be uniform and applicable to all state medical boards, i.e., application process, complaint resolution, development of board orders, reporting requirements, consent orders, and stipulated agreements.

The committee met in fall 1996, and again in fall 1997 at the Federation's national office.

### **The Committee's Focus and Approach to the Task**

The Special Committee reviewed a variety of Federation documents and policy statements, and concluded that the Federation has already taken positions via these statements (i.e., *Essentials*, *Elements*, public policy statements, etc.) that recommend uniform approaches to a wide range of regulatory issues. Both the *Essentials* and the *Elements* have recently undergone extensive revisions in order to more accurately reflect the optimum structure and function of medical boards in a dynamic environment. The committee found, however, that several major obstacles have impeded boards' adoption of the recommendations contained in these Federation documents.

These obstacles include a general lack of operational autonomy, political constraints arising from difficulties associated with modifying state medical practice acts, and limited funding and staffing levels. The committee acknowledges the difficulties boards will face in implementing its recommendations.

The committee determined that creating a sense of urgency among member boards toward implementing the existing recommendations of the Federation would be a necessary part of its task. It was further determined that the following three goals must be achieved in order for the committee's work to be successful:

1. Identification of desirable and achievable standards and procedures.
2. Communication of a sense of urgency to member boards regarding the need for implementing these standards and procedures.
3. Development and execution of a comprehensive action plan to implement these standards and procedures throughout the Federation's membership.

In 1996, the committee agreed to divide its work into three broad categories: medical licensure (both initial and endorsement), disciplinary procedures and terminology, and medical board structure. In April 1997, however, a new Special Committee was created for the purpose of conducting a review of the Federation's document, *Elements of a Modern State Medical Board: A Proposal*. This committee addressed the optimum structure for a medical board as it developed recommendations for revising this document. The committee subsequently agreed that medical board structure should, therefore, be left to the purview of this new committee. Several items in the *Elements* document, however, were specifically endorsed by the committee in the course of its deliberations. The committee determined to focus its efforts largely on recommendations in the areas of medical licensure and discipline.

This report is divided into four sections. In accordance with the committee's charge, the first section presents an overview of standards and procedures which the committee has found to be desirable and already largely in place. The second section presents those elements of consistency and uniformity which are not currently in place and which the committee considers vital for member boards to implement as soon as practical. The third section presents a compilation of the committee's recommendations, and the fourth presents the committee's thoughts on actualizing these recommendations.

## **Part 1. Standards and Procedures Generally in Place**

The Special Committee has identified and briefly summarized several areas where desirable uniform standards or procedures have already been implemented by most of the Federation's members. The committee wishes to emphasize the importance of adopting these standards/procedures to those boards that have not yet done so.

### **Licensure**

The committee finds that licensure requirements are generally consistent across the Federation's membership. Virtually all boards require an applicant to show evidence of having graduated from an accredited medical school, to have passed an acceptable examination sequence and to have successfully completed at least one year in an Accreditation Council for Graduate Medical Education (ACGME)- or American Osteopathic Association (AOA)-approved postgraduate training program. Those areas of licensure standards in which the committee recommends additional or new standards are addressed in Part II of this report. In addition, the committee notes that the process of computerizing the USMLE, which is scheduled for implementation in 1999, will create more uniformity and consistency in the administration of the examination process, particularly in the areas of determining the qualifications required to sit for the exam sequence and who (or what group) verifies those qualifications.

### **Disciplinary Terminology and Processes**

#### **1. Standard of proof required in disciplinary procedures**

The committee finds that the standard of proof required of boards in disciplinary proceedings can have a substantial impact on overall board disciplinary activity and effectiveness. The committee endorses the Federation's official policy as outlined in *A Guide to the Essentials of a Modern Medical Practice Act (Essentials)*. This document recommends that boards ". . . be authorized to use preponderance of the evidence as the standard of proof in [their] role as trier of fact."<sup>1</sup> While most boards (43) currently use the recommended standard of proof, 22 boards use "clear and convincing," and one board uses "beyond a reasonable doubt."<sup>2</sup> The committee recommends the uniform adoption of the "preponderance of the evidence" standard, as higher standards of proof may make taking a disciplinary action against an errant physician more difficult.

## **2. Frequency of Board Meetings**

The committee endorses the Federation's position as outlined in *Elements of a Modern State Medical Board*, which recommends that medical boards meet at least quarterly. The latest information available indicates that most boards meet three to 12 times per year.

## **3. Confidentiality and Immunity**

The committee endorses the Federation's position outlined in the *Essentials*. Granting immunity from liability and assuring confidentiality for good-faith reporting are critical elements in ensuring that adequate reporting occurs and that complaints provide complete information. The latest information available in the Federation's *Exchange3* indicates that most boards already comply with the recommendations outlined in the *Essentials*. The committee also emphasizes that confidentially sharing investigative information among medical boards is critical to public protection responsibilities. (This issue is discussed further in Part II of this report.)

## **4. Informing complainants of the final outcome of complaints**

The committee notes that virtually all of the member boards inform the complainant of the final outcome of his/her complaint.<sup>4</sup> The committee emphasizes that timeliness in informing complainants of final outcomes of their complaints is an important consideration for medical boards. The committee finds that no additional recommendations are necessary in this area.

## **5. Disciplinary hearing before full board**

The committee's research indicates that most boards (52) conduct disciplinary hearings before the full board,<sup>5</sup> and 49 boards report that they have the authority to issue, deny, and revoke/suspend a license. The committee recommends that the full board be the final, disciplinary decision-maker in all actions imposed by the board.

## **6. Ability to use "informal" conferences**

The committee's research indicates that most boards (48) currently have a mechanism for holding an informal conference with a licensee if the licensee requests or agrees to such a conference, which is in accordance with official FSMB policy as outlined in the *Essentials*: "*should* there be an open meeting law, an exemption to it should be authorized to permit the Board, at its discretion, to meet in informal conference with an accused licensee who seeks or agrees to such a conference."<sup>6</sup> The committee finds that informal conferences are appropriate in a variety of circumstances, including the investigative as well as the settlement phases of complaint resolution, as a useful expedited mechanism for receiving information directly from a respondent. The committee recommends that boards have the ability to use an informal conference after a complaint is received from an individual or organization (in lieu of, or prior to, any formal hearing), and should also have the ability to use informal investigative and settlement conferences.

## **7. Board release of disciplinary history to public**

The committee notes that virtually all (63) boards release the disciplinary history of licensees to the public upon request.<sup>7</sup> The committee fully supports this practice, and strongly urges all boards to adopt this policy.

## **Part II. Standards and Procedures Not Generally in Place**

This section presents those areas where the committee's research found a general lack of uniformity among the member boards. While some degree of uniformity may exist in several of these areas, enough disparity exists to give critics of state-based licensure some grounds for arguing that the inconsistencies warrant a system of national licensure. Proving these critics wrong will require the full support of FSMB's member boards as they move to implement the recommendations outlined below.

### **Licensure**

### **1. Board oversight of residents**

In April 1996, the House of Delegates approved as Federation policy the *Report on Licensure of Physicians Enrolled in Postgraduate Training Programs* developed by the Legislative and Legal Advisory Committee. This report includes a recommendation that boards develop a mechanism for ensuring medical board oversight [e.g., requiring satisfactory completion of USMLE Steps 1 and 2 or Parts 1 and 2 of the certifying examination administered by the National Board of Osteopathic Medical Examiners prior to acceptance into a postgraduate training (PGT) program, granting "residency training permits," and annual reporting by program directors] of all physicians enrolled in postgraduate training in their jurisdiction. Because of the issues surrounding the practice of "moonlighting" and the potential for physicians to practice outside the supervision of their residency training institutions, the committee believes it is important for boards to extend their oversight of physicians to cover the entire period of postgraduate training. At this time, 18 boards have no mechanism for ensuring oversight of physicians enrolled in postgraduate training, others have limited mechanisms that do not cover the full duration of PGT programs, and two-thirds of FSMB's member boards currently do not require passage of any examination toward licensure prior to entering a PGT program. The committee strongly endorses the current policy of FSMB, and recommends that medical boards implement such an oversight mechanism as soon as feasible.

### **2. Educational credentials and postgraduate training required of applicants for licensure**

The changing environment of postgraduate training has led to wide disparity in the amount and content of PGT that is required prior to initial licensure. The committee recommends that boards require all applicants for licensure to have satisfactorily completed three years of postgraduate training in an ACGME- or AOA-approved postgraduate training program, with completion of postgraduate year three (PGY3) level training required prior to full and unrestricted licensure. Because a medical license is granted for the general, undifferentiated practice of medicine, it is further recommended that postgraduate training include some exposure to general medical experience.

### **3. Documentation required of licensure applicants**

The committee strongly supports the Federation's Credentials Verification Service (FCVS) as a uniform requirement for primary-source verification of core credentials. The committee also reviewed and discussed two forms that may be useful in developing a standardized format for licensure applications, including a comprehensive Core Credentialing Data Form that was developed by the Medical Society Credentials Verification Organizations of America (MSCVOA) and the "Physician Information Profile" currently used by FCVS. The committee believes that it would be useful to have a uniform application for licensure. Using FCVS' Physician Information Profile as a model, the committee recommends developing a standardized licensure application form that could be utilized by all FSMB member medical boards.

### **4. Sharing of information by medical schools**

The committee strongly supports the concept of medical school monitoring and sharing of students' disciplinary and other behavioral information with medical boards. The committee recommends that boards develop mechanisms for expanding the availability of Impaired Physician Programs (IPPs) and other diversionary programs to medical students and physicians enrolled in ; postgraduate education if not already in place.

### **5. Criminal background checks of licensure applicants**

The committee recommends that boards require criminal background checks of all applicants for training permits or licensure. The Federation should pursue liaison relationships with and easier access to national criminal data banks on behalf of its member boards.

### **6. Licensure: Telemedicine, Endorsement, and Portability Issues**

The Federation's position on telemedicine is outlined in *A Model Act to Regulate the Practice of Medicine Across State Lines*. Reaction to the *Model Act* has been mixed, and many boards have opted to require full and unrestricted licensure.

During its deliberations, the committee visited the concept of "compact licensure." In theory, this concept requires reciprocal recognition of acceptable baseline standards for medical licensure and discipline. States

willing to accept these standards could utilize a model compact agreement to prospectively give full faith and credit to the licensing and disciplinary actions of other compact states. The committee noted several areas where uniform standards would eliminate, or at least alleviate, some of the problems of inconsistency and variation inherent in the current state-based system. Several members stressed the importance of avoiding the "lowest common denominator" approach in any mechanism or vehicle that might be considered. Licensure requirements must be maintained at a sufficiently high level to ensure the quality and fitness to practice of all applicants.

## **Disciplinary Terminology and Processes**

### **1. Definition of "complaint"**

Currently, there is no commonly-accepted definition for what constitutes a complaint. During its deliberations, the committee discussed the differences between a consumer's complaint (those received by a board from an individual or organization) and a formal complaint (a.k.a., charge document) issued by a board that officially notifies a practitioner that he/she has been charged with wrongdoing. The committee defines a complaint as "any allegation of physician misconduct." One of the committee's concerns is the extent to which the information contained in complaints is shared with other boards (to reduce the opportunity for a practitioner to move to another jurisdiction before a complaint can be investigated and prosecuted). The committee notes that having the ability to share information at the early stage of a complaint would be desirable; however, it is likely more achievable for boards to share complaint information after it has reached the investigative stage.

### **2. Definition of "investigation"**

Currently, there is no commonly-accepted definition for what constitutes an investigation. The committee recommends the following: A complaint should be deemed investigated if there has been additional information obtained for purposes of evaluating the merits of the allegation. Such investigative efforts may include conducting telephone inquiries or interviews and solicitation of related documents or other information.

### **3. Authority to take "reciprocal" disciplinary actions**

The committee endorses the following official FSMB policy, as outlined in the *Essentials*: "The Board should be authorized to take disciplinary action for unprofessional or dishonorable conduct, which should be defined to mean, but not be limited to . . . disciplinary action of another state or jurisdiction . . . based upon acts or conduct by the licensee similar to acts or conduct that would constitute grounds for action as defined in this section . . ." <sup>8</sup> The most recent information available indicates that 44 boards require a new hearing prior to taking any reciprocal disciplinary action. <sup>9</sup> The committee recommends that, at a minimum, medical boards be authorized to take reciprocal disciplinary action equivalent to the action taken by the board in the originating state without the necessity of a new hearing, and further, that boards be authorized to take more severe reciprocal action than the original action if such is deemed appropriate after a full hearing by the reciprocating board.

### **4. Separation of prosecutorial and judicial functions**

The committee endorses the Federation's official policy as outlined in the *Essentials*, which states that: "In the exercise of its power, the Board's investigative and judicial functions should be separated to ensure fairness . . ." <sup>10</sup>

Currently, the Federation has no statistics showing which boards have taken steps to ensure the separation of these functions. The committee notes, however, that this separation is a central element of due process, and failure to maintain adequate separation of powers may expose a board to allegations that due process was denied to a physician accused of wrongdoing, with the attendant risk that the disciplinary action taken may be stayed or set aside by a court.

### **5. Medical Board Autonomy in the Areas of Funding, Staffing, Licensure, and Discipline**

In both the *Essentials* and *Elements*, the Federation recommends that boards exercise full autonomy with

regard to setting fees, developing and adopting budgets, hiring, firing, evaluating and setting compensation for staff, issuing and denying licenses, and taking disciplinary actions against licensees. The latest information available in the Exchange indicates that at least two-thirds of the Federation's members do not exercise full autonomy in one or more of these areas. While the committee believes that no changes are necessary to the Federation's current recommendations in these areas, it recognizes the need for assistance to boards in acquiring this level of autonomy, as these powers often require statutory changes. Staff was directed to give particular emphasis to these areas as an implementation plan is developed to actualize these recommendations.

#### **6. Board sharing of investigative information**

The latest information available indicates that, at present, 40 boards do not share investigative information with other boards prior to final decision or disciplinary action.<sup>11</sup> The committee finds that increased sharing of this information with other boards would enhance public safety by reducing a licensee's ability to seek licensure in another state while his/her misconduct is being investigated. The committee recommends that boards develop ways to expand the sharing of investigative information at the earliest possible stages of complaint investigation.

#### **7. Formal "conflict of interest" policy for board**

The committee's research indicates that the Federation's membership is split evenly on this issue: 34 boards have a formal policy, while 30 have not developed such.<sup>12</sup> The Elements document recommends that boards have a formal policy; however, the components of such a policy are not specified in any Federation document. The committee recommends that all board members be required, at a minimum, to make any potential conflict of interest in a given proceeding known to their colleagues on the board, and that actual recusal be left to the discretion of the individual member.

#### **8. Standardized format for board orders**

The committee finds that a standardized format for board orders would be of great value to the member boards. The committee recommends the continued development of a standard format for board orders as part of an overall implementation plan to actualize the committee's recommendations.

### **Part III. Recommendations of the Special Committee**

In summary, the Special Committee on Uniform Standards and Procedures submits the following recommendations for consideration by FSMB's Board of Directors and House of Delegates:

#### **Licensure**

1. All applicants for postgraduate training shall have satisfactorily completed Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Parts 1 and 2 of the certifying examination administered by the National Board of Osteopathic Medical Examiners (NBOME) prior to acceptance into a postgraduate training program.
2. All applicants for licensure should have satisfactorily completed a minimum of three years of postgraduate training in an ACGME- or AOA-approved postgraduate training program, including completion of PGY3 level training prior to full and unrestricted licensure. Postgraduate training should include some exposure to general medical experience.
3. The Federation shall develop and encourage the use of a standardized licensure application form.
4. All physicians enrolled in postgraduate training programs shall be subject to medical board regulation and oversight through a mechanism that requires the physician to obtain a training permit or limited license expressly designed for such purpose. This mechanism also shall require that program directors report annually to the medical board on all individuals enrolled in their respective programs.
5. Medical boards shall require criminal background checks of all applicants for training permits or full licensure.

6. Medical boards shall encourage medical schools to share information with the medical boards regarding any disciplinary actions taken against students. Boards also shall explore mechanisms for extending the availability of Impaired Physician Programs and other diversionary programs to medical students and physicians enrolled in postgraduate training.

### **Disciplinary Terminology and Processes**

7. A "complaint" shall be defined as any allegation of physician misconduct received by a medical board from an individual or organization.
8. An "investigation" shall be defined as any effort to obtain additional information about a complaint for the purposes of evaluating the merits of the allegation outlined therein. Such efforts may include conducting telephone inquiries or interviews and solicitation of related documents or other information.
9. Medical boards should be authorized to take a "reciprocal" disciplinary action (based on an action originating in another state or jurisdiction) equivalent to the action taken by the board in the originating state without the necessity of a new hearing. In addition, boards should be authorized to take a more severe reciprocal action than the original action if such is deemed appropriate after a full hearing by the board.
10. In fulfilling their regulatory responsibilities, medical boards shall adopt procedures designed to ensure the adequate separation of prosecutorial and judicial powers.
11. Medical boards should adopt "preponderance of the evidence" as the standard of proof to be used in all disciplinary proceedings.
12. The medical practice act should provide immunity from liability arising from any action undertaken in good faith by individuals on behalf of the board. Further, boards should provide confidentiality to all individuals providing information in good faith to the board.
13. Medical boards should be the final arbiter in all disciplinary decisions.
14. Medical boards should be authorized to use informal conferences as part of the process of investigating and resolving complaints if a physician agrees to or requests such a conference.
15. Medical boards should share investigative information, at the early stages of complaint investigation, with other medical boards considering a licensure application.
16. All medical boards shall adopt and enforce a formal conflict-of-interest policy for board members which, at a minimum, shall require members to make any potential conflict of interest in a given proceeding known, in advance, to their colleagues on the board. Actual recusal may be left to the discretion of the individual member.
17. The Federation shall develop and encourage the use of a standardized format for board orders.

### **Part IV. Achieving Greater Uniformity**

Throughout the course of its work, the committee attempted to identify areas where uniformity could be implemented by rule or regulation. The committee acknowledges the difficulty in modifying a medical practice act or related state laws and that some of its recommendations will require statutory changes for many boards. The committee also acknowledges that attaining the uniform standards and procedures outlined in this report will be an ongoing process that will necessarily change as circumstances surrounding the delivery of health care continuously evolve. The committee believes that to achieve success, the Federation should implement, at a minimum, the following:

1. Identify areas of divergence from the committee's recommendations for each individual board. Identify and prioritize the opportunities to implement the recommendations across FSMB's membership.
2. Schedule meetings between FSMB staff and executive directors of member boards to review the recommendations outlined in this report and discuss strategies for bringing about change in the necessary areas.
3. Develop an ongoing dialogue with member boards to monitor implementation of these recommendations and to anticipate and address problems as, or before, they arise.

4. Identify a "target date" for each board to have successfully implemented all necessary modifications required to comply with the standards and procedures set forth in this report.
5. Consider the concept of interstate compacts as a vehicle in recognition of, or to hasten establishment of consistent, high standards for physician licensure to address the issues arising from telemedicine, endorsement licensure, and licensure portability.
6. Work proactively and directly with member boards to achieve the uniform standards and procedures outlined in this report utilizing an approach similar to the FLEX conversion effort.
7. Encourage and foster medical board relationships with organizations and groups that may aid member boards in the implementation of these recommendations.

## **Conclusion**

The Special Committee notes that successful implementation strategies may take a variety of forms. The committee recognizes the significant task facing medical boards as they move to implement the committee's recommendations. Proposals for implementation that may be adaptable for some boards may prove to be unsatisfactory for others. Federation staff is urged to solicit, evaluate and develop proposed implementation strategies from, and for, each of its individual member boards.

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## **References**

1. *Guide to the Essentials of a Modern Medical Practice Act*, eighth edition, section X, D, page 16
  2. *Exchange*, Section 3: Licensing Boards, Structure and Disciplinary Functions, page 72
  3. *Exchange*, Section 3: Licensing Boards, Structure and Disciplinary Functions
  4. *Exchange*, Section 3: Licensing Boards, Structure and Disciplinary Functions, pages 44-45
  5. *Exchange*, Section 3: Licensing Boards, Structure and Disciplinary Functions, pages 50-51
  6. *Guide to the Essentials of a Modern Medical Practice Act*, eighth edition, section X, E, page 16
  7. *Exchange*, Section 3: Licensing Boards, Structure and Disciplinary Functions, pages 64-65
  8. *Guide to the Essentials of a Modern Medical Practice Act*, eighth edition, section IX, D, 25, pages 13-14
  9. *Exchange*, Section 3: Licensing Boards, Structure and Disciplinary Functions, pages 48-49
  10. *Guide to the Essentials of a Modern Medical Practice Act*, eighth edition, section X, B, page 16
  11. *Exchange*, Section 3: Licensing Boards, Structure and Disciplinary Functions, pages 58-59
  12. *Exchange*, Section 3: Licensing Boards, Structure and Disciplinary Functions, page 73
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## **Special Committee on Uniform Standards and Procedures**

N. Stacy Lankford, MD, Chair  
Secretary, Indiana Medical Licensing Board  
Indiana Health Professions Bureau

George C. Barrett, MD  
Board Member  
North Carolina Medical Board  
Federation Board of Directors

Ray Q. Bumgarner, JD  
Executive Director  
State Medical Board of Ohio

Gary R. Clark  
Executive Director  
Oklahoma Board of Osteopathic Examiners

Larry D. Dixon  
Executive Director  
Alabama State Board of Medical Examiners

Karen W. Perrine, JD  
Deputy Executive Director, Discipline  
Virginia Board of Medicine

Bernard Robins, MD  
President  
New Jersey State Board of Medical Examiners

Susan M. Rose, DO  
Board Member  
Michigan Board of Osteopathic Medicine and Surgery

Rosemary C. Selinger, MD  
Board Member  
Oregon Board of Medical Examiners

R. Russell Thomas, Jr., DO, MPH  
Vice President  
Texas State Board of Medical Examiners

**Federation Staff**

Dale L. Austin, MA, Deputy Executive Vice President  
Stephen C. Harper, MPA, Administrative Associate