

Report on Physician Collective Bargaining and Unionization **FSMB Ethics and Professionalism Committee**

Provided as an Informational Report to the FSMB House of Delegates, May 2026

Executive Summary

In April 2025, George M. Abraham, MD, MPH, Chair of the Federation of State Medical Boards (FSMB), charged FSMB's Ethics and Professionalism Committee with studying emerging ethical challenges related to collective bargaining by physicians and its impact on state medical boards in fulfilling their responsibility to the public to support access to safe, quality medical care. Considering rapidly changing employment practices in medicine, it is pertinent to explore factors which may compel physicians, especially in recent times, to participate in collective bargaining and the effects it may have on medical regulation. The primary goal of this report is to raise awareness among state medical and osteopathic boards of a continuing shift in medical practice and the potential for it to impact patient safety and access to care, and to affirm the role of boards in responding to such changes within the limits of their statutory authority. Although the report focuses on physicians, it may similarly be applied to physician assistants/associates or other health care professionals regulated by the state medical or osteopathic board.

In the past decade, the number of employed physicians has increased substantially, thus increasing the number of physicians eligible for and participating in union membership. Resident unions have been prominent since the mid twentieth century and have helped drive advocacy for impactful positive changes, such as the 80-hour work week. However, an increase in strikes and other disruptive actions associated with collective bargaining, both domestically and internationally, merits ethical evaluation and understanding from the perspective of medical regulatory authorities.

The corporatization of medicine has also reshaped practice environments in ways that may conflict with professional obligations, particularly when financially driven policies compromise quality of, or access to, care. Evidence that private equity ownership may be associated with poorer patient outcomes, coupled with the widespread use of management services organizations and complex ownership structures, has heightened concern about non-physician influence over clinical practice and contributed to reports of moral injury and dignitary harm among physicians. It is understandable, therefore, that these developments may increasingly motivate physicians to seek a unified voice to advocate for policy and practice that will protect the safety and welfare of patients and physicians.

Neither union membership nor collective bargaining are inherently unethical as long as patient welfare is not threatened. Ethical concerns arise when disruptive collective actions such as work stoppages result in patient abandonment or undermine the primacy of patient welfare. Secondly, such actions can also have an ultimate impact on patient care because of the general loss of patient trust and erosion of the public's perception of the motivation of the healthcare workforce. State medical boards have a statutory obligation to protect the public and promote access to safe medical care. The Oregon Medical Board, in its response to a strike action at a major medical system in the state, demonstrated the importance of regulatory neutrality by maintaining licensing standards, avoiding intervention in labor negotiations, and focusing solely on patient access and safety.

The committee found that changes in medical practice and collective bargaining in response to those changes may have important implications for medical regulation. State medical boards should be aware of evolving developments and conditions and prepare for potential disruptive actions that may affect patient access or safety, while refraining from taking a position in any bargaining dispute that falls outside their statutory and professional regulatory responsibilities.

Definitions

For the purposes of this report, the following definitions apply:

Collective Bargaining – Negotiation between an employer and a labor union or a professional group.¹

Corporate Practice of Medicine – A legal doctrine, recognized in many U.S. states and territories, which restricts or prohibits unlicensed individuals and lay corporations from owning medical practices or employing physicians to prevent non-physician control of clinical decision-making and to safeguard patient welfare.

Medical Society – Ideally, a professional organization that primarily represents the interests and welfare of patients by advocating for improved health policy and the interests of physicians and other healthcare professionals.² Medical societies may advocate at the local, state, or federal level, but they generally do not negotiate directly with employers.

National Labor Relations Act (NLRA) – Federal legislation granting employees “the right to self-organization, to form, join, or assist labor organizations, to bargain collectively through representatives of their own choosing, and to engage in concerted activities for the purpose of collective bargaining or other mutual aid and protection.”³

Union - An organization of workers formed for the purpose of advancing its members' interests with respect to wages, benefits, and working conditions.⁴

Introduction

State medical and osteopathic boards hold a statutory obligation to regulate professional conduct regardless of the employment setting in which physicians practice. Whether physicians are self-employed, employed by health systems, or organized into collective bargaining units, boards retain their core duty to uphold standards of professional conduct and patient safety. The following report describes the structural landscape in which boards operate and is not intended as a commentary on ownership models or federal labor law, nor does it suggest that boards bear authority over these dynamics.

There has been a significant shift in the nature of physician practice in the United States over the past decade or so, with the percentage of corporately employed physicians

¹ “Collective Bargaining Definition & Meaning.” Merriam-Webster. Accessed March 20, 2026. <https://www.merriam-webster.com/dictionary/collective%20bargaining>.

² “What Is Medical Society? Healthcare Glossary.” Physician Leadership Coach. Accessed March 20, 2026. <https://jamesmckenna.org/glossary/medical-society/>.

³ “National Labor Relations Act (1935).” National Archives and Records Administration. Accessed March 20, 2026. <https://www.archives.gov/milestone-documents/national-labor-relations-act>.

⁴ “Labor Union Definition & Meaning.” Merriam-Webster. Accessed March 20, 2026. <https://www.merriam-webster.com/dictionary/labor%20union>.

increasing to 77.6% as compared to just 29% in 2012.⁵ In many instances, physicians report diminished autonomy in clinical decision making, poor working conditions, stress and burnout, changes to the physician-patient relationship, and related challenges. Given these changes to employment and ownership demographics in medicine, it becomes understandable that physicians may on occasion seek a collective voice to raise concerns and advocate for their ability to meaningfully provide safe and effective care to patients.

The primary goal of this report is to raise awareness among state medical and osteopathic boards of this continuing shift in medical practice and the potential for it to impact patient safety and access to care.

The Ethics and Professionalism Committee is a standing committee of the FSMB established to address ethical and professional issues pertinent to medical regulation including licensure, discipline, and public protection. The committee examines emerging issues and ongoing ethical challenges, and its prior work has addressed issues such as expert witness review, use of social media, and ethical incorporation of artificial intelligence into clinical practice. In April 2025, FSMB Chair George M. Abraham, MD, MPH, charged the committee to study ethical and professional considerations related to unionization and collective bargaining by physicians and state medical boards due to the potential impact of such actions on patient access and safety. In its deliberations, the committee reviewed peer-reviewed and grey literature, including white papers of national bodies, and heard from several experts, including those representing the Allegheny County Medical Society, the Oregon Medical Board, and the American Medical Association's Council on Ethical and Judicial Affairs (CEJA). While the committee found the input of these organizations incredibly valuable, it also recognized and notes that there are a number of other national bodies considering the ethical implications of these issues that may have varying perspectives depending upon their organizations and professions.

The National Labor Relations Act (NLRA), signed into law in 1935 by President Franklin D. Roosevelt as part of New Deal labor reforms, permits employed physicians in non-supervisory positions to join labor unions. As of 2019, approximately 7.2% of physicians belonged to a union.⁶ In terms of the inherent value of this option to address grievances and concerns, the American College of Physicians (ACP) has stated that collective bargaining can be used to “strengthen the patient–physician relationship, restore clinical autonomy, improve physician well-being, and promote professionalism.”⁷ From an ethics

⁵ Bowling, Daniel, Barak D. Richman, and Kevin A. Schulman. “The Rise and Potential of Physician Unions.” *JAMA* 328, no. 7 (August 16, 2022): 617. <https://doi.org/10.1001/jama.2022.12835>, “Physicians Advocacy Institute > Pai Research > Pai-AVALERE Study on Physician Employment-Practice Ownership Trends 2019-2023.” Physicians Advocacy Institute. Accessed March 20, 2026.

⁶ Advocacy issue brief: Collective Bargaining for physicians ... Accessed March 20, 2026. <https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf>.

⁷ Crowley, Ryan, David Hilden, Jenny R. Silberger, David Hilden, Jenny R. Silberger, Micah W. Beachy, Priscilla W. Carr, et al. “Empowering Physicians through Collective Action: A Position Paper from the American College of Physicians.” *Annals of Internal Medicine* 178, no. 6 (June 2025): 836–38. <https://doi.org/10.7326/annals-24-03973>.

perspective, it is important to note that neither union membership nor collective bargaining are considered inherently unethical. However, issues of harm and unethical actions arise when physicians take actions that may subvert the primacy of patient welfare. Organized physician groups like ACP and the AMA CEJA discourage strikes due to the likelihood of patient harm but support collective bargaining in the interest of improved patient care and minimizing patient harm, emphasizing non-disruptive tactics to achieve better systems of care, not simply better pay or working conditions.

Professionalism is demonstrated by individual physician actions but is also shaped and reinforced by the institutional frameworks in which care is delivered. Medical schools, residency programs, health systems, group practices, payors, professional associations, and regulatory bodies each play a critical role in establishing and maintaining environments that support ethical practice. Accordingly, promoting professionalism is a shared responsibility, requiring alignment between individual obligations and the broader systems that shape clinical care. It is difficult for an individual physician acting alone to fully counteract practice environments that systematically conflict with core professional commitments.

A recent example of balancing these concerns occurred in Oregon, when the state's medical board (Oregon Medical Board) responded thoughtfully to a strike action at a major health care system in the state (see page 7.) Though the Board played a limited role, as summarized later in this report, it prioritized patient interests and public safety within the confines of its statutory abilities. When medical boards consider the issue of physician collective bargaining, it must be through a lens that emphasizes patient safety, access to care, and physicians' fiduciary duty to patient interests.

Evolution of Physician Practice

The corporate practice of medicine in the United States has dramatically reshaped clinical environments, while expecting physicians to maintain prevailing standards of care. Studies have shown that patient outcomes are sometimes poorer at hospitals acquired by private equity firms.⁸ This could be due to increased emphasis placed on bottom-line incentives, which may be prioritized over patient safety and quality.⁹ Tension between the financial interests of for-profit owners and the public's interest in high quality care can create "dignitary harm" (non-physical injury to a physician that results from being treated as less worthy, less equal, or not fully a person, such as through disrespect, humiliation, or stereotyping) and "moral injury" (psychological and spiritual distress that arises when a clinician's core moral values or professional ethics are violated, especially when system constraints prevent them from providing the care they believe is right for the patient) for physicians.

⁸ Kannan, Sneha, Joseph Dov Bruch, and Zirui Song. "Changes in Hospital Adverse Events and Patient Outcomes Associated with Private Equity Acquisition." *JAMA* 330, no. 24 (December 26, 2023): 2365. <https://doi.org/10.1001/jama.2023.23147>.

⁹ Miller, Jake. "What Happens When Private Equity Takes Over a Hospital." Harvard Medical School, December 26, 2023. <https://hms.harvard.edu/news/what-happens-when-private-equity-takes-over-hospital>.

The practice of medicine has long been described as both an art and a science, reflecting physicians' professional judgement and independence in delivering individualized, patient-centered care. However, the corporatization of medicine has often required physicians to adhere to policies driven by financial and operational interests rather than clinical judgment. The erosion of much of the decision-making authority previously held by self-employed or contracted physicians may contribute to cognitive dissonance, stress, and burnout, which are already prevalent among health care professionals.

Many states have passed laws over the years that are aimed at limiting the corporate practice of medicine, but enforcement in these jurisdictions has been challenging and regulatory gaps persist. Common areas of ambiguity involve contracting with management-services organizations (MSOs), which provide practice and clinical support services that usually result in the MSO running the practice, even if physician owned. Another arrangement is the use of a “friendly physician” who owns the practice in title only while not clinically active at the practice location.¹⁰

Even operational decisions that appear benign, such as centralized scheduling, may remove flexibility from physicians regarding appointment availability and prioritization of urgent patient needs. Schedulers who work directly with a physician may have more knowledge of patient needs and this loss of flexibility can lead to frustration among physicians and patients alike.

The corporatization of medicine is also influencing how the notions of “access to care” and the “physician/patient relationship” are understood. Patients still seek the shared sense of trust, compassion, empathy, and understanding associated with longstanding personal relationships with their physicians. In recent times, however, corporate interests increasingly control the terms of access, including appointment availability and communication channels. Patients may still expect quick responses and timely care, even when physicians are facing staffing shortages, onerous bureaucratic demands, and contractual demands that often prioritize revenue over improved patient outcomes.

It is generally accepted that physicians have an ethical obligation to advocate on behalf of their patients. Whether advocating for regulatory change through public policy or institutional policies and practices, physicians are justified in participating in activities intended to improve patient safety and access.¹¹ With such significant changes to the practice environments in which physicians now find themselves, having a collective voice now seems understandable.

¹⁰ Zhu, Jane M., Hayden Rooke-Ley, and Erin Fuse Brown. “A Doctrine in Name Only — Strengthening Prohibitions against the Corporate Practice of Medicine.” *New England Journal of Medicine* 389, no. 11 (September 14, 2023): 965–68. <https://doi.org/10.1056/nejmp2306904>.
<https://www.nejm.org/doi/10.1056/NEJMp2306904>

¹¹ Fleming D. The Moral Agency of Physician Organizations: Meeting Obligations to Advocate for Patients and the Public. *Ann Internal Med*. 2015;163:918-921. Doi:10.7326/M15-2527

Organizations such as the AMA and ACP have recently shifted their policy language around collective bargaining to reflect the changes caused by the corporate practice of medicine and other influences on physician practice. The ACP uses the term “collective empowerment” to “describe actions that physicians may take, including advocacy, engaging the organized medical staff, and collective bargaining, to achieve better patient care, physician well-being, and other goals,” as collective bargaining is considered part of a larger picture of physician advocacy.¹² In addition, the AMA has added language to emphasize patient primacy when considering collective action, recognizing the increased interest in unionization by physicians.¹³

Collective Bargaining in the Practice of Medicine

The NLRA has for 90 years protected the rights of workers to collectively bargain, participate in labor organizations, and take actions, such as strikes, in a legally protected manner. Under the NLRA, physicians may belong to a union if they are an employee in a non-supervisory position. In addition, the NLRA requires a 10-day staffing notice if physicians plan to strike or picket to allow time for staffing preparations.¹⁴

As more physicians practice as employees, rather than as contractors or business owners, union eligibility and participation have and continue to rise. However, the definition of “non-supervisory” practice remains contested, as it sometimes excludes positions such as medical directors or tenured medical faculty.¹⁵ The AMA supports narrowing the definition of “supervisor” under the NLRA to expand the number of physicians covered under the act.¹⁶

Some physician unions include the Committee of Interns and Residents (CIR), which is a branch of the Service Employees International Union (SIEU), the Union of American Physicians and Dentists, and Doctors Council. Resident unions such as CIR have been widely popular since 1957 and have attracted residents for a variety of reasons, such as fair pay, better work hours, housing benefits, mitigation of fatigue, retirement benefits, and childcare benefits.^{17,18} Examples of resident union advocacy have included support for the 80-hour work week maximum, limits on on-call nights, and maternity leave

¹² Crowley, Ryan, David Hilden, Jenny R. Silberger, David Hilden, Jenny R. Silberger, Micah W. Beachy, Priscilla W. Carr, et al. “Empowering Physicians through Collective Action: A Position Paper from the American College of Physicians.” *Annals of Internal Medicine* 178, no. 6 (June 2025): 836–38. <https://doi.org/10.7326/annals-24-03973>.

¹³ Ama-ASSN. Accessed March 20, 2026. <https://www.ama-assn.org/system/files/a25-ceja-reports.pdf>.

¹⁴ “National Labor Relations Act.” National Labor Relations Board. Accessed March 20, 2026. <https://www.nlr.gov/guidance/key-reference-materials/national-labor-relations-act>.

¹⁵ Ama-ASSN. Accessed March 20, 2026. <https://www.ama-assn.org/system/files/a25-ceja-reports.pdf>.

¹⁶ Advocacy issue brief: Collective Bargaining for physicians ... Accessed March 20, 2026. <https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf>.

¹⁷ “Our History.” Committee of Interns and Residents. Accessed March 20, 2026. <https://www.cirseiu.org/our-history/>.

¹⁸ Weiner, Stacy. “Thousands of Medical Residents Are Unionizing. Here’s What That Means for Doctors, Hospitals, and the Patients They Serve.” AAMC News, June 7, 2022. <https://www.aamc.org/news/thousands-medical-residents-are-unionizing-here-s-what-means-doctors-hospitals-and-patients-they>.

benefits later codified by the Accreditation Council for Graduate Medical Education.¹⁹ Approximately 27% of residents belong to a union, a significant increase from 10% in 2019.²⁰

Non-resident physician unionization has also increased, with 7.2% of practicing physicians, compared to 5.7% in 2014.²¹ Factors contributing to this trend may include stress and burnout as a result of the recent COVID-19 pandemic, increased corporate ownership in medicine, lack of independence in clinical decision-making, changes to the physician-patient relationship, and a rise in other conditions contributing to moral injury.²²

In addition to increased membership in collective bargaining organizations in the United States, strike actions by physicians and physicians-in-training have been rising globally. Over the past several years, major physician strikes have occurred in the United Kingdom, South Korea, France, Michigan, New York, and Oregon.²³ These are often impacted by growing and constantly evolving issues that should be on the radar of all medical regulators. It is important for medical boards to be aware of these changes and to be prepared for their effects on physicians and patients alike.

Considerations for Physicians

Above all else, any collective bargaining efforts must put patients first and ensure continuity of care. The ACP prudently argues that “actions like a refusal to perform administrative requirements, billing duties, or concerted refusals to work should only be considered once all other negotiating tactics have been exhausted, and efforts have been made by all involved parties to ensure safe patient care.”²⁴ It is not the sole responsibility of physicians to ensure continuation of care though they do have a primary obligation not to abandon care for their patients when leaving practice, whether permanently or temporarily, especially those most critical and otherwise vulnerable. Guided by decision-makers from a clinical perspective, institutions have a role to play in

¹⁹ “Our History.” Committee of Interns and Residents. Accessed March 20, 2026. <https://www.cirseiu.org/our-history/>.

²⁰ McKenna, Jon. “An ‘Imperative’ to Organize?: Medscape Residents and Unions Report 2025.” Medscape, November 4, 2025. <https://www.medscape.com/slideshow/Medscape-Residents-and-Unions-Report-2025-6018721>.

²¹ Advocacy issue brief: Collective Bargaining for physicians ... Accessed March 20, 2026. <https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf>.

²² Crowley, Ryan, David Hilden, Jenny R. Silberger, David Hilden, Jenny R. Silberger, Micah W. Beachy, Priscilla W. Carr, et al. “Empowering Physicians through Collective Action: A Position Paper from the American College of Physicians.” *Annals of Internal Medicine* 178, no. 6 (June 2025): 836–38. <https://doi.org/10.7326/annals-24-03973>.

²³ Ramesh, Tarun, Carmel Shachar, and Hao Yu. “Striking a Balance — Advancing Physician Collective-Bargaining Rights and Patient Protections.” *New England Journal of Medicine* 392, no. 3 (January 16, 2025): 209–11. <https://doi.org/10.1056/nejmp2411647>.

²⁴ “American College of Physicians Recommends Ways Physicians Can Be More Effective Advocates for Patients and Profession.” American College of Physicians Recommends Ways Physicians Can Be More Effective Advocates for Patients and Profession | ACP Online, July 16, 2025. <https://www.acponline.org/acp-newsroom/american-college-of-physicians-recommends-ways-physicians-can-be-more-effective-advocates-for>.

ensuring access to care and are responsible for implementing policies and procedures prioritizing patient safety and access, as well as seeking and hearing physician feedback regarding policies that impact patient care. Institutions should have plans in place to minimize or eliminate chances of disruptive actions, including, but not limited to, awareness of state labor laws, awareness of state medical or osteopathic practice acts, clarification of the purpose(s) of any disruptive action, and steps to maintain minimum staffing levels.

Physicians must also be wary of collective bargaining groups made up of members outside of healthcare. If joining in collective bargaining, physicians should ensure that the mission of the group they are joining is similarly aligned with the professional mission and goals of physicians in advancing agendas that prioritize and protect patients.

Considerations for State Medical Boards

While state-related regulations and laws may vary in scope and application, it is clear that U.S. state and territorial medical boards have an important responsibility to protect the public and support access to safe, quality medical care. Any board actions regarding collective action should prioritize this goal. It is also important to consider that, from the medical regulatory perspective, employment conditions by themselves do not obviate the responsibilities inherent to the physician-patient relationship or compliance with standards for professional conduct. Physicians must uphold prevailing professional standards and be aware of what constitutes unprofessional conduct, including principles concerning patient abandonment and continuity of care. The Oregon Medical Board's (OMB) response to a physician strike in the state in 2024 provides an illustrative example. The board was approached by one of the state's hospital networks, which asked the OMB if it could help prevent physicians from going on strike by declaring that such conduct, were it to occur, was unprofessional and a violation of the state's Medical Practice Act. The OMB directed the hospital to reach out to its own legal resources to address the concerns of the physicians and promptly notified the governor's office and the OMB's attorney. Upon careful review of the AMA's Code of Ethics and the state medical practice act, the OMB determined that a physician strike would not, on its own, constitute "unprofessional conduct" in Oregon; however, if a complaint against a physician were to be filed with the OMB, it would be reviewed in full and acted upon only if appropriate. There was no legal vehicle to prevent the physicians from striking.

The affected hospitals also asked the OMB to reinstitute COVID-19 protocols by waiving the full license application for their locum tenens physicians. The OMB declined to do so but instead offered to expedite the processing of applications for these locums physicians, similar to the established procedure for rural applicants and for facilities with critical care needs in Oregon. The OMB ensured a 24-hour turnaround time on reviewing license applications.

Oregon Medical Board staff and leadership established direct lines of communication with hospital CMOs, were available on weekends, and committed to a 5-day license

application approval. By the time that the physician strike ended after 46 days, the OMB had licensed approximately 40 locum tenens physicians for the hospital system, in some cases within 24 hours of application receipt. The OMB did not intervene in the physician strike or negotiations protected by Oregon law and successfully upheld existing medical licensing policies, procedures, and standards. The focus from the beginning, according to its Executive Director, was on issuing licenses expeditiously and maintaining patient access to care for the duration of the work stoppage. Although the experience of the OMB is of a specific instance, the experience may help guide medical boards in future difficult cases.

The Oregon experience illustrates three principles of regulatory neutrality that other boards can apply: maintaining licensing standards, avoiding intervention in negotiations, and focusing solely on access and safety.

As previously noted, the information in this report is for informational and contextual purposes only and should not be construed as commentary on ownership structures or state and federal labor laws.

Regulatory Considerations

The nature of physician employment has been rapidly changing in the United States, with many concerns raised for physicians, including tensions with corporate goals, increased bureaucratic requirements, eroding physician-patient relationships, and physician well-being. Physicians and medical boards alike have the imperative to do whatever is within their means to protect patients and maintain continuity and access to quality care. Medical boards, specifically, should take actions as they deem appropriate to fulfill statutory duties of public protection and patient safety. This may include actions such as the ones taken by the Oregon Medical Board to preserve and facilitate access to care when that becomes necessary. Boards are encouraged to work within their own legal confines and with available resources to take any necessary action they deem appropriate for patient protection, preferably without taking a position in any bargaining dispute that may depart from the board's primary regulatory responsibilities. Boards should recognize that lawful labor activity, in and of itself, does not constitute unprofessional conduct.

In summary, state medical boards should consider:

1. Reviewing medical practice acts, rules, and regulations to clarify behavior that would potentially constitute “unprofessional conduct” in the context of strikes or collective actions, distinguishing lawful labor activities from conduct that might harm patients
2. Raising awareness among licensees regarding the board's expectations for licensees' professional conduct as related to participation in strikes or other collective actions.

3. Providing educational resources for licensees on ethically responsible participation in collective actions and strikes, including safeguards and potential consequences of compromising patient safety, continuity of care, and access.
4. Developing protocols for responding to anticipated or active strikes or other activities that may disrupt patient care. Protocols may include triage of inquiries or processes for monitoring potential impacts on patient access to care. These protocols should recognize applicable state and federal laws and regulations.
5. Preparing clear messaging and talking points for board staff in responding to questions from licensees, the public, media, and other interested and relevant parties in the event of strikes or other collective actions.

Although these recommendations are addressed primarily to state medical boards, the preservation of professionalism in an era of corporatization should not rest on physicians alone; it requires concerted participation by the institutions of medicine to design practice environments where ethical and fiduciary duties are realistic to fulfill. The primacy of patient safety requires institutions, collective bargaining groups, training programs, and others to uphold this principle.

Conclusion

Employment structures in medicine are evolving, and the trend toward collective representation among physicians is likely to continue. The Oregon Medical Board's experience demonstrates that it is possible to fulfill a state regulatory role effectively, maintaining neutrality in labor disputes while ensuring that patient access and safety remain protected throughout any work stoppage. By clarifying the scope of their authority, developing operational readiness, and communicating expectations clearly to licensees, state medical boards can navigate this evolving landscape in a manner that preserves public trust and upholds their core mission.

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