



Tristan McIntosh, PhD

Haley Oetterer, MPH

James M. DuBois, DSc, PhD

ORIGINAL RESEARCH ARTICLE

Empowering Change:

Evaluating a Policy
Implementation Workshop
for State Medical Boards
to Protect the Public



Abstract

Background: Our team's prior work engaging state medical boards (SMBs) resulted in 56 policy or practice recommendations boards can adopt to protect the public from egregious physician wrongdoing. Recommendations have not seen adoption at a national scale.

Objective: The purpose of this study was to design, conduct, and evaluate a policy implementation workshop that provided board members and staff with dedicated time and guidance to develop an action plan for implementing the policy recommendations.

Methods: Attendees of the 2024 Federation of State Medical Boards Annual Meeting were invited to participate in the workshop and complete a pre-workshop ($n=106$), immediate post-workshop ($n=35$),

and a long-term post-workshop ($n=19$) survey. Surveys measured policy interest, action plan focus, policy implementation, and reactions to the workshop.

Results: Attendees found the workshop valuable and focused on various policy recommendations in their action plans. In our five-month follow-up survey, 5 of 19 respondents reported implementing at least one policy recommendation after the workshop, with another 5 indicating that their board has no intentions to implement new policies.

Conclusions: There was not widespread adoption of new policies across boards, but there was some evidence that the workshop helped empower boards to take initial steps toward implementing new policies.

Introduction

A central mission of state medical boards (SMBs) is to protect the public via licensing, regulating, and disciplining physicians.^{1,2} It is estimated that nearly 0.1% of physicians receive severe disciplinary action (eg, license revocations, suspensions, voluntary surrenders) from SMBs annually, and while this may seem like a small percentage, it is similar to the rate of annual breast cancer diagnoses.^{3,4} The significance of this statistic is underscored by the nearly nine-fold variation in rates of severe disciplinary actions taken by SMBs across the United States for similar behaviors.^{3,4} It should be noted that there is not widespread agreement about the variation of state-based reported data from Public Citizen's analyses⁴ being a compelling indicator of potential problems at the state level. However, these data do point to the need for discourse about variability in state approaches to physician discipline. Types of physician behaviors that warrant such severe disciplinary action, behaviors we collectively refer to as egregious wrongdoing, include sexual abuse, performing unnecessary invasive procedures, and improperly prescribing controlled substances.⁵⁻⁹ These behaviors directly harm the public and should not be allowed to continue once identified.

Considering this concerning and inconsistent disciplinary landscape, there is a critical need for boards to implement new policies to protect the public from egregious wrongdoing. Our team engaged members of SMBs to generate and reach consensus on multiple high-impact policy recommendations that boards can adopt to better and more uniformly protect the public

from physicians who inflict harm.¹⁰ The policy recommendations map to five distinct domains: 1) board composition and characteristics, 2) board website, outreach, and education, 3) internal board operations and investigations, 4) coordination and information sharing between boards, and 5) licensing and disciplinary considerations.

Although these policy recommendations have been made available to boards via publications, a podcast, and presentations at the 2024 Federation of State Medical Boards annual meeting, the recommendations have not yet seen widespread adoption across SMBs. Implementation of these policy recommendations by boards nationally would substantially increase their collective capacity to protect the public from harmful physician conduct. However, boards face unique, board-specific constraints that limit national board uniformity in policies to protect the public, including issues related to state legislation, resource access, and policy implementation approach.¹¹⁻¹⁴

To help boards approach new policy implementation in a manner that is feasible within their board-specific context, we sought to design and deliver a policy implementation workshop where board members and staff could develop a customized action plan for feasibly adopting new policies and engage in discussion and deliberation with peers about putting their policy implementation plans into practice. Developing an action plan is a practical and effective approach for helping people set and follow through on goals, in this case the goal being for their board to implement new policies to protect the public.^{15, 16} Action plans require individuals to indicate how and when a goal will be implemented

and provide the specific steps needed for implementation.¹⁷⁻²⁰ A workshop not only enables peer-to-peer learning about strategies for successfully implementing policies, but also provides dedicated time and space to help facilitate and scale the adoption of policy recommendations across all 70 SMBs. The purpose of this study is to measure planned and actual policy implementation by SMBs after participating in a hands-on policy implementation workshop and to measure the perceived value of the workshop and action plan by board members and staff.

Methods

Our team partnered with the Federation of State Medical Boards to design and deliver a workshop for members and staff of SMBs intended to help boards implement new policies to protect the public from egregious physician wrongdoing. A total of three surveys were administered to measure boards' planned and actual adoption of new policies: a pre-workshop survey, an immediate post-workshop survey, and a long-term post-workshop survey. This study was approved by the Washington University Institutional Review Board (IRB #202309029).

Recruitment and Participants

The research team emailed 410 pre-registrants of the 2024 Federation of State Medical Boards Annual Meeting inviting them to participate in the policy implementation workshop and corresponding surveys about their board's policy adoption. Registrants included not only members and staff of state medical boards, but also individuals from other medical regulatory agencies and professional groups (eg: International Association of Medical Regulatory Authorities, American Academy of Family Physicians, Accreditation Council for Continuing Medical Education). The FSMB also advertised the workshop to boards in advance of the annual meeting and in the conference program. Approximately 3 weeks before the FSMB Annual Meeting, registrants were emailed a link to complete the pre-workshop survey, which was completed by 106 participants who were members or staff of state medical boards. Over 100 individuals participated in the workshop, but we suspect this is an underestimation; the exact number is not known. Immediately after the workshop, attendees were emailed with a link to the post-workshop survey, which was completed by 35 participants. The final long-term post-workshop survey was emailed approximately 5 months after the post-workshop survey, which was completed by 19 participants.

Workshop Design

Prior to the workshop, our team prepared and provided both electronic and physical copies of various documents for attendees to read and have available as a resource during and after the workshop to facilitate action plan development and implementation, including a consolidated list of all policy recommendations, and an annotated bibliography of articles reporting findings on our team's prior work about egregious wrongdoing and articles reporting summaries from FSMB workgroups to provide context about the importance of adopting new policies to protect the public.^{5-7,10,21-23} The workshop, titled "Addressing sexual misconduct and opioid misprescribing: A policy implementation workshop" lasted 75 minutes and was designed by the research team with input from FSMB staff leadership. Table 1 presents the workshop schedule, including details about different workshop components.

Each attendee was provided with an action plan template to help them think through how to implement a policy recommendation. The template comprised 4 primary sections: 1) defining the board's goal, 2) identifying resources to support implementation, 3) leveraging the board's network to support implementation, and 4) identifying and addressing barriers to implementation. To define the board's goal, attendees were asked to identify a policy recommendation to focus on, articulate what goals they are trying to achieve by implementing the policy, and a proposed timeline for implementing the policy. To identify resources to support implementation, attendees were then asked to specify what resources and information their board already has and that their board needs but does not yet have that can be leveraged to implement the policy recommendation. To identify how to leverage their professional networks, attendees were asked to specify what individuals or entities their board needs to coordinate with (eg: law enforcement, medical schools, professional societies, government officials, other board members and staff), what board leadership and personnel would be designated to manage the implementation of the recommendation(s), and what individuals or entities need to receive what type of information from the board about the newly implemented recommendation. And finally, to identify barriers, attendees were asked to anticipate what barriers their board is likely to face when adopting the specific policy and specify what strengths, resources, and facilitators their board can leverage to overcome those barriers. The research team did not collect or review action plans; workshop attendees were told that their action plans were for personal use only. In addition to being provided with an action plan template, attendees were also provided with a structured worksheet to take notes about key takeaways from

the flash presentations and group discussions during the workshop.

Data Collection

Pre-workshop survey. The pre-workshop survey intended to measure which policy recommendations boards were interested in adopting as part of their action

plan. For each of the aforementioned 5 policy clusters, participants were presented with all policy options within that cluster and asked 3 questions: 1) which recommendations from that cluster they believed would have the greatest positive impact on effective handling of cases of egregious wrongdoing if adopted, 2) what one recommendation from that cluster their board had not yet adopted that they would like their board to try

TABLE 1: Workshop Agenda

<p>Introduction (10 minutes)</p> <ul style="list-style-type: none"> • Opening remarks made about the purpose and value of the workshop, including an overview of workshop components. • Overview provided of prior FSMB efforts that aligned with the workshop (eg: workgroup on opioid addiction treatment, workgroup on physician sexual misconduct). • Summary of the team’s prior work on egregious wrongdoing provided.
<p>Reflection Exercises (5 minutes)</p> <ul style="list-style-type: none"> • Exercise #1: Presentation of 5 policy clusters with illustrative policies that aligned with the 2 policy recommendations from each cluster that boards were most interested in adopting based on the pre-workshop survey. Workshop attendees completed a virtual poll answering the question “Which of the 5 clusters of recommendations would you say your board struggles with the most?”. Group discussed challenges boards face and brainstormed about how to address and overcome these challenges. • Exercise #2: To encourage engagement and thinking about the workshop and implications for their board, attendees individually reflected on and then engaged in a group discussion about the prompt: “Think about a major improvement your board has implemented in the past that involved changes to state legislation. What went well? What didn’t? What were the major areas of resistance when the idea was originally proposed?”
<p>Flash Presentations (15 minutes)</p> <ul style="list-style-type: none"> • Representatives from 3 boards known for successfully implementing new policy recommendations each gave a 3-minute flash presentation about the policy recommendations they adopted and the process for doing so. Flash presenters also shared key lessons learned from their board’s experience to share with members of other boards.
<p>Action Plan Development (20 minutes)</p> <ul style="list-style-type: none"> • Attendees were provided with guidance on action plan development, including the recommendation to focus on 1 policy recommendation during the workshop to use as a starting point for their board to implement additional policies in the future. Specifically, attendees were encouraged to focus on a policy that does not require changes to state laws, does not require major new resources, and can be implemented relatively quickly.
<p>Action Plan Discussion (20 minutes)</p> <ul style="list-style-type: none"> • After independent work on action plans, attendees discussed action plan content with others at their table to get feedback and new ideas and insights. • After small group discussion about action plans, attendees shared highlights from small group discussion with the larger group. • Attendees were provided with a reminder of the materials assembled to be used as a resource.
<p>Closing Remarks (5 minutes)</p> <ul style="list-style-type: none"> • Concluding remarks were made, emphasizing 2 key points: 1) building relationships and effectively communicating with other stakeholders is essential, and, 2) leveraging a continuous improvement mindset as a means of protecting the public. • Attendees were reminded about completing the immediate and long-term post-workshop surveys.

to adopt over the next year, and 3) how many recommendations from that cluster their board had not adopted but may be interested in adopting. Participants were then asked to rate on a scale of 1 (strongly disagree) to 5 (strongly agree) their agreement with three statements: 1) *it would be beneficial for my board to adopt new policies and practices for handling cases of egregious wrongdoing*, 2) *to the extent possible, there should be some degree of uniformity in policies and practices across all state medical boards*, and, 3) *improvements are needed in how boards investigate and adjudicate egregious wrongdoing by physicians*. There was also an opportunity for participants to provide open-ended feedback or information about their board, its policies, and the forthcoming workshop.

During-workshop poll about policy clusters. During the workshop Reflection Exercise #1, workshop attendees were presented with a QR code for a live poll that asked, “Which of the five clusters of recommendations would you say your board struggles with the most?” Response options reflected the 5 aforementioned policy clusters. Responses auto populated on the presentation screen as attendees answered the question on their phones.

FSMB-administered Evaluation Survey. After the FSMB annual meeting, 458 meeting attendees were sent a feedback survey about different sessions and events at the annual meeting. There was one survey item asking attendees to rate the workshop on a scale of 1 (poor) to 5 (excellent). Attendees were also given the opportunity to provide open-ended feedback about the workshop.

Immediate post-workshop survey. The immediate post-workshop survey was intended to solicit feedback about the workshop itself and the action plan attendees developed as part of the workshop. Participants were asked to rate on a scale of 1 (strongly disagree) to 5 (strongly agree) their agreement with a series of evaluative statements about the workshop, their action plan, and the same 3 attitudinal statements presented in the pre-workshop survey. Participants were also asked to provide open-ended responses to questions asking what about the workshop they found most valuable, what their key takeaways were from the large group discussion about action plan content, and any other feedback about their action plan or the workshop. Additionally, participants were presented with the policy options for each of the 5 policy clusters and asked to identify any policy recommendations from that cluster they focused on in their action plan during the workshop.

Long-term post-workshop survey. The long-term post-workshop survey was intended to follow up with workshop attendees about the status of their action

plan and gather information about which policy recommendations their board had adopted since the workshop or planned to adopt in the future. Participants who indicated their board had implemented any policies since the workshop were asked to describe how many and what policies were recently implemented. Those whose boards had not implemented any new policies but had taken steps toward implementing new policies were asked to describe what policies their board is interested in and the steps their board had already taken toward implementing the policy. Participants whose boards had not taken steps toward implementation were asked if their board had any intentions to implement a new policy. Those who indicated their board had intentions to implement any new policies were asked to describe what policies their board is interested in, what steps their board plans to take to implement the new policies, and the timeline for their plan. Those who indicated their board does not have intentions to implement were asked to explain why their board does not intend to pursue implementing any policies. Participants were also given the opportunity to share any other open-ended feedback.

Data Analysis

Quantitative data were analyzed in SPSS Version 27. Given the small and unequal sample sizes across the three surveys, and the fact that the same participants did not complete all three surveys, we were limited to the extent to which we could use inferential statistics. Consequently, we focus on reporting descriptive statistics. Open-ended qualitative data were reviewed and analyzed in Excel.

Results

Participants. Demographic data across the 3 surveys were combined to characterize the sample. A range of boards were represented across the US and its territories, with an estimate of at least 42 unique boards participating in the surveys. Of the 128 participants who answered the demographic questions, 51 (40%) were physician members, 26 (20%) were executive directors, 11 (9%) were public members, 9 (7%) were legal counsel, and 31 (24%) considered themselves to be in an “other” position not listed (eg: licensing program manager, medical director, investigations manager, assistant director). Of the 116 participants who answered the demographic questions in the pre-workshop and immediate post-workshop surveys, they had an average of 5.25 years (SD = 4.78) of experience in their role.

Attitudes about policy implementation. During the workshop Reflection Exercise #1, attendees indicated

To help boards approach new policy implementation in a manner that is feasible within their board-specific context, we sought to design and deliver a policy implementation workshop where board members and staff could develop a customized action plan for feasibly adopting new policies and engage in discussion and deliberation with peers about putting their policy implementation plans into practice.

that policy Cluster #2 (ie: board website, outreach, and education) and Cluster #4 (ie: coordination and information sharing between boards) were domains where their boards struggled the most. Table 2 depicts pre-workshop and immediate post-workshop responses to the 3 attitudinal items focused on views about policy implementation. Given the low post-workshop survey response rate and a lack of matched pairs in our sample, pre-workshop and post-workshop survey data should not be compared to make inferences about the effect of the workshop. Pre-workshop survey responses indicated approximately 59% of participants agreed or strongly agreed with the statement “It would be beneficial for my board to adopt new policies and practices for handling cases of egregious wrongdoing (eg: sexual misconduct, opioid mis-prescribing).” Post-workshop survey responses indicated that 68% of participants agreed with the statement. About 84% of participants agreed or strongly agreed with the statement “To the extent possible, there should be some degree of uniformity in policies and practices across all state medical boards” in the pre-workshop survey. Approximately 92% of participants agreed with the statement in the post-workshop survey. Similarly, 64% of pre-workshop survey participants agreed or strongly agreed with the statement “Improvements are needed in how boards investigate and adjudicate egregious

wrongdoing by physicians.” About 74% of post-workshop participants agreed with the statement.

Open-ended feedback from the pre-workshop survey. Comments from participants who provided open-ended feedback during the pre-workshop survey varied, including praise for their board’s current practices, information about how their board is structured within their state, indication that several policy recommendations had already been adopted by their board, and that they were looking forward to the workshop. Example comments include, “Our board already has the majority of these recommendations in place,” “I believe the [Board] Staff are due diligent in responding in a timely manner to investigate and handle egregious wrongdoing by physicians,” and “This workshop will hopefully educate Boards to adopt stronger policies concerning sexual misconduct and opioid mis-prescribing.”

There was a contrast in perspectives about the perceived consistency and quality of disciplinary action. For example, one participant articulated their views about balancing physician and public protection: “It is important to always keep in [mind] that the function of the medical board is to “protect the public” while at the same time provide a fair and equitable investigation of

TABLE 2: Comparison of attitudes about policy adoption pre- and post-workshop

Survey Item	1- Strongly Disagree n (%)		2-Disagree n (%)		3-Neutral n (%)		4-Agree n (%)		5-Strongly Agree n (%)	
	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
It would be beneficial for my board to adopt new policies and practices for handling cases of egregious wrongdoing (eg: sexual misconduct, opioid mis-prescribing).	2 (2)	1 (3)	8 (9)	0 (0)	25 (29)	10 (29)	33 (39)	11 (31)	17 (20)	13 (37)
To the extent possible, there should be some degree of uniformity in policies and practices across all state medical boards.	4 (5)	0 (0)	2 (2)	0 (0)	8 (9)	3 (9)	40 (47)	17 (49)	31 (37)	15 (43)
Improvements are needed in how boards investigate and adjudicate egregious wrongdoing by physicians.	2 (2)	0 (0)	6 (7)	0 (0)	23 (27)	9 (26)	33 (39)	14 (40)	21 (25)	12 (34)

Note. Pre = pre-workshop survey respondents (n=106). Post = immediate post-workshop survey respondents (n=35). Not all participants completed all survey questions for both surveys, so pre- and post-workshop survey responses should not be compared to make inferences.

Physician accusations by the public of Provider misconduct egregious errors.” Another participant felt differently, “[Board] members need training in egregious wrongdoing by licensees...The board members are too generous when disciplining these egregious licensees, ie: they do not revoke. The [investigations team] regularly sees repeat offenders...for repeat conduct that is not addressed sufficiently by the board.”

Pre-workshop and immediate post-workshop policy implementation plans. In the supplementary material provided, Supplemental Table 1 depicts participant pre- and immediate post-workshop responses related to Cluster 1 policy recommendations (ie: board composition and characteristics). Participants who completed the pre-workshop survey indicated they were interested in adopting 1 (41%), 2 (12%) or 3 (12%) Cluster 1 policy recommendations; 16 participants (15%) indicated they were not interested in adopting any Cluster 1 recommendations. Of those who completed the immediate post-workshop survey, 16 (46%) did not choose a Cluster 1 policy recommendation to focus on in their action plan.

In the supplementary material provided, Supplemental Table 2 shows pre- and post-workshop responses related to Cluster 2 policy recommendations (ie: board website, outreach, and education). Pre-workshop survey results indicate participants were interested in adopting 1 (34%), 2 (20%) or 3 (14%) Cluster 2 recommendations, with 12 participants (13%) not interested in adopting any policies from this cluster. A total of 9 participants (26%) did not choose a Cluster 2 policy recommendation to focus on in their action plan.

In the supplementary material provided, Supplemental Table 3 illustrates pre- and post-workshop responses for Cluster 3 policy recommendations (ie: internal board operations and investigations). Prior to the workshop, participants were interested in adopting 1 (33%), 2 (23%) or 3 (12%) Cluster 3 policy recommendations, and 13 participants (14%) indicated no interest in Cluster 3 policy recommendations. Twelve (34%) participants did not choose Cluster 3 policy recommendations for their action plan.

In the supplementary material provided, Supplemental Table 4 depicts pre- and post-workshop responses for Cluster 4 policy recommendations (ie: coordination and information sharing between boards). For the pre-workshop survey, participants indicated interest in adopting 1 (26%), 2 (23%) or 3 (12%) Cluster 4 policy recommendations, with 8 participants (9%) expressing no interest in adopting Cluster 4 policies. Post-workshop assessment data indicate 12 participants (34%) did not

choose any Cluster 4 recommendations for their action plan.

In the supplementary material provided, Supplemental Table 5 shows pre- and post-workshop responses for Cluster 5 policy recommendations (ie: licensing and disciplinary considerations). Participants who completed the pre-workshop survey indicated interest in adopting 1 (29%), 2 (29%) or 3 (13%) Cluster 5 policies; 10 participants (12%) were not interested in adopting Cluster 5 policies. A total of 16 participants (46%) did not implement a Cluster 5 policy in their action plan.

Table 3 depicts quantitative participant reactions to the policy implementation workshop. Of the 35 participants who completed the immediate post-workshop survey, 33 (94%) agreed that they felt engaged during the workshop, and 30 (85%) agreed that the workshop was worth their time. Only 15 participants (43%) felt confident in their board’s capacity to address barriers to implementing their action plan. Many participants indicated they are aware of the resources they need ($n=24$; 69%) and know what stakeholders their board needs to coordinate with ($n=24$; 69%) to put their action plan into practice.

Open-ended feedback from the immediate post-workshop survey. Participants reported several components of the workshop being valuable, with the flash presentations about the experiences of other boards, question and answer discussions, and networking and information sharing being the most common. Example comments include, “*I’m glad we are discussing this at the national level,*” “*The fact that the examples were from what other boards have done and engaging in discussions with members of other boards to see that our struggles are not unique,*” and “*The manner in which items were clustered and groups was interesting. It made me think about things in a different way.*” One participant specifically mentioned that the action plan template was beneficial, “*The handouts were extremely helpful in showing a roadmap of how to implement an action plan.*”

Constructive feedback was also provided, with some participants reporting that certain recommendations are not feasible to implement and that they felt they did not have enough time during the workshop to complete their action plan. Example comments include, “*Some of the action items raised interesting questions for how we process cases. Some are statutorily out of reach. I think that the workshop would have benefited by a smaller group setting, but discussions by table was a good workaround,*” and “*I did not check most of the cluster recommendations because they are things*

already mandated in law or done by agency policy.” There were also some comments about the size of boards undermining the feasibility of policy implementation, “Many of the policies and discussions are NOT feasible for small boards. It would be beneficial to consider such small boards in developing recommendations—or provide alternative recommendations for small boards with limited staff and resources.”

Participants also reported several distinct takeaways from the large group discussion about action plan, including recognition that change needs to occur within their board, the value of providing quality training to board members, and the importance of developing a

good relationship with the state legislature. Example comments include, “My state needs to do some legislative and rule changes to create clearer definitions of sexual assault,” “Engaging legislators can be a key tool to achieving our goals,” and “It is important to assess practices at the micro level. Looking at various specific issue items helps in the assessment of whether all appropriate steps have been taken.”

FSMB-administered Evaluation Survey. Of the 72 individuals who completed the FSMB post-annual meeting survey and answered the questions about the workshop, 63 (88%) rated the session as “excellent” or “very good,” with the remaining respondents rating the session as “good” (n=8; 11%) or “fair” (n=1; 1%). Sixty-four

TABLE 3: Participant reactions to the policy implementation workshop

Question	1- Strongly Disagree n (%)	2-Disagree n (%)	3-Neutral n (%)	4-Agree n (%)	5-Strongly Agree n (%)
I felt engaged during the workshop.	0 (0)	0 (0)	2 (6)	20 (57)	13 (37)
The information shared during the workshop was useful.	1 (3)	0 (0)	2 (6)	17 (49)	15 (43)
I developed a quality policy implementation action plan for my board.	1 (3)	4 (11)	15 (43)	13 (37)	2 (6)
Attending the workshop was worth my time.	1 (3)	1 (3)	3 (9)	18 (51)	12 (34)
I feel confident about what my board needs to do next to implement the policy recommendation(s) detailed in my action plan.	0 (0)	0 (0)	17 (49)	13 (37)	5 (14)
I am confident in my board’s capacity to overcome barriers to implementing the policy recommendations(s) detailed in my action plan.	0 (0)	1 (3)	19 (54)	10 (29)	5 (14)
I am aware of the resources my board needs to implement the policy recommendation(s) detailed in my action plan.	0 (0)	4 (11)	7 (20)	19 (54)	5 (14)
I know what individual or entities my board needs to coordinate with to implement the recommendation(s) detailed in my action plan.	0 (0)	2 (6)	9(26)	21 (60)	3 (9)

Note. Immediate post-workshop survey n=35.

individuals who completed the FSMB post-meeting survey did not provide feedback about the workshop, as indicated by a “NA” response. Open-ended feedback provided in the FSMB-administered survey was mixed. One respondent felt it was overwhelming to have a policy change goal, and another respondent noted issues with limited time during the workshop, *“Time management was an issue, and it was difficult to develop a policy within the time allotted and with different states working together on a policy that doesn’t apply to all states’ needs.”* Other respondents mentioned enjoying the flash presentations and small and large group discussions. One respondent mentioned the workshop’s value in reference to future revisions to their board’s sexual misconduct rules, *“We have been long overdue for revising our sexual misconduct rules and listening to the Ohio Medical Board gave us some ideas about some best practices.”*

Long-term Post-Workshop Survey. Of the 19 participants who completed the long-term survey, 5 (26.3%) indicated their board had implemented at least one policy recommendation since the workshop. Of these 5, only 1 provided an open-ended response about what policy recommendation was implemented: *“updated our training for our interviewing investigators.”* There were 8 participants (42.1%) whose boards had taken at least some steps toward implementing a policy recommendation. Open-ended responses about what specific steps were taken include, *“looking into disciplinary protocols,” “creating additional communications,”* and *“updating rules and regs.”* One board indicated they had undertaken a rule project regarding chaperones.

One participant (5.3%) indicated their board has intentions to implement a new policy recommendation, with their open-ended justification being that it *“is only at the staff level; no board discussions.”* Five participants (26.3%) indicated that their board has no intentions of implementing a new policy recommendation. Reasons for the lack of interest varied, with many pertaining to perceived statute and rule limitations preventing policy adoption. Other responses included, *“board determined that no action was necessary,” “many of the policies are already in effect or do not apply to the board,”* and *“board already has most if not all of the policy recommendations in place by law or regulation.”*

When providing other open-ended feedback about the overall experience, comments were generally positive, with some caveats. Positive comments included, *“I congratulate the FSMB that this is an important area of evaluation and research,” “The project has been helpful in generating staff and board awareness,”* and

“The inclusion of policy implementation aspects for both topics [sexual misconduct and opioid misprescribing] suggests a thorough approach, helping attendees understand not just the issues but also practical steps for addressing them.” Yet one participant commented that, *“We are a complaint driven agency and it is very difficult to bring anonymous complaints under our state law.”*

Discussion

The policy implementation workshop was intended to help boards nationwide to protect the public from egregious physician wrongdoing through adoption of new policy and practice recommendations. Specifically, the workshop provided dedicated time for board members and staff to develop a policy implementation action plan that addresses the constraints and contextual factors unique to each board. It was noted in workshop

Participants reported several components of the workshop being valuable, with the flash presentations about the experiences of other boards, question and answer discussions, and networking and information sharing being the most common.

breakout group and large group discussions that board policy and practice changes were sometimes the result of negative publicity about the board or cases involving egregious physician wrongdoing being reported in the press.²⁴ A reactive approach to implementing policy changes is unlikely to sustain a board’s ability to protect the public in the long-term. Policy changes should be pursued proactively and intentionally, and the policy implementation workshop was a step forward in taking a proactive approach.

The workshop attracted many board members and staff across SMBs nationally, and evaluations of the workshop itself were generally quite positive. We found some support for the effectiveness of the workshop in empowering boards to take concrete steps toward implementing new policies to protect the public from egregious wrongdoing. Although response rates were low for the post-workshop follow-up surveys, the workshop was effective in raising collective awareness about areas for improvement and growth and mobilizing initial steps toward policy change. However, we did not

see widespread adoption of new policies across SMBs 5 months after the policy implementation workshop.

There are various factors that could explain this lack of policy adoption by boards. Some boards may have already been taking impactful steps toward policy change prior to the workshop; other boards may perceive limitations in their capacity to make certain policy changes. Similar efforts to enact policy change in other contexts (eg: hospitals, other types of state-level policies) have also faced struggles with getting policy recommendations put into practice, and there are important implementation lessons to be learned from these efforts.^{14,25,26} Prior research on policy implementation suggests several common barriers and facilitators to policy adoption that emerge at individual, policy, and external context levels. Such barriers include gaps in financial and human resources, organizational and operational complexities, ineffective coordination with other relevant stakeholder groups, nuances in state policies that make policy implementation cumbersome, and resistance to new policies.²⁷⁻²⁹ Resistance to new policies is unlikely to be due to a single factor; rather, resistance may be attributed to negative attitudes (eg: lack of agreement with policy, doubts about policy's relevance or impact) or a lack of knowledge or awareness of potential new policies.^{28,30}

We found some support for the effectiveness of the workshop in empowering boards to take concrete steps toward implementing new policies to protect the public from egregious wrongdoing.

One possible study-specific explanation for a lack of adoption lies in patterns of responses in the pre-workshop survey. Some policies in the pre-workshop survey were rated as high-impact but low-interest and vice versa, and this paradoxical perception about certain policies may affect motivation or willingness to implement a new policy. For example, the policy "*Board markets its purpose via social media, professional organizations, and liaising with hospitals and other relevant groups*" was perceived as impactful by 9% of respondents, but 28% respondents were interested in adopting the policy. In an inverse example, the policy "*The board website provides an easy-to-find platform for patients and other whistleblowers to file complaints*" was perceived as impactful by 37% of respondents but

only 9% indicated interest in adopting this policy. Future research is needed to understand these trends and what policy characteristics motivate interest in adopting them. Perhaps certain policies have more appeal to boards because of multiple perceived benefits (eg: making the board look attractive to legislators and other stakeholders) beyond solely protecting patients. Additionally, future research could identify policy-specific constraints that uniquely limit or discourage adoption by boards and implement solutions that help address these constraints.

Survey data also demonstrated heterogenous attitudes across participants and boards about the perceived need for policy change and for at least some uniformity in policies across boards. There are likely board members and staff who are strongly opposed or resistant to adopting new policies and may not see the value in having some degree of national board uniformity in policies to protect the public. Future efforts by FSMB leadership and others could work toward mitigating points of resistance by providing additional opportunities for discussion, information, and resources that help address assumptions and concerns related to policy change.

While the vast majority of workshop attendees felt engaged during the workshop and that attending it was worth their time, a sizeable portion of attendees were ambivalent about the quality of the action plan they developed, confidence in what steps their board needs to take next, and confidence in their board's capacity to address barriers to policy implementation. There was also a subset of workshop attendees who felt neutrally or negatively about their awareness of resources their board needs to implement new policies and what entities their board needs to coordinate with to be able to successfully put new policies into practice. This uncertainty about various policy implementation steps may have curtailed motivation or attempts to implement new policies within the five-month post-workshop period. These findings suggest additional efforts are likely needed to equip boards with further information, resources, and support to foster policy change.

There are several possible avenues for furthering board policy change to protect the public from egregious wrongdoing. Longer-term, multi-event (eg: workshop) interventions could help provide more routine information and resource sharing to boards to help support policy change. Each "mini event" could focus on different concerns about or components of policy change. Another initiative to support policy change is through the creation of a peer mentoring program where boards who have been successful navigating challenges related

to policy change are paired with and provide guidance to other boards currently facing similar struggles. At the state level, enhanced support from state legislatures and improved budgetary support for SMBs would also help address hurdles many boards face to implementing new policies. Prior research on policy implementation supports these recommendations.²⁷⁻²⁹ For example, prior empirical work suggests having influential policy champions to help motivate, focus, and mobilize stakeholders, allowing for flexible implementation of new policies to align with local contexts, and engaging policymakers early and often may be effective avenues for furthering policy implementation.

Limitations

First, most participants did not complete the immediate or five-month follow-up surveys, and we cannot be sure that they were represented in the pre-workshop survey group, because that survey was sent to everyone who pre-registered for the conference. This makes it impossible to compare pre- and post-workshop changes. The low response rate for the five-month survey limits understanding of the broader impact of the workshop. Furthermore, there may be a response bias where boards with certain characteristics or contexts may have self-selected into participating in the surveys.

Second, we were limited to only 75 minutes. It would have been ideal to dedicate an entire session to helping participants recognize the need for new policies and to explore their sense of efficacy to implement new policies, prior to setting goals, identifying barriers, and resources.³¹⁻³² We suspect a full-day workshop would be more effective, though the advantage of the 75-minute format was that it was feasible to attract a large group of participants who were attending the broader FSMB meeting. Finally, policy implementation takes a considerable amount of time and resources to come to fruition, so measuring planned and actual policy implementation five months after the workshop may not have been enough time.

Conclusion

We designed, implemented, and evaluated a first-of-its-kind policy implementation workshop for members and staff of state medical boards where attendees learned from other boards, engaged in group discussions, and developed an action plan. A one-time 75-minute workshop can only realistically accomplish so much. We also faced limitations of low survey response rates and possibly insufficient time for boards to implement new policies after the workshop. While the workshop was a meaningful step forward in providing boards with

initial awareness, motivation, and momentum for making internal board policy changes to protect the public from harmful physicians, additional efforts are needed to sustain forward progress in a manner that leads to large-scale policy change in the long-term.

There are several actionable steps that state medical boards can take to cultivate policy changes within their boards. Our team's prior work interviewing members of boards that have successfully implemented new policies to protect the public yielded 13 practical, actionable strategies that boards can adopt to facilitate successfully policy implementation.²⁴ For example, boards can establish and strengthen relationships with relevant stakeholders (eg: legislators, lobbyists, medical societies) to better advocate for legislative changes that support meaningful policy change. Boards can also establish a dedicated policy implementation team or include policy change as a dedicated agenda item in meetings to support accountability and make forward progress on policy implementation. Additionally, boards can hold regular public forums to engage relevant communities and gather their input on future policy changes. We hope that this narrative report about the workshop and associated survey data can help inform areas where such efforts might be most impactfully directed.

References

1. Federation of State Medical Boards. US medical regulatory trends and actions. Accessed February 25, 2026. <https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/state-medical-board-data/>
2. Federation of State Medical Boards. Guidelines for the structure and function of a state medical and osteopathic board. Published April 2024. Accessed February 25, 2026. <https://www.fsmb.org/siteassets/advocacy/policies/guidelines-for-structure-function-of-state-medical-and-osteopathic-board-2024.pdf>.
3. Harris JA, Byhoff E. Variations by state in physician disciplinary actions by US medical licensure boards. *BMJ Quality & Safety*. 2017;26(3):200-208. doi: 10.1136/bmjqs-2015-004974
4. Wolfe SM, Oshel RE. Report: Ranking of the rate of state medical boards' serious disciplinary actions, 2019-2021. *Public Citizen*. Published August 16, 2023. Accessed February 25, 2026. <https://www.citizen.org/article/report-ranking-of-the-rate-of-state-medical-boards-serious-disciplinary-actions-2019-2021/>
5. DuBois JM, Anderson EE, Chibnall JT, Mozersky J, Walsh HA. Serious ethical violations in medicine: A statistical and ethical analysis of 280 cases in the United States from 2008-2016. *Am J of Bioeth*. 2019;19(1):16-34. doi: 10.1080/15265161.2018.1544305

6. DuBois JM, Walsh HA, Chibnall JT, et al. Sexual violation of patients by physicians: A mixed-methods, exploratory analysis of 101 cases. *Sexual Abuse*. 2019;31(5):503-523. doi: 10.1177/1079063217712217
7. DuBois JM, Anderson EE, Chibnall JT, et al. Preventing egregious ethical violations in medical practice: Evidence-informed recommendations from a multidisciplinary working group. *J Med Regul*. 2018;104(4):23-31. doi: 10.30770/2572-1852-104.4.23
8. DuBois JM, Chibnall JT, Anderson EE, et al. Exploring unnecessary invasive procedures in the United States: A retrospective mixed-methods analysis of cases from 2008-2016. *Patient Saf Surg*. 2017;11(1). doi: 10.1186/s13037-017-0144-y
9. DuBois JM, Chibnall JT, Anderson EE, Eggers M, Baldwin K, Vasher M. A mixed-method analysis of reports on 100 cases of improper prescribing of controlled substances. *J Drug Issues*. 2016;46(4):457-472. doi: 10.1177/0022042616661836
10. McIntosh T, Pendo E, Walsh H, Baldwin K, DuBois JM. Protecting patients from egregious wrongdoing by physicians: Consensus recommendations from state medical board members and staff. *J Med Regul*. 2021;107(3):5-18. doi: 10.30770/2572-1852-107.3.5
11. Federation of State Medical Boards. *Report of the Special Committee on Professional Conduct and Ethics*. Published 2000. Accessed February 25, 2026. <https://www.fsmb.org/siteassets/advocacy/policies/report-of-the-special-committee-on-professional-conduct-and-ethics.pdf>
12. Teegardin C, Robbins D, Ernsthausen J, Hart A. License to betray. *The Atlanta Journal Constitution*. Published July 5, 2016. Accessed February 25, 2026. http://doctors.ajc.com/doctors_sex_abuse/.
13. Teegardin C. Georgia medical board easy on opioid violators. *The Atlanta Journal Constitution*. Published December 7, 2017. Accessed February 25, 2026. <https://www.myajc.com/news/public-affairs/georgia-lets-doc-tors-keep-practicing-despite-opioid-violations/VIWYD0o-plqfzb8BgDF4v1J>
14. Sisk BA, Mozersky J, Antes AL, DuBois JM. The "ought-is" problem: An implementation science framework for translating ethical norms into practice. *Am J Journal of Bioethic*. 2020;20(4):62-70. doi: 10.1080/15265161.2020.1730483
15. Locke EA, Latham GP. Building a practically useful theory of goal setting and task motivation: A 35-year odyssey. *American Psychologist*. 2002;57(9):705-717. doi: 10.1037/0003-066X.57.9.705.
16. Parks-Stamm, EJ, & Gollwitzer, PM. (2009). Goal implementation: The benefits and costs of if-then planning. In GB Moskowitz, & H. Grant (Eds.), *The psychology of goals* (pp. 362-391). Guilford Press.
17. Sniehotta FF, Scholz U, Schwarzer R. Bridging the intention-behaviour gap: Planning, self-efficacy, and action control in the adoption and maintenance of physical exercise. *Psychology & Health*. 2005;20(2):143-160. doi: 10.1080/08870440512331317670
18. Lorig K, Laurent DD, Plant K, Krishnan E, Ritter PL. The components of action planning and their associations with behavior and health outcomes. *Chronic Illn*. 2014;10(1):50-59. doi: 10.1177/1742395313495572
19. Gollwitzer PM. Implementation intentions: Strong effects of simple plans. *American Psychologist*. 1999;54(7):493-503. doi: 10.1037/0003-066x.54.7.493
20. Gollwitzer PM, Sheeran P. Implementation intentions and goal achievement: A meta-analysis of effects and processes. *Advances in Experimental Social Psychology*. 2006;38(1):69-119. doi: 10.1016/S0065-2601(06)38002-1
21. McIntosh T, Pendo E, Walsh HA, et al. What can state medical boards do to effectively address serious ethical violations? *J Law Med Ethics*. 2023;51(4):941-953. doi: 10.1017/jme.2024.6
22. Pendo E, McIntosh T, Walsh HA, Baldwin K, DuBois JM. Protecting patients from physicians who inflict harm: New legal resources for state medical boards. *Saint Louis University Journal of Health Law and Policy*. 2021;15(1):7-54. <https://scholarship.law.slu.edu/cgi/viewcontent.cgi?article=1277&context=jhlp>
23. Federation of State Medical Boards. Report and recommendations of the FSMB workgroup on physician sexual misconduct. *J Med Regul*. 2020;106(2):17-36. doi: 10.30770/2572-1852-106.2.17
24. McIntosh T, Oetterer H, DuBois JM. Learning from leading peers: An interview study with seven SMBs that recently implemented policies to protect patients. *J Med Regul*. (2025) 111 (2): 18-30. doi: 10.30770/2572-1852-111.2.18
25. Solomon ED, Mozersky J, Goodman M, et al. A randomized implementation trial to increase adoption of evidence-informed consent practices. *J Clin Transl Sci*. 2022;7(1):e28. doi: 10.1017/cts.2022.520
26. Shearer E, Magnus D. Using implementation science to enact specific ethical norms: The case of code status policy. *Am J Bioeth*. 2020;20(4):6-7. doi: 10.1080/15265161.2020.1735874
27. O'Toole Jr LJ, Slade CP, Brewer GA, Gase LN. Barriers, and facilitators to implementing primary stroke center policy in the United States: Results from 4 case study states. *Am J Public Health*. 2011;101(3):561-6. doi: 10.2105/AJPH.2010.197954
28. De Hert S, de Paula-Garcia WN. Implementation of guidelines in clinical practice; barriers and strategies. *Curr Opin Anesthesiol*. 2024;37(2):155-62. doi: 10.1097/ACO.0000000000001344
29. Ashcraft LE, Quinn DA, Brownson RC. Strategies for effective dissemination of research to United States policymakers: a systematic review. *Implement Sci*. 2020;15:1-17. doi: 10.1186/s13012-020-01046-3
30. Wang Z, Bero L, Grundy Q. Understanding professional stakeholders' active resistance to guideline implementation: the case of Canadian breast screening guidelines. *Soc Sci Med*. 2021;269:113586. doi: 10.1016/j.socscimed.2020.113586

31. Ajzen I. The theory of planned behavior. *Organizational Behavior and Human Decision Processes*. 1991;50(2):179-211. doi: [https://doi.org/10.1016/0749-5978\(91\)90020-T](https://doi.org/10.1016/0749-5978(91)90020-T)
32. Fishbein MA, Ajzen I. Belief, attitude, intention, and behaviour: An introduction to theory and research. Reading, MA: Addison-Wesley; 1975.

About the Authors

Tristan McIntosh, PhD, is an Assistant Professor of Medicine, Bioethics Research Center, Washington University School of Medicine, St. Louis, MO

Haley Oetterer, MPH is a Graduate Research Assistant, Bioethics Research Center, Washington University School of Medicine, St. Louis, MO

James M. DuBois, DSc, PhD, is the Steven J. Bander Professor of Medical Ethics and Professionalism, Bioethics Research Center, Washington University School of Medicine, St. Louis, MO

Acknowledgments: The authors would like to thank those who participated in the workshop and FSMB staff leadership for their support of this project and providing space at the FSMB annual meeting to host the workshop.

Keywords: Action plan, egregious wrongdoing by physicians, policy implementation, state medical boards

Received: February 6, 2025; **revision received:** July 3, 2025; **accepted:** August 4, 2025

Correspondence should be addressed to: Tristan McIntosh, PhD, Assistant Professor of Medicine, Bioethics Research Center, Washington University School of Medicine, Campus Box 8005, 4523 Clayton Avenue, St. Louis, MO 63110. Phone: 314-454-8164. Email: t.mcintosh@wustl.edu

Open Access: © 2026 The Authors. Published by the *Journal of Medical Regulation*. This is an Open Access article under the terms of the Creative Commons Attribution-NonCommercial License (CC BY-NC, <https://creativecommons.org/licenses/by-nc/4.0/>), which permits use and distribution in any medium, provided the original work is properly cited, and the use is noncommercial.

Author contributions:

TM: Study concept and design; acquisition of data; analysis and interpretation of data; drafting of the manuscript

HO: Acquisition of data; analysis and interpretation of data; critical revision of manuscript for important intellectual content

JD: Study concept and design; critical revision of manuscript for important intellectual content

Ethics statement: This study was approved by the Washington University Institutional Review Board (IRB #202309029).

Funding/support: This study was supported by a Greenwall Foundation Bridging Bioethics Research & Policy Making Grant (PI: McIntosh).

Other disclosures: N/A

Supplemental Material

SUPPLEMENTAL TABLE 1: Cluster 1 pre- and immediate post-workshop action plan

Cluster 1 Recommendations	Pre-Workshop Respondents (n=106)	
	Perceived Positive Impact of Recommendation	Interest in Adopting
	n (%)	n (%)
1. Board has an adequate number of investigative staff.	32 (30)	20 (19)
2. Board is required to include gender diversity.	4 (4)	5 (5)
3. Board has adequate number of administrative staff.	3 (3)	11 (10)
4. Board is required to be racially diverse.	1 (1)	5 (5)
5. Board has an adequate number of members with clinical expertise that is reasonably current.	5 (5)	7 (7)
6. Board has access to adequate legal counsel.	8 (8)	2 (2)
7. Sexual misconduct cases are investigated by specialized gender-diverse teams.	16 (15)	28 (26)
8. Board utilizes a role-diverse investigative team (eg: including clinicians, public members, and legal counsel).	30 (28)	16 (15)
9. Board includes more than one public member with no ties to medicine or industry.	7 (7)	12 (11)
Cluster 1 Recommendations	Immediate Post-Workshop Respondents (n=35)	
	Action Plan Focus	
1. Board has an adequate number of investigative staff.	4 (11)	
2. Board is required to include gender diversity.	4 (11)	
3. Board has adequate number of administrative staff.	2 (6)	
4. Board is required to be racially diverse.	2 (6)	
5. Board has an adequate number of members with clinical expertise that is reasonably current.	7 (20)	
6. Board has access to adequate legal counsel.	4 (11)	
7. Sexual misconduct cases are investigated by specialized gender-diverse teams.	7 (20)	
8. Board utilizes a role-diverse investigative team (eg: including clinicians, public members, and legal counsel).	5 (14)	
9. Board includes more than one public member with no ties to medicine or industry.	3 (9)	

Note. Participants were asked to select all that apply for the policy recommendations presented in the immediate post-workshop assessment.

Supplemental Material

SUPPLEMENTAL TABLE 2: Cluster 2 pre- and post-workshop action plan reactions

Cluster 2 Recommendations	Pre-Workshop Respondents (n=106)	
	Perceived Positive Impact of Recommendation	Interest in Adopting
	n (%)	n (%)
1. The board website provides an easy-to-find platform for patients and other whistleblowers to file complaints.	35 (37)	9 (9)
2. Board publishes documents on hearings and disciplinary actions on its website.	5 (5)	2 (2)
3. Board website includes information about state laws and board policy on sexual misconduct.	19 (20)	14 (15)
4. The board website includes information about the investigation process and what the person reporting can expect.	7 (7)	15 (16)
5. Board markets its purpose via social media, professional organizations, and liaising with hospitals and other relevant groups.	9 (9)	27 (28)
6. Board website defines physician sexual misconduct.	7 (7)	7 (7)
7. Board provides physicians with specific information on what disciplinary actions occur if they violate provisions of the medical practice act.	14 (15)	22 (23)
Cluster 2 Recommendations	Immediate Post-Workshop Respondents (n=35)	
	Action Plan Focus	
1. The board website provides an easy-to-find platform for patients and other whistleblowers to file complaints.	9 (26)	
2. Board publishes documents on hearings and disciplinary actions on its website.	4 (14)	
3. Board website includes information about state laws and board policy on sexual misconduct.	9 (26)	
4. The board website includes information about the investigation process and what the person reporting can expect.	10 (29)	
5. Board markets its purpose via social media, professional organizations, and liaising with hospitals and other relevant groups.	15 (43)	
6. Board website defines physician sexual misconduct.	11 (31)	
7. Board provides physicians with specific information on what disciplinary actions occur if they violate provisions of the medical practice act.	7 (20)	

Note. Participants were asked to select all that apply for the policy recommendations presented in the immediate post-workshop assessment.

Supplemental Material

SUPPLEMENTAL TABLE 3: Cluster 3 pre- and post-workshop action plan reactions

Cluster 3 Recommendations	Pre-Workshop Respondents (n=106)	
	Perceived Positive Impact of Recommendation	Interest in Adopting
	n (%)	n (%)
1. Board has the authority to open an investigation in the absence of a complaint based on factors such as criminal history reports, prosecutorial charging instruments, FSMB, NPDB, and PMP reports, other agency and jurisdictional enforcement actions, or journalistic reporting.	27 (29)	9 (10)
2. Board established qualifications for experts consulted during investigations and hearings.	5 (5)	7 (8)
3. Board obtains relevant mental health information during investigations.	3 (3)	5 (5)
4. Board allows patients to present complaints in strict confidentiality.	10 (11)	5 (5)
5. Board requires all physicians to complete a criminal background check at the time of their application.	6 (7)	3 (3)
6. The board permits anonymous reporting.	4 (4)	5 (5)
7. The board defines which types of alleged misconduct trigger special procedures to protect the public (eg: consideration of emergency suspension of a license, expedited investigation).	10 (11)	17 (19)
8. Board has a screening committee that triages incoming complaints.	7 (8)	9 (10)
9. Board routinely checks the Prescription Monitoring Program (PMP) for the top prescribers of opioids and checks for suspicious patterns of prescribing or dispensing opioids.	11 (12)	9 (10)
10. When the National Practitioner Data Bank (NPDB) has a plausible category to characterize wrongdoing (eg: sexual misconduct), then the Board would ban the use of the "other" or "N/A" categories. "Other" or "N/A" categories would be used as a last resort.	3 (3)	8 (9)
11. Board requires all physicians to complete a criminal background check at the time of their renewal.	6 (7)	15 (16)

Note. Participants were asked to select all that apply for the policy recommendations presented in the immediate post-workshop assessment.

Supplemental Material

SUPPLEMENTAL TABLE 3: Cluster 3 pre- and post-workshop action plan reactions

Cluster 3 Recommendations	Immediate Post-Workshop Respondents (n=35)
	Action Plan Focus
1. Board has the authority to open an investigation in the absence of a complaint based on factors such as criminal history reports, prosecutorial charging instruments, FSMB, NPDB, and PMP reports, other agency and jurisdictional enforcement actions, or journalistic reporting.	2 (6)
2. Board established qualifications for experts consulted during investigations and hearings.	7 (20)
3. Board obtains relevant mental health information during investigations.	8 (23)
4. Board allows patients to present complaints in strict confidentiality.	5 (14)
5. Board requires all physicians to complete a criminal background check at the time of their application.	6 (17)
6. The board permits anonymous reporting.	5 (14)
7. The board defines which types of alleged misconduct trigger special procedures to protect the public (eg: consideration of emergency suspension of a license, expedited investigation).	5 (14)
8. Board has a screening committee that triages incoming complaints.	1 (4)
9. Board routinely checks the Prescription Monitoring Program (PMP) for the top prescribers of opioids and checks for suspicious patterns of prescribing or dispensing opioids.	4 (11)
10. When the National Practitioner Data Bank (NPDB) has a plausible category to characterize wrongdoing (eg: sexual misconduct), then the Board would ban the use of the "other" or "N/A" categories. "Other" or "N/A" categories would be used as a last resort.	4 (11)
11. Board requires all physicians to complete a criminal background check at the time of their renewal.	3 (9)

Note. Participants were asked to select all that apply for the policy recommendations presented in the immediate post-workshop assessment.

Supplemental Material

SUPPLEMENTAL TABLE 4: Cluster 4 pre- and post-workshop action plan reactions

Cluster 4 Recommendations	Pre-Workshop Respondents (n=106)	
	Perceived Positive Impact of Recommendation	Interest in Adopting
	n (%)	n (%)
1. Board issues subpoenas for witnesses and medical and business records.	1 (1)	0 (0)
2. Board provides disciplinary information to the FSMB Physician Data Center, which allows for disciplinary alerts to be sent to other jurisdictions in which the physician holds a license.	11 (12)	2 (2)
3. Hospitals are required to report to boards when employed physicians have been dismissed or resigned due to concerns about egregious wrongdoing.	20 (22)	19 (21)
4. Board requires medical schools and post-graduate training programs to report egregious wrongdoing as a condition to licensure eligibility.	2 (2)	3 (3)
5. Board requires all physicians to report any disciplinary action during medical school at the time of their application (eg: suspension, warning, probation, expulsion, being requested or allowed to resign in lieu of discipline).	2 (2)	3 (3)
6. State law indemnifies those who, in good faith, provide mandated reports or assist the board with investigations. (To indemnify means to protect the individuals from legal actions brought against them for performing their duties.)	7 (8)	8 (9)
7. Information sharing is required between the board and the VA system, including information about physicians.	5 (6)	13 (14)
8. Board informs law enforcement that they can report accusations against a physician to the board even if criminal charges are not filed.	6 (7)	5 (6)
9. Board requires medical schools and post-graduate training programs to report any disciplinary complaints about physicians during medical school as a condition for licensure eligibility.	1 (1)	1 (1)
10. Board allows unfettered investigative information sharing about physicians with other boards, including when a physician applies for licensure and when potentially actionable out-of-state conduct occurs.	17 (19)	12 (13)
11. Insurance companies are required to report to the board each time a payment is made in a malpractice case.	1 (1)	8 (9)
12. Board has a duty to report to law enforcement any time it becomes aware of sexual misconduct or other instances of egregious wrongdoing.	2 (2)	2 (2)
13. Board coordinates investigations with community partners (eg: local and state police, healthcare organizations, other state agencies).	7 (8)	6 (7)
14. Board reports impaired physicians to the National Practitioners Data Bank (NPDB).	1 (1)	0 (0)
15. Board conducts joint investigations with other professional boards (eg: nursing, physician assistants, dentistry) within the state.	8 (9)	9 (10)

Note. Participants were asked to select all that apply for the policy recommendations presented in the immediate post-workshop assessment.

Supplemental Material

SUPPLEMENTAL TABLE 4: Cluster 4 pre- and post-workshop action plan reactions

Cluster 4 Recommendations	Immediate Post-Workshop Respondents (n=35)
	Action Plan Focus
1. Board issues subpoenas for witnesses and medical and business records.	1 (3)
2. Board provides disciplinary information to the FSMB Physician Data Center, which allows for disciplinary alerts to be sent to other jurisdictions in which the physician holds a license.	3 (9)
3. Hospitals are required to report to boards when employed physicians have been dismissed or resigned due to concerns about egregious wrongdoing.	9 (26)
4. Board requires medical schools and post-graduate training programs to report egregious wrongdoing as a condition to licensure eligibility.	5 (14)
5. Board requires all physicians to report any disciplinary action during medical school at the time of their application (eg: suspension, warning, probation, expulsion, being requested or allowed to resign in lieu of discipline).	5 (14)
6. State law indemnifies those who, in good faith, provide mandated reports or assist the board with investigations. (To indemnify means to protect the individuals from legal actions brought against them for performing their duties.)	3 (9)
7. Information sharing is required between the board and the VA system, including information about physicians.	5 (14)
8. Board informs law enforcement that they can report accusations against a physician to the board even if criminal charges are not filed.	5 (14)
9. Board requires medical schools and post-graduate training programs to report any disciplinary complaints about physicians during medical school as a condition for licensure eligibility.	5 (14)
10. Board allows unfettered investigative information sharing about physicians with other boards, including when a physician applies for licensure and when potentially actionable out-of-state conduct occurs.	4 (11)
11. Insurance companies are required to report to the board each time a payment is made in a malpractice case.	4 (11)
12. Board has a duty to report to law enforcement any time it becomes aware of sexual misconduct or other instances of egregious wrongdoing.	3 (9)
13. Board coordinates investigations with community partners (eg: local and state police, healthcare organizations, other state agencies).	3 (9)
14. Board reports impaired physicians to the National Practitioners Data Bank (NPDB).	2 (6)
15. Board conducts joint investigations with other professional boards (eg: nursing, physician assistants, dentistry) within the state.	3 (9)

Note. Participants were asked to select all that apply for the policy recommendations presented in the immediate post-workshop assessment.

Supplemental Material

SUPPLEMENTAL TABLE 5: Cluster 5 pre- and post-workshop action plan reactions

Cluster 5 Recommendations	Pre-Workshop Respondents (n=106)	
	Perceived Positive Impact of Recommendation	Interest in Adopting
	n (%)	n (%)
1. Board has the authority to make decisions and take action independently in disciplinary matters.	10 (12)	3 (4)
2. Board allows an emergency suspension or restriction of a physician when physicians are credibly accused of sexual misconduct with a minor.	7 (8)	3 (4)
3. The board is authorized to enact an emergency suspension to prevent ongoing, egregious wrongdoing when allegations are credible, or a physician has been arrested in connection with such conduct.	19 (22)	7 (8)
4. The board monitors physicians and their continued practice following a finding of sexual wrongdoing if a license is not revoked or suspended.	7 (8)	6 (7)
5. The board has the authority to permanently revoke the license of a physician who is convicted of sexual misconduct.	5 (6)	8 (9)
6. When a physician agrees to a disciplinary recommendation, an order is presented to the full board for approval.	0 (0)	1 (1)
7. When a physician declines to accept a disciplinary recommendation, formal charges are filed, and a contested case is publicly held.	1 (1)	1 (1)
8. The board considers revocation when a physician repeatedly commits lesser acts of wrongdoing, especially following remedial efforts.	2 (2)	4 (5)
9. Certain criminal acts by physicians (eg: sexual misconduct) are raised to the felony level subjecting them to mandatory reporting.	2 (2)	6 (7)
10. Board suspends a physicians' license when their license is suspended in another jurisdiction.	3 (4)	5 (6)
11. Board allows an emergency suspension or restriction of a physician when physicians are in possession of a controlled substance without a valid prescription.	2 (2)	1 (1)
12. Board imposes penalties on physicians for not reporting peers who engage in egregious wrongdoing.	5 (6)	9 (11)
13. Board utilizes preponderance of the evidence as the standard of proof in all disciplinary proceedings (rather than "clear and convincing evidence" or other standards).	10 (12)	1 (1)
14. Board fines hospitals and academic medical centers for failure to report instances of egregious wrongdoing.	12 (14)	30 (35)

Note. Participants were asked to select all that apply for the policy recommendations presented in the immediate post-workshop assessment.

Supplemental Material

SUPPLEMENTAL TABLE 5: Cluster 5 pre- and post-workshop action plan reactions

Cluster 5 Recommendations	Immediate Post-Workshop Respondents (n=35)
	Action Plan Focus
1. Board has the authority to make decisions and take action independently in disciplinary matters.	3 (9)
2. Board allows an emergency suspension or restriction of a physician when physicians are credibly accused of sexual misconduct with a minor.	5 (14)
3. The board is authorized to enact an emergency suspension to prevent ongoing, egregious wrongdoing when allegations are credible, or a physician has been arrested in connection with such conduct.	4 (11)
4. The board monitors physicians and their continued practice following a finding of sexual wrongdoing if a license is not revoked or suspended.	7 (20)
5. The board has the authority to permanently revoke the license of a physician who is convicted of sexual misconduct.	4 (11)
6. When a physician agrees to a disciplinary recommendation, an order is presented to the full board for approval.	4 (11)
7. When a physician declines to accept a disciplinary recommendation, formal charges are filed, and a contested case is publicly held.	3 (9)
8. The board considers revocation when a physician repeatedly commits lesser acts of wrongdoing, especially following remedial efforts.	8 (23)
9. Certain criminal acts by physicians (eg: sexual misconduct) are raised to the felony level subjecting them to mandatory reporting.	4 (11)
10. Board suspends a physicians' license when their license is suspended in another jurisdiction.	3 (9)
11. Board allows an emergency suspension or restriction of a physician when physicians are in possession of a controlled substance without a valid prescription.	1 (3)
12. Board imposes penalties on physicians for not reporting peers who engage in egregious wrongdoing.	3 (9)
13. Board utilizes preponderance of the evidence as the standard of proof in all disciplinary proceedings (rather than "clear and convincing evidence" or other standards).	3 (9)
14. Board fines hospitals and academic medical centers for failure to report instances of egregious wrongdoing.	6 (17)

Note. Participants were asked to select all that apply for the policy recommendations presented in the immediate post-workshop assessment.