Marijuana for Medical Purposes

This statement was adopted by the full Medical Board on May 7, 2004 and amended in October 2014.

On November 5, 1996, the people of California passed Proposition 215. Through this Initiative Measure, Section 11362.5 was added to the Health and Safety Code, and is also known as the Compassionate Use Act of 1996. The purposes of the Act include, in part:

> "(A) To ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where the medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief; and
>
> (B) To ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction."

Furthermore, Health and Safety Code section 11362.5(c) provides strong protection for physicians who choose to participate in the implementation of the Act. "Notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes."

The Medical Board of California developed this statement since marijuana is an emerging treatment modality. The Medical Board wants to assure physicians who choose to recommend marijuana for medical purposes to their patients, as part of their regular practice of medicine, that they WILL NOT be subject to investigation or disciplinary action by the Medical Board if they arrive at the decision to make this recommendation in accordance with accepted standards of medical responsibility. The mere receipt of a complaint that the physician is recommending marijuana for medical purposes will not generate an investigation absent additional information indicating that the physician is not adhering to accepted medical standards.

These accepted standards are the same as any reasonable and prudent physician would follow when recommending or approving any other medication, and include the following:

1. History and an appropriate prior examination of the patient.
2. Development of a treatment plan with objectives.
3. Provision of appropriate consent including discussion of side effects.
4. Periodic review of the treatment's efficacy.
5. Consultation, as necessary.
6. Proper record keeping and maintenance thereof that supports the decision to recommend the use of marijuana for medical purposes.

In other words, if physicians use the same care in recommending marijuana to patients as they would recommending or approving medications, they have nothing to fear from the Medical Board.

Here are some important points to consider when recommending marijuana for medical purposes:

1. Although it could trigger federal action, making a recommendation in writing to the patient will not trigger action by the Medical Board of California.

2. A patient need not have failed on all standard medications in order for a physician to recommend or approve the use of marijuana for medical purposes.
3. The physician should determine that marijuana use is not masking an acute or treatable progressive condition, or that such use will lead to a worsening of the patient's condition.
4. The Act names certain medical conditions for which marijuana may be useful, although physicians are not limited in their recommendations to those specific conditions. In all cases, the physician should base his/her determination on the results of clinical trials, if available, medical literature and reports, or on experience of that physician or other physicians, or on credible patient reports. In all cases, the physician must determine that the risk/benefit ratio of marijuana is as good, or better, than other treatment options that could be used for that individual patient.
5. A physician who is not the primary treating physician may still recommend marijuana for a patient's symptoms. However, it is incumbent upon that physician to consult with the patient's primary treating physician or obtain the appropriate patient records to confirm the patient's underlying diagnosis and prior treatment history.
6. The initial examination for the condition for which marijuana is being recommended must be an appropriate prior examination and meet the standard of care. Telehealth, in compliance with Business and Professions Code section 2290.5, is a tool in the practice of medicine and does not change the standard of care.
7. Recommendations should be limited to the time necessary to appropriately monitor the patient. Periodic reviews should occur and be documented at least annually or more frequently as warranted.
8. If a physician recommends or approves the use of marijuana for a medical purpose for a minor, the parents or legal guardians must be fully informed of the risks and benefits of such use and must consent to that use.

Physicians may wish to refer to the following CMA documents:

- ON-CALL Document #1315 titled "The Compassionate Use Act of 1996", updated annually for additional information and guidance
- "Physician Recommendation of Medical Cannabis", Guidelines of the Council on Scientific Affairs Subcommittee on Medical Marijuana Practice Advisory

Although the Compassionate Use Act allows the use of marijuana for medical purposes by a patient upon the recommendation or approval of a physician, California physicians should bear in mind that marijuana is listed in Schedule I of the federal Controlled Substances Act, which means that it has no accepted medical use under federal law. However, in Conant v. Walters (9th Cir.2002) F.3d 629 the United States Court of Appeals recognized that physicians have a constitutionally-protected right to discuss marijuana as a treatment option with their patients and make oral or written recommendation for marijuana. However, the court cautioned that physicians could exceed the scope of this constitutional protection if they conspire with, or aid and abet, their patients in obtaining marijuana.

Model Guidelines for the Recommendation of Marijuana in Patient Care

Report of the FSMB Workgroup on Marijuana and Medical Regulation

Adopted as policy by the Federation of State Medical Boards
April 2016

INTRODUCTION

Over the past two decades, the attitudes and laws in the United States have become more tolerant towards marijuana, with the proportion of adults using the substance doubling between 2001 and 2013. Due to the increasing number of state governments authorizing the use of marijuana and marijuana infused product for "medicinal purposes," state medical and osteopathic boards now have the added responsibility for the regulatory oversight of physicians choosing to incorporate the recommendation of marijuana in patient care and management.

The Federation of State Medical Boards (FSMB) Chair, J. Daniel Gifford, MD, FACP, appointed the Workgroup on Marijuana and Medical Regulation to develop model policy guidelines regarding the recommendation of marijuana in patient care, including conditions, diseases, or indications for which marijuana may be recommended. The Workgroup was further tasked with the development of a position statement or white paper regarding the regulation of licensees who use marijuana, which will be addressed in a separate document.

In order to accomplish this charge, the Workgroup reviewed existing laws and medical and osteopathic board rules, regulations and policies related to marijuana; reviewed current literature and policies related to the incorporation of marijuana by health care professionals in their professional practice and related research; and reviewed cases of board disciplinary actions related to the recommendation of marijuana in patient care and/or use and abuse of marijuana by licensees.

This policy document is intended as a resource to state medical boards in regulating physicians and physician assistants (or other licensees regulated by the board) with a full and unrestricted license participating in marijuana programs and may also be valuable in educating licensees as to the board's expectations when recommending marijuana to a patient for a particular medical condition. The guidelines should in no way be construed as encouraging or endorsing physicians to recommend marijuana as a part of patient care.

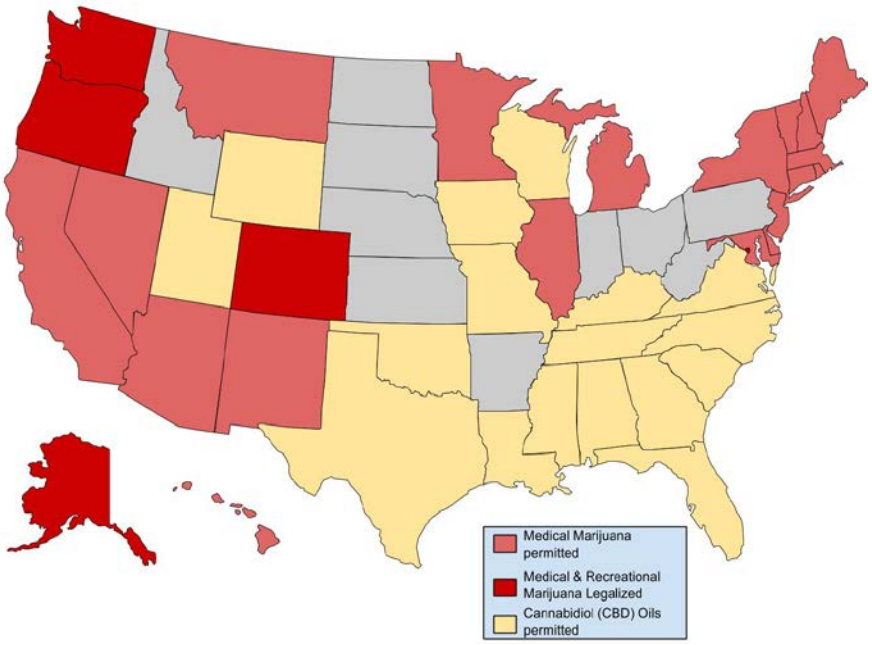
In developing the model guidelines that follow, the Workgroup conducted a comprehensive review of marijuana statutes, rules, and state medical board policies currently enacted across the country, and considered research reports, peer-reviewed articles, and policy statements regarding the recommendation of marijuana in patient care. In addition, a survey of FSMB member boards was conducted to determine which issues related to marijuana and medical regulation are of high priority to state boards. Fifty-one out of 70 state boards completed the survey, yielding a 72.9% response rate. Many boards reported several issues being most important to their board about

marijuana and medical regulation, including guidance on handling recreational use by physicians (31.4%), guidance on handling marijuana for medical use by physicians (47.1%), and model guidelines for recommending marijuana for medical purposes to patients (49.0%).

Section One. Background.

Marijuana has been suggested for alleviating symptoms of a range of debilitating medical conditions, such as cancer, HIV/AIDS, multiple sclerosis, Alzheimer's Disease, post-traumatic stress disorder (PTSD), epilepsy, Crohn's Disease, and glaucoma, as well as an alternative to narcotic painkillers. Accordingly, marijuana use in patient care has increased in popularity nationwide since 1996 when California voters passed Proposition 215, making it the first state to allow marijuana to be recommended in patient care. Since then, 22 other states, in addition to the District of Columbia and Guam, have enacted laws or passed ballot initiatives establishing comprehensive "medical marijuana programs," authorizing marijuana for medical purposes.[1] Moreover, 17 states have enacted laws to permit limited use of cannabidiol (CBD) oils for the treatment of specific illnesses and symptoms.[2] See Figure 1.

Figure 1: State Map of Marijuana and Cannabidiol Oils Laws



.

[1] The states and territories that have enacted comprehensive marijuana programs are: Alaska (AS 17.37.070), Arizona (A.R.S. § 36-2801), California (Cal. Health & Safety Code § 11362.7 et seq.), Colorado (Colo. Rev. Stat. § 25-1.5-106), Connecticut (Conn. Gen. Stat. §420f-21a-408), Delaware (Del. Code tit. 16 § 4901A et seq.), District of Columbia (D.C. Code § 7-1671.01 et seq.), Guam (10 Guam Code Ann. § 122501 et seq.), Hawaii (Haw. Rev. Stat. § 329-121), Illinois (410 Ill. Comp. Stat. § 130/10), Maine (Me. Stat. tit. 22, § 2422 et seq.), Maryland (Md. Code, Health Gen. § 13-3301 et seq.), Massachusetts (105 Code of Mass. Regs. 725.000), Michigan (Mich. Comp. Laws § 333.26423), Minnesota (Minn. Stat. § 152.21 et seq.), Montana (Mont. Code Ann. § 50-46-301 et seq.), Nevada (NRS 453A), New Hampshire RSA 126-X), New Jersey (N.J.S.A. C.24:6I-3), New Mexico (N.M. Stat. § 26-2B-1 et seq.), New York (NY Pub Health Law § 3360), Oregon (Or. Rev. Stat. § 475.300 et seq.), Rhode Island (R.I. Gen. Laws § 21-28.6-3), Vermont (18 V.S.A. § 4472 et seq.), and Washington (RCS 69.51A).
Recreational Marijuana Ballot Initiatives: Alaska (2014); Colorado (2012); District of Columbia (2014); Oregon (2014); Washington (2012).

[2] The states that have enacted laws permitting limited use of cannabidiol oils are: Alabama, Florida, Georgia, Iowa, Kentucky, Louisiana, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming.

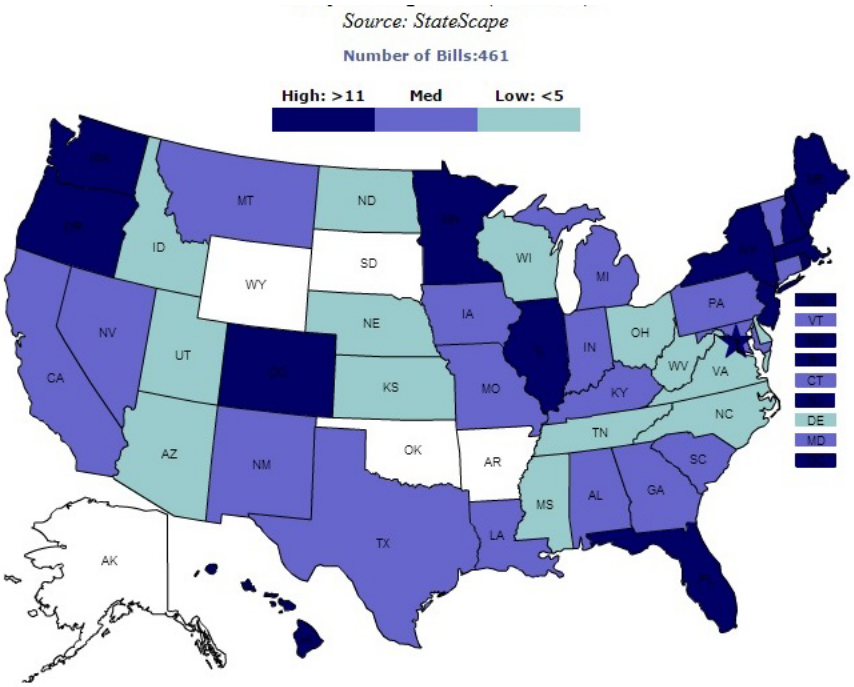
Although states have enacted laws permitting the use of both medical and recreational marijuana, the prescribing of marijuana remains illegal under federal law, as marijuana has not been subject to the U.S. Food and Drug Administration's evaluation and approval process. Marijuana is classified in federal law as a Schedule 1 substance under the Controlled Substance Act.[3] As a Schedule 1 substance, the federal government classifies marijuana as a substance with high potential for dependency or addiction, with no accepted medical use. Federal law prohibits knowingly or intentionally distributing, dispensing, or possessing marijuana.[4] Additionally, a person who aids and abets another in violating federal law or engages in a conspiracy to purchase, cultivate, or possess marijuana may be punished to the same extent as the individual who commits the crime.[5]

Providers and state regulators should continue to monitor usage and adverse effects of marijuana. See Figure 2. Based on the increasing number of states permitting the recommendation of marijuana in patient care, the U.S. Department of Justice updated its marijuana enforcement policy in August 2013. The updated policy reiterates marijuana's classification as an illegal substance under federal law, but advises states and local governments that authorize marijuana-related conduct to implement strong and effective regulatory and enforcement systems to address any threat state laws could pose to public safety, public health, and other interests. Should these state efforts be insufficient, the federal government may seek to challenge the regulatory structure itself and bring forward individual enforcement actions.[6]

The Guidelines that follow are designed to communicate to state medical board licensees that if marijuana is recommended, these recommendations should be consistent with accepted professional and ethical practices.

[3] 21 U.S.C. §812.
[4] 21 U.S.C. §841-44.
[5] 18 U.S.C. §2; 21 U.S.C. §846.
[6] James M. Cole, "Guidance Regarding Marijuana Enforcement [Memorandum]," Washington, DC: Department of Justice. (August 19, 2013).

Figure 2: Marijuana Legislation (2013-2015)



AL 5	AZ 4	CA 11	CO 14	CT 5	DC 27	DE 3	FL 20	GA 6	HI 50
IA 11	ID 1	IL 21	IN 5	KS 3	KY 5	LA 6	MA 18	MD 8	ME 17
MI 10	MN 14	MO 9	MS 3	MT 8	NC 3	ND 2	NE 4	NH 15	NJ 19
NM 5	NV 8	NY 15	OH 1	OR 15	PA 8	RI 21	SC 10	TN 3	TX 5
US 1	UT 1	VA 4	VT 6	WA 26	WI 1	WV 4			

Section Two. Definitions.

For the purposes of these guidelines, the following definitions apply:

"Marijuana" means the leaves, stems, flowers, and seeds of all species of the plant genus cannabis, whether growing or not. It does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture or preparation of the mature stalks, fiber, oil or cake or sterilized seed of the plant which is incapable of germination.

"Medical Marijuana Program" is the term used in some state statutes, rules, and regulations that provide for the medical use, cultivation and dispensing of marijuana for medical purposes, which may or may not include specific medical conditions for which a physician (or other licensed health care provider) may issue a recommendation, attestation, or authorization for a patient to obtain and use marijuana.

"Cannabidiol (CBD) Oil" means processed cannabis plant extract, oil, or resin that contains a high percentage of cannabidiol, but a low percentage of tetrahydrocannabinol.

"Tetrahydrocannabinol (THC)" means the primary psychoactive compound in cannabis, delta-9-tetrahydrocannabinol (THC), which is a partial agonist at cannabinoid receptors in the body.

Section Three. Guidelines.

The [Name of Board] has adopted the following guidelines for the recommendation of marijuana in patient care:

Physician-Patient Relationship: The health and well-being of patients depends upon a collaborative effort between the physician and the patient. The relationship between a patient and a physician is complex and based on the mutual understanding of the shared responsibility for the patient's health care. The physician-patient relationship is fundamental to the provision of acceptable medical care. Therefore, physicians must have documented that an appropriate physician-patient relationship has been established,[7] prior to providing a recommendation, attestation, or authorization for marijuana to the patient. Consistent with the prevailing standard of care, physicians should not recommend, attest, or otherwise authorize marijuana for themselves or family member.

Patient Evaluation: A documented in-person medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient must be obtained before a decision is made as to whether to recommend marijuana for medical use. At minimum, the evaluation should include the patient's history of present illness, social history, past medical and surgical history, alcohol and substance use history, family history with emphasis on addiction or mental illness/ psychotic disorders, physical exam, documentation of therapies with inadequate response, and diagnosis requiring the marijuana recommendation.

Informed and Shared Decision Making: The decision to recommend marijuana should be a shared decision between the physician and the patient. The physician should discuss the risks and benefits of the use of marijuana with the patient. Patients should be advised of the variability and lack of standardization of marijuana preparations and the effect of marijuana. Patients should be reminded not to drive or operate heavy machinery while under the influence of marijuana. If the patient is a minor or without decision-making capacity, the physician should ensure that the patient's parent, guardian or surrogate is involved in the treatment plan and consents to the patient's use of marijuana.

[7] The health and well-being of patients depends upon a collaborative effort between the physician and patient. The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient's health care. Although the Board recognizes that it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks assistance from a physician who may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient. FSMB *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine* (HOD 2014).

Treatment Agreement: A health care professional should document a written treatment plan that includes:

- Review of other measures attempted to ease the suffering caused by the terminal or debilitating medical condition that do not involve the recommendation of marijuana.
- Advice about other options for managing the terminal or debilitating medical condition.
- Determination that the patient with a terminal or debilitating medical condition may benefit from the recommendation of marijuana.
- Advice about the potential risks of the medical use of marijuana to include:
    - The variability of quality and concentration of marijuana;
    - The risk of cannabis use disorder;
    - Exacerbation of psychotic disorders and adverse cognitive effects for children and young adults;
    - Adverse events, exacerbation of psychotic disorder, adverse cognitive effects for children and young adults, and other risks, including falls or fractures;
    - Use of marijuana during pregnancy or breast feeding;
    - The need to safeguard all marijuana and marijuana-infused products from children and pets or domestic animals; and
    - The need to notify the patient that the marijuana is for the patient's use only and the marijuana should not be donated or otherwise supplied to another individual.
- Additional diagnostic evaluations or other planned treatments.
- A specific duration for the marijuana authorization for a period no longer than twelve months.
- A specific ongoing treatment plan as medically appropriate.

Qualifying Conditions: At this time, there is a paucity of evidence for the efficacy of marijuana in treating certain medical conditions. Recommending marijuana for certain medical conditions is at the professional discretion of the physician. The indication, appropriateness, and safety of the recommendation should be evaluated in accordance with current standards of practice and in compliance with state laws, rules and regulations which specify qualifying conditions for which a patient may qualify for marijuana.

Ongoing Monitoring and Adapting the Treatment Plan: Where available, the physician recommending marijuana should register with the appropriate oversight agency and provide the registry with information each time a recommendation, attestation, authorization, or reauthorization is issued [see Appendix 1]. Where available, the physician recommending marijuana should check the state Prescription Drug Monitoring Program (PDMP) each time a recommendation, attestation, authorization, or reauthorization is issued.

The physician should regularly assess the patient's response to the use of marijuana and overall health and level of function. This assessment should include the efficacy of the treatment to the patient, the goals of the treatment, and the progress of those goals.

Consultation and Referral: A patient who has a history of substance use disorder or a co-occurring mental health disorder may require specialized assessment and treatment. The physician should seek a consultation with, or refer the patient to, a pain management, psychiatric, addiction or mental health specialist, as needed.

Medical Records: The physician should keep accurate and complete medical records. Information that should appear in the medical record includes, but is not necessarily limited to the following:

- The patient's medical history, including a review of prior medical records as appropriate;
- Results of the physical examination, patient evaluation, diagnostic, therapeutic, and laboratory results;
- Other treatments and prescribed medications;
- Authorization, attestation or recommendation for marijuana, to include date, expiration, and any additional information required by state statute;
- Instructions to the patient, including discussions of risks and benefits, side effects and variable effects;
- Results of ongoing assessment and monitoring of patient's response to the use of marijuana;
- A copy of the signed Treatment Agreement, including instructions on safekeeping and instructions on not sharing.

Physician Conflicts of Interest: A physician who recommends marijuana should not have a professional office located at a dispensary or cultivation center or receive financial compensation from or hold a financial interest in a dispensary or cultivation center. Nor should the physician be a director, officer, member, incorporator, agent, employee, or retailer of a dispensary or cultivation center.

REFERENCES

American Medical Association. *H-95.952 Cannabis for Medicinal Use*.

The American Osteopathic Academy of Addiction Medicine. *Position Paper on "Medical" Marijuana,* September 2011.

American Academy of Pain Medicine, American Osteopathic Academy of Addiction Medicine, & American Society of Addiction Medicine. *The Role of the Physician in "Medical" Marijuana,* April 2010.

American Society of Addiction Medicine. *Public Policy Statement on Marijuana, Cannabinoids and Legalization,* September 2015, http://www.asam.org/docs/default-source/publicy-policy-statements/marijuana-cannabinoids-and-legalization-9-21-20156d6e0f9472bc604ca5b7ff000030b21a.pdf?sfvrsn=0.

American Society of Addiction Medicine. *Public Policy Statement of Medical Marijuana,* April 2010.

American Society of Pain Management Nursing. *Statement of the Use of Medical Marijuana,* June 2015.

Andrew M. Seaman, "Marijuana use, disorders doubled since 2001, *Reuters Health*, Oct. 22, 2015, http://www.reuters.com/article/2015/10/22/us-health-marijuana-use-disorders-idUSKCN0SF2NC20151022.

A. Neumeister et al., "Elevated brain cannabinoid CB receptor availability in post-traumatic stress disorder: a positron emission tomography study," *Mol Psychiatry* 10.1038/mp.2013.61(2013).

A. W. Zuardi, "Cannabidiol: from an inactive cannabinoid to a drug with wide spectrum of action," *Rev Bras Psiquiatr* 30, no. 3 (2008).

Brenda E Porter and Catherine Jacobson, "Report of a parent survey of cannabidiol-enriched cannabis use in pediatric treatment-resistant epilepsy," *Epilepsy & Behavior* 29, no. 3 (2013).

California Medical Association. *Physician Recommendation of Medical Cannabis, Guidelines of the Council on Scientific Affairs Subcommittee on Medical Marijuana Practice Advisory.*

C. Cao et al., "The Potential Therapeutic Effects of THC on Alzheimer's Disease," *J Alzheimers Dis* (2014).

Coats v. Dish Network, 13 Co. S. Ct. 394 (2015).

Cole, James M. (2013, August 19). *Guidance Regarding Marijuana Enforcement* [Memorandum]. Washington, DC: Department of Justice.

Colorado Department of Public Health and Environment. *Answers to Common Questions About Marijuana.* https://www.colorado.gov/pacific/sites/default/files/MJ_RMEP_Factsheet-Common-Questions.pdf.

Colorado Department of Public Health and Environment. *Physician Requirements.* https://www.colorado.gov/pacific/cdphe/physician-requirements.

Colorado Physician Health Program. *7.6 Marijuana Policy for the Colorado PHP*, October 2013.

Colorado Medical Marijuana Registry. *Medical Marijuana Policy Number 2015-04_001, Physician Referrals to the Department of Regulatory Agencies/Medical Board and Department Sanctions.*

D. I. Abrams et al., "Cannabis in painful HIV-associated sensory neuropathy: a randomized placebo-controlled trial," *Neurology* 68, no. 7 (2007).

D. I. Abrams et al., "Cannabinoid-opioid interaction in chronic pain," *Clin Pharmacol* Ther 90, no. 6 (2011).

Drug Policy Alliance. *Fact Sheet: Medical Marijuana.* June 2015. http://www.drugpolicy.org/sites/default/files/DPA_Fact_Sheet_Medical_Marijuana_June2015.pdf.

George A. Fraser, "The Use of a Synthetic Cannabinoid in the Management of Treatment Resistant Nightmares in Posttraumatic Stress Disorder (PTSD)," *CNS Neuroscience & Therapeutics* 15, no. 1 (2009).

Gil Bar-Sela et al., "The medical necessity for medicinal cannabis: prospective, observational study evaluating the treatment in cancer patients on supportive or palliative care," *Evidence-Based Complementary and Alternative Medicine* 2013(2013).

Gundersen MD, Doris C (2015, May 12). Medical Marijuana – a Prescription for Trouble? *Missouri Physicians Health Program.* http://themphp.org/Archive/Articles/tabid/98/ArticleID/182/Medical-Marijuana-a-Prescription-for-Trouble-by-Doris-C-Gundersen-MD-Medical-Director-Colorado-Physicians-Health-Program.aspx.

Hawaii Department of Public Safety. *Physician's Guideline & Patient Information for Completing Hawaii's Written Certification/Registry Identification Forms for the Medical Use of Marijuana.* http://dps.hawaii.gov/wp-content/uploads/2012/09/Physian-Information-Med-Marijuana-rev113011.pdf.

Johnson, Kate (2012, October 29). Do Physicians Use Marijuana? *Medscape.* http://www.medscape.com/viewarticle/83914.

Jody Corey-Bloom et al., "Smoked cannabis for spasticity in multiple sclerosis: a randomized, placebo-controlled trial," *Canadian Medical Association Journal* 184, no. 10 (2012).
L. Degenhardt et al., "Experience of Adjunctive Cannabis Use for Chronic Non-Cancer Pain: Findings from the Pain and Opioids in Treatment (Point) Study," *Drug Alcohol Depend* (2014).

Marcoux RPh MBA, Rita M., Larrat RPh PhD, E. Paul, & Vogenberg RPh PhD, F. Randy (2013). Medical Marijuana and Related Legal Aspects. *P&T*, 38(10): 612, 615-619. doi:Oct. 2013.

Medical Board of California. *Marijuana for Medical Purposes.* http://www.mbc.ca.gov/Licensees/Prescribing/medical_marijuana_cma-recommend.pdf.

M. J. Milloy et al., "High-Intensity Cannabis Use Associated with Lower Plasma Human Immunodeficiency Virus-1 Rna Viral Load among Recently Infected People Who Use Injection Drugs," *Drug Alcohol Rev* (2014).

National Conference of State Legislatures. *State Medical Marijuana Laws.* http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx.

Nevada State Board of Osteopathic Medicine. *Statement of Policy Regarding Medical Marijuana and Osteopathic Physicians*, Approved September 9, 2014.

Nevada State Board of Medical Examiners. *Advisory Opinion of the Board of Medical Examiners in the Matter of Participation of Licensee as a Shareholder, Officer or Managing Member of Any Medical Marijuana Cultivation Facility, Dispensary or other Establishment or Entity Authorized Under NRS 453A.* http://medboard.nv.gov/uploadedFiles/medboardnvgov/content/Resources/Opinions/No14-1AdvOp.pdf

N. M. Kogan and R. Mechoulam, "Cannabinoids in health and disease," *Dialogues Clin Neurosci* 9, no. 4 (2007).

Nussbaum MD, A., Boyer MD, J., & Konrad MD, E. (2011). But my Doctor Recommended Pot: Medical Marijuana and the Patient-Physician Relationship. *J Gen Intern Med.*, 26(11), 1364–1367. doi:Nov. 2011.

Pablo Roitman et al., "Preliminary, Open-Label, Pilot Study of Add-on Oral Δ9-Tetrahydrocannabinol in Chronic PostTraumatic Stress Disorder," *Clinical drug investigation* 34, no. 8 (2014).

Peckham, Carol (2015, February 5). Do Physicians Use Marijuana? *Medscape.* http://www.medscape.com/viewarticle/839149.

Philippe Lucas et al., "Cannabis as a substitute for alcohol and other drugs: A dispensary-based survey of substitution effect in Canadian medical cannabis patients," *Addiction Research & Theory* 21, no. 5 (2013).

P. K. Riggs et al., "A pilot study of the effects of cannabis on appetite hormones in HIV-infected adult men," *Brain Res* 1431(2012).

Rhode Island Board of Medical Licensure and Discipline. *Minimum Standards for Authorizing Medical Marijuana.* http://www.health.ri.gov/healthcare/medicalmarijuana/for/providers/.

Ronald J Ellis et al., "Smoked medicinal cannabis for neuropathic pain in HIV: a randomized, crossover clinical trial," *Neuropsychopharmacology* 34, no. 3 (2008).

Seaman, Andrew M, "Marijuana use, disorders doubled since 2001, *Reuters Health*, Oct. 22, 2015, http://www.reuters.com/article/2015/10/22/us-health-marijuana-use-disorders-idUSKCN0SF2NC20151022.

Suzanne Johannigman and Valerie Eschiti, "Medical Use of Marijuana in Palliative Care," *Clinical Journal of Oncology Nursing* 17, no. 4 (2013).

Timna Naftali et al., "Cannabis Induces a Clinical Response in Patients with Crohn's Disease: A Prospective Placebo-Controlled Study," *Clinical Gastroenterology and Hepatology* 11, no. 10 (2013).

Torsten Passie et al., "Mitigation of post-traumatic stress symptoms by Cannabis resin: A review of the clinical and neurobiological evidence," *Drug Testing and Analysis* 4, no. 7-8 (2012).

Volkow MD, Nora D., Baler PhD, Ruben D., Compton MD, Wilson M, & Weiss PhD, Susan R.B. (2014, June 5). Adverse Health Effects of Marijuana Use. *N Eng J Med* 2014; 370:2219-2227.

Washington State Department of Health. *Medical Marijuana Authorization Guidelines.*

Appendix 1: Registration

Many states that permit the recommendation of marijuana to patients for the treatment of serious medical conditions have laws establishing a registry to track and monitor the utilization of marijuana in patient care.[8]

In these states, physicians recommending marijuana to patients for the treatment of conditions are required to register with the regulatory agency overseeing the marijuana program, and must provide the registry with information each time a recommendation is issued.

The state's registry is required by law to regularly perform analyses of the number of recommendations issued. With the statistical review of physician recommendations, the regulating agency periodically determines whether a physician should be referred to the state medical or osteopathic board for review and possible sanction.

The following are common factors oversight agencies rely on in referring physicians to the state board for possible abuse of marijuana recommendations:

1. Physician caseload as determined by the number of patients for whom marijuana is recommended. A high caseload is calculated as 3,521 or more patient recommendations in one year for a general practitioner. This reflects the recommendation of patients equal to or greater than the national average of patient visits per year for a generalist physician as reported by the Centers for Disease Control and Prevention (Co. Registry Policy # 2014-04_001);
2. The plant and ounce recommendations by the physician. Physicians recommending an amount of marijuana above the standard set within a state's statutes will be referred to the state medical board for review;
3. Age demographics of the patient caseload. According to the CDC, older adults have a significantly higher prevalence of chronic conditions than younger adults. Physicians for whom more than one-third of the patient caseload is under the age of 30 may be recommended for referral; and
4. Other circumstances determined by the overseeing agency. The oversight agency may also refer physicians to the state medical board if there is evidence of potential violation of the constitution, statutes, state medical board regulations or any violation of the Medical Practice Act.

If evidence supports a referral, the overseeing agency will issue a formal referral to the state medical board with the physician's identifying information, the reason for the referral, and any statistical data supporting the referral. Once the referral is received, the state medical board typically reviews the documentation and conducts an investigation as deemed appropriate.

[8] *See e.g.* Colorado Medical Marijuana Registry; *See e.g.* Minnesota Medical Cannabis Registry

WORKGROUP MEMBERS

Gregory B. Snyder, MD, DABR, Chairman
Past President, Minnesota Board of Medical Practice

Eustaquio O. Abay, II, MD
Past Member, Kansas Board of Healing Arts

Eric R. Groce, DO
President, Colorado Medical Board

Ronald D. Hedger, DO
President, Nevada Board of Osteopathic Medicine

Kimberly Kirchmeyer (Associate Member)
Executive Director, Medical Board of California

Howard R. Krauss, MD
Member, Medical Board of California

Micah Matthews, MPA
Deputy Executive Director, Washington Medical Quality Assurance Commission

James V. McDonald, MD, MPH (Associate Member)
Chief Administrative Officer, Rhode Island Board of Medical Licensure and Discipline

Marc E. Rankin, MD
Member, District of Columbia Medical Board

EX OFFICIOS

J. Daniel Gifford, MD, FACP
Chair, FSMB

Arthur S. Hengerer, MD, FACS
Chair-elect, FSMB

Humayun J. Chaudhry, DO, MACP
President and CEO, FSMB

STAFF SUPPORT

Lisa A. Robin
Chief Advocacy Officer, FSMB

Shiri Hickman, JD
Director, State Legislation & Policy, FSMB

John P. Bremer
State Legislative and Policy Coordinator, FSMB

ESSENTIALS OF A STATE MEDICAL AND OSTEOPATHIC PRACTICE ACT

Adopted as policy by the Federation of State Medical Boards in April 2015

TABLE OF CONTENTS

Section I:	Statement of Purpose	3
Section II:	Definitions	4
Section III:	The State Medical Board	6
Section IV:	Examinations	10
Section V:	Requirements for Full Licensure	10
Section VI:	Graduates of Foreign Medical Schools	12
Section VII:	Licensure by Endorsement, Expedited Licensure by Endorsement, and Temporary and Special Licensure	13
Section VIII:	Limited Licensure for Physicians in Postgraduate Training	16
Section IX:	Disciplinary Action against Licensees	17
Section X:	Procedures for Enforcement and Disciplinary Action	22
Section XI:	Impaired Physicians	24
Section XII:	Dyscompetent Physicians	25
Section XIII:	Compulsory Reporting and Investigation	26
Section XIV:	Protected Action and Communication	28
Section XV:	Unlawful Practice of Medicine: Violations and Penalties	29
Section XVI:	Periodic Renewal	30
Section XVII:	Physician Assistants	31
Section XVIII:	Rules and Regulations	33
Section XIX:	Funding and Fees	33

ESSENTIALS OF A STATE MEDICAL AND OSTEOPATHIC PRACTICE ACT

INTRODUCTION

As early as 1914, the Federation of State Medical Boards of the United States and its member boards recognized the need for what was to become *A Guide to the Essentials of a Modern Medical Practice Act*. First published in 1956, the stated purposes of the document have always been the same:

1. to serve as a guide to those states that may adopt new medical practice acts or may amend existing laws and

2. to encourage the development and use of consistent standards, language, definitions and tools by boards responsible for physician and physician assistant regulation.

Changes in medical education, in the practice of medicine and in the diverse responsibilities that face medical boards necessitate regular revision of medical practice acts. The *Essentials* has undergone numerous revisions in order to respond to these changes and to provide assistance to member boards in the evaluation and revision of their medical practice acts. The Federation urges member boards to consider including any recommendation contained in the Essentials in its medical practice act or under its rules.

The *Essentials* applies equally to practice acts that govern physicians who have acquired the M.D. or D.O. degree in the same statute or in separate statutes. The terms used herein should be interpreted throughout with this understanding.

PREAMBLE

An essential is that element, quality or property that is indispensable in making a body, character, or structure what it is. It constitutes the essence. The Federation of State Medical Boards of the United States believes that each of the 19 sections of this document express an essential of a modern medical practice act and that the recommendations in each section are basic to the realization of that essential.

Section I: Statement of Purpose
The medical practice act should be introduced by a statement of policy specifying the purpose of the act. This statement should include language expressing the following concepts:

A. The practice of medicine is a privilege granted by the people acting through their elected representatives.

B. In the interests of public health, safety, and welfare, and to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent, and/or deceptive practice of medicine, it is necessary for the government to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine.

C. The primary responsibility and obligation of the state medical board is to act in the sovereign interests of the government by protecting the public through licensing, regulation and education as directed by the state government.

Section II: Definitions

A. Definitions: As used in this Act, the following terms shall have the following meanings:
"Assessment Program" means a formal system to examine or evaluate a physician's competence within the scope of the physician's practice.

"Competence" means possessing the requisite abilities and qualities (cognitive, non-cognitive, and communicative) to perform effectively within the scope of the physician's practice while adhering to professional ethical standards.

"Dyscompetence" means failing to maintain acceptable standards of one or more areas of professional physician practice.

"Impairment" means a physician's inability to practice medicine with reasonable skill and safety due to:

1. mental, psychological, or psychiatric illness, disease, or deficit;

2. physical illness or condition, including, but not limited to, those illnesses or conditions that would adversely affect cognitive, motor, or perceptive skills; or

3. habitual, excessive, or illegal use or abuse of drugs defined by law as controlled substances, illegal drugs, alcohol, or of other impairing substances.

"Incompetence" means lacking the requisite abilities and qualities (cognitive, non-cognitive, and communicative) to perform effectively in the scope of the physician's practice.

"Licensed physician" means a physician licensed to practice medicine in the jurisdiction.

"Physician assistant" means a skilled person who by training, scholarly achievements, submission of acceptable letters of recommendations, and satisfaction of other requirements of the Board has been licensed for the provision of patient services under the supervision and direction of a licensed physician who is responsible for the performance of that person.

"Physician Assistant Council" means a council appointed by the Board or other means that reviews matters relating to physician assistants reports its findings to the Board and makes recommendations for action. The medical practice act should provide definitions of the practice of medicine as governed by the act as well as exceptions to the act. These provisions of the act should implement or be consistent with the following:

"Practice of medicine" means:

1. advertising, holding out to the public, or representing in any manner that one is authorized to practice medicine in the jurisdiction;

2. offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other person;

3. offering or undertaking to prevent or to diagnose, correct, and/or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of any person, including the management of pregnancy and parturition;

4. offering or undertaking to perform any surgical operation upon any person;

5. rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient within a state by a physician located outside the state as a result of transmission of individual patient data by electronic or other means from within a state to such physician or his or her agent;

6. rendering a determination of medical necessity or a decision affecting the diagnosis and/or treatment of a patient; and

7. using the designation Doctor, Doctor of Medicine, Doctor of Osteopathic Medicine/Doctor of Osteopathy, Physician, Surgeon, Physician and Surgeon, Dr., M.D., D.O., or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition unless such a designation additionally contains the description of another branch of the healing arts for which one holds a valid license in the jurisdiction where the patient is located.

"Remediation" means the process whereby deficiencies in physician performance identified through an examination or assessment program are corrected, resulting in an acceptable state of physician competence.

"Supervising physician" means a licensed physician in good standing in the same jurisdiction as the physician assistant who the Board approved to supervise the services of a physician assistant, and who has in writing formally accepted the responsibility for such supervision.

B. The medical practice act shall not apply to:

1. students while engaged in training in a medical school approved or recognized by the state medical board, unless the Board licenses the student;

2. those providing service in cases of emergency where no fee or other consideration is contemplated, charged or received by the physician or anyone on behalf of the physician;

3. commissioned medical officers of the armed forces of the United States and medical officers of the United States Public Health Service or the Veterans Administration of the United States in the discharge of their official duties and/or within federally controlled facilities, provided that such

persons who hold medical licenses in the jurisdiction should be subject to the provisions of the act and provided that all such persons should be fully licensed to practice medicine in one or more jurisdictions of the United States, further the military physician should be subject to the Military Health System Clinical Quality Assurance (CQA) Program 10 U.S.C.A. § 1094; Regulation DOD 6025.13-R;

4. those practicing dentistry, nursing, optometry, podiatry, psychology, or any other of the healing arts in accord with and as provided by the laws of the jurisdiction;

5. those practicing the tenets of a religion or ministering religious based medical procedures or ministering to the sick or suffering by mental or spiritual means in accord with such tenets;

6. a person administering a lawful domestic or family remedy to a member of his or her own family;

7. those fully licensed to practice medicine in another jurisdiction of the United States who briefly render emergency medical treatment or briefly provide critical medical service at the specific lawful direction of a medical institution or federal agency that assumes full responsibility for that treatment or service and is approved by the state medical board; and

8. a physician licensed in another state, territory, or jurisdiction of the United States is exempted from the licensure requirements in (state) if the physician is employed or formally designated as the team physician by an athletic team visiting (state) for a specific sporting event and the physician limits the practice of medicine in (state) to medical treatment of the members, coaches and staff of the sports entity that employs (or has designated) the physician.

C. For the purpose of the medical practice act, the practice of medicine is determined to occur where the patient is located in order that the full resources of the state are available for the protection of that patient.

Section III: The State Medical Board

The medical practice act should provide for a separate state medical board, acting as a governmental agency, (referred to hereafter as the Board) to regulate the practice of medicine, including the licensure and discipline of physicians, in the jurisdiction. These provisions of the act should implement or be consistent with the following:

A. Whatever the professional regulatory structure established by the government of the jurisdiction, physicians should bear the primary responsibility for licensing and regulating the medical profession for the protection of the public, without abusing physicians in the discharge of that duty. Every Board should include both physician and public members. All Board members shall act to further the interest of the state, and not their personal interests.

B. Whatever the professional regulatory structure established by the government of the jurisdiction, the Board, within the context of the act and the requirements of due process, should have, at a minimum, the following powers and responsibilities:

1. Promulgate rules and regulations;

2. Select and/or administer licensing examination(s);

3. Develop and adopt policies and guidelines related to medical practice, other health care professions, and regulation;

4. Evaluate medical education and training of applicants;

5. Evaluate or verify certification of medical and training programs to determine if these pro- grams are appropriately preparing physicians for the practice of medicine;

6. Evaluate previous professional performance of applicants;

7. Issue or deny initial or endorsement licenses;

8. Maintain secure and complete records on individual licensees;

9. Provide the public with a profile of all licensed physicians;

10. Approve or deny applications for license renewal;

11. Develop and implement methods to identify physicians who are in violation of the medical practice act;

12. Develop and implement methods to identify and rehabilitate, if appropriate, physicians with an alcohol, drug and/or psychiatric illness;

13. Receive, review, and investigate complaints including sua sponte complaints;

14. Review and investigate reports received from entities having information pertinent to the professional performance of licensees;

15. Review, investigate, and take appropriate action to enjoin reports received concerning the unlicensed practice of medicine;

16. Share investigative information at the early stages of a complaint investigation with other Boards;

17. Issue subpoenas, subpoenas duces tecum, administer oaths, receive testimony, and conduct hearings;

18. Discipline licensees found in violation of the medical practice act;

19. Develop policies for disciplining or rehabilitating physicians that demonstrate inappropriate

sexual behavior with patients or other professional boundaries violations;

20. Institute actions in its own name and enjoin violators of the medical practice act;

21. Acknowledge receipt of complaints or other adverse information to persons or entities reporting to the Board and to the physician, and inform them of the final disposition of the matters reported;

22. Develop and implement methods to identify dyscompetent physicians and physicians who fail to meet acceptable standards of care;

23. Develop or identify and implement methods to assess and improve physician practice;

24. Develop or identify and implement methods to ensure the ongoing competence of licensees;

25. Establish appropriate fees and charges to ensure active and effective pursuit of its legal responsibilities;

26. Develop and adopt its budget;

27. Develop educational programs to facilitate licensee awareness of provisions contained in the medical practice act and to facilitate public awareness of the role and function of state medical boards; and

28. Acquire real property or other capital for the administration and operation of the Board.

C. Members of the Board, whether appointed or elected, should serve staggered terms to ensure continuity. All appointments and elections should be confirmed through the legislative branch of the jurisdiction.

D. The length of terms on the Board should be set to permit development of effective skill and experience by members (e.g., three or four years). However, a limit should be set on consecutive terms of service (e.g., two or three).

E. Members of the Board should receive appropriate compensation for services and reimbursement for expenses at the State's current approved rate.

F. A member of the Board should be subject to removal only when he or she

1. ceases to be qualified;

2. is found guilty of a felony or an unlawful act involving moral turpitude by a court of competent jurisdiction;

3. is found guilty of malfeasance, misfeasance or nonfeasance in relation to his or her Board duties by a court of competent jurisdiction;

4. is found mentally incompetent by a court of competent jurisdiction;

5. fails to attend three successive Board meetings without just cause as determined by the Board or, if a new member, fails to attend a new members' training program without just cause as determined by the Board;

6. is disciplined for violations of the medical practice act; or

7. is found in violation of the conflict of interest/ethics law.

G. All physician members of the Board should hold full and unrestricted medical licenses in the jurisdiction, should be persons of recognized professional ability and integrity, and should have resided, practiced in the jurisdiction long enough to have become familiar with policies and practice in the jurisdiction (e.g., five years).

H. The Board should include public members who:

1. are not licensed physicians or providers of health care;

2. have no substantial personal or financial interests in the practice of medicine or with any organization regulated by the Board;

3. have no immediate familial relationships with individuals involved in the practice of medicine or any organization regulated by the Board;

4. are residents of the State; and

5. are individuals of recognized ability and integrity.

I. The Board should be authorized to appoint committees from its membership. To effectively perform its duties under the Act, the Board should also be authorized to hire, discipline, and terminate staff, including an executive secretary or director. It should also be assigned adequate legal counsel by the office of the attorney general and/or be authorized to employ private counsel or its own full-time attorney.

J. The Board should conduct, and new members should attend, a training program designed to familiarize new members with their duties and the ethics of public service.

K. Travel, expenses, and daily compensation should be paid for each Board member's attendance, in or out of state, for education or training purposes approved by the Board and directly related to Board duties.

L. Telephone or other telecommunication conference should be an acceptable form of Board meeting if the president/chair alone or another officer and two Board members believe the Board's business can be properly conducted by teleconference. The Board shall be authorized to establish procedures by which its committees may meet by telephone or other telecommunication conference

system.

Section IV: Examinations

The medical practice act should provide for the Board's authority to approve an examination(s) of medical knowledge satisfactory to inform the Board's decision to issue a full, unrestricted license to practice medicine and surgery in the jurisdiction.

A. In order to ensure a high quality, valid, and reliable examination of physician preparedness to practice medicine, the Board may delegate the responsibilities for examination development, administration, scoring, and security to a third party or nationally recognized testing entity. Such an examination should be consistent with recognized national standards for professional testing such as those reflected in Standards for Educational and Psychological Testing.

B. No person should receive a license to practice medicine in the jurisdiction unless he or she has successfully completed all components of an examination(s) identified as satisfactory to the Board.

1. The currently administered USMLE Steps 1,2,3 or COMLEX-USA Levels 1,2,3; or

2. previously administered examinations such as the FLEX, NBME Parts or NBOME Parts; or

3. a combination of these examinations identified as acceptable by the Board.

C. The examination(s) approved by the Board shall be in the English language and designed to ascertain an individual's fitness for an unrestricted license to practice medicine and surgery.

D. The Board may stipulate the numeric score or performance level required for passing the examination(s) or accept the recommended minimum passing score as determined by the developers of the examination.

E. The Board should be authorized to limit the number of times an examination may be taken, to require applicants to pass all examinations within a specified period, and to specify further medical education required for applicants unable to do so.

F. In order to support periodic or mandated reviews of its approved examination(s), the Board should be provided with reasonable access by the third party or testing entity in order to review the examination design, format, and content, as well as performance data and relevant procedures for test administration, security, and scoring.

Section V: Requirements for Full Licensure

The medical practice act should provide minimum requirements for full licensure for the independent practice of medicine that bear a reasonable relationship to the qualifications and fitness necessary for such practice. These provisions of the act should implement or be consistent with the following:

A. The applicant should provide the Board, or its agent, and attest to, or provide the means to obtain and verify the following information and documentation in a manner required by the Board:

1. his or her full name and all aliases or other names ever used, current address, Social Security number, and date and place of birth;
2. a signed photograph not more than two (2) years old and, at the board's discretion, other documentation of identity;

3. originals of all documents and credentials required by the Board, notarized photocopies, or other verification acceptable to the Board of such documents and credentials;

4. a list of all jurisdictions, United States or foreign, in which the applicant is licensed or has ever applied for licensure to practice medicine or is authorized or has ever applied for authorization to practice medicine, including all jurisdictions in which any license application or authorization has been withdrawn;

5. a list of all jurisdictions, United States or foreign, in which the applicant has been denied licensure or authorization to practice medicine or as any other health care professional or has voluntarily surrendered a license or an authorization to practice medicine or as any other health care professional;

6. a list of all sanctions, judgments, awards, settlements, or convictions against the applicant in any jurisdiction, United States or foreign, that would constitute grounds for disciplinary action under the medical practice act or the Board's rules and regulations;

7. a detailed educational history, including places, institutions, dates, and program descriptions of all his or her education including all college, pre-professional, professional, and professional postgraduate education;

8. a detailed chronological life history, including places and dates of residence, employment, and military service (United States or foreign) including periods of absence from the active practice of medicine;

9. all Web sites associated with the applicant's practice and professional activities;

10. a list and current status of all specialty certifications and the name of certifying organization; and

11. any other information or documentation the Board determines necessary.

B. The applicant should possess the degree of Doctor of Medicine or Doctor of Osteopathic Medicine/Doctor of Osteopathy from a medical college or school located in the United States, its territories or possessions, or Canada that was approved by the Board or by a private nonprofit accrediting body approved by the Board at the time the degree was conferred. No person who graduated from a medical school that was not approved at the time of graduation should be examined for licensure or be licensed in the jurisdiction based on credentials or documentation from that school nor should such a person be licensed by endorsement.

C. Should the applicant graduate from a medical school in a foreign country, other than Canada, the

applicant should meet all the requirements established by the Board to determine the applicant's fitness to practice medicine.

D. The applicant should have satisfactorily completed at least thirty-six (36) months of progressive post-graduate medical training accredited by the Board, the Accreditation Council for Graduate Medical Education (ACGME), or the American Osteopathic Association (AOA).

E. The applicant should have passed the USMLE Steps 1, 2, 3 or COMLEX Levels 1, 2, 3 or a predecessor examination (FLEX, NBME Parts, NBOME Parts) or a combination of these examinations identified as accredited by the Board.

F. The applicant should have demonstrated a familiarity with the statutes and regulations of the jurisdiction relating to the practice of medicine and the appropriate use of controlled or dangerous substances.

G. The applicant should be physically, mentally, and professionally capable of practicing medicine in a manner acceptable to the Board and should be required to submit to a physical, mental, professional competency, or chemical dependency examination(s) or evaluation(s) if deemed necessary by the Board.

H. The applicant should not have been found guilty by a competent authority, United States or foreign, of any conduct that would constitute grounds for disciplinary action under the regulations of the Board or the act. The Board may be authorized, at its discretion, to modify this restriction for cause, but it should be directed to use such discretionary authority in a consistent manner.

I. If the applicant's license is denied or in accordance with Board policy, the applicant should be allowed a personal appearance before the Board or a representative thereof for interview, examination or review of credentials. At the discretion of the Board, the applicant should be required to present his or her original medical education credentials for inspection at the time of personal appearance.

J. The applicant should be held responsible for verifying to the satisfaction of the Board the validity of all credentials required for his or her medical licensure. The Board or its agent should verify medical licensure credentials directly from primary sources, and utilize recognized national physician information services (e.g., the Federation of State Medical Boards' Board Action Data Bank and Credentials Verification Service, the files of the American Medical Association and the American Osteopathic Association, and other national data banks and information resources.)

K. The applicant should have paid all fees and have completed and attested to the accuracy of all application and information forms required by the Board before the Board's verification process begins. The Board should require the applicant to authorize the Board to investigate and/or verify any information provided to it on the licensure application.

L. Applicants should have satisfactorily passed a criminal background check.

Section VI: Graduates of Foreign Medical Schools

The medical practice act should provide minimum requirements, in addition to those otherwise established, for full licensure of applicants who are graduates of schools located outside the United States, its territories or possessions, or Canada. These provisions of the act should implement or be consistent with the following:

A. Such applicants should possess the degree of Doctor of Medicine, Bachelor of Medicine, or a Board-approved equivalent based on satisfactory completion of educational programs acceptable to the Board.
B. Such applicants should be eligible by virtue of their medical education, training, and examination for unrestricted licensure or authorization to practice medicine in the country in which they received that education and training.

C. Such applicants should have passed an examination acceptable to the Board that adequately assesses the applicants' medical knowledge.

D. Such applicants should be certified by the Educational Commission for Foreign Medical Graduates or its Board-approved successor(s), or by an equivalent Board-approved entity.

E. Such applicants should have a demonstrated command of the English language satisfactory to the Board.

F. Such applicants should have satisfactorily completed at least thirty-six (36) months of progressive post-graduate medical training accredited by the Board, the Accreditation Council for Graduate Medical Education (ACGME), or the American Osteopathic Association (AOA).

G. All credentials, diplomas, and other required documentation in a foreign language submitted to the Board by or on behalf of such applicants should be accompanied by certified English translations acceptable to the Board.

H. Such applicants should have satisfied all of the applicable requirements of the United States Immigration and Naturalization Service.

Section VII: Licensure by Endorsement, Expedited Licensure by Endorsement, and Temporary and Special Licensure

The medical practice act should provide for licensure by endorsement, expedited licensure by endorsement, and in certain clearly defined cases, for temporary and special licensure. These provisions of the act should implement or be consistent with the following:

A. Endorsement for Licensed Applicants:
The Board should be authorized, at its discretion, to issue a license by endorsement to an applicant who:

1. has complied with all current medical licensing requirements save that for examination administered by the Board;

2. has passed a medical licensing examination given in English by another state, the District of Columbia, or a territory or possession of the United States or Canada, provided the Board determines that examination was equivalent to its own current examination, or an independent testing agent designated by the Board; and

3. has a valid current medical license in another state, the District of Columbia, or a territory or possession of the United States or Canada.

B. Expedited Licensure by Endorsement:
The Board should be authorized, at its discretion, to issue an expedited license by endorsement to an applicant who provides documentation of:

1. identity as required by the Board;

2. all jurisdictions in which the applicant holds a full and unrestricted license;

3. graduation from an approved medical school;

a. Liaison Committee on Medical Education (LCME) or American Osteopathic Association (AOA) approved medical school;

b. Fifth Pathway certificate; or

c. Educational Commission for Foreign Medical Graduates (ECFMG) certificate

4. passing one or more of the following examinations acceptable for initial licensure within three attempts per step/level;

a. United States Medical Licensing Examination (USMLE) Steps 1-3 or its predecessor examinations (National Board of Medical Examiners (NBME) I-III or the Federation Licensing Examination (FLEX).

b. Examinations offered by the National Board of Osteopathic Medical Examiners (COMLEX-USA) Levels 1-3 or its predecessor examination(s).

c. Medical Council of Canada Qualifying Examinations (MCCQE) or its predecessor examination(s) offered by the Licentiate Medical Council of Canada.

5. successful completion of the total examination sequence within seven (7) years, except when in combination with a Ph.D. program;

6. successful completion of three (3) years of progressive postgraduate training in a program accredited by the Accreditation Council on Graduate Medical Education (ACGME) or the AOA; and/or

7. certification or recertification by a medical specialty board recognized by the American Board of Medical Specialties (ABMS) or the AOA within the previous ten (10) years. Lifetime certificate holders who have not passed a written specialty recertification examination must demonstrate successful completion of the Special Purpose Examination (SPEX), Comprehensive Osteopathic Medical Variable Purpose Examination (COMVEX) or applicable recertification examination.

Boards should obtain supplemental documentation including, but not limited to:

1. Criminal background check;

2. Absence of current/pending investigations in any jurisdiction where licensed;

3. Verification of specialty board certification; and

4. Professional experience.

Physicians desiring an expedited process for licensure must utilize the Federation Credentials Verification Service (FCVS), or credentials verification meeting equivalent standards for verification of core credentials, including:

1. medical school diploma,

2. medical school transcript,

3. dean's certificate,

4. examination history,

5. disciplinary history,

6. identity (photograph and certified birth certificate or original passport),

7. ECFMG certificate, if applicable,

8. Fifth Pathway certificate, if applicable, and postgraduate training verification.

C. Temporary Licensure:
The Board should be authorized to establish regulations for issuance of a temporary medical license for the intervals between Board meetings. Such a license should:

1. be granted only to an applicant demonstrably qualified for a full and unrestricted medical license under the requirements set by the medical practice act and the regulations of the Board and

2. automatically terminate within a period specified by the Board.

D. Special Licensure:
The Board should be authorized to issue conditional, restricted, probationary, limited or otherwise circumscribed licenses as it determines necessary. It is to the discretion of the state medical board to set the criteria for issuing special purpose licenses. This provision should include, but not be limited to, the ability to issue a special license for the following purposes:

1. to practice medicine across state lines;

2. to provide medical services to a traveling sports team, coaches and staff for the duration of the sports event;

3. to provide volunteer medical services to under-insured/uninsured patients;

4. to provide medical services to youth camp enrollees, counselors and staff for the duration of the youth camp; and

5. to engage in the limited practice of medicine in an institutional setting by a physician who is licensed in another jurisdiction in the United States.

Section VIII: Limited Licensure for Physicians in Postgraduate Training

The medical practice act should provide that all physicians in all postgraduate training in the state or jurisdiction who are not otherwise fully licensed to practice medicine should be licensed on a limited basis for educational purposes. These provisions of the act should implement or be consistent with the following:

A. To be eligible for limited licensure, the applicant should have completed all the requirements for full and unrestricted medical licensure except postgraduate training or specific examination requirements.

B. Issuance of a limited license specifically for postgraduate training shall occur only after the applicant demonstrates that he or she is accepted in a residency program. The application for limited licensure should be made directly to the Board in the jurisdiction where the applicant's postgraduate training is to take place.

C. The Board should establish by regulation restrictions for the limited license to assure that the holder will practice only under appropriate supervision and within the confines of the program within which the resident is enrolled.

D. The limited license should be renewable annually and upon the written recommendation of the supervising institution, including a written evaluation of performance, until the Board regulations require the achievement of full and unrestricted medical licensure.

E. Program directors responsible for postgraduate training should be required annually to provide the Board a written report on the status of program participants having a limited license.

1. The report should inform the Board about program participants who have successfully completed the program, have departed from the program, have had unusual absences from the program, or have had problematic occurrences during the course of the program.

2. The report should include an explanation of any disciplinary action taken against a limited licensee for performance or behavioral reasons which, in the judgment of the program director, could be a threat to public health, safety, and welfare; unapproved or unexplained absences from the program; resignations from the program or nonrenewal of the program contract; dismissals from the program for performance or behavioral reasons; and referrals to substance abuse pro-grams not approved by the Board.

3. Failure to submit the annual program director's report shall be considered a violation of the mandatory reporting provisions of the medical practice act and shall be grounds to initiate such disciplinary action as the Board deems appropriate, including fines levied against the supervising institution and suspension of the program director's medical license.

F. The disciplinary provisions of the medical practice act should apply to the holders of the limited and postgraduate training license as if they held full and unrestricted medical licensure.

G. The issuance of a limited license should not be construed to imply that a full and unrestricted medical license would be issued at any future date.

Section IX: Disciplinary Action Against Licensees

The medical practice act should provide for disciplinary and/or remedial action against licensees and the grounds on which such action may be taken. These provisions of the act should implement or be consistent with the following:

A. Range of Actions: A range of progressive disciplinary and remedial actions should be made available to the Board. These should include, but not be limited to, the following:

1. revocation of the medical license;

2. suspension of the medical license;

3. probation;

4. stipulations, limitations, restrictions, probation, and conditions relating to practice;

5. censure (including specific redress, if appropriate);

6. reprimand;

7. chastisement, letters of concern, and advisory letters;

8. monetary redress to another party;

9. a period of free public or charity service, either medical or non-medical;

10. satisfactory completion of an educational, training and/or treatment program(s), or professional developmental plan;

11. levy fine; and

12. payment of administrative and disciplinary costs.

The Board should be authorized, at its discretion, to take disciplinary, non-disciplinary, public or non-public actions, singly or in combination, as the nature of the violation requires and to promote public protection.

B. Letter of Concern or Advisory Letter: The Board should be authorized to issue a confidential (if allowed by state law), non-reportable, non-disciplinary letter of concern, or advisory letter to a licensee when evidence does not warrant formal discipline, but the Board has noted indications of possible errant conduct by the licensee that could lead to serious consequences and formal action if the conduct were to continue. In its letter of concern or advisory letter, the Board should also be authorized,

at its discretion, to request clarifying information from the licensee.

C. Examination/Evaluation: The Board should be authorized, at its discretion, to require profes-sional competency, physical, mental, or chemical dependency examination(s) or evaluation(s) of any applicant or licensee, including withdrawal and laboratory examination of bodily fluids, tissues, hair, or nails.

D. Grounds for Action: The Board should be authorized to take disciplinary action for unprofes-sional or dishonorable conduct, which should be defined to mean, but not be limited to, the following:

1. fraud or misrepresentation in applying for or procuring a medical license or in connection with applying for or procuring periodic renewal of a medical license;

2. cheating on or attempting to subvert the medical licensing examination(s);

3. the commission or conviction or the entry of a guilty, nolo contendere plea, or deferred adjudication (without expungement) of:

a. misdemeanor whether or not related to the practice of medicine and any crime involving moral turpitude;

b. or a felony, whether or not related to the practice of medicine. The Board shall revoke a licensee's license following conviction of a felony, unless a 2/3 majority vote of the board members present and voting determined by clear and convincing evidence that such licensee will not pose a threat to the public in such person's capacity as a licensee and that such person has been sufficiently rehabilitated to warrant the public trust;

4. conduct likely to deceive, defraud, or harm the public;

5. disruptive behavior and/or interaction with physicians, hospital personnel, patients, fam-ily members, or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient;

6. making a false or misleading statement regarding his or her skill or the efficacy or value of the medicine, treatment, or remedy prescribed by him or her or at his or her direction in the treatment of any disease or other condition of the body or mind;

7. representing to a patient that an incurable condition, sickness, disease, or injury can be cured;

8. willfully or negligently violating the confidentiality between physician and patient except as required by law;

9. professional incompetency as one or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes negligence, as determined by the board;

10. being found mentally incompetent or of unsound mind by any court of competent jurisdiction;

11. being physically or mentally unable to engage in the practice of medicine with reasonable skill and safety;

12. practice or other behavior that demonstrates an incapacity or incompetence to practice medicine;

13. the use of any false, fraudulent, or deceptive statement in any document connected with the practice of medicine;

14. giving false, fraudulent, or deceptive testimony while serving as an expert witness;

15. practicing medicine under a false or assumed name;

16. aiding or abetting the practice of medicine by an unlicensed, incompetent or impaired person;

17. allowing another person or organization to use his or her license to practice medicine;

18. commission of any act of sexual misconduct, including sexual contact with patient surrogates or key third parties, which exploits the physician-patient relationship in a sexual way;

19. habitual or excessive use or abuse of drugs, alcohol, marijuana or other substances that impair ability;

20. failing or refusing to submit to an examination or any other examination that may detect the presence of alcohol or drugs upon Board order or any other form of impairment;

21. prescribing, selling, administering, distributing, diverting, ordering or giving any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug for other than medically accepted therapeutic purposes;

22. knowingly prescribing, selling, administering, distributing, ordering, or giving to a habitual user or addict or any person previously drug dependent, any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug, except as otherwise permitted by law or in compliance with rules, regulations, or guidelines for use of controlled substances and the management of pain as promulgated by the Board;

23. prescribing, selling, administering, distributing, ordering, or giving any drug legally classified as a controlled substance or recognized as an addictive drug to a family member or to himself or herself;

24. violating any state or federal law or regulation relating to controlled substances;

25. signing a blank, undated, or predated prescription form;

26. obtaining any fee by fraud, deceit, or misrepresentation;

27. employing abusive, illegal, deceptive, or fraudulent billing practices;

28. directly or indirectly giving or receiving any fee, commission, rebate, or other compensation for professional services not actually and personally rendered, though this prohibition should not preclude the legal functioning of lawful professional partnerships, corporations, or associations;

29. disciplinary action of another state or federal jurisdiction against a license or other authorization to practice medicine or participate in a federal program (payment or treatment) based upon acts or conduct by the licensee similar to acts or conduct that would constitute grounds for action as defined in this section, a certified copy of the record of the action taken by the other state or jurisdiction being conclusive evidence thereof;

30. failure to report to the Board any adverse action taken against oneself by another licensing jurisdiction (United States or foreign), by any peer review body, by any health care institution, by any professional or medical society or association, by any governmental agency, by any law enforcement agency, or by any court for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;

31. failure to report or cause a report to be made to the Board any physician upon whom a physician has evidence or information that appears to show that the physician is incompetent, guilty of negligence, guilty of a violation of this act, engaging in inappropriate relationships with patients, is mentally or physically unable to practice safely, or has an alcohol or drug abuse problem;

32. failure of physician who is the chief executive officer, medical officer, or medical staff to report to the Board any adverse action taken by a health care institution or peer review body, in addition to the reporting requirement in 31. (note: a report under 31 may need to wait until the peer review and due process procedures are completed, but the report under 30 must be reported immediately without waiting for the final action of the health care institution and applies to all physicians not just staff physicians);

33. failure to report to the Board surrender of a license limitation or other authorization to practice medicine in another state or jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society has surrendered the authority to utilize controlled substances issued by any state or federal agency, or has agreed to a limitation to or restriction of privileges at any medical care facility while under investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;

34. any adverse judgment, award, or settlement against the licensee resulting from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;

35. failure to report to the Board any adverse judgment, settlement, or award arising from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;

36. failure to provide pertinent and necessary medical records to another physician or patient in a

timely fashion when legally requested to do so by the subject patient or by a legally designated representative of the subject patient regardless of whether the patient owes a fee for services;

37. improper management of medical records, including failure to maintain timely, legible, accurate, and complete medical records and to comply with the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Part 160 and 164, of the Health Insurance Portability and Accountability Act of 1996.

38. failure to furnish the Board, its investigators, or representatives information legally requested by the Board or failure to comply with a Board subpoena or order;

39. failure to cooperate with a lawful investigation conducted by the Board;

40. violation of any provision(s) of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board;

41. engaging in conduct calculated to, or having the effect of, bringing the medical profession into disrepute, including but not limited to, violation of any provision of a national code of ethics acknowledged by the Board;

42. failure to follow generally accepted infection control procedures;

43. failure to comply with any state statute or board regulation regarding a licensee's reporting responsibility for HIV, HVB (hepatitis B virus), seropositive status or any other reportable condition (including child abuse and vulnerable adult abuse) or disease;

44. practicing medicine in another state or jurisdiction without appropriate licensure;

45. conduct which violates patient trust, exploits the physician-patient relationship, or violates professional boundaries;

46. failure to offer appropriate procedures/studies, failure to protest inappropriate managed care denials, failure to provide necessary service, or failure to refer to an appropriate provider within such actions are taken for the sole purpose of positively influencing the physician's or the plan's financial wellbeing;

47. providing treatment or consultation recommendations, including issuing a prescription via electronic or other means, unless the physician has obtained a history and physical evaluation of the patient adequate to establish diagnosis and identify underlying conditions and/or contraindications to the treatment recommended/provided;

48. violating a Board formal order, condition of probation, consent agreement, or stipulation;

49. representing, claiming, or causing the appearance that the physician possesses a particular medical specialty certification by a Board recognized certifying organization (ABMS, AOA) if not true;

50. failing to obtain adequate patient informed consent;

51. using experimental treatments without appropriate patient consent and adhering to all necessary and required guidelines and constraints;

52. any conduct that may be harmful to the patient or the public;

53. failing to divulge to the Board upon legal demand the means, method, procedure, modality, or medicine used in the treatment of an ailment, condition, or disease;

54. conduct likely to deceive, defraud, or harm the public;

55. the use of any false, fraudulent, or deceptive statement in any document connected with the practice of the healing arts including intentional falsifying or fraudulent altering of a patient or medical care facility record;

56. failure to keep written medical records which accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination results, and test results;

57. delegating professional responsibilities to a person when the licensee knows or has reason to know that such person is not qualified by training, experience, or license to perform them;

58. using experimental forms of therapy without proper informed patient consent, without conforming to generally accepted criteria or standard protocols, without keeping detailed legible records, or without having periodic analysis of the study and results reviewed by a committee or peers; and

59. failing to properly supervise, direct, or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation, or practice protocols.

Section X: Procedures for Enforcement and Disciplinary Action

The medical practice act should provide for procedures that will permit the Board to take appropriate enforcement and disciplinary action when and as required, while assuring fairness and due process to licensees. These provisions of the act should implement or be consistent with the following:

A. Board Authority: The Board should be empowered to commence legal action to enforce the provisions of the medical practice act and to exercise full discretion and authority with respect to disciplinary actions. In the course of an investigation, the Board's authority should include the ability to issue subpoenas to licensees, health care organizations, complainants, patients, and witnesses to produce documents or appear before the Board or staff to answer questions or be deposed. The Board should have the power to enforce its subpoenas, including disciplining a non-compliant licensee, and it is incumbent upon the subpoenaed party to seek a motion to quash the subpoena.

B. Administrative Procedures: The existing administrative procedures act or similar statute, in whole or in part, should either be applicable to or serve as the basis of the procedural provi-

sions of the medical practice act. The procedural provisions should provide for Board investigation of complaints; notice of formal or informal charges or allegations to the licensee; a fair and impartial hearing for the licensee before the Board, an examining committee or hearing officer; an opportunity for representation of the licensee by counsel; the presentation of testimony, evidence and arguments; subpoena power and attendance of witnesses; a record of the proceedings; and judicial review by the courts in accordance with the standards established by the jurisdiction for such review. The Board should have subpoena authority to conduct comprehensive reviews of a licensee's patient and office records and administrative authority to access otherwise protected peer review records. The Board should not need the patients' consent to obtain copies of medical records, nor shall health care institutions' peer-review privilege bar the Board from obtaining copies of peer review information. Once in the Board's possession, the patient records and peer review records should have the same legal protection from disclosure as they have when in the possession of the licensee, the patient or the peer-review organization.

C. Standard of Proof: The Board should be authorized to use preponderance of the evidence as the standard of proof in its role as trier of fact for all levels of discipline.

D. Informal Conference: Should there be an open meeting law, an exemption to it should be authorized to permit the Board, at its discretion, to meet in informal conference with a licensee who seeks or agrees to such a conference. Disciplinary action taken against a licensee because of such an informal conference and agreed to in writing by the Board and the licensee should be binding and a matter of public record. However, license revocation and suspension should be held in open formal hearing, unless executive session is permitted by the State's open meetings law. The holding of an informal conference should not preclude an open formal hearing if the Board determines such is necessary.

E. Summary Suspension: The Board should be authorized to summarily suspend or restrict a license prior to a formal hearing when it believes such action is required to protect the public from an imminent threat to public health and safety. The Board should be permitted to summarily suspend or restrict a license by means of a vote conducted by telephone conference call or other electronic means if appropriate Board officials believe such prompt action is required. Proceedings for a formal hearing should be instituted simultaneously with the summary suspension. The hearing should be set within a reasonable time of the date of the summary suspension. No court should be empowered to lift or otherwise interfere with such suspension while the Board proceeds in a timely fashion.

F. Cease and Desist Orders/Injunctions: The Board should be authorized to issue a cease-and-desist order and/or obtain an injunction to restrain any person or any corporation or association and its officers and directors from violating any provision of the medical practice act. Violation of an injunction should be punishable as contempt of court. No proof of actual damage to any person should be required for issuance of a cease-and-desist order and/or an injunction, nor should issuance of an injunction relieve those enjoined from criminal prosecution, civil action, or administrative process for violation of the medical practice act.

G. Board Action Reports: All the Board's final disciplinary actions, non-administrative license withdrawals, and license denials, including related findings of fact and conclusions of law, should be matters of public record. The Board should report such actions and denials to the Board Action Data Bank of the Federation of State Medical Boards of the United States within 30 days of the action being taken, to any other data repository required by law, and to the media. Voluntary surrender of

and voluntary limitation(s) on the medical license of any person should also be matters of public record and should also be reported to the Federation of State Medical Boards of the United States and to any other data repository by law. The Board should have the authority to keep confidential practice limitations and restrictions due to physical impairment when the licensee has not violated any provision in the medical practice act.

H. Tolling Periods of License Suspension or Restriction: The Board should provide, in cases of license suspension or restriction, that any time during which the disciplined licensee practices in another jurisdiction without comparable restriction shall not be credited as part of the period of suspension or restriction.

I. The Board should have the authority, at its discretion, to share investigative and adjudicatory files with other state and territorial medical boards at any time during the investigational or adjudicative process.

Section XI: Impaired Physicians

The medical practice act should provide for the limitation, restriction, conditioning, suspension or revocation of the medical license of any licensee whose mental or physical ability to practice medicine with reasonable skill and safety is impaired.

The Board should have available to it a confidential impaired physician program approved by the Board and charged with the evaluation and treatment of licensees who are in need of rehabilitation. The Board may directly provide such programs or through a formalized contractual relationship with an independent entity whose program meets standards set by the Board. The Board shall have the ability to monitor or audit the program to ensure the program meets the requirements of the Board.

The Board should be authorized, at its discretion, to require a licensee or applicant to submit to a mental or physical examination, body fluid, nail, or hair follicle test, or a chemical addiction, abuse, or dependency evaluation conducted by an independent evaluator designated or approved in advance by the Board. The results of the examination or evaluation should be admissible in any hearing before the Board or hearing officer, despite any claim of privilege under a contrary rule or statute. Every person who receives a license to practice medicine or who files an application for a license to practice medicine should be deemed to have given consent to submit to mental or physical examination or a chemical addition, abuse, or dependency evaluation, and to have waived all objections to the admissibility of the results in any hearing before the Board. If a licensee or applicant fails to submit to an examination or evaluation when properly directed to do so by the Board, the Board should be permitted to enter a final order upon proper notice, hearing, and proof of refusal.

If the Board finds, after an evaluation, examination or hearing, that a licensee is mentally, physically, or chemically impaired, it should be authorized to take one or more of the following actions:

A. direct the licensee to submit to therapy, medical care, counseling, or treatment acceptable to the Board and comply with monitoring to ensure compliance;

B. suspend, limit, restrict, or place conditions on the licensee's medical license for the duration of the impairment and monitoring or treatment; and/or

C. revoke the licensee's medical license.

Any licensee or applicant who is prohibited from practicing medicine under this provision should be afforded at reasonable intervals an opportunity to demonstrate to the satisfaction of the Board that he or she can resume or begin the practice of medicine with reasonable skill and safety. A license should not be reinstated, however, without the payment of all applicable fees and the fulfillment of all requirements as if the applicant had not been prohibited from practicing medicine.

While all impaired licensees should be reported to the Board in accord with the mandatory reporting requirements of the medical practice act, unidentified and unreported impaired licensees should be encouraged to seek treatment. To this end, the Board should be authorized, at its discretion, to establish rules and regulations for the review and approval of a medically directed Physician Health Program (PHP). Those conducting a Board-approved PHP should be exempt from the mandatory reporting requirements relating to an impaired licensee who is participating satisfactorily in the program, or the Board should hold its report in confidence and without action, unless or until the impaired licensee ceases to participate satisfactorily in the program. The Board should require a PHP to report any impaired licensee whose participation is unsatisfactory to the Board as soon as that determination is made. Participation in an approved PHP should not protect an impaired licensee from Board action resulting from a report of his or her impairment from another source. The Board should be the final authority for approval of a PHP, should conduct a review of its approved program(s) on a regular basis and should be permitted to withdraw or deny its approval at its discretion. The PHP should be required to report to the Board information regarding any violation of the medical practice act by a PHP participant, other than the impairment, even if the violation is unrelated to the licensee's impairment.

Section XII: Dyscompetent and Incompetent Licensees

The medical practice act should provide for the restriction, conditioning, suspension, revocation, or denial of the medical license of any licensee who the Board determines to be dyscompetent or incompetent. These provisions of the act should implement or be consistent with the following:

A. The Board should be authorized to develop and implement methods to identify dyscompetent or incompetent licensees and licensees who fail to provide the appropriate quality of care. The Board should also be authorized to develop and implement methods to assess and improve licensee practices.

B. The Board should have access to a Board-approved assessment program charged with assessing licensees' clinical competency.

C. The Board should be authorized, at its discretion, to require a licensee or an applicant for licensure to undergo a physician competency evaluation conducted by a Board-designated independent evaluator at licensee's own expense. The results of the assessment should be admissible in any hearing before the Board or hearing officer, despite any claim of privilege under a contrary rule or statute. Every person who receives a license to practice medicine or who files an application for a license to practice medicine should be deemed to have given consent to submit to a physician competency evaluation, and to have waived all objections to the admissibility of the results in any hearing before the Board or hearing officer. If a licensee or applicant fails to submit to a competency assessment when properly directed to do so by the Board, the Board should be permitted to enter a final order upon proper notice, hearing, and proof of refusal to submit to such an evaluation.

D. If the Board finds, after evaluation by the assessment program, that a licensee or applicant for

licensure is unable to competently practice medicine, it should be authorized to take one or more of the following actions:

1. suspend, revoke, or deny the licensee's medical license or application;
2. restrict or limit the licensee's practice to those areas of demonstrated competence and comply with monitoring to ensure compliance;

3. place conditions on the licensee's license; and/or

4. direct the licensee to submit to a Board approved remediation program and comply with monitoring to ensure compliance to resolve any identified deficits in medical knowledge or clinical skills acceptable to the Board.

E. Any licensee or applicant for licensure who is prohibited from practicing medicine, or who has had restrictions or conditions placed upon his license, under Subsection D of this section should be afforded, at reasonable intervals, an opportunity to demonstrate to the satisfaction of the Board that he or she can resume or begin the practice of medicine, or can practice without the restrictions or conditions, with reasonable skill and safety. A license should not be reinstated, however, without the payment of all applicable fees and the fulfillment of all requirements as if the applicant had not been previously prohibited.

F. The Board should be authorized to require the assessment program to provide to the Board a written report of the results of the assessment with recommendations for remediation of the identified deficiencies.

G. The Board should have access to Board approved remedial medical education programs for referral of licensees in need of remediation. Such programs shall incorporate and comply with standards set by the Board. During remediation, the program shall provide, at Board determined intervals, written reports to the Board on the licensee's progress. Upon completion of the remediation program, the program shall provide a written report to the Board addressing the remediation of the previously identified areas of deficiency. The Board should be authorized to mandate that the licensee undergo post-remediation assessment to identify areas of continued deficit. The licensee shall be responsible for all expenses incurred as part of the assessment and the remediation.

Section XIII: Compulsory Reporting and Investigation

The medical practice act should provide that certain persons and entities report to the Board any possible violation of the act or of the Board's rules and regulations by a licensee. These provisions of the act should implement or be consistent with the following:

A. Any person should be permitted to report to the Board in a manner prescribed by the Board, any information he or she believes indicates a medical licensee is or may be dyscompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine.

B. The following should be required to report to the Board promptly and in writing any information that indicates a licensee is or may be dyscompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine; and any restriction,

limitation, loss or denial of a licensees staff privileges or membership that involves patient care:

1. all licensees licensed under the act,

2. all licensed health care providers,

3. the state medical associations and its components,

4. all hospitals and other health care organizations in the state, to include hospitals, medical centers, long term care facilities, managed care organizations, ambulatory surgery centers, clinics, group practices, coroners, etc.,

5. all chiefs of staff, medical directors, department administrators, service directors, attending physicians, residency directors, etc.,

6. all liability insurance organizations,

7. all local medical/osteopathic societies,

8. all local professional societies,

9. all state agencies,

10. all law enforcement agencies in the state,

11. all courts in the state,

12. all federal agencies (e.g., DEA, FDA, and CMS),

13. all peer review bodies in the state, and

14. resident training program directors.

C. A licensee's voluntary resignation from the staff of a health care organization or voluntary limitation of his or her staff privileges at such an organization should be promptly reported to the Board by the organization if that action occurs while the licensee is under formal or informal investigation by the organization or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct, or mental, physical, alcohol or drug impairment.

D. Malpractice insurance carriers, the licensee's attorney, a hospital, a group practice, and the affected licensees should be required to file with the Board a report of each final judgment, settlement, arbitration award, or any form of payment by the licensee or on the licensee's behalf by any source upon any demand, claim, or case alleging medical malpractice, battery, dyscompetence, incompetence, or failure of informed consent. Licensees not covered by malpractice insurance carriers should be required to file the same information with the Board regarding themselves. All such reports should be made to the Board promptly (e.g., within 30 days).

E. The Board should be permitted to investigate any evidence that appears to show a licensee is or

may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine.

F. Any person, institution, agency, or organization who reports in good faith and not made in bad faith, a licensee pursuant to subsections (A) or (B) of this section should not be subject to civil damages or criminal prosecution for so reporting. A bad faith report is grounds for disciplinary action under the medical practice act. There should be no monetary liability on the part of, and no cause of action for damages should arise against, any person, institution, agency, or organization for reporting in good faith.

G. To assure compliance with compulsory reporting requirements, specific civil penalties should be established for demonstrated failure to report (e.g., up to $10,000 per instance).

H. The Board should promptly acknowledge all reports received under this section. The Board should promptly notify persons or entities reporting under this section of the Board's final disposition of the matters reported.

Section XIV: Protected Action and Communication

The medical practice act should provide legal protection for the members of the Board and its staff and for those providing information to the Board in good faith. These provisions of the act should implement or be consistent with the following:

A. Qualified Immunity

1. There shall be no liability on the part of, and no action for damages against, any member of the board, its agents, its employees, or any member of an examining committee of physicians appointed or designated by the board, for any action undertaken or performed by such person within the scope of the duties, powers, and functions of the board or such examining committee as provided for in this Part when such person is acting in good faith and in the reasonable belief that the action taken by him is warranted.

2. No person, committee, association, organization, firm, or corporation providing information to the board in good faith and in the reasonable belief that such information is accurate and, whether as a witness or otherwise, shall be held, by reason of having provided such information, to be liable in damages under the law of the state or any political subdivision thereof.

3. In any suit brought against the board, its employees or agents, any member of an examining committee appointed by the board or any person, firm, or other entity providing information to the board, when any such defendant substantially prevails in such suit, the court shall, at the conclusion of the action, award to any such substantially prevailing party defendant against any such claimant the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the claim was frivolous, unreasonable, without foundation, or in bad faith. For the purposes of this Section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.

4. There shall be no liability on the part of and no action for damages against any corporation, foundation, or organization that enters into any agreement with the board related to

the operation of any committee or program to identify, investigate, counsel, monitor, or assist any licensed physician who suffers or may suffer from alcohol or substance abuse or a physical or mental condition which could compromise such physician's fitness and ability to practice medicine with reasonable skill and safety to patients, for any investigation, action, report, recommendation, decision, or opinion undertaken, performed, or made in connection with or on behalf of such committee or program, in good faith, and in the reasonable belief that such investigation, action, report, recommendation, decision, or opinion was warranted.

5. There shall be no liability on the part of and no action for damages against any person who serves as a director, trustee, officer, employee, consultant, or attorney for or who otherwise works for or is associated with any corporation, foundation, or organization that enters into any agreement with the board related to the operation of any committee or program to identify, investigate, counsel, monitor, or assist any licensed physician who suffers or may suffer from alcohol or substance abuse or a physical or mental condition which could compromise such physician's fitness and ability to practice medicine with reasonable skill and safety to patients, for any investigation, action, report, recommendation, decision, or opinion undertaken, performed, or made in connection with or on behalf of such committee or program, in good faith and in the reasonable belief that such investigation, action, report, recommendation, decision, or opinion was warranted.

6. In any suit brought against any corporation, foundation, organization, or person described in Subsection 4 or 5 of this Section, when any such defendant substantially prevails in the suit, the court shall, at the conclusion of the action, award to any substantially prevailing party defendant against any claimant the cost of the suit attributable to such claim, including reasonable attorney fees, if the claim was frivolous or brought without a reasonable good faith basis. For purposes of this Subsection, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains a judgment for damages, permanent injunction, or declaratory relief.

B. Indemnity and Defense

The state should defend a current or former member, officer, administrator, staff member, committee member, examiner, representative, agent, employee, consultant, witness, contractor, or any other person serving or having served the Board against any claim or action arising out of the act, omission, proceeding, conduct, or decision related to his or her duties undertaken or performed in good faith and within the scope of the function of the Board. The State should provide and pay for such defense and should pay any resulting judgment, compromise or settlement.

C. Protected Communication

1. Every communication made by or on behalf of any person, institution, agency,or organization to the Board or to any person(s) designated by the Board relating to an investigation or the initiation of an investigation, whether by way of report, complaint or statement, should be privileged. No action or proceeding, civil or criminal, should be permitted against any person, institution, agency or organization that made such a communication in good faith.

2. The protections afforded in this provision should not be construed as prohibiting a respondent or his or her legal counsel from exercising the respondent's constitutional right of due process under the law.

Section XV: Unlawful Practice of Medicine: Violations and Penalties

The medical practice act should provide a definition of the unlawful practice of medicine and penalties for such unlawful practice. These provisions of the act should implement or be consistent with the following:

A. It should be unlawful for any person, corporation, or association to perform any act constituting the practice of medicine as defined in the medical practice act without first obtaining a medical license in accord with that act and the rules and regulations of the Board. Other licensed health care professionals may provide medical services within the scope of their authorizing license.

B. The Board should be authorized to issue a cease-and-desist order and/or obtain injunctive relief against the unlawful practice of medicine by any person, corporation, or association.

C. It should be a felony crime for any person, corporation, or association that performs any act constituting the practice of medicine as defined in the medical practice act, or causing or aiding and abetting such actions.

D. A physician located in another state practicing within the state by electronic or other means without a license (full, special purpose or otherwise) issued by the Board should be deemed guilty of a felonious offense.

Section XVI: Periodic Renewal

The medical practice act should provide for the periodic renewal of medical licenses to permit the Board to review the qualifications of licensees on a regular basis. These provisions of the act should implement or be consistent with the following:

A. At the time of periodic renewal, the Board should require the licensee to demonstrate to its satisfaction his or her continuing qualification for medical licensure. The Board should design the application for licensure renewal to require the licensee to update and/or add to the information in the Board's file relating to the licensee and his or her professional activity. It should also require the licensee to report to the Board the following information:

1. Any action taken for acts or conduct similar to acts or conduct described in the medical practice act as grounds for disciplinary action against a licensee by:

a. any jurisdiction or authority (United States or foreign) that licenses or authorizes the practice of medicine or participation in a payment or practice program;

b. any peer review body;

c. any specialty certification board;

d. any health care organization;

e. any professional medical society or association;

f. any law enforcement agency;

g. any health insurance company;

h. any malpractice insurance company;

i. any court; and

j. any governmental agency.

2. Any adverse judgment, settlement, or award against the licensee or payment by or on behalf of the licensee arising from a professional liability demand, claim, or case.

3. The licensee's voluntary surrender of or voluntary limitation on any license or authorization to practice medicine in any jurisdiction, including military, public health, and foreign.

4. Any denial to the licensee of a license or authorization to practice medicine by any jurisdiction, including military, public health, and foreign.

5. The licensee's voluntary resignation from the medical staff of any health care organization or voluntary limitation of his or her staff privileges at such an organization if that action occurred while the licensee was under formal or informal investigation by the organization or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct, or mental, physical, alcohol, or drug impairment.

6. The licensee's voluntary resignation or withdrawal from a national, state, or county medical society, association, or organization if that action occurred while the licensee was under formal or informal investigation or review by that body for any reason related to possible medical incompetence, unprofessional conduct, mental, physical, alcohol, or drug impairment.

7. Whether the licensee has abused or has been addicted to or treated for addiction to alcohol or any chemical substance.

8. Whether the licensee has had any physical injury, impairment, condition, disease, or mental or psychological illness that adversely affected or interrupted his or her practice of medicine.

9. The licensee's completion of continuing medical education or other forms of professional maintenance and/or evaluation, including specialty board certification or recertification, within the renewal period.

B. The Board should be authorized, at its discretion, to require continuing medical education for license renewal and to require documentation of that education. The Board should have the authority to audit, randomly or specifically, licensees for compliance.

C. The Board should require the licensee to apply for license renewal in a manner prescribed by the board and attest to the accuracy and truthfulness of the information submitted.

D. The Board should be directed to establish an effective system for reviewing renewal forms. It should also be authorized to initiate investigations and/or disciplinary proceedings based on information submitted by licensees for license renewal.

E. Failure to report fully and correctly should be grounds for disciplinary action by the Board.

Section XVII: Physician Assistants

The medical practice act should provide for the Board to license and regulate physician assistants. These provisions of the act should implement or be consistent with the following:

A. Administration: The Board should administer and enforce these provisions of the medical practice act with the advice and assistance of the Physician Assistant Council.

B. Physician Assistant Licensing

1. No person should perform or attempt to practice as a physician assistant without first obtaining a license from the Board and having a supervising physician.

2. An applicant for licensure as a physician assistant should complete all Board application forms and pay a nonrefundable fee. The forms should request the applicant provide their name and address and such additional information as the Board deems necessary. The Board may issue a license to a physician assistant applicant who fulfills all board requirements for licensure. However, a licensed physician assistant is prohibited from practicing until they have an agreement with a supervising physician(s).

3. Each licensed physician assistant should renew their license and file updated documentation stating their name and current address and any additional information as required by the Board. A fee set by the Board should accompany each renewal and filing of updated documentation.

4. The Board may require written notification by the supervising physician and the physician assistant if the relationship is changed or severed for a reason that would have an adverse effect for patient care.

5. Persons not licensed by the Board who hold themselves out as physician assistants should be subject to penalties applicable to the unlicensed practice of medicine.

C. Rules and Regulations: The Board should be empowered to adopt and enforce rules and regulations for:

1. setting qualifications of education, skill, and experience for the licensing of a person as a physician assistant and providing forms and procedures for licensure and for renewal; and

2. evaluating applicants for licensure as physician assistants.

D. Disciplinary Actions: The Board should be empowered to deny, revoke, or suspend any license, to limit or restrict the location of practice, to issue reprimands, to remove the authorization of a supervising physician, and to limit or restrict the practice of a physician assistant upon grounds and according to procedures similar to those for such disciplinary actions against licensed physicians. Such actions should be reported to the Federation of State Medical Boards.

E. Duties and Scope of Practice: A physician assistant should be permitted to provide those medical services delegated to them by the supervising physician that are within their training and experience.

F. Responsibility of Supervising Physician: Every physician supervising or employing a physician assistant should be legally responsible for the delegation of health care tasks, the performance and the acts and omissions of the physician assistant. Nothing in these provisions, however, should be construed to relieve the physician assistant of any responsibility for any of their own acts and omissions. No physician should have under their supervision more staff, physician assistant, or otherwise than the physician can adequately supervise. In the event the supervising physician is absent, he or she must provide for appropriate supervision of the physician assistant by another licensed physician. Each and every relationship should adhere to all statutory requirements for licensure.

G. The Board should be authorized, at its discretion, to require evidence of satisfactory completion of continuing medical education for license renewal.

Section XVIII: Rules and Regulations

The medical practice act should authorize the Board to promulgate rules and regulations to facilitate the enforcement of the act. These provisions of the act should implement or be consistent with the following:

A. The Board should be authorized to adopt and enforce rules and regulations to carry out the provisions of the medical practice act and to fulfill its duties under the act.

B. The Board should adopt rules and regulations in accord with administrative procedures established in the jurisdiction.

Section XIX: Funding and Fees

The medical practice act should provide that Board fees be adequate to fund the Board's effective regulation of the practice of medicine under the act and that those fees paid by licensees be used only for purposes related to licensee licensure, discipline, and Board administration. These provisions of the act should implement or be consistent with the following:

A. The Board should be fully supported by the revenues generated from its activities, including fees, charges and reimbursed costs, which the Board should deposit in an appropriate account, and the Board should also receive all interest earned on the deposit of such revenues. Such funds should be appropriated continuously. All fines levied by the Board may be deposited in the State General Fund, unless otherwise allowed by law. All administrative, investigative and adjudicatory costs recoupment should be deposited in the Board's account.

B. The Board should develop and adopt its own budget reflecting revenues, including the interest thereon, and costs associated with each health care field regulated. Revenues and interest thereon, from each health care field regulated should fully support Board regulation of that field. The budget should include allocations for establishment and maintenance of a reasonable reserve fund.

C. The Board should be authorized to set fees and charges pursuant to its proposed budget needs. Reasonable notice should be provided for all increases or decreases in fees and charges.

D. The Board should operate on the same fiscal year as the State.

E. A designated officer of the Board or employee, at the direction of the Board, should oversee the collection and disbursement of funds.

F. The State Auditor's Office (or the equivalent State office) should routinely audit the financial records of the Board and report to the Board and the Legislature.

FSMB ADVISORY COUNCIL OF BOARD EXECUTIVES

Kimberly Kirchmeyer
Medical Board of California

Robert C. Knittle, MS
West Virginia Board of Medicine

Mari Robinson, JD
Texas Medical Board

Kathleen Selzler Lippert, JD
Kansas State Board of Healing Arts

EX OFFICIO MEMBERS

Margaret B. Hansen, PA-C
President, Administrators in Medicine

Kevin D. Bohnenblust, JD
Vice President, Administrators in Medicine

Lyle R. Kelsey, MBA
FSMB Board of Directors, Oklahoma Board of Medical Licensure and Supervision

Jacqueline A. Watson, DO, MBA
FSMB Board of Directors
District of Columbia Board of Medicine

STAFF SUPPORT

Lisa A. Robin, MLA
Chief Advocacy Officer, FSMB

Shiri Hickman, JD
State Legislative and Policy Manager, FSMB

© Copyright 2015 by the Federation of State Medical Boards
(817) 868-4000 | www.fsmb.org