



FINAL REPORT OF THE FSMB WORKGROUP ON DIVERSITY, EQUITY AND INCLUSION IN MEDICAL REGULATION AND PATIENT CARE

Provided as an Informational Report to the FSMB House of Delegates, May 2023

Section 1: Introduction

The American healthcare system is engaged in significant work to eliminate discrimination and mitigate biases based on numerous factors, including age, race and ethnicity, sex, sexual orientation, gender identity, disability and socio-economic status. While progress is cause for celebration, this important work – aimed at protecting patients from harm and mitigating health disparities is ongoing because achieving equity is a process and biases can never be fully eliminated.

In the spirit of this ongoing work, the FSMB Workgroup on Diversity, Equity and Inclusion in Medical Regulation and Patient Care (the Workgroup) drafted this report. The report contains practical guidance for implementing initiatives in Diversity, Equity and Inclusion (DEI) that are already proceeding in several states; strategies and tactics that have been proposed within the medical regulatory community; and new suggestions for addressing themes and overcoming obstacles that have been raised since the Workgroup released its most recent guidance for state medical boards.

The Workgroup has learned a great deal in its conversations with representatives from state medical boards, experts in DEI and communities with which Workgroup members have recently engaged. The Workgroup is pleased to share these learnings with state medical boards and others in the medical regulation and education communities. The report is divided into the following four areas of opportunity:

1. Framing Professional Responsibilities for Equitable Practice
2. The Pathways into Medical Education and Practice
3. Collection and Uses of Medical Regulatory Data
4. Equitable Access to Regulatory Processes

Section 2: Charge

In May 2021, the Chair of the Federation of Medical Boards (FSMB), Kenneth Simons, MD, established the FSMB Workgroup on Diversity, Equity and Inclusion in Medical Regulation and Patient Care to identify best practices for state medical and osteopathic boards (referred to

hereinafter as “state medical boards”) to help recognize, mitigate and eliminate racism, discrimination and systemic inequities in medical regulation and patient care. In fulfillment of this task, the Workgroup examined:

1. The current status of DEI efforts among state medical boards,
2. The composition of state medical boards and the board appointment process,
3. Education for board members, staff and licensees,
4. Data collection, analysis and policies for data use,
5. Communication practices of state medical boards, and
6. Patient and Practice Resources.

The Workgroup issued an Interim Report which contained several recommendations that were adopted by the FSMB House of Delegates in April 2022. This, the second and Final Report of the Workgroup, is meant to serve as a companion document to the Workgroup’s Interim Report. The primary purpose of this new, Final Workgroup Report is to provide resources to support the implementation of the Workgroup’s Interim Report recommendations, and to offer additional information to help integrate DEI principles and best practices into the work of state medical boards and the practices of their licensees.

The Final Report provides guidance to state medical boards on how to clearly express DEI goals for boards and regulatory processes based on the Workgroup’s learnings, and how to pursue physician and board accountability when discrimination or bias towards patients or licensees is suspected. In the United States healthcare system today, racism is considered a leading cause of death and preventable harm.¹ The effects of discrimination based on other patient characteristics, such as age, race and ethnicity, sex, sexual orientation, gender identity, disability, socio-economic status, and many others, are also deeply impactful and troubling. By prioritizing DEI in medical licensing and discipline, it is possible to increase our awareness of biases and thus decrease discrimination at the source and solidify key skills early on in medical education, training and practice. This document represents best practice suggestions that state medical boards can adopt to effectively identify and act upon discrimination towards and by physicians. These suggestions are meant as much for state medical boards that do not currently have policies supporting anti-discrimination and health equity, as for those who are already further along in their journeys towards health equity and equitable regulatory processes.

Section 3: Framing Professional Responsibilities for Equitable Practice

Achieving “Equity Fluency”

A variety of objectives exist under the umbrella of DEI. These broad goals include equitable treatment, just distribution of healthcare resources, diversity within the medical profession that reflects the population and optimal inclusion of all perspectives. These goals are important in terms of the provision of quality medical care to patients, as well as in the structure and functions

¹ Krumholz H M, Massey D S, Dorsey K B. Racism as a leading cause of death in the United States *BMJ* 2022; 376 :o213 doi:10.1136/bmj.o213

of state medical boards. Progress towards these goals can occur through a variety of means which will necessarily be different in clinical, as opposed to regulatory spaces. However, these spaces share an important baseline without which progress is significantly more difficult: achieving a basic level of “equity fluency” among all players involved in health care and medical regulation.

Equity fluency refers to an ability to incorporate thinking and practice aimed at bringing about more equitable states of affairs and to consistently exhibit culturally safe practices in all processes and interactions.² Equity fluency is achieved through ongoing training, practice and cultural consciousness, is an essential part of medical professionalism and should be expected of all licensees, and members and staff of state medical boards. If health care is to be truly just, equity fluency should be seen as a core competency of medical practice.

The goal of equity fluency, habitual practices aimed at achieving greater equity, and the abilities that go along with it, provide a meaningful framework through which DEI education, training and initiatives can be strategically planned. When considering a range of resources or educational opportunities, such as those listed in the Workgroup’s Playbook from its Interim Report,³ equity fluency positions physicians and medical regulators to ask questions about how best to achieve equity in patient care, licensing decisions or disciplinary proceedings. Nuanced understanding of the multiple dimensions of bias, discrimination and inequity in healthcare allows physicians and regulators to procure resources needed to promote equity and equitable decision-making. It also allows physicians to better recognize and rectify inequitable circumstances, including discrepant outcomes between or among patients and patient populations. Professional responsibility requires using the physician’s knowledge, power and ability to improve outcomes and mitigate inequities, whether through patient education, adjustments to the clinical environment or other reasonable accommodations to improve care and patient circumstances. These could be fulfilled by implementing objective clinical protocols for record-keeping, tracking and reporting variances in outcomes; training protocols for clinic staff; and resources offered to patients who have been identified as having adverse or inequitable outcomes.

Redefining Professional Misconduct

The medical profession is moving towards a common understanding that equitable care is part of the profession’s promise to patients and society. Clearly stated definitions of what constitutes professional misconduct in terms of a violation of DEI principles through discrimination, unchecked bias or other inequitable or unjust practices will amplify this understanding across the profession. Redefining professional misconduct to recognize discrimination as grounds for disciplinary action can be an important step and many states have done so. Explicit recognition of discrimination in the context of professional misconduct will improve a board’s ability to hold

² The Workgroup Chair and FSMB staff were introduced to the concept of equity fluency in conversations with Christen Behzadi, MD, and wish to thank Dr. Behzadi for her contributions that informed this report.

³ Federation of State Medical Boards, *Interim Report of the FSMB Workgroup on Diversity, Equity and Inclusion in Medical Regulation and Patient Care*, Adopted 2022. The “Playbook” can be found at Appendix C of the Interim Report, beginning on page 26. See Appendix A of this Report for an updated and expanded version of the Playbook.

physicians accountable for discriminatory practice and focus attention on bias which may previously have been too subjective to address. To this end, boards may find the following language from the *North Carolina Nursing Home Administrator Act* helpful:

“The Board may suspend, revoke, or refuse to issue a license or may reprimand or otherwise discipline a licensee after due notice and an opportunity to be heard at a formal hearing, upon substantial evidence that a licensee...has discriminated among patients, employees, or staff on account of race, gender, religion, color, national origin, mental or physical disability, or any other class protected by State or federal law.”⁴

Where legislative change is not feasible, policy guidance or statements of the board’s position against discrimination can be useful alternatives. For example, policy language along the following lines adapted from the Washington Medical Commission’s Policy Statement on Discrimination in Health Care could be used:

“Discrimination in health care violates the standard of care and presents a risk of harm to patients and is unprofessional conduct under [state’s unprofessional conduct act].

All [state] commissioners, attorneys and investigators are required to receive training to identify discriminatory behavior by health care practitioners and the understanding of its impact on the delivery of care.

Discrimination encompasses a broad continuum of behavior, including but not limited to neglect of care, inappropriate medication prescription, implicit bias (unintentional behavior), and deliberate discriminatory behavior. At one end of the continuum, the behavior may be remediated with education and guidance. At the other end of the continuum, when the behavior is deemed reckless or intentional, the [state] may consider stronger measures, such as restriction of practice, mental or physical examination, and a public statement of remorse. If the practitioner continues discriminatory measures after additional training and restrictions, the [state] may choose to revoke the practitioner’s license to practice medicine in accordance with [law] to protect the public from harm.

Practitioners should be aware that discriminatory behavior may also violate both state and federal law, including [State Act Against Discrimination, the Civil Rights Act of 1964, and the Americans with Disabilities Act.]”

In determining whether discrimination occurred, or bias played a part in care that has resulted in an adverse outcome or complaint, a board may wish to work with experts on staff or within state health equity offices. It may also be useful to have an objective protocol to evaluate misconduct, including a common set of questions that are asked in all cases. These may include:

- Is it possible that discrimination or bias played a role in the outcome?

⁴ North Carolina General Statutes Chapter 90. Medicine and Allied Occupations § 90-285.1. Suspension, revocation or refusal to issue a license

- Is it possible that the physician decided not to order a test or treatment due to the patient’s race/ethnicity, ability, age or social background?
- Did the communication, verbal or non-verbal, in this health care encounter change based on the patient’s characteristics? Was the change made for the benefit of the patient?
- Were treatment options offered or discussed limited or expanded based on the patient’s race/ethnicity, socioeconomic status, or abilities?
- Were there inequitable circumstances that were known to the physician? Could they have been rectified? Were they rectified?
 - Some examples of inequitable circumstances include whether care was denied, withheld or delivered unequally or differently based on an individual’s race, ethnicity, sex, sexual orientation or other characteristics; whether overt discrimination has occurred, verbally or otherwise; or whether preventive and supportive treatments and services are denied.

Section 4: The Pathways into Medical Education and Practice

Composition of State Medical Boards

The Workgroup’s Interim Report cites strong evidence demonstrating that a diverse medical profession, as well as greater diversity among those who make education and regulatory policy decisions, will lead to a more equitable healthcare system.^{5,6,7} The Report further cites language from the *Code of Maryland Health Occupations* which calls for diversity in several forms among those who serve on the state’s licensing boards for health professionals.⁸ However, diversity on medical boards is only possible if diversity already exists among the licensees in a given state. A barrier to diversity on state medical boards exists in multiple states because the diversity within the profession does not reflect the state’s population.

There are interim strategies that state medical boards may use to achieve greater degrees of diversity to reflect the diversity of their states. Until such time as the diversity of the profession has increased to a degree where it is no longer challenging to find diverse candidates to serve on state medical boards, consideration could be given to making use of public member positions on the board since these do not depend on a diverse profession, but only diversity within the general population of a state. Boards may also consider extending personal invitations to licensees who may not have engaged with the Board prior; contacting board member colleagues to seek recommendations; inviting faculty from academic medical centers; and using connections with the medical society to further the goal of a diverse board. Similarly, diversity among state medical board staff, particularly staff in higher-level positions who directly support the work of

⁵ Eze N, Driving Health Equity Through Diversity in Health Care Leadership, NEJM Catalyst, October 20, 2020.

⁶ Acosta DA, Poll-Hunter NI, Eliason J. (2017) Trends in racial and ethnic minority applicants and matriculants to U.S. medical schools, 1980-2016. AAMC Analysis in Brief. 17(3):1-4

⁷ Rock D and Grant H, Why Diverse Teams are Smarter, Harvard Business Review, November 4, 2016.

⁸ See *FSMB Interim Report* at page 11: “To the extent practicable, the members appointed to each health occupations board authorized to issue a license or certificate under this article shall reasonably reflect the geographic, racial, ethnic, cultural, and gender diversity of the State.”

board members, could support many of the same goals that would be achieved by a diverse board. However, true progress in expanding the pool of individuals capable of serving in physician positions on state medical boards is likely achieved through pathway programs and other efforts to increase diversity within the profession.

Enriching the Pathways

The Workgroup's Playbook references several barriers to entry into medical education pathways for members of historically excluded communities, including a lack of access to financial resources required for examinations and examination preparation, a lack of opportunities for mentorship and divergent requirements based on IMG status, costly and stigmatizing testing accommodations or the need to take leave from education or training.

Some of these barriers relate to socioeconomic status, while others relate to race or ethnicity, disability and gender. These barriers should prompt questions in those concerned about health equity regarding when the pathway into medical education begins, barriers to entry, how pathways into medicine are being conceptualized, what constitute equitable admissions to the pathway and when they should occur. Those committed to achieving a more diverse profession could consider opportunities for community engagement around health equity that raises awareness not only about health professional roles, but also about opportunities for entering the profession, gaining mentorship along the way and obtaining access to supportive resources, whether financial or otherwise.

Some state medical boards have launched creative initiatives for involving medical students in their work. There may be opportunities to reach broader communities prior to this stage in ways that could convince interested individuals that they do have opportunities to enter the medical profession. If these possibilities are not made visible to minoritized populations, a large swath of potential applicants to medical school, or the sciences in general, could be excluded.

The organizations responsible for medical education and training have also started important initiatives. For example, the Workgroup benefited from conversations with representatives of the American Association of Colleges of Osteopathic Medicine (AACOM) about its organizational initiatives, many of which are led by its Council on Diversity and Equity and support the commitment of osteopathic medical schools to increase medical student diversity and ensure that medical education is accessible to all.⁹ The Association of American Medical Colleges (AAMC) has also established programs aimed at increasing diversity in medical schools for underrepresented minorities, and Black/African-American men in particular,¹⁰ and has recently engaged in an Action Collaborative in partnership with the National Medical Association.¹¹ The Accreditation Council for Graduate Medical Education (ACGME) is engaged in similar

⁹ See, e.g., AACOM's Academic Recognition Program: <https://www.aacom.org/programs-events/programs-initiatives/academic-recognition-program>.

¹⁰ Association of American Medical Colleges, *Altering the Course: Black Males in Medicine*, 2015.

¹¹ Association of American Medical Colleges, *Action Collaborative for Black Men in Medicine*: <https://www.aamc.org/about-us/equity-diversity-inclusion/action-collaborative-black-men-medicine>

initiatives for the medical resident community, including its “Equity Matters” work which is designed, in part, to address structural barriers to developing a diverse physician workforce.¹²

If additional progress is to be made in achieving a more diverse workforce, greater awareness of opportunities prior to entry into medical school is essential for individuals from historically excluded communities to consider a career in medicine. Several such opportunities, including pathway grant and recruitment programs operated through the federal government, have been highlighted in the Workgroup’s Playbook. However, matriculation rates for minoritized individuals are lower than those for non-minoritized ones. Efforts to recruit minoritized groups into the medical education pathway should therefore be complemented by efforts to retain and support them in their matriculation. The Workgroup commends the work of organizations like Nth Dimensions and Urology Unbound whose leaders were generous in sharing information about their missions and substantial accomplishments to inform this report.

Curricular Strategies for Improving Health Equity

It is easy to assume that achieving greater diversity in the profession and on state medical boards will automatically result in improvements to health equity and equitable decisions and processes by state medical boards. However, it is important to remain cognizant of equity, and that diversity is but one means of fostering equity. Medical school curricula should include public health content about health equity and ways of improving it in order that all future physicians can be culturally safe and achieve equity fluency. Continuing medical education should provide educational opportunities for practicing physicians to maintain a level of equity fluency and continuously learn how optimally equitable care can be provided as additional research emerges.

CME for DEI

State medical boards are beginning to recognize the value of implicit bias training, DEI and cultural competency Continuing Medical Education (CME), as evidenced by their inclusion in requirements for initial licensure and license renewal. There are many different ways in which state medical boards and licensees can approach DEI CME and training. Creating awareness of a bias is one step in the process, but the next is approaching bias as a habit that can be addressed. Utilizing multiple tools together such as simulations, patient interactions, self-reflection, and stereotype replacement has been shown to have the best long-term impact on creating an awareness of bias toward patients. Examples of CME opportunities for consideration by state medical boards and practicing physicians have been added to the DEI Playbook.

State medical boards may also choose to provide recommendations to licensees about the types of DEI-related CME that could be most impactful on licensee practice and patient outcomes. Characteristics of valuable CME opportunities might include:

- Pre- and post-bias assessments

¹² Accreditation Council for Graduate Medical Education, “Equity Matters”: <https://www.acgme.org/what-we-do/diversity-equity-and-inclusion/ACGME-Equity-Matters/>

- Longer-term evaluations (at least six months) with options to resume or repeat training if scores fall below particular thresholds
- Multi-factorial training which includes interaction, patient perspectives, and the ability for physicians to empathize with patients and others
- Data-driven training that adds relevance and tangibility based on state or jurisdictional health metrics
- Reflective elements of training, allowing physician learners to empathize and internalize the biases their patients experience
- Corrective measures to mitigate biases and eliminate discriminatory practices

In addition to suggesting or requiring that licensees engage in CME related to DEI, state medical boards that are interested in measuring the effectiveness of these requirements may wish to choose metrics to track impact. Metrics could include:

- Number of complaints or disciplinary action related to discrimination;
- Improvements on state health outcome indices, particularly for specific marginalized populations;
- Improvements in self-reported well-being among licensees.

If state medical boards are interested in tracking progress and ensuring accountability among licensees and in board practices, they may consider making metrics publicly available through dashboards on their websites.

Social Determinants of Health

Social determinants of health are now widely recognized contributing factors to health status and health outcomes. Traditionally the province of public health, today's medical students are expected and eager to learn about the broader population-level context in which they will practice. Social determinants of health can be grouped into five domains: economic stability; education access and quality; health care access and quality; neighborhood and built environment; and social and community context.¹³ Under each domain fall specific determinants of health, such as literacy, presence or absence of discrimination, access to safe housing, employment opportunities, access to nutritious foods and availability of medical care. Understanding these factors and how they influence treatment options and health outcomes should be within the knowledge base of every physician. Medical schools are beginning to include curricular content about the social determinants of health and knowledge of these broader determinants should be expected of licensed physicians as well. This was part of the rationale behind a resolution introduced to the FSMB House of Delegates by the New York State Board for Medicine, the New York State Education Department's Office of Professions and the New York State Board of Regents to incorporate the care of persons with intellectual and

¹³ Office of Disease Prevention and Health Promotion. (n.d.). Health care access and quality. *Healthy People 2030*. U.S. Department of Health and Human Services. <https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality>

developmental disabilities into the medical school curriculum.¹⁴ While perhaps not traditionally considered under the purview of state medical boards, it is certainly possible to envision scenarios where licensee practice or conduct could be seen as inappropriate or inadequate if broader factors are ignored during healthcare encounters or in treatment options presented to patients. For example, treatment costs should be considered in shared decision-making with patients, particularly when patients are financially under resourced. When making dietary recommendations, access to and cultural acceptance of particular types of food should be considered. When engaging with patients, their intellectual ability might dictate the developmental approach, including communication of the physician. Most broader determinants of health are also bases for marginalization and discrimination against patients and should be considered in physicians' bias mitigation strategies.

Section 5: Collection and Uses of Medical Regulatory Data

In its Interim Report, the Workgroup made recommendations regarding state medical board use of data and the development of strategies for data collection and use. Specifically, the Workgroup encouraged state medical boards to develop a strategy for collecting data from licensees, board members themselves, complainants and other members of the public with whom the board interacts. Relevant data fields could include typical bases for discrimination, such as age, race and ethnicity, sex, sexual orientation, gender identity, disability and socio-economic status. The Workgroup recommended both increased collection of data, particularly disaggregated data, as well as the redaction of data during regulatory processes when the data has the potential to bias decision-makers.

As part of their strategies for data collection and use, state medical boards may wish to consider how data arising from complaints or disciplinary processes could be coded and categorized according to the fields noted above to support an understanding of the circumstances in which and how frequently discrimination occurs, as well as to measure the impact of regulatory interventions to eliminate it. It may therefore be valuable to categorize complaints and disciplinary actions according to whether discrimination occurred, bias (implicit or explicit) may have been present in physician practice, and care has been delivered in an inequitable manner, for instance, by inappropriately offering or withholding particular treatments based on a patient's background characteristics which do not relate to their health condition.

State medical boards may also find it beneficial to begin tracking progress towards achieving DEI-related goals in their states. This could include scores on implicit bias tests, such as the Implicit Association Test (IAT),¹⁵ patient feedback and trends in preventive medicine and social determinants of health among different communities. The goal of this exercise would be to track whether DEI efforts are beneficial over time to both patients and the state. If the state medical board does not have the ability or bandwidth to collect this data, they can partner with other

¹⁴ Federation of State Medical Boards, Resolution 21-1: Incorporating the care of persons with intellectual and developmental disabilities into the medical school curriculum (Adopted 2021).

¹⁵ Harvard Implicit Association Test is available at <https://implicit.harvard.edu/implicit/takeatest.html>

stakeholders that have the resources to do so, including academic institutions, hospital systems and the FSMB.

None of the strategies mentioned above would be possible without a consistent strategy for collecting data as part of licensing processes. Every state medical board already collects data that is used for regulatory processes, including information necessary to verify the identity of a licensee or applicant for licensure and their educational credentials. However, a subset of boards collects supplementary information that could contribute to an understanding of broader characteristics of the licensee population, such as race, ethnicity, languages spoken and practice characteristics. Understanding the demographics of complainants can also assist state medical boards in finding trends or patterns regarding the types of patients who are discriminated against. This may be made public and included on dashboards to further inform policy makers and potential interventions or educational opportunities for licensees.

Section 6: Equitable Access to Regulatory Processes

Efforts to improve the ways in which patients and licensees interact with state medical boards could improve both the collection of data, as well as the ways in which data is used. The Workgroup, therefore, offers the following suggestions for achieving greater patient engagement, including improving access to the complaints process for patients and optimizing how information is presented outwardly by the state medical board.

Facilitating the Complaints Process

Complaint forms or online portals could be made accessible in multiple languages, with prioritization of languages in use by the communities served. At a minimum, we suggest English and Spanish.^{16,17} Numerous options are available to provide translation at low cost, some of which have been included in the Workgroup’s Playbook (ConveyThis!, Weglot, Polylang). Forms could also include spaces or fields where complainants can indicate whether they believe that discrimination has played a part in the misconduct leading to their complaint. To ensure that these fields are used appropriately, education can be offered to patients about implicit bias and discrimination in health care. This could include information about how to handle medical discrimination, as well as tip sheets about patient rights and potential questions to be equipped with during medical encounters.¹⁸

State Medical Board Websites

¹⁶ Vermont Department of Health, “Posters, Flyers, and Fact Sheets in Multiple Languages” <https://www.healthvermont.gov/news-information-resources/translated-information/language>

¹⁷ State of Connecticut Department of Public Health, “Policy and Procedures for Communicating with Persons of Limited English Proficiency” (2016) https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/hems/health_equity/LanguageAccessPolicyandProceduresFINAL2016withlinkspdf.pdf

¹⁸ Glass, Kelly, “What to Say if You’re a Black Woman and your Doctor Won’t Listen,” *Today* (July 24, 2020), accessible at: <https://www.today.com/health/what-say-if-you-re-black-woman-your-doctor-won-t187769>

The format of state medical board websites can be designed not only to demonstrate a commitment to DEI through the categories of information and resources provided, but also to make it easier for patients experiencing issues related to discrimination to find helpful information or to access the complaints process, while also providing education to multiple audiences. State medical boards may wish to consider the following categories of information or resources for websites:

Policies & Recommendations

- Anti-Discrimination Statement from the state medical board

Education

- Licensee Resources
 - DEI and bias training opportunities
 - CME requirements related to DEI or cultural safety
 - Links to FSMB educational events
- Patient Resources
 - Information on patient rights and responsibilities ([example](#))
 - Contact information for state resources for health equity (e.g., state health equity office)
 - Question checklist for next visit ([example](#))
 - [What Should I Ask My Doctor During a Checkup? | National Institute on Aging \(nih.gov\)](#)
 - [How to Prepare for a Doctor's Appointment | National Institute on Aging \(nih.gov\)](#)
 - LEP.gov link and resource (I-Speak cards)
 - How to File a Civil Rights Complaint ([link](#))
 - Access to translations

Medical Board Metrics

- Annual Reports with spotlights on DEI data
- Tracking and dashboards on Social Determinants of Health within the state¹⁹

Patient Navigators

Interactions with medical board websites and the complaints process may be the final contact points for many patients. However, for many complainants, these are only the first of several interactions with state medical boards over what can often be perceived as a difficult and confusing journey. In response to patient needs throughout regulatory processes, some state medical boards have implemented the role of patient navigator or liaison to assist patients along the way, helping them understand regulatory procedures, outcomes and potential delays. The navigator role is not always implemented exclusively for non-discrimination or equity-related

¹⁹ See, e.g., Vermont Department of Health, “Clear Impact” scorecards: <https://clearimpact.com/scorecard/case-studies/vermont-department-health/>

purposes. Rather, there is value in the role for its accessibility or ability to assist patients during what can often be a traumatic, confusing and lengthy process. Having a contact person who is available to respond to questions, clarify next steps or offer a rationale for board procedures can be an effective way to foster inclusivity for patients and achieve more equitable regulatory processes and outcomes.

Section 7: Conclusion

This report and the Workgroup's Interim Report from 2022 address a wide array of topics under the umbrella of DEI. Deciding where to begin implementation of recommendations or operationalizing the guidance offered in these reports may seem daunting. It may be helpful for state medical boards beginning their journeys in DEI to recognize that much of what is suggested herein relates broadly to education, as well as data collection and use; these may be helpful places to direct initial efforts. The ways in which state medical boards provide education to their board members, staff, licensees and patients, as well as the strategies they implement around the collection and use of data are arguably the areas that can be most immediately, directly and easily impacted by state medical boards.

The Workgroup's Playbook has been expanded significantly in terms of the educational options it includes. It also includes resources related to the collection of data and suggestions for redacting those data, where appropriate. State medical boards are encouraged to consult these resources as they plan and build upon their DEI-related initiatives.

Discrimination is a threat to patient safety, and health outcomes are negatively impacted by inequities faced by patients. Many of these can be addressed by state medical boards and certainly by licensee interventions in their care and clinical environment. The Workgroup hopes that the resources offered in its reports and Playbook will assist state medical boards and licensees in achieving greater health equity for all.

APPENDIX A

Playbook: Regulatory Processes and Proposed Mitigation Strategies and Resources

The following tables highlight state medical board practices which may be vulnerable to bias and discrimination. Recognizing that not all state medical boards have the same degree of resources or operational autonomy to be able to implement DEI programs and strategies, the tables offer a variety of suggestions for how these vulnerabilities may be addressed. This “Playbook” is an updated and expanded version of the Playbook presented to the FSMB House of Delegates in April 2023.

Licensing	
Vulnerabilities	Mitigation Strategies & Resources
Exam Requirements	<ul style="list-style-type: none"> • Evaluate access barriers to exams, including cost, policies on retakes, ECFMG certification. • Consider possible subsidies through partnerships with funding organizations. • Ensure that appropriate accommodations are available to examinees with disabilities.
Testing on Applications	<ul style="list-style-type: none"> • Consider bias training and education about Social Determinants of Health and health disparities. • Opportunity to reinforce bias mitigation as a professional responsibility. • Consider requiring applicants to take a preliminary bias test, such as the IAT, and requiring additional training as seen fit
Application Questionnaire	<ul style="list-style-type: none"> • Collect demographic data to achieve minimum DEI dataset and establish a baseline for measuring diversity. • Collection of data should not preclude redaction of potentially biasing data in licensing, disciplinary, or other processes.
Education/CME Requirements	<ul style="list-style-type: none"> • Consider recommendation or mandate of continuing medical education on bias and equity/disparities on initial licensing and license renewal. • FSMB to support boards through curriculum development and listing resources. <ul style="list-style-type: none"> ○ Sample available trainings: <ul style="list-style-type: none"> ▪ Implicit Bias Training Course SWD at NIH ▪ Health Disparities AMA Ed Hub ▪ A-22: Leadership in Times of Diversity, Equity and Inclusion Evolution AMA Ed Hub

	<ul style="list-style-type: none"> ▪ How Does Cognitive Bias Affect Conversations With Patients About Dietary Supplements? Complementary and Alternative Medicine AMA Ed Hub • Consider including following criteria for DEI training: <ul style="list-style-type: none"> ○ include pre- and post-training bias evaluations (such as IAT) ○ include long-term evaluation (6 months), if no improvement in score, consider re-taking trainings ○ trainings should be multi-factorial, including patient perspectives, simulations, and an opportunity for reflection ○ trainings should include hard facts and data for trainee to grasp ○ trainings should include a reflective element to allow trainee to properly empathize and attempt to internalize the bias patients feel
Access to educational, Exam Prep, Mentoring Resources	<ul style="list-style-type: none"> • Adopt position that socioeconomic status should not disadvantage access to exam prep courses. • Consider/Develop partnerships with professional organizations to subsidize or provide review materials.
USMG vs IMG Requirements	<ul style="list-style-type: none"> • Apply equity lens in consideration of rules/statutes that apply to IMGs vs USMGs. • Consider resources to help better differentiate quality of medical education beyond US vs “other”.
Bias or Lack of Uniformity in Licensure Review Process	<ul style="list-style-type: none"> • Review licensing criteria to ensure consistency and standardization to avoid bias or “gut feelings” about candidates. • Establish process for review by multiple individuals when applications are identified as concerning. Ensure diversity among reviewers. • Apply equity lens in all application reviews. • Consider redacting applicant photo and name from initial licensure review
Subjectivity in Reference Forms	<ul style="list-style-type: none"> • Consider subjectivity and potential bias in reference forms that accompany licensing applications.

Additional (Statutory) Requirements (e.g., explanation of leave from training/practice)	<ul style="list-style-type: none"> • Acknowledge changing norms regarding leave from practice for parental leave or other reasons that do not impact patient care. • Review processes and requirements for disclosure that may dissuade licensees from taking legitimate leave from practice, seeking treatment for health conditions, or are otherwise unfair.
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Policy, Communications & Patient/Public Relations	
Vulnerabilities	Mitigation Strategies & Resources
Website	<ul style="list-style-type: none"> • Adopt a public statement explaining the board’s position on diversity, equity and inclusion. This can outline the value of health equity for patients, the board’s commitment to equitable processes for licensees, and the board’s position against discrimination of any sort as a professional expectation. <ul style="list-style-type: none"> ○ FSMB Statement on DEI in Medical Regulation and Health Care ○ UNC School of Medicine Statement on Equity & Inclusion • Provide access to educational resources focused on reducing health inequities, mitigating bias or other opportunities to promote equity. <ul style="list-style-type: none"> ○ FSMB Educational Resources on DEI ○ Training and Resources from Maryland Dept of Health ○ AAMC Diversity and Inclusion Toolkit • Feature vignettes or narrative stories regarding health equity. • Highlight instances of systemic discrimination and advocate for change.
Policies and Guidelines	<ul style="list-style-type: none"> • Create committee responsible for reviewing all policies and guidelines through equity lens. Recruit state’s health equity office for guidance • Consider including office of health equity when reviewing less-concrete cases – use their guidance to using a health equity lens during evaluation. • Redefine ‘professional misconduct’ by including discrimination and implicit bias. • Draft internal and external policies regarding non-discrimination and Anti-Racism.

	<ul style="list-style-type: none"> ○ Washington Medical Commission Statement on Discrimination in Health Care ● Offer training to Board members and staff.
Publications (Newsletters, Journals, etc.)	<ul style="list-style-type: none"> ● Ensure that all publications are accessible to persons with disabilities. ● Dedicate space in board publications to DEI and consider “special editions.” ● Feature “stories” or vignettes from individuals reflecting experiences with diversity in medical regulation, education or patient care.
Social Media	<ul style="list-style-type: none"> ● Leverage social media to promote awareness of systemic discrimination and opportunities for increasing DEI among licensees and the public. <ul style="list-style-type: none"> ○ Include physician and patient narratives of discrimination in health care. ● Promote board efforts in DEI and celebrate achievements.
Advocacy (Selection of Issues)	<ul style="list-style-type: none"> ● Seek input from board members, licensees and the public on issues they would like to see prioritized.
Involvement of Other Stakeholders (e.g., medical society, PHP)	<ul style="list-style-type: none"> ● Conduct a landscape review to identify partners at the local, state and national levels that have a nexus to DEI and can support the board’s DEI efforts. ● Partner with state or local office of health equity and invite them attend board meetings for DEI input. ● Consider appointing one or two board members to act as the liaison between the board and the state’s office of health equity.

Complaints through Investigations	
Vulnerabilities	Mitigation Strategies & Resources
Information on Complaints Process and How to File	<ul style="list-style-type: none"> ● Offer multiple pathways for filing complaints to make the complaints process more accessible to the public. ● Consider whether language barriers exist to the complaints process. ● Aim to offer all resources in at least English in Spanish. ● Consider whether disability status presents a barrier to the complaints process. ● Identify or hire a patient liaison or navigator to support complainants through the process.

	<ul style="list-style-type: none"> • Consider including the patient advocacy contact information on the board website. • Consider including informational printouts to be kept in hospitals/health care settings that inform patients of their rights and about implicit bias.
Intake	<ul style="list-style-type: none"> • Collect, but redact information about the complainant that may be potentially biasing, e.g., age, gender, ethnicity, level of education completed, geographic location. • Collect, but redact information about the subject licensee, e.g., age, gender, ethnicity, medical school, specialty, type of practice. • Create complaints categories for allegations of bias, discrimination, and inequitable care.
Triage	<ul style="list-style-type: none"> • Include multiple individuals in the triage process for complaints that are not initially triaged to investigations. • Review “flagged” complaints through an equity lens, screen for bias against the complainant and the licensee.
Communication throughout Process	<ul style="list-style-type: none"> • Consider appointing a liaison, a staff member with a role to communicate with the complainant, provide updates as needed and be available to hear and respond to complainant questions/concerns.
Investigative Procedures	<ul style="list-style-type: none"> • Require all investigators and investigative team members to undergo bias training and trauma-informed training. • Track complaints which could be driven by discrimination. • Recognize the “upstream factors” that may disproportionately place licensees under board scrutiny.
Interaction with Complainant, Licensee, Other	<ul style="list-style-type: none"> • Provide opportunity for complainants to speak before the board, similar to licensee opportunity. • Offer patient liaison and interpretive services as needed. • Allow virtual and in-person options to increase accessibility.
Case Development (Legal Staff)	

Hearings and Discipline	
Vulnerabilities	Mitigation Strategies & Resources
Hearing Process	<ul style="list-style-type: none"> • Consider allowing complainants to testify before the board. • Include members of Office of Health Equity in order to provide input.
Adjudication	
Publication of Disciplinary Actions	<ul style="list-style-type: none"> • Consider ways in which publication of particular details may stigmatize certain groups or individuals. • In cases involving discrimination or bias, use the opportunity to communicate that bias and discrimination constitute professional misconduct and are appropriately subject to regulation. • Consider adopting a standardized approach to publishing data on website, that includes clear categorization of the complaint (See example in above DEI Workgroup Report).
Monitoring	<ul style="list-style-type: none"> • Track and categorize all cases as “closed,” “closed after investigation,” “action taken” (including type of action and whether hearing occurred). • Facilitate retrospective analysis by including subcategories for each type of case, e.g., sexual misconduct, boundary violation, improper prescribing, substandard care, etc.
Remediation	<ul style="list-style-type: none"> • Collaborate with organizations that provide assessment and remediation services to ensure the availability of remedial education and training for physicians who engage in discrimination or who have exhibited biases.

Board Functioning and Appointments	
Vulnerabilities	Mitigation Strategies & Resources
Board Member Appointments	<ul style="list-style-type: none"> • Adopt as policy that board composition should reflect the communities served. • Attempt to include expertise on board related to reducing health disparities among demographic subgroups and at least one expert on women’s health. • Work with state government to develop approaches to increasing diversity among board members.

	<ul style="list-style-type: none"> • Partner with state and local organizations representing communities that have been marginalized to identify potential appointees.
Board Member Qualifications	<ul style="list-style-type: none"> • Evaluate requirement for board members to be American Citizens or graduates of US medical schools. • Consider removing age or minimum years in practice for board members to increase representation among newly practicing physicians.
Board Member Training	<ul style="list-style-type: none"> • Mandate bias training and trauma informed education. <ul style="list-style-type: none"> • Encourage board members to attend seminars held by the state’s health equity office or webinars hosted by the FSMB. • Implement interaction/simulation studies as part of training. • Take the IAT surveys before and after each training, and then 6 months after training to evaluate long term impact. • Meet with physicians and patients who have experienced implicit bias and racism in healthcare and foster ability to understand and empathize with their stories. • Utilize programs that implement stereotype-incongruent biases. • Have the state’s office of health equity become more involved with the training of board members.
Board Leadership	<ul style="list-style-type: none"> • Encourage diversity of board members who serve in leadership roles. • Consider whether compensation models are appropriate for service required. • When board diversity is not an option, be sure to implement continuous DEI training throughout the year. <ul style="list-style-type: none"> ○ American Academy of Family Physicians DEI Resources ○ Accreditation Council for Continuing Medical Education DEI Resources ○ AAMC Healthcare Executive Diversity and Inclusion Certificate Program ○ National Institutes of Health Inclusion, Antiracism and Wellness Resources

Committee Creation and Member Selection	<ul style="list-style-type: none"> • Mandate minimum levels of diversity for membership on board committees. • Work with legislature and state medical society or other appointing body to create shared goal of increasing diversity
Board Meeting Procedures	<ul style="list-style-type: none"> • Encourage opportunities for public and stakeholder comment at open meetings. • Encourage members of the state’s office of health equity to attend meetings and provide input on disciplinary cases.
Insufficient Diversity in Licensee Population	<ul style="list-style-type: none"> • Ensure diversity in public member appointees. • Consider grant opportunities to increase diversity and access to diverse providers: <ul style="list-style-type: none"> ○ Health Resources & Services Administration Grants ○ Rural Health Information Hub • Promote grant opportunities for careers in medicine: <ul style="list-style-type: none"> ○ HHS Pipeline Grants

FSMB Workgroup on Diversity, Equity and Inclusion in Medical Regulation and Patient Care

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