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WHAT CAN WE DO TO PROTECT LEGITIMATE PAIN CARE FOR PATIENTS IN NEED?

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Because things are the way they are, things will not stay the way they are.

—Bertolt Brecht

ONE OF THE ADVANTAGES OF GETTING OLDER is the wisdom that comes from seeing the world around us change: We learn patience as seemingly insurmountable problems are solved over time, and we learn gratitude as the precious things that we wish could last forever inevitably slip away. If we are lucky, along the way, we also learn the art of flexibility—the capacity to adjust to, and thrive within, the changing circumstances around us. Nowhere is all of this more evident than in our professional lives, where we veterans of the health care system have seen great change in recent decades—much of it directly impacting medical regulation. In this issue of the *Journal* we give you a glimpse, in virtually every article, of how much things have changed—and are changing: On page 22 we travel back in time to the 1980s, as Dr. Susan Behrens recounts the challenges she faced in breaking the gender barrier and becoming the first female president of the FSMB. In the second article in our FSMB history series, beginning on page 12, we examine regulation in the early 20th century, a time when many states still lacked the most fundamental regulatory tool—the ability to revoke a medical license. On a more contemporary note, we offer on page 7 a commentary on opioid abuse—a topic that has dramatically emerged in less than a decade to become one of the nation's most urgent public health problems. And on page 27 we bring you the FSMB's new model policy on the use of social media by physicians—a topic that will certainly continue to challenge our capacity to change our mindsets in years to come…**We have much to contemplate, looking both backwards and forwards, during this Centennial year of the FSMB, and we hope that these articles help you think about the challenges and responsibilities of medical regulation with new perspectives that help you adapt and grow.** As Bertolt Brecht so aptly stated, the one thing we can be sure of is that nothing around us will stay the same.

Susan R. Johnson, MD
Editor-in-Chief

FSMB Announces Annual Award Winners

The FSMB recently announced the recipients of its 2012 annual awards, recognizing outstanding service and leadership in the field of medical regulation.

The Lifetime Achievement Award was presented to **Regina M. Benjamin, MD, MBA**, Surgeon General of the United States and Past Chair of the FSMB, for her extraordinary service and commitment to the field of medical licensure and discipline. As a part of her long career in medicine, Dr. Benjamin was active in the medical regulatory community on the state and national level for 20 years. She served as FSMB Chair from 2008 to 2009.

The Distinguished Service Award was presented to **J. William McCord, Jr., DO**, and **Daniel W. Morrissey, OP**. Dr. McCord was honored for his many years of service to the FSMB, including 13 years on the FSMB Board of Directors, as well as many contributions and accomplishments as a former vice president of the American Association of Osteopathic Examiners and more than 16 years of service on the Tennessee Board of Osteopathic Examiners (BOE). Father Morrissey was honored for his service as a public member of the New Hampshire Board of Medicine, a public member of the New York State Board of Professional Medical Conduct for more than 20 years, a member of the FSMB Board of Directors from 1998 to 2005, and a member of the executive board and board of directors of the National Board of Medical Examiners.

The John H. Clark, MD, Leadership Award, given in recognition of leadership in the field of medical licensure and discipline, was presented to **Stan T. Ingram, Esq,** and **C. William Schmidt**. Mr. Ingram, an attorney, was recognized for his long career of prosecution and defense in licensure and certification hearings in Mississippi. Mr. Schmidt was recognized for 38 years of service as executive director of the Kentucky Board of Medical Licensure. Under his leadership, the board grew from a three-person office to an agency with 21 employees.

The Meritorious Service Award was presented to **Jaime B. Garanflo** and **Barbara Neuman**. Ms. Garanflo served the Texas Medical Board for 30 years in a number of different positions, including division director of licensure. Ms. Neuman served as a medical board executive director for 16 years with the Massachusetts Board of Registration in Medicine and the Vermont Board of Medical Practice. She is currently executive director for Administrators in Medicine.

The Ray L. Casterline Award for Excellence in Writing was presented to **Holly J. Mulvey, MA**, et al, for the article "Pediatricians Over 50 Reentering Clinical Practice: Implications for Physicians and the Regulatory Community," which appeared in the *Journal of Medical Regulation*.

Meeting of Leading Regulatory Groups to Focus on Future of State-Based Regulation

As a part of its 2012 Centennial celebration, the FSMB will host a special symposium October 17–18 in Washington, D.C., in partnership with the National Council of State Boards of Nursing and the National Association of Boards of Pharmacy.

Titled "The Future of State-Based Regulation: Opportunities and Challenges," the symposium will unite the three key regulatory groups representing the nation's physicians, nurses and pharmacists.

Keynote speakers include former HHS Secretary Donna Shalala, PhD, and Edward Salsberg, MPA, Director of the National Center for Health Workforce Analysis.

For more information about the symposium, please visit www.fsmb.org. ■

Building Public Confidence in the Medical Profession: Good for Patients, Good for Physicians

Lance Talmage, MD
Chair, Board of Directors
Federation of State Medical Boards

IN BRIEF **Dr. Talmage discusses the "dualism" inherent in medical regulation, which simultaneously benefits the reputation of physicians while protecting the public.**

It is a great honor for me to begin my year as Chair of the Federation of State Medical Boards during its Centennial celebration.

The FSMB was launched 100 years ago in an environment of change, at a time when the American public was becoming better informed and the nation was putting a new emphasis on public health improvements. A growing awareness of the need for greater oversight and regulation of the medical profession led directly to our charter and a century of service to the nation.

Today, more than 850,000 physicians are licensed in the United States, and our work as the voice of the regulatory community impacts each and every one of them. The FSMB helps the nation's state medical boards succeed in medical regulation and licensure — a task that is vital to the stable operation of our health care system.

The end product of this professional community is trust extending in many directions.

Medical regulation ensures trust in patients that their physician is qualified and can be counted on to offer care — the first step in building a strong patient-physician relationship, and the very cornerstone of medicine.

At the same time, medical regulation helps ensure trust in physicians that the integrity of their profession is maintained through a fair and established process of consistently applied standards of quality.

The bottom line is that, as an organization, we have always been fundamentally linked with physicians — and we remain so.

In our early years, we focused strongly on helping improve the quality and consistency of the U.S. medical education system. Since then we have addressed the need for better systems to regulate unprofessional behavior, more consistent licensing examination practices, and improved systems for credentials verification and sharing of information.

We have established standards and model policies to help state boards, and played a leadership role on topics that significantly impact physicians — from telemedicine to drug-prescribing.

In our early years, the FSMB was closely aligned with physician groups, including the American Medical Association, with whom we shared meetings and even office space.

Over time, though, we have become more independent as the voice of the regulatory community. And along the way, we have had to balance the tension that naturally may occur between practicing physicians and medical boards charged with regulating their practices and disciplining unprofessional behavior.

MEDICAL REGULATION ENSURES TRUST IN PATIENTS THAT THEIR PHYSICIAN IS QUALIFIED AND CAN BE COUNTED ON TO OFFER CARE — THE FIRST STEP IN BUILDING A STRONG PATIENT-PHYSICIAN RELATIONSHIP.

During this year of Centennial celebration, one of my goals as Chair is to encourage a positive relationship between physicians and medical boards.

I would like to help physicians appreciate the dualism of state medical board activity — which actually benefits their reputation and stature while simultaneously protecting the public.

Unethical or unqualified physicians diminish all of us—that's why ensuring that they will be rehabilitated or removed from practice enhances the rest of the profession. Our work helps enhance the integrity of the medical profession by seeking out bad players—giving conscientious physicians the confidence that their profession is held in good standing by the public.

Dualism starts with licensing. Rigorous licensing processes guarantee the public a baseline of qualifications and assure the medical community that our colleagues are legitimately trained and personally qualified to practice among us.

Dualism extends into discipline. Every time we find and discipline an unethical physician, we reassure the public that their physician is among the 99 percent of practitioners who uphold the ethics of our profession—thereby enhancing the reputation of all physicians. By stopping fraudulent billing and medical care, the remaining physicians are recognized as caring about medical costs and legitimate treatments.

And dualism also extends into professionalism. It is not enough to simply license physicians; our regulatory system must have mechanisms to ensure they maintain their professional skills year by year. The FSMB's Maintenance of Licensure (MOL) initiative is aimed at moving our system in this direction. The public expects physicians to adopt

RIGOROUS LICENSING PROCESSES GUARANTEE THE PUBLIC A BASELINE OF QUALIFICATIONS AND ASSURE THE MEDICAL COMMUNITY THAT OUR COLLEAGUES ARE LEGITIMATELY TRAINED AND PERSONALLY QUALIFIED TO PRACTICE AMONG US.

changes in practice and new technologies; by instituting MOL we can encourage the minority to bring themselves up to the standard most of us set for our continuing education.

As the MOL initiative continues to move forward during my year as Chair, we are committing to helping shape a system that will be unobtrusive and as integrated into everyday practice as possible—while having the rigor to ensure quality in our system.

Again, as physicians we must accept the dualism implicit in medical regulation: Documenting compliance with a system of continuous professional development will help ensure public confidence in physicians. MOL moves us strongly toward this goal.

In all of this, it's important to keep in mind another element inherent in the dualism of regulation: rehabilitation. A previously impaired physician

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(one who has recovered from substance abuse, emotional illness or a physical illness or injury) who is rehabilitated and can honorably practice again demonstrates to the public the strength and fairness of our system.

During my year as Chair I will encourage our physician groups, medical institutions and insurers to understand the nature of impairment and that rehabilitated physicians deserve to be reaccepted into practice as long as they remain healthy. The dualism of regulation with restoration must be accepted.

In summary, my goal is to reinforce the support and esteem of all physicians, with the understanding that we must maintain a high level of public confidence and trust in the medical profession.

As regulators, we must communicate and take pride in the dualism of what we do to eliminate unprofessional practices and maintain a high standard of medical care. Our patients deserve it—our conscientious physicians deserve it—and we, the FSMB and the state medical boards, are committed to getting the job done. ■

Commentary

Pill Mills Are Not Pain Clinics: The Challenge of Addressing One Without Harming the Other

Robert K. Twillman, PhD, FAPM

IN BRIEF **Dr. Twillman discusses rogue medical clinics commonly known as "pill mills" — which are highly visible manifestations of ongoing problems with prescription opioid misuse. Dr. Twillman contends that, to date, legislative and regulatory responses have focused largely on establishing standards of practice or increasing statutory and regulatory requirements for pain management clinics and that these efforts may unintentionally produce harmful consequences for the 100 million American adults that the Institute of Medicine (IOM) estimates are living with chronic pain. He offers alternative solutions aimed at eliminating pill mills while ensuring patients with chronic pain have access to treatment.**

The documentary *The OxyContin Express*[1] shows hundreds of people traveling long distances to patronize scores of self-labeled pain management clinics in Broward County, Florida. Long lines of customers are shown entering the clinics and leaving with hundreds of doses of controlled substances, despite not having medical problems to justify the prescriptions. The customers drive or fly hundreds of miles home, where they abuse the medications or sell them to others. Similar stories have been told many times in print and electronic media, highlighting the danger posed by the practices of these "pill mills." Elected officials and government agency administrators have testified to the dangers of these enterprises and proposed intensive efforts to eliminate them. In response, some states, counties, and cities have begun to take action, but unwittingly may be harming people with chronic pain as a result of that effort. In their haste to throw out the bath water, they also may be throwing out the baby.

Pill mills are the most visible manifestation of our nation's ongoing struggle with prescription medication misuse, abuse, and addiction. While a substantial number of people are addicted to prescription opioids, many more misuse them in other ways. The 2010 National Survey on Drug Use and Health[2] estimates that 12.2 million Americans over the age of 12 used prescription opioids for nonmedical purposes (defined as "using these medications without a prescription of the respondent's own or solely for the experience or feeling the drug caused"[3]) in the previous year, with 1.9 million of them meeting DSM-IV-TR diagnostic criteria for opioid dependence or abuse (as close as DSM-IV comes to a diagnosis of "addiction"). The remaining 10.3 million are using someone else's medication to control pain or engaging in episodic recreational use without the increased distress or impaired functioning required for the DSM-IV diagnoses. It is not clear how many fall into each group. Various solutions for the medication misuse problem have been proposed, most notably the 2011 National Drug Control Strategy issued by the Office of National Drug Control Policy in May, 2011[4]. Eliminating pill mills is included in most plans as a key tactic to control the "supply side" of the medication misuse equation.

Pill Mills Are Not Pain Clinics

Previous policy efforts to facilitate eliminating pill mills have focused largely on developing new laws, regulations, and rules regarding the standards of practice in pain management clinics. The fact that most pill mills label themselves as "pain clinics" is the primary reason for this focus. However, the fact that pill mills call themselves pain clinics does not make them such, and as policymakers debate how to eliminate the former, care should be exercised not to harm the latter. For the sake of clarity, consider some of the key characteristics of pill mills and pain clinics:

THE FACT THAT PILL MILLS CALL THEMSELVES PAIN CLINICS DOES NOT MAKE THEM SUCH, AND AS POLICYMAKERS DEBATE HOW TO ELIMINATE THE FORMER, CARE SHOULD BE EXERCISED NOT TO HARM THE LATTER.

- In a pill mill, an extremely cursory history is taken and a physical exam often consists of little more than a quick glance to ensure that the "patient" is breathing. Referrals from other practitioners are not required; notes from previous health care encounters are not solicited or reviewed; and if laboratory and diagnostic test results are presented, they are accepted regardless of how old they are, whether or not they have positive findings, and even if they appear to be obviously falsified. The decision about what prescription to write is based on the customer's response to the question, "What do you want me to give you?", rather than the physician's response to the question "What is the best option, in my professional opinion?" Every patient is prescribed controlled substances, to the exclusion of other medications. Documentation is inadequate, if it exists at all, and follow-up visits are not scheduled. Referrals to other providers are never made. Medications are dispensed in the next room, and the customer walks away with hundreds of doses of (often multiple) controlled substances. Insurance is not accepted, so all services are provided on a cash-only basis.
- In a pain clinic, a thorough assessment with complete history and physical exam is conducted. Notes from referring physicians, laboratory findings, and previous diagnostic study results are reviewed and new ones ordered if necessary. A comprehensive treatment plan is developed based on the assessment and the provider's professional judgment. The treatment plan often involves more than one discipline and type of intervention, and controlled substances may or may not be prescribed. Complete documentation of the assessment and plan is placed into a medical chart, and the patient is scheduled for a follow-up visit or referred to another provider for that follow-up. If a prescription has been written, it is most often taken to a pharmacy, where a second health care professional reviews it for accuracy and safety, then dispenses the medication and educates the patient if the prescription is judged to be appropriate. At each step, payment by insurance is accepted if the patient and providers are covered.

Clearly, what goes on in a pill mill does not meet the standard for lawful prescribing of controlled substances; that is, that they "must be issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice."[5] The United States Drug Enforcement Administration also requires prescribers and dispensers to make "reasonable efforts to prevent abuse and diversion,"[6] yet pill mills either ignore these issues or intentionally cater to them. Without meeting these standards, the act of prescribing violates federal law, and undoubtedly state law in all or nearly all states; yet authorities report difficulty in closing pill mills. To make closing them more expedient, do we need new statutes, rules, and regulations to make what goes on there *more* illegal? Or do we need to find more effective ways of exposing them to professional and legal sanctions under existing policies?

Why Do We Struggle to Close Pill Mills?

The primary challenge in addressing pill mills is the requirement for most professional licensing boards that a complaint be filed before an investigation can be opened. Clearly, customers who depend on pill mills for the medications on which they may be physically dependent, to which they may be addicted, and which may constitute their sole source of income, are not going to complain about receiving substandard medical care. Other health care professionals who become aware of a pill mill may not feel that they have sufficient evidence to file a complaint, and may be afraid to do so for fear of reprisal from pill mill operators. Moreover, few physicians understand medical practice act rules on reporting inappropriate behavior of other licensees. Law enforcement agencies are reluctant to file complaints even when they have sent undercover officers into the pill mill because they do not want to blur the lines between law enforcement and health care regulation, and do not want to risk exposing their investigations. Insurance companies will not complain because the pill mill operates on a cash-only basis, leaving them on the sidelines as disinterested spectators. Who is left to complain?

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The investigation of a pill mill, if one can be opened, often proceeds slowly because of a backlog

of cases to be addressed by understaffed and underfunded licensing boards. In some cases, standard practice is to avoid opening full-scale investigations unless multiple complaints are filed. Fear of violence against investigators certainly

SOME STATES ALLOW MEDICAL CLINICS TO BE OWNED AND OPERATED BY PEOPLE WITHOUT A PROFESSIONAL LICENSE, MAKING THOSE INDIVIDUALS AND THE CLINICS THEMSELVES IMMUNE TO ACTIONS BY LICENSING BOARDS.

complicates the conduct of the investigation if one is opened. Finally, the most effective investigatory strategy is one in which an unannounced inspection is carried out, so that investigators can see what is going on in the clinic on a regular basis, yet such inspections may not be permitted by law.

Sanctioning owners and practitioners in pill mills after violations are found can be difficult as well. As has been well documented in Florida, some states allow medical clinics to be owned and operated by people without a professional license, making those individuals and the clinics themselves immune to actions by licensing boards. The only people subject to administrative sanction are the licensed professionals, and pill mill owners have little trouble replacing them with others who are willing to serve as hired prescription writers. Couple that with the requirement in some jurisdictions that a *pattern* of unprofessional behavior be in evidence (suggesting the need for multiple or repeated complaints), and even imposing a harsh sanction such as suspension or revocation of a license can become a challenge, regardless of how bad a single case may be.

Targeting Pill Mills, Not Pain Clinics

Can we successfully address this problem by allowing licensing boards greater freedom to act against the illegal practices of pill mills? If so, how? To date, seven states (Louisiana, Texas, Florida, Ohio, Tennessee, Kentucky, and West Virginia) have tried to do this by passing statutes to regulate pain clinics and one additional state, Georgia, has approved new medical licensing board rules to do the same. The underlying thought is that, since pill mills call themselves pain clinics, they should be held to the high standards of practice one would expect to see in specialty clinics, effectively making their typical behavior *more* illegal. Given that pain clinics currently do not have special standards in most jurisdictions, policymakers are developing new standards that are higher than those expected of other medical practices, sometimes including features that allow for inspections without complaints being filed.

While this may be an effective strategy, it is misguided and risks exacerbating a public health problem much greater than the size of the prescription opioid misuse problem — namely, chronic pain. As noted, millions of Americans live daily with chronic pain. The strategy of setting higher standards for pain clinics in an effort to close down pill mills is analogous to this scenario: Faced with the presence of a "crack house" in the middle of a residential neighborhood, the city council responds by requiring that all the homeowners in that subdivision pour new driveways, paint their houses, and install new roofs. Unfortunately, this strategy will result in some homeowners leaving the neighborhood, and it is much more costly and inefficient than just raiding and closing the "crack house."

Dramatic changes in medical practice have taken place in states implementing new pain clinic policies, and the fear is that legitimate pain clinics, already in short supply, will simply "leave the neighborhood." For instance, in Ohio, one criterion defining a pain clinic is "the majority of the patients of the prescribers at the facility are provided treatment for pain or chronic pain that includes the use of controlled substances, tramadol or

THERE ARE ALTERNATIVE STRATEGIES TO STRENGTHEN OUR ABILITY TO ADDRESS THE PILL MILL PROBLEM WITHOUT IMPOSING ONEROUS HIGHER STANDARDS ON PAIN CLINICS. THESE STRATEGIES DO NOT RISK OUR RESPONSE TO THE PANDEMIC.

carisoprodol, or other drugs specified in rules by the board."[7] At the public hearing before these rules were promulgated, three independent witnesses testified that they had received information about physicians abruptly ceasing to prescribe controlled substances for some patients to ensure they would not exceed the 50 percent limit in their practices. Some of those patients were noted to

have been seen in other clinics and in emergency departments suffering from acute opioid withdrawal. These were not people with addictions, but people with pain who were being treated appropriately and who had developed the expected physical dependence on opioids. In short, poorly conceived policies or rule changes can harm legitimate patients. Are we comfortable if such changes

IN GENERAL, PAIN CLINICS AND THE PROFESSIONAL SOCIETIES OF WHICH THEY AND THEIR PRACTITIONERS ARE MEMBERS NEED TO FOSTER A GREATER SENSE OF COOPERATION WITH LAW ENFORCEMENT AND PROFESSIONAL LICENSING BOARDS TO ENSURE THAT THEIR CONCERNS ARE HEARD.

bankrupt innocent people with chronic pain and put some of them through opioid withdrawal as a consequence?

There are alternative strategies to strengthen our ability to address the pill mill problem without imposing onerous higher standards on pain clinics. These strategies do not risk our response to the pandemic that finds an estimated 100 million adult Americans with chronic pain, costing us about $600 billion every year.[8] The following are proposed as starting points for discussion:

- Require that all medical practices be owned by licensed health care practitioners, either individually or jointly through instruments such as professional associations or professional limited liability corporations.
- Require that all medical practices designate a qualified medical director who is responsible for overseeing practices within the clinic and ensuring that they are appropriate and meet relevant legal and ethical standards.
- If they do not already exist, promulgate licensing board rules for all medical practices, clearly stating what constitutes evidence of a legitimate medical purpose and standards for the usual course of professional practice, as well as identifying best practices for reasonable steps to prevent abuse and diversion.
- Allow all professional health-related licensing boards to carry out unannounced inspections of medical practices without a complaint being filed, as is already allowed in some states. (Note that this would also require development of criteria for which practices should be inspected, and may require reallocation of resources. Effective action by licensing boards should reduce the need for law enforcement activity around pill mills, so perhaps those agencies could assist with funding.)
- Limit dispensing of controlled substances from medical practices, either by restricting them to an emergency supply sufficient to allow the patient to get to a pharmacy, or by making such dispensing subject to relevant pharmacy rules and regulations. (Note that this may require pharmacy licensing boards to regulate this portion of the practice and to carry out unannounced inspections without cause as well.)
- Require any dispensing from a medical practice to be reported to the state's prescription monitoring program.
- Allow licensing boards to make a judgment about the severity of dangers to both individual patients and the public posed by practices uncovered in investigations and then to issue sanctions commensurate with those dangers without having to wait for the accumulation of a series of cases showing a pattern of misbehavior.
- Encourage greater cooperation between licensing boards and law enforcement, such that law enforcement does not hesitate to ask a board's opinion about the appropriateness of medical practices and boards are not reluctant to refer providers for possible criminal prosecution if they believe the behavior in evidence crosses the line between medical malpractice and criminal behavior.

Pain clinics also can promote these efforts by doing some of the following:

- Using sound medical practices in all respects and fully documenting all aspects of a patient's care.
- Obtaining education and developing referral networks that enable them to design and implement treatment plans with multiple types of interventions (e.g., pharmacotherapy along with physical therapy, psychotherapy, acupuncture, etc.) addressing all of the biopsychosocial aspects of chronic pain, thereby de-emphasizing the role of controlled substances.

- Using prescription monitoring programs on a regular basis to ensure that their patients are not also patronizing pill mills or other providers who are prescribing the same or similar medications; some newer laws and rules are requiring that this be done.
- Reviewing licensing board rules on ethical and legal obligations to report suspected illegal activity on the part of fellow licensees.
- Not hesitating to file complaints when they uncover evidence of pill mill activity, and asking authorities to take any necessary steps to ensure that they are protected from reprisals for making legitimate complaints.
- In general, pain clinics and the professional societies of which they and their practitioners are members need to foster a greater sense of cooperation with law enforcement and professional licensing boards to ensure that their concerns are heard; that any new standards are reasonable and effective; and in general that their practices, and their ability to provide the highest quality of care for people with chronic pain, are protected.

Through this kind of policy development, pill mills could be selectively eliminated without endangering care delivered at legitimate, professional pain clinics. We should make this approach a top priority. ■

About the Author

Robert K. Twillman, PhD, FAPM, is Director of Policy and Advocacy at the American Academy of Pain Management. He is also 2011-2012 Mayday Pain and Society Fellow and Clinical Associate Professor in the Department of Psychiatry and Behavioral Sciences at the University of Kansas School of Medicine.

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The History of the Federation of State Medical Boards: Part Two — Beginnings, Growth and Challenges, 1912–1929

David Johnson, MA

Humayun J. Chaudhry, DO

ABSTRACT: The Federation of State Medical Boards celebrates its centennial anniversary in 2012. In honor of this milestone, the *Journal of Medical Regulation* offers the second in a series of articles presenting the history of the FSMB within the context of the growth of America's medical regulatory system. These articles are adapted from the forthcoming *Medical Licensing and Discipline in America: A History of the Federation of State Medical Boards* set for release in September 2012 by Lexington Books, a subsidiary of Rowman and Littlefield Publishing Group.

Keywords: Federation of State Medical Boards, centennial, state medical boards, medical regulation

Under its original constitution and bylaws the Federation was more akin to a voluntary association than a membership organization in the truest sense. What its founders sought was an organization comprised of "progressive boards" who might act as a *de facto* "national force" influencing other states to seek the same "degree of excellence."[1] This clearly resonated with the mainstream press. A 1913 article in *Harper's Weekly* offered a "hearty welcome" to the Federation as a vehicle for fostering greater uniformity and increased standards for physicians. *Harper's* envisioned the Federation — through its collective membership — serving as a "natural…agency of reform" on a national scale. A *New York Times* editorial two days later evinced a similar theme, calling for the Federation to "campaign" for the creation of a federal department of health. This reflected an early perception that the organization, through its collective membership, might be able to provide a national voice in addressing problems viewed previously as local or regional issues.[2]

These flattering aspirations expected too much, however, and misunderstood the organization's true nature and authority. They conflated an annual gathering of representatives from individual state agencies with a truly national body akin to a federal agency — or at least one possessing the voice, if not the power and authority, of a national body. This was not the case with the Federation at the time because the obstacles to fulfilling such a role were significant. With no permanent office or headquarters, the early Federation lacked sufficient resources to play the role that some envisioned for it. It initially possessed neither permanent paid staff nor monetary resources. Indeed, the first financial statement for the organization in 1913 showed a balance of $250.[3]

Despite these challenges, the prospects for the Federation were bright. In part, this stemmed from the organization's understanding of the major challenges facing state medical boards. In 1917, Federation President David Strickler identified the issues most in need of attention by medical boards: greater uniformity in medical practice acts; the content of licensing examinations; classification systems for medical schools; limiting the activities of drugless practitioners; annual registration of licensees; a central bureau to track disciplined physicians; public education on the value of state boards.[4] These issues consumed the energy of the Federation and the state board community during the organization's first two decades.

UNDER ITS ORIGINAL CONSTITUTION AND BYLAWS THE FEDERATION WAS MORE AKIN TO A VOLUNTARY ASSOCIATION THAN A MEMBERSHIP ORGANIZATION IN THE TRUEST SENSE.

Examinations for Medical Licensure

If today the American public generally associates the phrase "medical examiner" with forensics, no such connotation existed in the popular imagination a century ago. The ubiquitous presence of the term "examiner" in the name of most of the early 20th century state medical boards reflected their primary function in personally examining the fitness to practice of their licensure candidates. In this particular area, state boards experienced considerable success in their public protection role, even before the Federation's founding.

From the beginning of the second wave of medical licensing laws enacted across the United States starting in the 1870s, provision was made for an examination of physicians by a duly constituted examining board. Early on, the examination component was often one of several alternatives for being licensed. One review of state statutes for the period 1867 to 1895 concluded that 23 states either required an examination or offered one as a mechanism for obtaining a medical license. In most instances, the examinations were written, though an oral examination before the board seems also to have been likely since statutes often spoke in terms of the board's authority to "examine" a candidate without reference to the exam's format. The rigor behind these exams varied greatly between a *pro forma* exercise and an in-depth assessment lasting several days.[5]

Examination content varied markedly between states though some areas were commonly covered by most states, e.g., hygiene, anatomy, physiology, pathology, chemistry, surgery and obstetrics. Some boards were reluctant to assess therapeutics or *materia medica* as these areas led into philosophical differences among physicians concerning approaches to treating disease and illness. When board membership contained "regular," homeopathic and eclectic physicians in proportional representation, they commonly allowed each the right to exam candidates in their respective area.[6]

Not all boards were reluctant to assess in contested areas. In states with separate homeopathic and eclectic boards, examinations could assess areas such as these without touching off contentious arguments. On occasion, even states with a single examining board, such as Missouri, addressed these areas directly though Missouri may have been atypical in this regard. The Texas approach — omitting contentious fields from the explicitly identified content of the exam — appears to have been more the norm in those states with a single board.[7]

As states expanded the breadth of coverage of their licensing exams, a simultaneous move to make them mandatory rather than an alternative to obtaining a license was also underway. In 1915, Federation Secretary-Treasurer Walter Bierring claimed that all states utilized some form of medical licensing exam. Progress in reaching this point had not come easily. It appears that by 1907 — and perhaps even earlier — all 46 states, the New Mexico and Arizona territories, and the District of Columbia were administering some form of written examination for licensure as evidenced by the annual state board issue of *JAMA*. What is less obvious are the requirements surrounding these examinations — specifically, whether they were mandated. Available evidence seems to indicate that by the time of Bierring's statement only New Mexico lacked a required exam as part of its licensure requirements.[8]

AS STATES EXPANDED THE BREADTH OF COVERAGE OF THEIR LICENSING EXAMS, A SIMULTANEOUS MOVE TO MAKE THEM MANDATORY RATHER THAN AN ALTERNATIVE TO OBTAINING A LICENSE WAS ALSO UNDERWAY.

Another important question was how significant a challenge these exams represented for physicians. From a national perspective, the period witnessed a steady increase in the pass rate on these various exams. The pass rate for all states' exams reached 78–81 percent during the period 1904–1914, rising to 90–94 percent for the period 1925–1932. One explanation for this improvement stems from ongoing reforms in medical education. The decade prior to Abraham Flexner's 1910 report on U.S. medical education witnessed multiple new schools appearing and even more closing or consolidating. The latter trend accelerated after 1910 when the number of medical schools dropped from 133 to 65 "approved" medical schools in 1932. The rapid decline in proprietary schools meant fewer marginally or inadequately trained candidates sitting for medical licensing examinations. Meanwhile, graduates from approved medical schools accounted for an increasing percentage of all licensees — reaching nearly 94 percent in 1932.[9]

Another factor may have been the practice of crediting extra points, or an additional percentage, to the exam results of established practitioners previously licensed in another state. Texas, Illinois and Massachusetts utilized this practice. The lack of negative comments concerning this practice in the extant literature seems to indicate this was neither uncommon nor unexpected. It may have represented a political compromise designed to assuage the concerns of both "elderly" practitioners and state legislatures.[10]

A look at state-specific data reveals a wide variance in the pass/fail rates on these examinations. Between 1910 and 1913, the fail rates reported by each state on their medical licensing examination ranged from 0 percent to 45 percent. Thus, at the time of the Federation's founding, a significant variance existed in the standard that each state applied to its licensing examination. Twenty years later much of this wide variance in the range of pass rates disappeared. In 1929, 44 of 51 boards reported a failure rate of 12 percent or lower. Perhaps more significant was the preponderance of boards now reporting no failures at all on their state examinations. Whereas this was uncommon in 1910, by 1932 this was now the case for approximately half of all state boards.[11] Such variability in the standard would continue to hinder efforts toward greater uniformity nationally.

The most important trend evidenced in medical licensing examinations during the first decades of the Federation involved the use of practical examinations. State boards had long suspected their written examinations were inadequate to "test the fitness" of prospective licensees as modern medicine seemed to demand "hands-on" clinical assessment. A 1917 survey revealed that 16 boards were already administering a *practical* examination in addition to their written exam, with many more strongly in favor of this approach.[12]

Hospitals and medical school facilities were utilized by most of the 16 boards, with the remainder conducting the assessment at board or state offices. This practical component varied considerably among boards to include laboratory work, use of medical instruments, and examinations using mannequins or even live human subjects. For example, Minnesota's candidates spent one day in written examinations followed by one half-day in laboratory work, with the remainder of that day spent performing a bedside examination. The written examination contained several major topics (medicine, surgery) and several minor topics (materia medica, therapeutics, medical jurisprudence, etc). Laboratory work included urinalysis and microscope analysis of specimens followed by physical diagnosis of a patient(s) at the nearby university hospital. The exam concluded with several state board examiners interviewing the candidate about the case(s).[13]

Perhaps the greatest impetus spurring state medical boards to think more seriously about the content and construct of their licensing examinations was the establishment of the National Board of Medical Examiners (NBME) in 1915. National Board founder William Rodman had long advocated for a voluntary national examining board to foster uniformity and physician mobility by authoring an examination representing a high standard that all state medical boards could accept for licensure qualification. The eligibility criteria for sitting the examination represented a standard equal to, or higher than, that mandated by any of the state boards. The examination lasted six days, covering not only cognitive knowledge but also practical aspects of medicine, including laboratory work and a bedside examination of patients. Results from the first administration in 1916 reflected the exam's rigor when only half of the 32 applicants were deemed to have met the educational prerequisites and only 5 of the 10 candidates who appeared for the examination passed.[14]

BETWEEN 1910 AND 1913, THE FAIL RATES REPORTED BY EACH STATE ON THEIR MEDICAL LICENSING EXAMINATION RANGED FROM 0 PERCENT TO 45 PERCENT.

The Federation dedicated much of its 1916 annual meeting to the topic of the recently constituted National Board with tough questions and strong opinions coming from many attendees. Supportive state board members and Rodman addressed concerns and presented a persuasive case. Pennsylvania board president John Baldy spoke forcefully in addressing colleagues' concerns. While acknowledging that some state statutes might prohibit recognizing the National Board's proposed examination, he made clear that seeking statutory relief was nothing new to state boards seeking higher standards. He pointed to another voluntary national organization — the Association of American Medical Colleges — as evidence of the effectiveness of such bodies and their ability to gain support despite a lack of

compulsory power. Ultimately, strong support from representatives of the Pennsylvania, Iowa, West Virginia, Kentucky, Ohio, Louisiana, Wisconsin and New Jersey boards carried the day, and the Federation endorsed the National Board.[15]

The National Board administered its first certifying exam in 1916, and within a year, 12 state medical boards had formally recognized this credential as meeting their medical licensing examination requirements. Steady progress continued, with 31 recognizing boards by 1925.[16] Further evidence of Federation and state board support for the NBME was evidenced by the many members of the licensing community who subsequently served as members of the National Board.

License Reciprocity or Endorsement

At the time of the Federation's founding, reciprocal agreements between state medical boards seemed a viable solution to the problem of expeditiously licensing physicians relocating from one state to another. Such agreements had flourished in the early years of the 20th century. In 1912, they were still viewed favorably enough that the Federation's original bylaws incorporated the reciprocity standard. However, by the 1920s there were increasing reservations about use of such agreements.

The shift away from formal reciprocity agreements stemmed from several factors. Such agreements penalized the physician emigrating from a state that did not have a reciprocity agreement with the medical board in the new jurisdiction. Additionally, such agreements were deemed inadequate for dealing with applicants possessing questionable moral character. Some feared that state boards utilizing such agreements generally were not doing enough to investigate the physician's practice record and "standing in the community." Even the language of the discussion had begun to shift. The term "reciprocity" fell into disfavor in the 1920s; instead, speakers began using the term 'endorsement' as one more reflective of a state board's decision to *endorse* the credentials of an applicant previously licensed elsewhere.[17]

A 1922 Federation survey of 18 southern states underscored the challenges inherent to administering an equitable process for reciprocity or endorsement. Sixteen of the 18 boards had some "fixed" process for reciprocal agreements but little consensus existed beyond the use of such agreements. Some boards adhered strictly to an examination requirement; others accepted candidates based upon a medical diploma and license from an originating state; others required both licensure examination and medical diploma. The details varied depending upon the specific agreement in place with a given state. The requirement for "practical experience" varied widely as well. Depending upon the state, upwards of five years of experience after licensure was required under these agreements.[18]

A certain irony can be found in the early success of the reciprocity/endorsement movement. In 1904, 27 states had "reciprocal relations" with other states; by 1922 the number had risen to 44 states. State boards had moved aggressively to facilitate licensing physicians seeking to relocate between jurisdictions. However, broad remedies developed by boards to facilitate license portability seemed to be matched equally by an array of complicating factors. One was the discrepancy in the quality of the medical education of prospective licensees. Medical education reform in the early 20th century could not account for the vast number of previously licensed physicians whose educational credentials from inferior schools predated this period. More distressing was the experience of state boards in dealing with issues of moral character. The practical experience of boards soon taught them the numerous ways that dishonest candidates could circumvent the system. Imposters sitting exams, frauds assuming the identity of licensed physicians and frequent relocations one step ahead of local authorities provided every state board with cautionary tales. Administrative procedures calling for personal appearances before the board, "advance filing" of the endorsement licensure application and duplicate photographs became commonplace as mechanisms for combating deception. The lesson being absorbed by state boards in the 1920s was clear: There was more to fear from the small number of practitioners with poor character and good education than the more numerous physicians with a lesser education but solid moral character.[19]

MEDICAL EDUCATION REFORM IN THE EARLY 20TH CENTURY COULD NOT ACCOUNT FOR THE VAST NUMBER OF PREVIOUSLY LICENSED PHYSICIANS WHOSE EDUCATIONAL CREDENTIALS FROM INFERIOR SCHOOLS PREDATED THIS PERIOD.

Discipline

The volumes of the *Federation Bulletin* underscore the significant challenges facing state boards as they sought to regulate the practice of medicine. Although the *Bulletin* included news items that alerted readers to criminal convictions against physicians and subsequent actions taken by the board against such individuals, this was widely recognized as insufficient. What most frustrated the licensing community was the knowledge that information on physicians of "questionable character" was too often inaccessible and buried in another state's records.[20]

Boards desperately needed a "central bureau" to serve as a clearinghouse for information about practitioners. Unfortunately, limited resources and a prospective cost in excess of $3,000 annually left the Federation convinced that it was not yet able to undertake such an initiative. Instead, the Federation formulated an arrangement with the Biographical Department of the AMA. State boards were encouraged to make routine, systematic reports to the AMA Biographical Department on frauds, imposters, criminal convictions and "all official actions" taken by the boards and to provide photographic copies of their applications and physicians' photographs. Such measures occasionally bore fruit but were generally ineffective.[21]

…IN VIRGINIA THE STATE BOARD LACKED AUTHORITY TO REVOKE A LICENSE UNTIL AFTER 1910, NEARLY TWENTY-FIVE YEARS AFTER THE BOARD'S CREATION.

Another challenge facing state boards arose from a more fundamental level. Not all state legislatures had codified the disciplinary function of their medical board. For example, in Virginia the state board lacked authority to revoke a license until after 1910, nearly 25 years after the board's creation. It was only later in the 20th century that the disciplinary and regulatory functions of the boards came increasingly to the forefront. In the first decades of the 20th century, state boards repeatedly faced disinterest, non-cooperation, and sometimes even opposition, from both local courts and the public in seeking to regulate the practice of medicine.[22]

This lack of support can be seen in boards' experiences with pursuing cases involving illegal practitioners. A 1919 Federation survey of state boards showed that only 14 states saw any significant activity in prosecuting such cases, with most of these centered in Illinois, California, Pennsylvania, Indiana and Ohio. Until 1921 North Carolina's medical practice act contained a "fee and reward" clause such that the board had to prove not only the unlicensed practice of medicine but that the individual had received compensation for his or her services. For boards, dogged persistence was necessary to interest the average local prosecutor to collaborate in prosecuting and shutting down unlicensed practitioners.[23]

State boards began looking more critically at their disciplinary and enforcement functions, starting with their medical practice act. Too often legislation in this area was "piecemeal" rather than a single piece of overarching legislation. The resulting legislation was sometimes almost "unenforceable," with physician misconduct handled at the local level by county or state medical societies, when it was addressed at all. Even long established boards, such as that in North Carolina, did not benefit from updated legislation that clearly defined the practice of medicine until 1921. In other instances (e.g., California), the medical board spent much of its early energy defending its legal status as the entity authorized to regulate the medical profession.[24]

Of necessity, state medical boards in the 1920s were learning the importance of their procedural processes for medical discipline. Some state boards grew savvier in structuring their meetings along more legalistic lines for dealing with disciplinary matters. Some took appropriate measures that allowed for "degrees of punishment" such as reprimand, probation and suspension rather than recourse to a draconian revocation. Procedural safeguards for due process not only ensured fairness and equity for the licensee but provided a solid defense for the board's action should it be tested within the courts system.[25]

Developing appropriate investigative mechanisms proved critical for state boards grappling with the problem of individuals seeking a medical license by fraudulent means. While such cases continued to plague the system, far more troubling were the "diploma mills" still operating during the 1920s. Several questionable medical schools operated throughout the country, including the Kansas City College of Medicine and Surgery (Missouri). That school's operations led to major investigations and harsh criticism of state boards in several states. A 1923 *St. Louis Star* exposé tracked some of the school's graduates to the Connecticut Eclectic

Board of Medical Examiners whose standing with the public proved irreparably damaged by revelations that advance copies of their licensing examination were delivered to the school to prepare candidates. Licenses for 175 physicians were revoked and a "vigorous housecleaning" soon followed that replaced the entire eclectic board.[26] Similar repercussions fell upon the Missouri board. Extortion and "influence" by the school with a member of the medical board supposedly sufficient to keep one of the school's graduates from appearing before the board created major news headlines. The governor removed most of the board, retaining only three members who had been diligent in pursuing the investigation.[27]

A widely circulated report on the scandal turned an unsparing eye on the eclectic boards in Arkansas and Connecticut. The report attributed much of these boards' failure to their examination processes — specifically, inadequate proctoring during the licensing examination; frequent reuse of questions on their examination; and overly "generous" exam scoring. The Arkansas eclectic board was also harshly criticized for its persistence in licensing graduates of the school well after the scandal broke.[28]

The Federation used this unfolding drama to advocate for specific practices, including a renewed call for a single board of medical examiners in each state. The Federation also encouraged all states to reconsider their practices for appointment to state boards. Specifically cited were practices such as excluding medical educators from appointments or blatant political appointments without regard to qualifications.[29] The diploma mill scandal underscored the need for continued vigilance on the part of state medical boards. Meanwhile, in the field of medical education, the Federation and state medical boards enjoyed the fruits of reform measures begun earlier in the century.

State Boards and Medical Education

The licensing community's interest in medical education dates back to the 19th century and the work of John Rauch in Illinois. State boards made significant progress in mandating higher standards for education that were consistent with the reform efforts of progressive medical schools committed to a model of academic medicine. Yet much work remained to be done. Abraham Flexner's 1910 report on medical education in the United States devoted an entire chapter to state medical boards and their role in facilitating quality medical education. Flexner and others recognized that state boards alone possessed the legal authority to secure higher standards for medical education and deny licensure to graduates from substandard schools unwilling or unable to implement such standards. According to Flexner, the licensing examination was the great "lever…[by] which the entire field may be lifted." Furthermore, limiting access to the examination "only after a fair presumption of intellectual fitness…has been established" served a similar salutary function. The medical licensing community must have been gratified by Flexner's strong assertion that final improvement in medical education would derive "from control of all schools through the state boards."[30]

ACCORDING TO FLEXNER, THE LICENSING EXAMINATION WAS THE GREAT 'LEVER… [BY] WHICH THE ENTIRE FIELD MAY BE LIFTED.'

The Federation spent considerable energy on this topic, continuing the work of its predecessor organizations. In the span of a single generation, state boards helped transform medical education through mandated higher standards as requirements for licensure. In 1904, only 10 states required a high school diploma as a requirement for a license and no state required college course work. By 1929, 43 states mandated 1–2 years of college course work in addition to the high school diploma. Additionally, 14 states required a one-year hospital internship after medical school.[31]

The complementary efforts of the Federation, state medical boards, the Association of American Medical Colleges (AAMC) and the AMA Council on Medical Education wrought major improvements in the quality of the medical education. While much of the impetus for reform came from the many progressive schools, the reality remained that many proprietary schools were not receptive environments for reform. Only the "regularizing influence" of the AAMC and the AMA working in concert with the statutory mandate of state medical boards allowed the reform movement to achieve its goals. The number of Class C (or after 1928, "nondescript") medical schools dropped from 23 in 1913 to six in 1932. Class A schools that once accounted for only half of all the medical school graduates in 1918 accounted for 87 percent of all graduates by 1929. Where once only 31 medical schools were recognized

by all state boards (1914), 70 schools enjoyed such recognition by 1927. The boards' focus on bringing inferior schools up to minimum standards carried an almost moral imperative. Unlike 50 years earlier, the education and training of a physician *did matter* in terms of patient outcomes.[32] The public protection function envisioned for state medical boards' necessitated their involvement even if that role was largely one as the regulatory hammer extracting the last few rusty nails among the planks of medical education.

At the close of the 1920s, discussion between the medical education and licensing communities shifted toward avoiding "duplication" in overseeing medical education and avoiding overly detailed and inelastic state requirements that hampered curricular changes. Even well-intended standards could prove counterproductive at times as evidenced by the Pennsylvania board's 1914 directive to Tufts medical school that it would no longer examine its graduates if the school continued admitting students "on condition." This despite the fact that Tufts was rated as a Class A school by the AMA Council on Medical Education in 1913.[33]

Clearly, the vigilance necessary to foster improvements in medical education during the earlier years of the 20th century was now less critical. Identifying the appropriate accrediting body to set standards seemed now the more appropriate means for ensuring quality. The Federation agreed, as evidenced by a 1929 resolution adopted by its membership, calling for revisions to their medical practice acts that "conform[ed] as far as possible with the principles" of the AAMC.[34] Consensus was not always so easily achieved in other areas.

Professional Tensions and Basic Science Laws

At the turn of the century, professional identity and economic self-interest were significant pressures on the medical profession. Physicians saw the former as critical to a formalizing profession. Critics saw the latter motivating physicians feeling threatened in the marketplace. These tensions spilled over into the medical licensing community.

After World War I, the number of international medical graduates (IMGs) presenting themselves for licensure increased. State boards examined fewer than 100 IMGs annually between 1917–1920 before a sharp increase to 500 annually in 1924–25. America's post-war atmosphere had changed markedly. A heightened sensitivity to political radicalism impacted both the Federation and state boards. Language such as "alien invasion" and "influx of undesirable foreign applicants" crept into the *Federation Bulletin's* editorials.[35] Meanwhile, state legislatures amended their medical practice acts to include U.S. citizenship as a requirement for licensure. By 1926, 11 states had such a requirement and 15 others required naturalization papers or a declaration of intent to be filed. Some state boards (Michigan, New York) required a year's work in a U.S. medical school or a hospital internship year (Pennsylvania).[36]

IN THE LATE 19TH CENTURY, PHYSICIANS WERE OFTEN DIFFERENTIATED AS HOMEOPATHIC, ECLECTIC OR 'REGULAR,' WITH MANY STATES MAINTAINING SEPARATE BOARDS FOR EACH.

More significant tensions arose from the different practitioners treating patients in some form or fashion other than what was deemed traditional medical practice. Here the passions grew more heated. Just as an earlier generation of physicians argued against cooperation with homeopathic and eclectic counterparts, physicians on state medical boards now cast a wary eye toward osteopathic physicians, chiropractors, Christian Scientists and "drugless healers." Critics faulted these groups for alleged inadequate education/training and a tendency to stray outside their system to include treatment options (e.g., administering drugs) that fell under the statutory definition of the practice of medicine. The Federation identified this tension as the "most important problem" facing state boards in 1917.[37]

These tensions were hardly new. In the late 19th century, physicians were often differentiated as homeopathic, eclectic or 'regular,' with many states maintaining separate boards for each. By the 1920s the profession had integrated and subsumed homeopathic and eclectic physicians under the commonly shared mantle of MD. The animosity now directed toward osteopathic physicians, chiropractors and others was noteworthy only for the vehemence of the attacks. Disparaging terms such as "cults" were assigned these groups with the harshest language reserved for the chiropractic community and Christian Scientists.[38]

Osteopathic physicians encountered significant opposition within the medical profession but

were making progress in gaining professional independence. Vermont was the first state to license osteopaths in 1896, with 14 more states doing so by 1901. Extending state licensing privileges to osteopathic physicians, however, did not always mean the general unrestricted medical practice they desired. Some states issued limited licenses that restricted the scope of practice of osteopathic physicians. In 1903, Michigan became the first state to extend "unlimited practice rights" to osteopathic physicians. By 1929, 15 states enacted similar laws. Such progress was offset by setbacks such as the military's opposition to commissioning osteopathic physicians in the Army and Navy Medical Corps during World War I.[39]

Approximately 17 states provided for a separate osteopathic medical board during that same time period. The osteopathic experience in states where a single composite board had members representing multiple 'systems' varied markedly. In some instances, the board modified its licensing examinations accordingly for osteopathic candidates (e.g., dropping *materia medica* questions). In other states, the results were different, such as in Iowa, where the board refused to accredit any osteopathic medical schools.[40]

Some individuals hoped to curb the inflammatory language. Federation President David Strickler sounded a conciliatory tone in 1917 by acknowledging that the intent of many individuals pushing for a single examining board in each state was to "eliminate the sectarian" physician. He championed making room within the profession for those willing to ensure adequate education and training for practitioners and condemned the "vindictive spirit" prevalent in the profession. His pragmatic call for

OSTEOPATHIC PHYSICIANS ENCOUNTERED SIGNIFICANT OPPOSITION WITHIN THE MEDICAL PROFESSION BUT WERE MAKING PROGRESS IN GAINING PROFESSIONAL INDEPENDENCE.

a "clinical study of [those] systems of healing" already enjoying public support and/or recognition drew favorable comment from the AMA, the American Osteopathic Association, the American Institute of Homeopathy and the AMA Council on Education. Before the proposal could gain traction, however, independent initiatives in Wisconsin and Connecticut channeled discussions in a new direction.[41]

In 1920, Wisconsin enacted legislation requiring an examination in the basic sciences for all persons practicing the healing arts. The impetus for this proposal stemmed from turf wars between the state's physicians and chiropractors, leading to the first basic science law in 1925. Until their demise nearly 60 years later, independent boards assessing candidates in the basic sciences would appear in 23 states and administer 150,000 examinations.[42]

Wisconsin's law sought to protect the public against ignorant and unskillful practitioners whatever their training. The state established a basic sciences board (composed of educators unaffiliated with any of the healing arts) to test candidates in four areas: anatomy, physiology, pathology and diagnosis. Anyone treating the sick would have to

IN 1920, WISCONSIN ENACTED LEGISLATION REQUIRING AN EXAMINATION IN THE BASIC SCIENCES FOR ALL PERSONS PRACTICING THE HEALING ARTS.

pass the basic science examination and present this credential to the respective licensing board (e.g., medical, chiropractic). The licensing board could then accept this credential in lieu of further examination in these basic sciences as part of its licensing requirements.[43]

This model soon spread elsewhere. Connecticut enacted a similar law later in the same year, though primarily in response to the diploma mill scandal that tainted that state's eclectic board. Eight states followed suit by the early 1930s. The composition of these boards usually followed the Wisconsin model, though when membership drew from the respective fields of practice, they usually placed an equal number of representatives for physicians (allopathic and osteopathic) and chiropractors.[44]

The Federation struggled in identifying an appropriate response to this trend. It belatedly opposed these boards, fearing they would make permanent the division of licensing boards within these states — a reality inconsistent with the organization's position supporting a single board of medicine. Additionally, pass/fail statistics on the basic science boards seemed to indicate these examinations represented a major hurdle to the non-MD physicians taking

them. Far from advantaging the interests of these other practitioners, the basic science laws appeared to set a minimum standard that many struggled to meet. Additionally, the introduction of these examinations added yet another variable into the licensing system.[45] The persistence of these examinations for decades to come meant that state medical boards were saddled with an unevenly adopted requirement that did little to foster the uniformity in standards. ■

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Recollections of the First Woman to Serve As President of the FSMB

Susan F. Behrens, MD

IN BRIEF **Dr. Behrens recounts the many steps and challenges she faced in breaking gender barriers during the 1980s. She was elected the first woman president (now referred to as chair) of the FSMB in 1989. This is the third in a series of articles observing the FSMB's 100th Anniversary in 2012.**

They were on the dais. All sitting side by side behind a long table. The Federation of State Medical Boards Board of Directors. Most of them close to or beyond retirement age. All of them white and all of them male.

It was the early 1980s. I was a surgeon, a few years into my practice, already vice chair of the Wisconsin Medical Examining Board, attending my first Federation meeting — and a woman.

I remember looking at this staid line up on stage and I realized that total male control of the FSMB would have to change in the very near future.

What I could not foresee was that I would find it necessary to take on a major role in bringing women to the leadership of the Federation of State Medical Boards.

Let's put the early 1980s into perspective. The women's movement of the 1960s and 1970s was starting to have an impact. The inclusion of minorities and previously excluded groups was getting a lot of press, and a few pioneering women were finding themselves in positions and places of authority unknown to women just a decade earlier. About 11 percent of practicing physicians were women. While there were still no laws in place to help guarantee equality as there are today, the entire country was aware of the need for nondiscrimination.

At that meeting most of the women who were state board members got together one afternoon for snacks. There were about seven of us.

Committee Member

The Wisconsin Medical Examining Board (MEB) members had supported me to be nominated for the Federation's Long Range Planning Committee. I was the only woman on the slate of candidates for office and committee membership. At that time, there were always two candidates nominated for each committee position and office. The Federation president (now the president is called the chair) began introducing the nominees and offering some personal information or anecdote about each candidate. When he came to me, he could not pronounce my name, and only said that I was from Wisconsin. (Not an auspicious introduction to an election.)

But I had talked to many people at the meeting. I had written a letter to each board introducing myself. (This was in the days before email or texting, of course.) My loyal supporters on the Wisconsin MEB had networked for me.

THE WOMEN'S MOVEMENT OF THE 1960S AND 1970S WAS STARTING TO HAVE AN IMPACT…AND A FEW PIONEERING WOMEN WERE FINDING THEMSELVES IN POSITIONS AND PLACES OF AUTHORITY UNKNOWN TO WOMEN JUST A DECADE EARLIER.

And when the election was over, I was the first woman on a Federation committee. I was elated.

Board of Directors

After I became chair of the Wisconsin Medical Examining Board, the board members again supported me in 1985, this time as a candidate for the Federation Board of Directors. So, with the help of the many people I had come to know on boards throughout the country, my candidacy was again successful, and I became the first woman on the Federation Board of Directors. I was enthused, involved in Wisconsin and nationally, and enjoying every minute of it.

Vice President

In 1987, my board supported me for vice president of the FSMB. At that time, there were always two candidates for vice president, and traditionally, the winning candidate was the only person nominated for president-elect the following year and was elected to that position by acclamation.

To be recommended for this position was truly an honor, but before allowing my name to be submitted, I had to be sure this was the right decision for the Federation and for me. Should I win, this would be an intense three-year commitment. I had serious discussions about it with several people, including the two women physicians in highly visible medical leadership roles at that time. They were Dr. Edithe Levit, who was then the first woman president and CEO of the National Board of Medical Examiners, and Dr. Nancy Dickey, who had recently been the first woman elected to the American Medical Association (AMA) Board of Trustees, and who would become the first woman president of the AMA about a decade later in 1997. I am very grateful for the advice I received from both of them. In summary, they both told me "If you know you can do the job, go for it." I took this and everything else into consideration in making my decision.

THE NEXT QUESTIONS TO CONSIDER WERE: IF I PURSUED A WRITE-IN CAMPAIGN, WAS WINNING A REALISTIC GOAL? WHAT REALLY WERE MY CHANCES? IF I LOST, WHAT HAD I ACCOMPLISHED? WAS IT WORTH IT?

The Nominating Committee did place me on the slate as one of the two candidates for Federation vice president.

When the votes were counted, I had won the vice presidency. What a grand day that was for me. And there were so many people, both men and women, who were happy along with me.

And Then Things Changed

During those years, my interests and attentions were drawn to the many issues facing the Federation and the state boards. I was really not focusing on the internal politics of the Federation.

But the Nominating Committee decided that they would not nominate me for president-elect. A "technicality" in the bylaws supposedly disqualified me. It seems that the committee had misread my resume and assumed that I had left the Wisconsin board at a time that made me ineligible to run for the office. This was a moot point because I rejoined the Wisconsin board about a year later.

Instead of dwelling on the committee's confusion or being perplexed by its action, I decided to approach the matter in a more constructive way.

There were more important questions to consider. The first one was: Is there some way I would harm the Federation if I were president? And, was there a valid reason why I should not be FSMB president?

After contemplation, and private discussions with a few knowledgeable people, it became clear to me that the answer to these questions was "no."

After the candidate list was published and people on other boards became aware of what had happened, there were phone calls from all over the country. I never realized how many friends I had in the Federation.

Uniformly, the statements were: "How could they do this to you?" "How can I help you?" "How can my board help you?" I was overwhelmed by the support and encouragement I received from so many people.

Also, both men and women on numerous state boards were thinking deeply about what had occurred and were very concerned about its implications. This concern arose because the organization was starting to become a major player nationally and the last thing it needed was a reputation of discrimination.

My Decision

I analyzed and contemplated my options. It was evident that I had two possible routes to follow:

1. Quietly withdraw.

2. Start preparations for a write-in campaign.

So the next questions to consider were: if I pursued a write-in campaign, was winning a realistic goal? What really were my chances? If I lost, what had I accomplished? Was it worth it? I had to consider both the winning and losing scenarios, and what the fallout of each would be for the Federation.

There had been a few unsuccessful write-in campaigns in Federation history. But there was a difference between those campaigns and what this one would be. Here there was an obvious irregularity in how the nomination process had been handled. This

write-in campaign would be a referendum on fair play within the Federation. Did the membership want an organization which was still run by the techniques of "an old boys' club" (I don't care for that term, but there is none other that fits), or did they want decisions to be made in a more equitable way?

After all, just being represented in the recent elections was progress for women. At one of the Federation meetings I had spoken with a woman public member. She had applied for an appointive position on a Federation committee in the 1970s. She had been told that as a woman or as a public member she was not eligible to hold office or serve on a Federation committee.

I am not a feminist. I was not one of the protesting, bra-burning, activist women who threw themselves into the controversy of equal rights for women during that era of our nation's growth. During the years that feminist protests were grabbing the headlines, I was busy studying to reach my goal of becoming a physician and surgeon, since at that time there were few spots for women in medical schools.

But in this situation, I began to realize that I must stand up for the principles of equality for women and other minorities. I did not complete my general surgery residency and fellowship by being a shrinking violet. Surgery at that time was still very much a man's field. It was tough for a woman in surgery training then. I have never taken the easy way out of demanding situations. So, if a write-in campaign was the best course of action, I would follow it.

If I did pursue a write-in campaign, I wanted it done in a dignified, honorable, gracious manner. I would not be involved in any underhanded attacks or innuendo.

So, after much thought, deliberation and analysis, I decided that a write-in campaign was my only feasible option, for several reasons:

First, if not challenged, similar tactics could be used again in the future against any qualified candidate.

Second, because it had happened to me, I was the only one who could tackle this injustice effectively. I firmly believed that this issue had to be addressed openly.

Third, I wanted another woman or other minority to be able to take on leadership in the Federation without having to go through similar circumstances.

Fourth, I trusted the members of the Federation to work this out for what was best for the Federation.

Fifth, if I lost, it would still make it uncomfortable for the decision makers to do such a thing again.

Sixth and most importantly, if there was not an effort to correct what the nominating committee had done, the reputation of discrimination would follow the Federation for years to come. This would mean that the Federation would lack some of the integrity it needed to accomplish its mission in the national arena.

How Does One Create a Successful Write-In Campaign?

Wanting to do it, and being able to do it successfully, are two very different things.

The first step? I knew that I would need some knowledgeable advice. A friend who is very astute on political situations gave me much encouragement, information on what to expect from various people,

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and how best to prepare. Another lifelong friend was/is a national expert on parliamentary procedure — wrote the book, so to speak. We looked at the parliamentary challenges from every angle. My fellow Wisconsin board members were there for me every minute with a positive attitude, backing and suggestions.

I carefully drafted a letter to each state board and delegate of the Federation Annual Meeting. I had brochures which outlined my qualifications. I went to the Annual Meeting with a good understanding of the parliamentary issues that could arise, along with an awareness of other possible scenarios, and plans for how each could best be handled. My campaign was based on my merits in being able to lead the Federation and that there was no technicality that should keep me from holding the office.

The Annual Meeting was a whirlwind. Several of the senior and longtime Federation members, some members of the Board of Directors and other men in leadership positions were more supportive than

I could have imagined. It soon became evident that each one, on his own or working with small groups, had taken on a project to help my campaign. For example, several were doing detailed analysis of the Federation's bylaws. Others were thinking through the election process itself and wanted to make sure that it was fair in every way for each candidate. Some made it their project to network for me with the delegates. One was concerned that people might not know how to spell my name, so he had "Write-in Behrens for President-Elect" pens made for everyone. I did not ask for all this. These men voluntarily gave me their help and assistance. There were a few women who were Federation members at that time and they were as helpful as they could be also.

While it was an important issue for the members to address, this election overshadowed some of the chief functions of the Federation's Annual Meeting. The valuable time between lectures and at meals was not being used to discuss Federation policies and individual state board problems or to review the excellent lectures. Instead, the election turned into the main topic of conversation. Much to my distress, I found that untrue rumors seemed to start in the ether and take on a life of their own. Despite my best intentions to have a dignified and gracious campaign, there were times when I had no control over what was being said. These effects I regret.

And, yes, when the votes were counted, I won the election for president-elect of the Federation of State Medical Boards.

My years as president-elect and president were busy and rewarding. It was a privilege and an honor to be able to serve the Federation in these offices. It was like having a second full-time job, as there was so much going on in the FSMB at that time.

The FSMB Becomes the Go-to Organization

While the Federation had been in existence since 1912 and while it had some influence in its earlier years, it was during the time I was active in the Federation that it became a go-to organization on the national stage. Our policies and activities caught the attention of all groups and agencies interested in licensure and regulation.

The Federation Board Action Data Bank had recently gone online and was at the cutting edge of using computers to store data and communicate with the states. Computer use was still primitive. There were only 1,000 hosts on the Internet in 1984. But the Federation developed the system and policy to start using computers to obtain and disseminate organized data about disciplined physicians with the state boards. There were challenges however. For example, with very little protection against computer hacking, some boards were very hesitant to use computers to transfer their data. But in addition to a top-of-the-line mainframe computer, the Federation also had one of the first effective firewalls. Also, to protect each day's data, a copy of the computer tape had to be hand-carried to a secure location off-site each evening. Few other agencies or organizations at that time were using computers as effectively or as safely as the FSMB.

THE ELECTION TURNED INTO THE MAIN TOPIC OF CONVERSATION. MUCH TO MY DISTRESS, I FOUND THAT UNTRUE RUMORS SEEMED TO START IN THE ETHER AND TAKE ON A LIFE OF THEIR OWN.

The Elements of a Modern State Medical and Osteopathic Board was a landmark document and was adopted during my term as president. It was requested by the U.S. Department of Health and Human Services as a blueprint for the structure and function of a modern state medical board. It was consistent with the Federation policy document, *A Guide to the Essentials of a Modern Medical Practice Act.* It reflected the relevant characteristics of effective medical boards, and became an indispensable document for anyone interested in the regulation of medical practice.

The Federation was the main advisor as the government developed its policy for use of a National Practitioner Data Bank.

There were many serious discussions starting on a variety of subjects, including impaired physicians and their rehabilitation, prescribing of narcotics, mandating of continuing medical education, and having uniformity in licensing for foreign medical graduates.

The groundwork for the United States Medical Licensing Examination (USMLE) was finalized during my term as president and the papers were signed making it a reality. Also that year the National Board of Medical Examiners celebrated its 75th anniversary,

and I was privileged to pay tribute to it during the FSMB's Annual Meeting. That speech was published in the *Federation Bulletin,* January 1991, Vol. 78, Number 1.

With all these things going on, there was a need for expanding the Federation office, and this was also accomplished.

In other words, those years laid the foundation for what the Federation has now become. I am proud to be associated with these developments in a small way. Also, I thoroughly enjoyed working with then Executive Vice President Dr. Bryant Galusha (that position is now called the president and CEO). His many skills served the Federation well during these years.

THERE ARE STILL SOME INSTANCES THAT REQUIRE WOMEN TO STAND UP AGAINST SOCIAL AND HISTORICAL NORMS THAT NEED TO BE MODIFIED. WHEN EACH BIAS IS RECOGNIZED, MUCH EFFORT AND ENERGY HAS TO BE INVESTED TO TRY TO BRING ABOUT THE NEEDED CHANGES.

Looking Back

So, would I do it again—take on a write-in campaign to stand up for principles I believe in? Absolutely.

Am I glad I stood my ground? Of course.

Given the world as it is today, it is difficult to envision how problematic the circumstances of that election were and how many people realized that the credibility of the FSMB depended on how this event was handled. It was not a fight that I could have won on my own.

Today, it is not unusual to have a woman or a member of a minority group (and in the Federation, that includes public members and foreign medical graduates) in various leadership positions in the FSMB.

I have the privilege of knowing the six capable women who have served the Federation as president or chair since my tenure. I admit that I smile at the knowledge that the paths to their leadership roles were made a bit easier because of the stand I took a little over 20 years ago. The Federation also elected the first public member, foreign medical graduate and African American presidents within 10 years after my term. There had been a Hispanic president in 1984 and an osteopath in 1988. In other words, all of these so-called "glass ceilings" have been broken in the FSMB, and all this occurred before the position name was changed from president to chair in 2003.

There are currently 70 member boards in the Federation. Women serve as the executive director for 37 of the 70 boards. And women comprise approximately 40 percent of the 540-plus members serving on these state boards.

We women of 2012 are descendants of women who were not allowed to vote. We know the saga of women's suffrage and we are grateful for it, but it is thought-provoking for us to realize that the struggle for the vote for women lasted 70 years.

Today women have the luxury of being able to take most of our participation for granted, be it in government positions, organizational leadership roles or in any institution. There are still some instances that require women to stand up against social and historical norms that need to be modified. When each bias is recognized, much effort and energy has to be invested to try to bring about the needed changes.

The years have passed and I have been involved in other challenging situations, a variety of organizations and other leadership roles. It has truly become a different world for women.

Am I glad that the world has changed?

I can't imagine going back to the world as it used to be. ■

About the Author

Dr. Behrens is a retired surgeon in Wisconsin and past president of the FSMB.

Model Policy Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice

ABSTRACT: In recent years the medical profession has become aware of the opportunities and challenges that social media and social networking websites present for physicians. As technology has advanced, many hospitals and health care organizations have found it necessary to create their own policies in order to protect physicians and patients alike. In 2011, FSMB Chair Janelle A. Rhyne, MD, MACP, asked the members of the Special Committee on Ethics and Professionalism to develop guidelines for state medical and osteopathic boards to consider for their use in educating their licensees on the proper use of social media and social networking websites. The Special Committee on Ethics and Professionalism was charged with providing ethical and professional guidance to the FSMB membership with regard to the use of electronic and digital media by physicians (and physician assistants, where appropriate) that may be used to facilitate patient care and nonprofessional interactions. Such electronic and digital media include, but are not limited to, e-mail, texting, blogs and social networks. The committee's proposed model guidelines contained in this report also focus on ways that physicians can protect the privacy and confidentiality of their patients as well as maintain a standard of professionalism in all social media and social networking interactions. The Model Policy Guidelines are being published in this issue of the *Journal of Medical Regulation* as a service to our readers. The policy can be accessed at www.fsmb.org.

Keywords: social media, social networking, medical privacy and confidentiality

This policy was adopted by the House of Delegates of the Federation of State Medical Boards of the United States, Inc., in April 2012.

Section I: Preamble

The use of social media has become increasingly important across all industries—including health care. *QuantiaMD* surveyed more than 4,000 physicians and reported in September 2011 that 87 percent use a social media website for personal use and 67 percent use social media for professional purposes.[1] In addition, there is evidence that physicians connect with patients through social media websites. Research indicates that 35 percent of practicing physicians have received friend requests from a patient or a member of their family, and 16 percent of practicing physicians have visited an online profile of a patient or patient's family member.[2]

Social media use presents several challenging questions for administrators and physicians, such as where the boundary of professionalism lies, and whether work experiences can be shared without violating the privacy and confidentiality of patients. One meta-analysis of physician blogs found that nearly 17 percent included enough information about patients for them to be identified.[3]

Medical schools and their students often use online social networking websites,[4,5] and students have been disciplined for posting unprofessional online content.[6] In addition, most physician licensing authorities in the United States have reported incidents of physicians engaging in online professionalism violations, many of which have resulted in serious disciplinary actions. In a 2010 survey of executive directors at state medical boards in the United States, 92 percent indicated that violations of online professionalism were reported in their jurisdiction. These violations included Internet use for inappropriate contact with patients (69 percent), inappropriate prescribing (63 percent), and misrepresentation of credentials or clinical outcomes (60 percent). In response to these violations, 71 percent of boards held formal disciplinary proceedings and 40 percent issued informal warnings. Outcomes from the disciplinary proceedings included serious actions such as license limitation (44 percent), suspension (29 percent), or revocation (21 percent) of licensure.[7]

ONE META-ANALYSIS OF PHYSICIAN BLOGS FOUND THAT NEARLY 17 PERCENT INCLUDED ENOUGH INFORMATION ABOUT PATIENTS FOR THEM TO BE IDENTIFIED.

These growing concerns about physician use of social media underscore the need for social media policies. Many hospitals and health care organizations, such as the American Medical Association, American College of Physicians, Cleveland Clinic, and Mayo Clinic, have developed social media policies.[8,9,10,11]

Social media has enormous potential for both physicians and their patients. It can be used to disseminate information and forge meaningful professional relationships. However, these benefits must occur within the proper framework of professional ethics, and physicians need information on the importance of maintaining the same professional and ethical standards in their online activity or communications using other forms of electronic media.

The FSMB has developed this policy to encourage physicians who use social media and social networking to protect themselves from unintended consequences of such practices and to maintain the public trust by:

- Protecting the privacy and confidentiality of their patients
- Avoiding requests for online medical advice
- Acting with professionalism
- Being forthcoming about their employment, credentials and conflicts of interest
- Being aware that information they post online may be available to anyone, and could be misconstrued

The FSMB acknowledges that there may be instances in which a physician's professionalism or care is questionable and not addressed in this policy or other FSMB policy. Anytime a physician enters into a relationship with a patient, whether it is electronically or in person, the physician should abide by the same rules or statutes established by the state medical board.

Section II: An Appropriate Physician-Patient Relationship

The health and well-being of a patient depend upon a collaborative effort between the physician and patient. The physician-patient relationship is fundamental to the provision of acceptable medical care, and physicians are expected to recognize the obligations, responsibilities and patient rights associated with establishing and maintaining an appropriate physician-patient relationship. The relationship between a physician and patient begins when an individual seeks assistance from a physician for a health-related matter, and the physician agrees to undertake diagnosis and treatment of the patient.[12] The physician-patient relationship can begin without a personal encounter, which allows for online interactions to constitute the beginning of the relationship. Physicians should remember that when using electronic communications they may be unable to verify that the person on the other end of the electronic medium is truly the patient; likewise, the patient may not be able to verify that a physician is on the other end of the communication. For that reason, the standards of medical care do not change by virtue of the medium in which physicians and their patients choose to interact.

THE FSMB HAS DEVELOPED THIS POLICY TO ENCOURAGE PHYSICIANS WHO USE SOCIAL MEDIA AND SOCIAL NETWORKING TO PROTECT THEMSELVES FROM UNINTENDED CONSEQUENCES OF SUCH PRACTICES AND TO MAINTAIN THE PUBLIC TRUST…

The following narratives demonstrate examples where unintended consequences of physicians' use of social media and social networking may undermine a proper physician-patient relationship and the public trust.

1. A urologist who is an astute clinician and well-respected by his colleagues recently began posting his comments, views and observations on Twitter. The same day that the United States Preventive Services Task Force came out with a recommendation, in October 2011, against routine Prostate-Specific Antigen (PSA) screening in healthy men for prostate cancer, he posted a tweet with writing that used disrespectful language to disagree with the recommendation. The tweet has now gone viral and has been read by many of his patients, colleagues, fellow researchers, family and friends.
2. A patient noted disrespectful language on a physician's blog when the physician expressed frustration towards another patient who had to visit the emergency department multiple times for failing to monitor her sugar levels. The physician referred to the patient as "lazy" and "ignorant" on their blog.
3. Approximately two years after a physician left his private practice, a former patient asked to "friend" him on Facebook. The physician had set up a Facebook account to participate in a review course for Maintenance of Certification (MOC), but remained on Facebook to stay in touch with family. The physician felt conflicted about the request because he was no longer the patient's physician, and had no intention of returning to private practice. The patient was also very emotionally fragile, and cried at most office

visits. The physician wrestled with whether or not to accept the request, but eventually did so for fear that rejecting the request would damage the former patient's self-esteem. The former patient never posted anything inappropriate, and only contacted the physician to wish him a happy birthday. The physician still feels uncomfortable maintaining this online "friendship," and has considered closing his Facebook account.

4. A psychiatrist in her 30s used Facebook to befriend a former female patient of similar age who she took care of when she was a psychiatry resident in another state. They had "hit it off" because they had similar tastes in music and art and developed a level of trust that the patient said she had not had with anyone else. They now periodically exchange pleasantries on Facebook, but lately the patient's affect online appears different, worrying the psychiatrist. The psychiatrist is planning to spend the holidays with her family in the same state as her former patient, and is considering getting together with her former patient to "catch up," but is unsure how to properly initiate contact with her former patient. Should the psychiatrist just meet her for coffee? Is it appropriate for them to meet at all? She knows she probably shouldn't use Facebook because it may not be private, but she also doesn't want to give the patient her personal email address.
5. A concerned patient notes that her physician frequently describes "partying" on his Facebook page, which is accompanied by images of himself intoxicated. The patient begins to question whether her physician is sober and prepared to treat her when she has early morning doctor's appointments.
6. A physician comes across the profile of one of his patients on an online dating website and invites her to go on a date with him. The patient feels pressured to accept the invitation because her next appointment with her physician would be awkward if she refuses.
7. A first-year resident films another doctor inserting a chest tube into a patient. The patient's face is clearly visible. The resident posts the film on YouTube for other first-year residents to see how to properly do the procedure.

These examples highlight the importance of proper boundaries within the physician-patient relationship. Even seemingly innocuous online interactions with patients and former patients may violate the boundaries of a proper physician-patient relationship.

Physicians should not use their professional position, whether online or in person, to develop personal relationships with patients. The appearance of unprofessionalism may lead patients to question a physician's competency. Physicians should refrain from portraying any unprofessional depictions of themselves on social media and social networking websites.

Section III: Parity of Professional and Ethical Standards

To ensure a proper physician-patient relationship, there should be parity of ethical and professional standards applied to all aspects of a physician's practice, including online interactions through social media and social networking sites. Referencing the FSMB House of Delegate's *Model Guidelines for the Appropriate Use of the Internet in Medical Practice,* adopted in 2002, physicians using social media and social networking sites are expected to observe the following ethical standards:

EVEN SEEMINGLY INNOCUOUS ONLINE INTERACTIONS WITH PATIENTS AND FORMER PATIENTS MAY VIOLATE THE BOUNDARIES OF A PROPER PHYSICIAN-PATIENT RELATIONSHIP.

Candor

Physicians have an obligation to disclose clearly any information (e.g., financial, professional or personal) that could influence patients' understanding or use of the information, products or services offered on any website offering health care services or information.

Privacy

Physicians have an obligation to prevent unauthorized access to, or use of, patient and personal data and to ensure that "de-identified" data cannot be linked back to the user or patient.

Integrity

Information contained on websites should be truthful and not misleading or deceptive. It should be accurate and concise, up-to-date, and easy for patients to understand. Physicians using medical websites should strive to ensure that information provided is, whenever possible, supported by current medical peer-reviewed literature, emanates from a recognized body of scientific and clinical knowledge and conforms to minimal standards of care. It should

clearly indicate whether it is based upon scientific studies, expert consensus, professional experience or personal opinion.

How these ethical standards relate to the proper use of social media by physicians is explored further in the next section.

Section IV: Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice

The following guidelines are recommended for physicians who use social media and social networking in their personal and professional lives.

Interacting with Patients

Physicians are discouraged from interacting with current or past patients on personal social networking sites such as Facebook. Physicians should only have online interaction with patients when discussing the patient's medical treatment within the physician-patient relationship, and these interactions should never occur on personal social networking or social media websites. In addition, physicians need to be mindful that while advanced technologies may facilitate the physician-patient relationship, they can also be a distracter which may lessen the quality of the interactions they have with patients. Such distractions should be minimized whenever possible.

Discussion of Medicine Online

Social networking websites may be useful places for physicians to gather and share their experiences, as well as to discuss areas of medicine and particular treatments. These types of professional interactions with other physicians represent an ancillary and convenient means for peer-to-peer education and dialogue. One current example is Doximity, a professional network with more than 567,000 U.S. physician members in 87 specialties. Using Doximity, physicians are said to be able to exchange HIPAA-compliant messages and images by text or fax and discuss the latest treatment guidelines and medical news in their specialty.[13] While such networks may be useful, it is the responsibility of the physician to ensure, to the best of his or her ability, that professional networks for physicians are secure and that only verified and registered users have access to the information. These websites should be password protected so that non-physicians do not gain access and view discussions as implying medical advice, which may be counter to the physicians' intent in such discussions. Physicians should also confirm that any medical information from an online discussion that they plan to incorporate into their medical practice is corroborated and supported by current medical research.

PHYSICIANS SHOULD ONLY HAVE ONLINE INTERACTION WITH PATIENTS WHEN DISCUSSING THE PATIENT'S MEDICAL TREATMENT WITHIN THE PHYSICIAN-PATIENT RELATIONSHIP.

Privacy/Confidentiality

Just as in the hospital or ambulatory setting, patient privacy and confidentiality must be protected at all times, especially on social media and social networking websites. These sites have the potential to be viewed by many people and any breaches in confidentiality could be harmful to the patient and in violation of federal privacy laws, such as HIPAA. While physicians may discuss their experiences in non-clinical settings, they should never provide any information that could be used to identify patients. Physicians should never mention patients' room numbers, refer to them by code names, or post their picture. If pictures of patients were to be viewed by others, such an occurrence may constitute a serious HIPAA violation.

Disclosure

At times, physicians may be asked or may choose to write online about their experiences as a health professional, or they may post comments on a website as a physician. When doing so, physicians must reveal any existing conflicts of interest and they should be honest about their credentials as a physician.

Posting Content

Physicians should be aware that any information they post on a social networking site may be disseminated (whether intended or not) to a larger audience, and that what they say may be taken out of context or remain publicly available online in perpetuity. When posting content online, they should always remember that they are representing the medical community. Physicians should always act professionally and take caution not to post information that is ambiguous or that could be misconstrued or taken out of context. Physician employees of health care institutions should be aware that employers may reserve the right to edit, modify, delete, or review Internet communications. Physician writers assume all risks related to the

security, privacy and confidentiality of their posts. When moderating any website, physicians should delete inaccurate information or others' posts that violate the privacy and confidentiality of patients or that are of an unprofessional nature.

Professionalism

To use social media and social networking sites professionally, physicians should also strive to adhere to the following general suggestions:

- Use separate personal and professional social networking sites. For example, use a personal rather than professional email address for logging on to social networking websites for personal use. Others who view a professional email attached to an online profile may misinterpret the physician's actions as representing the medical profession or a particular institution.
- Report any unprofessional behavior that is witnessed to supervisory and/or regulatory authorities.
- Always adhere to the same principles of professionalism online as they would offline.
- Cyber-bullying by a physician towards any individual is inappropriate and unprofessional.
- Refer, as appropriate, to an employer's social media or social networking policy for direction on the proper use of social media and social networking in relation to their employment.

Medical Board Sanctions and Disciplinary Findings

State medical boards have the authority to discipline physicians for unprofessional behavior relating to the inappropriate use of social networking media, such as:

- Inappropriate communication with patients online
- Use of the Internet for unprofessional behavior
- Online misrepresentation of credentials
- Online violations of patient confidentiality
- Failure to reveal conflicts of interest online
- Online derogatory remarks regarding a patient
- Online depiction of intoxication
- Discriminatory language or practices online

State medical boards have the option to discipline physicians for inappropriate or unprofessional conduct while using social media or social networking websites with actions that range from a letter of reprimand to the revocation of a license.

Future Changes

The Federation of State Medical Boards recognizes that emerging technology and societal trends will continue to change the landscape of social media and social networking, and how these websites are used by patients and physicians will evolve over time. These guidelines are meant to be a starting point for the discussion of how physicians should properly communicate with their patients using social media. These guidelines will need to be modified and adapted in future years as technology advances, best practices emerge, and opportunities for additional policy guidance are identified.

THE FEDERATION OF STATE MEDICAL BOARDS RECOGNIZES THAT EMERGING TECHNOLOGY AND SOCIETAL TRENDS WILL CONTINUE TO CHANGE THE LANDSCAPE OF SOCIAL MEDIA AND SOCIAL NETWORKING, AND HOW THESE WEBSITES ARE USED BY PATIENTS AND PHYSICIANS WILL EVOLVE OVER TIME.

Section V: Key Definitions and Glossary

***Blog*—**Blog is a word that was created from two words: "web log." Blogs are usually maintained by an individual with regular entries of commentary, descriptions of events, or other material such as graphics or video. Entries are commonly displayed in reverse-chronological order. "Blog" can also be used as a verb, meaning to maintain or add content to a blog.

***Bridging*—**Bridging can refer to the function patient networking sites serve for people living with chronic disease. Social networking for the chronically ill bridges the gap between the restrictive conditions in which they live and access to support groups and other resources that are important for coping and recovery.

***Chat*—**Chat can refer to any kind of communication over the Internet, but traditionally refers to one-to-one communication through a text-based chat application commonly referred to as instant messaging applications.

***Comment*—**A comment is a response that is often provided as an answer of reaction to a blog post or message on a social network. Comments are a primary form of two-way communication on the social web.

E-mail — Electronic mail, commonly called e-mail or email, is a method of exchanging digital messages from an author to one or more recipients. Modern e-mail operates across the Internet or other computer networks.

Facebook — Facebook is a social utility that connects people with friends and others who work, study and live around them. Facebook is the largest social network in the world with more than 800 million users.

Forums — Also known as a message board, a forum is an online discussion site. It originated as the modern equivalent of a traditional bulletin board, and a technological evolution of the dialup bulletin board system.

Hashtag — A hashtag is a tag used on the social network Twitter as a way to annotate a message. A hashtag is a word or phrase preceded by a "#". Example: #yourhashtag. Hashtags are commonly used to show that a tweet, a Twitter message, is related to an event or conference.

Instant Messaging — Instant messaging (IM) is a form of real-time direct text-based communication between two or more people. More advanced instant messaging software clients also allow enhanced modes of communication, such as live voice or video calling.

LinkedIn — LinkedIn is a business-oriented social networking site. Founded in December 2002 and launched in May 2003, it is mainly used for professional networking. As of June 2010, LinkedIn had more than 70 million registered users, spanning more than 200 countries and territories worldwide

New Media — New Media is a generic term for the many different forms of electronic communications that are made possible through the use of computer technology. The term is in relation to "old" media forms such as print newspapers and magazines that are static representations of text and graphics.

Skype — Skype is a free program that allows for text, audio and video chats between users. Additionally, users can purchase plans to receive phone calls through their Skype account.

Social Media — Electronic communication through which users create online communities to share information, ideas, personal messages, and other content.

Social Networking — Networking using an online service, platform, or site that focuses on building social relations among people who share interests and/or activities.

Texting — Text messaging, or texting, refers to the exchange of brief written text messages between fixed-line phone or mobile phone and fixed or portable devices over a network.

Tweet — A message or update that one posts on Twitter.

Twitter — Twitter is a platform that allows users to share 140-character-long messages publicly. Users can "follow" each other as a way of subscribing to each others' messages. Additionally, users can use the @username command to direct a message towards another Twitter user.

Webinar — A webinar is used to conduct live meetings, training, or presentations via the Internet.

Wiki — A wiki is a website that allows the easy creation and editing of any number of interlinked web pages via a web browser, allowing for collaboration between users.

Wikipedia — Wikipedia is a free, web-based, collaborative, multilingual encyclopedia project supported by the non-profit Wikimedia Foundation.

Yelp — Yelp is a social network and local search website that provides users with a platform to review, rate and discuss local businesses and services.

YouTube — YouTube is a video-sharing website on which users can upload, share, and view videos. ■

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Global Organizations

2012 IAMRA Conference on Medical Regulation Convenes Oct. 2–5

The International Association of Medical Regulatory Authorities (IAMRA) will hold its 10th Biennial Conference on Medical Regulation in Ottawa, Ontario, Canada, Oct. 2-5, 2012. With the theme

THE PROGRAM CONSISTS OF A COMBINATION OF PLENARY AND BREAKOUT SESSIONS, ALONG WITH PRESENTATIONS OF ORAL ABSTRACTS, WORKSHOPS AND POSTERS.

"Medical Regulation in the Real World: Bringing Evidence to Bear," the conference will bring together more than 250 delegates representing more than 30 countries.

Conference delegates will discuss the importance of the use of evidence in medical regulation and will spend a significant portion of their time building on the work completed by delegates at the 2010 meeting—which focused on assembling global best practices in medical regulation.

As the effort to compile best practices continues, delegates will focus on three key content areas: registration and licensure, complaints and resolution, and quality assurance of a physician's practice.

The program consists of a combination of plenary and breakout sessions, along with presentations of oral abstracts, workshops and posters. All sessions are designed to be relevant to every participant regardless of their level of expertise, resources or the current status of their regulatory processes and infrastructure.

Preceding the 2012 conference is the half-day IAMRA Institute: Medical Regulation 101, which will focus on the essential practice aspects and challenges for medical regulators. The institute offers an excellent opportunity to meet and establish relationships with colleagues from other jurisdictions prior to the conference.

To register for the 2012 IAMRA Conference on Medical Regulation, visit www.buksa.com/IAMRA. ■

Brazil Joins IAMRA

The International Association of Medical Regulatory Authorities has announced its newest member, the Brazilian General Medical Council. IAMRA currently has 72 members from 35 countries. The Brazilian General Medical Council was founded in 1951. ■

Source: IAMRA website, August 2012

Canada

Medical Council of Canada Celebrates 100 years

The Medical Council of Canada (MCC) is holding a series of special events and activities throughout 2012 as it celebrates its centennial year.

During the course of the year, the Council is sponsoring an invitational workshop on physician assessment for university medical faculty in Canada. Following each workshop, the MCC will host a reception to bring together the university's medical faculty with representatives from the provincial medical regulatory authority.

DURING THE COURSE OF THE YEAR, THE COUNCIL IS SPONSORING AN INVITATIONAL WORKSHOP ON PHYSICIAN ASSESSMENT FOR UNIVERSITY MEDICAL FACULTY IN CANADA.

Also in conjunction with its 2012 Annual Meeting, the Council will host the biennial conference of

the International Association of Medical Regulatory Authorities (IAMRA), Oct. 2–5. ■

Source: Medical Council of Canada website, August 2012

United Kingdom

General Medical Council Lays Out Requirements for Physician Revalidation

The General Medical Council (GMC) of the United Kingdom (UK) and the UK's four health departments have agreed on minimum requirements that doctors must meet before they go through the UK's new re-licensure process, known as Revalidation.

The Revalidation system, which has been evolving over the last several years in the UK, is similar to the FSMB's Maintenance of Licensure (MOL) concept, which is just moving forward in the United States.

THE GMC ANNOUNCED THAT IT WILL BEGIN REVALIDATING PHYSICIANS AT THE END OF 2012, WITH THE FIRST IMPLEMENTATION STAGE OF THE NEW SYSTEM TO LAST UNTIL THE END OF MARCH 2018.

The GMC announced that it will begin revalidating physicians at the end of 2012, with the first implementation stage of the new system to last until the end of March 2018. A GMC news release noted that the GMC expects to have all physicians revalidated by that time, and "the vast majority to have revalidated by the end of March 2016."

During the roughly five-year period, physicians will be expected to meet a number of minimum requirements, which will be clearly communicated by the GMC. Among them are three key steps: Physicians will be expected to take part in an annual appraisal process, to have completed at least one appraisal based on the GMC's framework for appraisal and to have collected and reflected on the six types of revalidation supporting information required in the new system. These types of information range from evidence of continuing professional development (CPD) and quality improvement activities to feedback from colleagues and patients.

In the UK's Revalidation system, according to the GMC, physicians may also bring team-based (as opposed to individualized) information to their appraisal, as long as they have "reflected on what the information means for their individual practice." They may also use evidence of patient and colleague feedback obtained up to five years before a revalidation recommendation is made, as long as it is relevant to their current scope of practice.

In an effort to keep the new system flexible, the GMC said that in compiling their revalidation materials, "physicians may use feedback that does not fully meet our criteria as long as it is objective and focuses on their practice and the quality of care they have given to their patients." ■

Source: General Medical Council website, August 2012

Iowa

Board Offers New Agreement for Physicians Who Prescribe to Patients with Chronic Pain

The Iowa Board of Medicine has created a new sample "pain management agreement" physicians can use when prescribing controlled substances to patients with long-term chronic pain. The agreement is offered as a tool to help physicians strengthen their chronic pain management practice.

The model agreement for use between physicians and patients spells out specifics in the use of the pain control medications and the consequences for their misuse. It is intended to prevent misunderstandings about high-strength opioid painkillers, which can be highly addictive if they are not managed properly.

The Iowa Board encourages physicians to use pain management agreements if they believe a patient is at risk of abusing or diverting medications. The sample agreement is now available on the Board's website,www.medicalboard.iowa.gov.

In a news release, the Board said that "physicians should not fear Board action for treating pain with controlled substances as long as the physicians' prescribing is consistent with appropriate pain management practices. These practices, which are

THE MODEL AGREEMENT FOR USE BETWEEN PHYSICIANS AND PATIENTS SPELLS OUT SPECIFICS IN THE USE OF THE PAIN CONTROL MEDICATIONS AND THE CONSEQUENCES FOR THEIR MISUSE.

delineated in administrative rules, include a comprehensive examination of the patient, a treatment plan, and a periodic review of the drug therapy."

"In addition, if the physician believes the patient is at risk of drug abuse or diversion, then there should be a pain management agreement and periodic drug-testing to ensure the patient is receiving appropriate levels of the prescribed medications," the Board said.

The Board is also encouraging physicians to use to the Iowa Prescription Monitoring Program database, which contains a patient's controlled substance prescription history.

The Iowa Department of Public Health's Bureau of Vital Statistics reports the drug overdose death of at least 130 Iowans over the past three years due to prescription pain relievers such as oxycodone, hydrocodone and methadone. ■

Source: Iowa Board of Medicine news release, July 9, 2012

Maryland

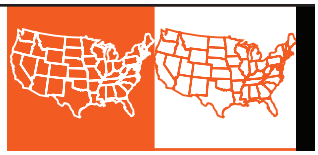
Maryland Board of Physicians Appoints Catalfo As New Executive Director

The Maryland Board of Physicians (MBP) has appointed Carole J. Catalfo, Esq., as its new Executive Director.

Catalfo, a member of the Kentucky and District of Columbia Bar Associations, is a former prosecutor and government trial attorney. She has a long history of public service in compliance and regulation, including leadership positions with Daymar College in Louisville, Ky., and the Commonwealth of Kentucky on behalf of the Educational Professional Standards Board and Cabinet for Families and Children. She most recently served as an Education Program Specialist in teacher licensure with the Maryland State Department of Education.

In a statement about her appointment, the MBP said Catalfo "has participated in all phases of the institutional licensure and regulatory process, and has extensive experience in program administration, complex litigation management, quality assurance initiatives, and strategic operations planning."

She earned her bachelor's degree in Animal Science (Bioscience & Technology) from the University of



New Hampshire, and her J.D. from the University of Louisville School of Law. ■

Source: Maryland Board of Physicians newsletter, Spring 2012

Nevada

Nevada State Board of Medical Examiners Releases 2011 Highlights and Statistics

The Nevada State Board of Medical Examiners recently released highlights and summaries of its activities in 2011, detailing a year in which the Board successfully advanced several legislative initiatives that enhanced and streamlined its work.

Among the initiatives that moved forward in 2011, the Board reduced from 30 to five the number of days a medical facility has to report to the Board on a physician's loss of privileges for specific behavioral and competency issues; established a 14-day sentinel event reporting timeline; and established, at five days, the time allowed a health care provider to produce in-state medical records upon request. The Board also successfully advanced legislation that allows it to process applicants for unrestricted licensure (of residents) at 24 months, with provisions to safeguard the public. Previously, the Board was allowed to process resident applications for full licensure at the end of the third year of post-graduate training only. The Board reports that this step will make Nevada more competitive in its attempts to attract new physicians to the state.

AN UPWARD TREND IN COMPLAINTS PROCESSED BY THE BOARD CONTINUED IN 2011, WITH 828 INVESTIGATIONS OPENED, 687 INVESTIGATIONS CLOSED, AND 46 DISCIPLINARY ACTIONS IMPOSED IN 45 MATTERS.

An upward trend in complaints processed by the Board continued in 2011, with 828 investigations opened, 687 investigations closed, and 46 disciplinary actions imposed in 45 matters. The Board reports that the number of disciplinary matters it resolves has continued to increase over the last seven years.

The Board took an average of 7.2 disciplinary actions per 1,000 active-status licensed physicians in 2011, compared with 5.7 actions in 2010 and 5.3 actions in 2009.

The Board issued licenses to 477 physicians, 79 physician assistants, 172 respiratory therapists, and three perfusionists.

In 2011, the ratio of physicians to 100,000 in population increased only slightly over the previous year, reaching 171 per 100,000. From 1980 to 1992, the ratio of physicians to 100,000 population was relatively static, staying between 140 and 151 physicians per 100,000 population. From 1993 through 2007, the ratio increased, averaging between 153 and 161 physicians per 100,000. In 2008, the ratio increased to 164; in 2009 it increased to 166; and in 2010, the ratio increased to 170. The Board also reported that the number of physician assistants in the state increased by 2.5 percent in 2011. The number of respiratory therapists in the state increased by 4.6 percent and the number of perfusionists decreased by 3.8 percent. ■

Source: Nevada State Board of Medical Examiners Annual Report, 2011

North Carolina

North Carolina Medical Board Introduces Online Reentry Center

The North Carolina Medical Board (NCMB) has established a new online resource to provide licensees and others with information and tools related to the NCMB's physician and physician assistant reentry requirements. The state's reentry programs are designed for professionals who

return to medical practice after a significant period of inactivity.

The NCMB has created a special section at its website that offers a variety of resources on reentry, ranging from sample reentry plans and form letters to details of the NCMB's reentry requirements. Licensees who have been out of clinical practice for two or more years are required to complete an approved program of reentry

LICENSEES WHO HAVE BEEN OUT OF CLINICAL PRACTICE FOR TWO OR MORE YEARS ARE REQUIRED TO COMPLETE AN APPROVED PROGRAM OF REENTRY BEFORE RETURNING TO UNRESTRICTED PRACTICE IN NORTH CAROLINA.

before returning to unrestricted practice in North Carolina. In a story about its new online resource in its newsletter, *Forum,* the NCMB said it views its reentry program as "a cost-effective alternative to other ways of demonstrating clinical competence before reentering active clinical practice, such as completing a mini-residency program or a formal personalized education program."

The NCMB established formal standards for reentry in 2011 with the implementation of administrative rules that list specific factors that affect the terms of an individual's reentry program. These factors include the length of time out of practice, the prior intensity of practice, the skills needed for the intended area of practice, the reason for the interruption in practice, and the licensee's activities during the interruption in practice, including the amount of practice-relevant CME completed.

The NCMB's standards call for a "multiphase period of mentoring under a physician approved by the Board." Phases of the program include an observation phase, during which the reentry candidate observes his or her mentor in practice; a phase during which the reentry candidate practices under their mentor's direct supervision; and a final phase during which the reentry candidate practices under the mentor's indirect supervision.

More than 150 physicians and physician assistants have successfully completed reentry programs to date, according to the NCMB.

To see the NCMB's online reentry resources, visit www.ncmedboard.org/professional_resources and click on "Special Topics." ■

Source: North Carolina Medical Board *Forum*, 2012, Vol. 1

Ohio

State Medical Board of Ohio Adopts Position Statement on Telemedicine

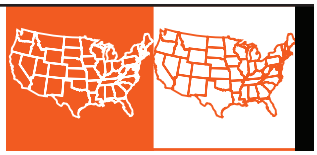
The State Medical Board of Ohio has adopted a position statement on telemedicine in response to increased inquiries from providers, patients, and businesses related to the status of telemedicine and telehealth in Ohio.

The Board formally adopted its statement in May after meeting with a variety of interested parties in what it called a "concerted effort to ensure a viable framework for telemedicine moving forward."

In its statement, the Board said it "recognizes that technological advances have made it possible for

THE BOARD FORMALLY ADOPTED ITS STATEMENT IN MAY AFTER MEETING WITH A VARIETY OF INTERESTED PARTIES IN WHAT IT CALLED A 'CONCERTED EFFORT TO ENSURE A VIABLE FRAMEWORK FOR TELEMEDICINE MOVING FORWARD.'

licensees to provide medical care to patients in ways that were not feasible in the past. As a result, telemedicine is a potentially useful tool that, if employed appropriately, can provide important



benefits to patients, including increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and potential reductions in the cost of patient care."

The Medical Board cautions in the statement, however, that "licensees practicing via telemedicine will be held to the same standards of care as licensees employing more traditional in-person medical care. A failure to conform to appropriate standards of care whether that care is rendered in person or via telemedicine may subject the licensee to potential discipline by the Medical Board."

In its statement the Board provided guidelines and definitions as clarification for physicians who hold a full medical license or telemedicine certificate in Ohio and provide medical services via oral, written or electronic communication.

Telemedicine is defined in Ohio as "the practice of medicine in this state through the use of any communication, including oral, written or electronic communication, by a physician located outside this state."

The Board's statement stipulates that staff involved in a telemedicine visit should be trained in the use of the telemedicine equipment and competent in its operation.

The statement sets forth a definition of what the Board calls a "Licensee–Patient Relationship," stating that "a licensee using telemedicine should have some means of verifying that the patient seeking treatment is in fact who they claim to be. A diagnosis should be established through the use of accepted medical practices, i.e., a patient history, mental status examination, physical examination, and any appropriate diagnostic and laboratory testing. Licensees using telemedicine should also ensure the availability for appropriate follow-up care and maintain a complete medical record that is available to the patient and other treating health care providers."

The statement also sets forth definitions and expectations for examinations, which must be conducted before diagnosis or treatment, but "need not be in person if the technology is sufficient to provide the same information to the licensee as if the exam had been performed face-to-face."

Other parameters for telemedicine practice defined in the statement cover prescribing, the use of medical records, and the use of licensure requirements.

THE STATEMENT ALSO SETS FORTH DEFINITIONS AND EXPECTATIONS FOR EXAMINATIONS, WHICH MUST BE CONDUCTED BEFORE DIAGNOSIS OR TREATMENT.

To read the statement in full, visit the State Medical Board of Ohio website at www.med.ohio.gov. ■

Source: State Medical Board of Ohio website, August 2012

INFORMATION FOR AUTHORS

The Journal accepts original manuscripts for consideration of publication in the *Journal of Medical Regulation.* The Journal is a peer-reviewed journal, and all manuscripts are reviewed by Editorial Committee members prior to publication. (The review process can take up to eight weeks.) Manuscripts should focus on issues of medical licensure and discipline or related topics of education, examination, postgraduate training, ethics, peer review, quality assurance and public safety.

Queries and manuscripts should be sent by email to editor@fsmb.org or by mail to:
Editor
Journal of Medical Regulation
Federation of State Medical Boards
400 Fuller Wiser Rd., Suite 300,
Euless, TX 76039

Manuscripts should be prepared according to the following guidelines:

1. An email or letter should introduce the manuscript, name a corresponding author and include full address, phone, fax and email information. The email or letter should disclose any financial obligations or conflicts of interest related to the information to be published.

2. The title page should contain only the title of the manuscript. A separate list of all authors should include full names, degrees, titles and affiliations.

3. The manuscript pages should be numbered, and length should be between 2,750 and 5,000 words, with references (in Associated Press style) and tables attached.

4. The manuscript should include an abstract of 200 words or less that describes the purpose of the article, the main finding(s) and conclusion. Footnotes or references should not be included in the abstract.

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8. If sent by mail, a PC- or Mac OS-compatible CD-ROM should accompany a printed copy of the manuscript. Microsoft Word format is the preferred file format.

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