



# ***Guidelines for the Structure and Function of a State Medical and Osteopathic Board***

***Adopted by FSMB House of Delegates, April 2024***

## **INTRODUCTION**

As early as 1914, the Federation of State Medical Boards (FSMB), which now represents 70 state and territorial medical and osteopathic licensing and disciplinary boards (hereafter referred to as “state medical board(s)” or “board(s)”), recognized the need for a guidance document supporting U.S. states and territories in their development, and updating as needed, of their medical practice acts, and the corresponding structures and functions of their medical boards.

Following extensive consultation with members and staff of state medical boards, and a review of emerging best practices, the FSMB first issued *A Guide to the Essentials of a Modern Medical Practice Act* in 1956. The stated purposes of this guidance document were:

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.

Over the years, dynamic changes in medical education, in the practice of medicine, and in the diverse responsibilities that face medical boards have necessitated frequent revision of a state or territory’s medical practice act. *The Essentials* underwent numerous revisions to respond to these changes and assist member boards to be consistent with best practices in the interests of public protection and patient safety.

The guidance document adopted in 2018, *Guidelines for the Structure and Function of a State Medical and Osteopathic Board* (“*Structure and Function*”), incorporated the contents of prior *Elements* and *Essentials* documents, containing the principles of state medical board responsibility, duty, empowerment, and accountability that the initial documents outlined, as well as detailing the essential components for the structure and function of a state medical board.

*Structure and Function* was reviewed and updated in 2021 and now again in 2024 to reflect relevant characteristics of effective medical boards, incorporating recently adopted FSMB policies, and best practices and innovative concepts. This guidance document is worthy of consideration for adaptation to the requirements of any state or territorial jurisdiction. Although it could hardly be expected that any one jurisdiction would accept every component of these guidelines, it should lead every jurisdiction to assess its present board structure and function. Does the status quo provide maximum potential for protection of the public interest? Though presented for consideration as an integrated whole, the guidelines offer approaches to a variety of issues that concern many boards, including funding and budgeting,

confidentiality, board authority, personnel and staffing, administration, emergency powers, training of board members, immunity and indemnity, standards of evidence, and the transparency.

Recognizing the differences among jurisdictions, this document is designed with the flexibility to accommodate as many of those differences as possible, while maintaining the integrity of the overall concept. Some sections empower boards to adopt alternatives of their choice, provided they are in accordance with other state statutes, while other sections are phrased loosely to allow boards necessary discretionary authority. These guidelines may thus be seen not as one proposal but as various proposals. Each is applicable in one form or another to a diversity of settings, and all are aimed at increasing or refining the ability of state medical boards to better protect the health, safety, and welfare of the public.

The Federation urges member boards to consider including any recommendations contained herein in their respective medical practice acts, rules, or their own guidance documents.

The following guidelines apply equally to boards that govern physicians who have acquired the M.D. or D.O. degree, and the terms used herein should be interpreted throughout with this understanding.

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## Section I. Definitions

The following terms 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 in one or more areas of professional physician practice.<sup>1</sup>

“Impairment” means the inability of a physician to provide medical care with reasonable skill and safety due to illness or injury.<sup>2</sup>

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

“License” means any license, certificate, or other practice authorization granted by the Board pursuant to the medical practice act, or any other applicable statute.

“Licensee” means the holder of any license, certificate, or other practice authorization granted by the Board.

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

“Medical Practice Act” means the statute that determines the structure and function of a state medical or osteopathic board. Section II below addresses categories to which the medical practice act does not typically apply.

“Physician assistant” means an individual licensed to practice medicine in the jurisdiction in accordance with team based or supervision requirements of the Board. The best practice is a written document outlining the practice arrangement between the supervising or collaborating physician and the physician assistant. Any other title or status adopted to replace the term “physician assistant” shall be deemed synonymous with “physician assistant” and shall confer the same rights and responsibilities.

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<sup>1</sup> FSMB, *Report of the Special Committee on Evaluation of Quality of Care and Maintenance of Competence*. April 1999, available at: <https://www.fsmb.org/siteassets/advocacy/policies/evaluation-of-quality-of-care-and-maintenance-of-competence.pdf>.

<sup>2</sup> FSMB, *Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health*. April 2021, available at: <https://www.fsmb.org/siteassets/advocacy/policies/policy-on-physician-impairment.pdf>.

“Practice of medicine” is consistent with the following:

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 use by 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;
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 the physician's 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.

The definition of the practice of medicine may also include several exceptions, which exempt certain activities from the categorization of the practice of medicine.

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.

“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 or collaborating physician” means a licensed physician in good standing in the same jurisdiction as the physician assistant who may supervise the services of a physician assistant, and/or who has in writing formally accepted the responsibility for such supervision or collaboration.

“Telemedicine” means the practice of medicine using electronic communications, information technology, or other means between a licensee in one location, and a patient in another location, with or without an intervening healthcare provider. Telemedicine is not an e-mail/instant messaging conversation or fax-based interaction. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, in-person encounter between a provider and a patient. Telemedicine may include audio-only communications, but audio-only communications should only be used as a substitute when a patient is

unable or unwilling to access live-interactive modalities or when audio-only interactions are considered the standard of care for the corresponding healthcare service being delivered.<sup>3</sup>

## **Section II. The Medical Practice Act**

The structure and function of each of the 70 medical regulatory boards (allopathic, osteopathic and composite) within the United States and its territories are determined by a unique state statute (or group of statutes), usually referred to as a medical practice act. The differences among these statutes are related to the general administrative structure of each jurisdiction and to the needs of the public as they are perceived by each responsible legislative body.

The medical practice act should provide for a separate state medical board, acting as a full authority governmental agency to regulate the practice of medicine, in order to protect the public from unlawful, incompetent, unqualified, impaired, or unprofessional practitioners of medicine, through licensure, regulation, and rehabilitation of the medical profession in the state.

Generally, the medical practice act should authorize boards to promulgate rules and regulations to facilitate the enforcement of the act. Boards should be authorized to adopt and enforce rules and regulations to carry out the provisions of the medical practice act and to fulfill their duties under the act. Boards should adopt rules and regulations in accordance with administrative procedures established in the respective jurisdiction.

### **Statement of purpose**

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

- The practice of medicine is a privilege granted by the people acting through their elected representatives.
- In the interests of public health, safety, and welfare, and to protect the public from any 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.
- 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.

Sample Statement of Purpose:

*As a matter of public policy, the practice of medicine is a privilege granted by the people of the State acting through their elected representatives by their adoption of the Medical Practice Act. Therefore, in the interests of public health, safety and welfare, and to protect the public from any unprofessional, improper, incompetent, unlawful, fraudulent, and/or deceptive practice of medicine, it is necessary to*

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<sup>3</sup> FSMB, *Appropriate Use of Telemedicine Technologies in the Practice of Medicine*. April 2022, available at: <https://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf>.

*provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine and to ensure, as much as possible, that only qualified and fit persons hold that privilege. The Board's primary responsibility and obligation is to protect the public, and any license, certificate or other practice authorization issued pursuant to this statute shall be a revocable privilege and no holder of such a privilege shall acquire thereby any irrevocable right.*

## **Exemptions**

The medical practice act should 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 or registers 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, the Veterans Administration of the United States, or the Indian Health Service 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, psychology, or any other of the healing arts in accordance 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 accordance with such tenets;
6. Those administering a lawful domestic or family remedy to a member of one's own family;
7. Those fully licensed to practice medicine in another jurisdiction of the United States who temporarily 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. Those fully licensed to practice medicine in another jurisdiction of the United States who is employed or formally designated as the team physician by an athletic team visiting the jurisdiction for a specific sporting event, and the physician limits the practice of medicine in the jurisdiction to medical treatment of the members, coaches, and staff of the sports entity that employs (or has designated) the physician.
9. Exemptions relating to telemedicine:<sup>4</sup>
  - a. Those practitioners who are licensed in an out-of-state jurisdiction who provide a consultation to a peer duly licensed within the jurisdiction of the state medical board, provided the in-state practitioner remains responsible for diagnosing and treating the patient in the state where the patient is located.
  - b. Those practitioners who are licensed in an out-of-state jurisdiction that provide specialty assessments or consultations to a patient in order to screen a patient for acceptance of a

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<sup>4</sup> FSMB, *Appropriate Use of Telemedicine Technologies in the Practice of Medicine*. April 2022, available at: <https://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf>.

referral provided they do not diagnose, counsel, or treat outside of the state where they are licensed.

- c. Those practitioners who are licensed in an out-of-state jurisdiction that provide care to patients with an established relationship that may be temporarily located outside the jurisdiction of the practitioner, provided it is possible for them to gather sufficient clinical information during the evaluation to provide care that meets the accepted standard of care.
- d. Those practitioners who are licensed in an out-of-state jurisdiction that provides patients with follow-up care after traveling for surgical or medical treatment, provided they ensure that the patient has backup plans to receive care locally if changes in their medical condition make that necessary.
- e. Those practitioners who are licensed in an out-of-state jurisdiction that recruit patients for clinical trials, provided they ensure that the patient has backup plans to receive care locally if changes in their medical condition make that necessary.

### **Unlawful Practice of Medicine**

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:

1. It should be unlawful to perform any act constituting the practice of medicine as defined in the medical practice act without first obtaining authorization in accordance with the requirements of the act and the rules and regulations of the Board. Other licensed health care professionals may provide medical services within the scope of the laws governing that profession.
2. The Board should be authorized to seek civil remedies pursuant to state law to address the unlawful practice of medicine.
3. It should be a felony 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.
4. Unless rules governing the practice of medicine are suspended or temporarily modified by an executive order or action of the Board, a physician located in another state practicing within the state by electronic or other means without a license (full, special purpose or authorization) issued by the Board should be deemed guilty of a felonious offense.

### **Section III. State Medical Board Duty, Responsibility, and Power**

In some states, responsibility for licensing and disciplinary functions is divided between two separate Boards. In others, Boards are subject to supervision or, in some cases, complete control by larger administrative or umbrella agencies. In a few states, the Board is simply an advisory body. In most states, the Board regulates both allopathic and osteopathic physicians; in others, separate boards exist. And in some states, narrow constitutional restrictions inhibit effective Board funding. Clearly, the following section proposes a true working board with real and effective power and support, a proposal some states are much better prepared to implement than others. The section also reflects those principles the authors consider to be basic to the operation of any accountable medical board, regardless of the administrative structure of the state, the size or distribution of the physician population being regulated, the form of legislation required for funding, or the title of the body to which responsibility and power for regulation have been entrusted. It may be drawn upon by both allopathic and osteopathic boards, making

appropriate adaptations in the area of Board membership. Larger administrative agencies can use it to better assess their own structures and functions and to explore the broader roles their medical boards might play in meeting public expectations.

It is necessary that boards have the responsibilities and powers necessary to fulfill the duties conferred on the Board by the medical practice act. These duties, responsibilities, and powers are to be liberally construed to protect the health, safety, and welfare of the people of the Board's state. It is the duty of boards to determine a physician's initial and continuing qualification and fitness for the practice of medicine. Boards should be empowered to initiate proceedings against the unprofessional, improper, incompetent, unlawful, fraudulent, deceptive, or unlicensed practice of medicine, and enforce the medical practice act and related rules. Boards should discharge these duties and responsibilities in accordance with the medical practice act and other governing laws.

In addition to any other duty, responsibility, and power provided to the Board in the medical practice act, the Board, acting in accordance with its medical practice act and the requirements of due process, should:

1. Enforce the provisions of the medical practice act;
2. Develop, adopt and enforce rules and regulations to affect the provisions of the medical practice act and to fulfill the Board's duties thereunder;
3. Select and/or administer licensing examination(s);
  - a. Employ or contract with one or more organizations or agencies known to provide acceptable examinations for the preparation, administration, and scoring of required examinations;
  - b. Prepare, select, conduct, or direct the conduct of, set passing requirements for, assure security of, and impose conditions for (e.g., time or attempt limits) successful completion of the licensing and other required examinations;
  - c. Impose conditions, sanctions, deny licensure, levy fines, seek appropriate civil and/or criminal penalties, or any combination of these, against those who violate or attempt to violate examination security, those who obtain or attempt to obtain licensure by fraud or deception, and those who knowingly assist in such activities;
4. Acquire information about and evaluate medical education and training of applicants;
5. Determine which professional schools, colleges, universities, training institutions, and educational programs are acceptable relating to licensure under the medical practice act and are appropriately preparing physicians for the practice of medicine, and to accept the approval of such facilities and programs by Board-recognized accrediting bodies in the United States and Canada;
6. Develop and use applications and other necessary forms and related procedures it finds appropriate for purposes of the medical practice act;
7. Require supporting documentation or other acceptable verifying evidence of any information provided the Board by an applicant or licensee;
8. Require information on and evaluate an applicant's or a licensee's fitness, qualification, and previous professional record and performance from recognized data sources, including, but not limited to, the Federation of State Medical Boards' Federation Physician Data Center, other national data repositories, licensing and disciplinary authorities of other jurisdictions, professional education and training institutions, liability insurers, health care institutions, and

- law enforcement agencies;
9. Issue, renew, provide conditional, restrict, or deny licenses as it determines necessary, in consideration of the applicant/licensee's conduct;
  10. Maintain secure and complete records on individual licensees including, but not limited to license application, verified credentials, disciplinary information, and malpractice history;
  11. Provide the public with a profile of all licensed physicians;
  12. Develop and implement methods to identify physicians who are in violation of the medical practice act;
  13. Require the self-reporting by applicants or licensees of any information the Board determines may indicate possible deficiencies in practice, performance, fitness, or qualification.
  14. Require all licensees, healthcare professionals, healthcare facilities, and medical societies and organizations to report to the Board information that appears to show another licensee is, or may be, professionally incompetent, engaging in unprofessional conduct, or mentally or physically unable to engage safely in practice, and to report to the Board and/or to an agency designated by the Board a licensee's possible dependence on alcohol or other addictive substances which have the potential to impair. Require licensees, malpractice insurance companies, attorneys, and healthcare facilities to report any payments on a demand, claim, settlement, arbitration award or judgment by or on behalf of a licensee;
  15. Develop and implement methods to identify and rehabilitate, if appropriate, physicians with an alcohol, drug, and/or psychiatric illness;
  16. When deemed appropriate by the Board to do so, require professional competency, physical, mental or chemical dependency examination, and evaluations of any applicant or licensee, including withdrawal and laboratory examination of bodily fluids;
  17. Establish a mechanism, which, at the Board's discretion, may involve cooperation with and/or participation by one or more Board-approved professional organizations, for the identification and monitored treatment of licensees who are dependent on or abuse alcohol or other addictive substances which have the potential to impair;
  18. Establish a mechanism by which licensees who abuse or may be dependent on or addicted to alcohol or other addictive substances which have the potential to impair, and who have not been identified by the Board through other sources of information, will be encouraged to report themselves voluntarily to the Board and/or, at the Board's discretion, to report themselves confidentially to a professional organization approved by the Board to seek assistance and monitored treatment;
  19. Receive, review, and investigate complaints and adverse information about licensees, including *sua sponte* complaints;
  20. Review and investigate reports received from entities having information pertinent to the professional performance of licensees;
  21. Act to halt the unlicensed or illegal practice of medicine; review, investigate, and take appropriate action to enjoin reports received concerning the unlicensed practice of medicine; and seek penalties against those engaged in such practices;
  22. Adjudicate those matters that come before it for judgement under the medical practice act and issue final decisions on such matters;
  23. Share investigative information at any stage of a complaint investigation with the licensing and disciplinary boards of other states and jurisdictions of the United States and foreign countries

- as allowed by state public records limitations;
24. Obtain court orders and injunctions to halt unlicensed practice, violation of the medical practice act or the rules of the Board;
  25. Institute actions in its own name and enjoin violators of the medical practice act;
  26. Act on its own motion in disciplinary matters, administer oaths, issue notices, issue subpoenas in the name of the state including for patient records, receive testimony, conduct hearings, institute court proceedings for contempt to compel testimony or obedience to its orders and subpoenas, take evidentiary depositions, and perform such other acts as are reasonably necessary under the medical practice act or other laws to carry out its duties;
  27. Issue subpoenas in the course of an investigation, including for *duces tecum* to compel production of documents or testimony to any party or entity that may possess relevant information regarding the subject of the investigation;
  28. Institute proceedings in courts of competent jurisdiction to enforce its orders and the provisions of the medical practice act;
  29. Use preponderance of the evidence as the standard of proof and to issue final decisions;
  30. Present to the proper authorities information it believes indicates an applicant or licensee may be subject to criminal prosecution;
  31. Discipline licensees found in violation of the medical practice act;
  32. Take the following actions, in accordance with applicable state statutes, alone or in combination, against those found in violation of the medical practice act:
    - a. Revoke, suspend, condition, restrict, and/or otherwise limit the license;
    - b. Place the licensee on probation with conditions;
    - c. Levy fines and/or assess the costs of proceedings against the licensee;
    - d. Censure, reprimand and/or otherwise admonish the licensee;
    - e. Require the licensee to provide monetary redress to another party, and/or provide a period of free public or community service;
    - f. Require the licensee to satisfactorily complete an educational, training, and/or treatment program or programs;
    - g. Require the licensee to successfully complete an examination, examinations, or evaluations designated by the Board; and
    - h. Summarily suspend a license when there is imminent risk of the public health and safety prior to hearing and final adjudication;
  33. Enforce final disciplinary action against a licensee as deemed necessary to protect public health and safety;
  34. Report all final disciplinary actions, non-administrative license withdrawals as defined by the Board, license denials, and voluntary license limitations or surrenders related to physicians, with any accompanying license limitations or surrenders related to physicians, with any accompanying Board orders, findings of fact and conclusions of law, to the Federation Physician Data Center of the Federation of State Medical Boards of the United States and to any other data repository required by law, and report all such actions, denials and limitations or surrenders related to other licensees, with the same supporting documentation, to the National Practitioner Data Bank as required by law;
  35. Develop policies for disciplining physicians who demonstrate sexual misconduct or other professional boundaries violations;

36. Refer instances of law violations to law enforcement or the local prosecution body as deemed appropriate or required by law;
37. 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;
38. Develop or identify and implement methods to assess and improve physician practice;
39. Develop or identify and implement methods to ensure the ongoing competence of licensees;
40. Determine and direct the Board's operating, administrative, personnel, and budget policies and procedures in accordance with applicable state statutes;
41. Acquire real property or other capital for the administration and operation of the Board;
42. Set necessary fees and charges to ensure active and effective pursuit of all of its responsibilities, legal and otherwise;
43. Develop and adopt its budget;
44. Employ, direct, reimburse, evaluate, and dismiss when appropriate the Board's executive director, in accordance with the Board's state's procedures; Supervision of staff is the purview of the executive director.
45. Develop, recommend, and adopt rules, standards, policies, and guidelines related to qualifications of physicians and medical practice;
46. Direct the preparation and circulation of educational material, policies, and guidelines the Board determines are helpful and proper for licensees;
47. 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;
48. Delegate to the executive director the Board's authority to discharge its duties as appropriate; and
49. Recommend to the Legislature those changes in, or amendments to, the medical practice act that the Board determines would benefit the health, safety, and welfare of the public.

#### **Section IV. State Medical Board Membership**

State medical boards bear primary responsibility for licensing and regulating the medical profession for the protection of the public. Every board should include physician and public members. All board members should act to further the public interest, not their personal or professional interests.

##### **Composition and Size**

The Board should consist of enough members to appropriately discharge its duties, and at least 25% should be public members. The Board should consider several factors when determining the appropriate size and composition, including the size of a state's physician population, the composition and functions of board committees, adequate separation of prosecutorial and judicial powers, and the other work of the board described throughout this document. The Board should be of sufficient size to allow for recusals due to conflicts of interest and occasional member absences to avoid concentrating final decisions in the hands of too few members or loss of a quorum.

## **Qualifications**

Board membership should be drawn from different regions of the state and diverse specialties, and should reflect the demographics of the state.

Sex, race, national or ethnic origin, creed, religion, disability, gender identity, sexual orientation, marital status, or age above majority should not preclude an individual from serving on the board.

All physician board members should reside in the state and be in active practice<sup>5</sup> at least 20 hours per week, hold a full and unrestricted medical license in the jurisdiction, be persons of recognized professional ability and integrity, and resided or practiced in the jurisdiction long enough to be familiar with the laws, policies, and practice in the jurisdiction (e.g., five years). In addition, physician members should not be currently under investigation or have had any public disciplinary action by any licensing board during the past ten years before applying for appointment, no history of felony convictions of any kind, and no misdemeanor convictions related to the practice of medicine.

Public members should reside in the state and be persons of recognized ability and integrity; not be licensed physicians, providers of health care, or retired physicians or health care providers; have no past or current substantial personal or financial interests in the practice of medicine or with any organization regulated by the Board (except as a patient or caregiver of a patient); and have no immediate familial relationships with any licensees or any organization regulated by the Board, unless otherwise required by law. Public members should represent a wide range of careers.

Board members should not be registered as a lobbyist representing any health care interest or association nor be an officer, board member, or employee of a state or national organization established for advocating the interests of individuals involved in the practice of medicine or any organization regulated by the Board.

## **Terms**

Appointed board members should serve staggered terms to ensure continuity. Term lengths should be set to permit development of effective skills 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 consecutive terms).

A board member may be reappointed two years after completion of such service. A person who serves more than half of an un-expired term should be considered to have served a full term.

## **Requirements**

Before assuming the duties of office, the following should be required of each board member:

1. Take a constitutional oath or affirmation of office;
2. Swear or affirm that the member is qualified to serve under all applicable statutes;
3. Sign a statement agreeing to disclose any potential conflicts of interest that may arise for that member in the conduct of board business; and

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<sup>5</sup> FSMB's *Report of the Special Committee on Reentry to Practice (2012)* defines the clinically active physician as one who, at the time of license renewal, is engaged in direct, consultative, or supervisory patient care, or as further defined by the states.

4. Sign a confidentiality and ethics statement agreeing to maintain the confidentiality of confidential board business and patient identification and uphold high ethical standards in discharging board duties.

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

### **Appointment**

Board members should be appointed by the Governor or Legislature, and the appointment should be made at least 30 calendar days prior to the beginning of the board term. The appointing authority should fill an unexpired term within 30 calendar days of the vacancy's occurrence. The incumbent should serve until the appointing authority names a replacement. Any individual, organization or group should be permitted to recommend potential board appointees.

### **Removal**

The appointing authority should remove board members from the Board if they:

1. Cease to be qualified;
2. Submit a written resignation to the appointing authority;
3. Are absent from the state for a period of more than six months;
4. Are found guilty of a felony or an unlawful act involving moral turpitude by a court of competent jurisdiction;
5. Are found guilty of malfeasance, misfeasance, or nonfeasance in relation to their Board duties by a court of competent jurisdiction;
6. Are found to be mentally incompetent by a court of competent jurisdiction;
7. Fail to attend three successive board meetings without just cause as determined by the board, or if a new member fails to attend the new members' training program without just cause as determined by the board;
8. Are found to be in violation of the medical practice act; or
9. Are found to be in violation of the conflict of interest/ethics law.

The Board should have the authority to recommend a member's removal to the appointing authority.

### **Compensation/Reimbursement**

Board members should receive appropriate compensation for services and reimbursement for expenses.

- Compensation: Service on the Board should not present an undue economic hardship. Board members should therefore receive compensation in an amount sufficient to allow full participation and not preclude qualified individuals from serving.
- Expenses: Each board member's reasonable travel expenses necessarily and properly incurred for active board service should be reimbursed.
- Education/Training: Travel expenses, and daily compensation should also be paid for each board member's attendance, in or out of the board's jurisdiction, at education or training programs approved by the board and directly related to board duties.

## **Section V. State Medical Board Structure**

### **Officers**

The board should elect annually from its members a president/chair and a vice president/vice-chair, and those other officers it determines are necessary to conduct its business. The officers shall serve for a one-year term.

- **President/Chair:** The president/chair should approve board meeting agendas, preside at board meetings, appoint board committees and their chairs, and perform those other duties assigned by the board and the medical practice act.
- **Vice President/Vice-Chair:** The vice president/vice-chair should assist the president/chair in all duties as requested by the president/chair and should perform the duties of the president/chair in that officer's absence.

### **Committees**

To effectively facilitate its work, fulfill its duties and exercise its powers, the board should establish standing committees. Examples include committees for licensing, investigation, finance, administration, personnel, rules, legislative, communications, public information, and other health professions regulated by the Board.

The chair should also be empowered to name ad hoc committees as required.

### **Funding**

Board fees should be adequate to fund the Board's ability to effectively regulate the practice of medicine under the act, and fees paid by licensees should be used only for purposes related to licensure, discipline, education and board administration. The Board should deposit all revenues in an appropriate account, and the Board should also receive all income earned on the deposit of such revenues.

All fines levied by the Board may be deposited in the State General Fund or other fund as legally required. All administrative, investigative and adjudicatory costs recouped should be deposited in the Board's account.

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

In the event the Legislature imposes additional responsibilities on the Board, and its staff, the Legislature should appropriate additional funds, staffing, and resources sufficient to carry out such additional responsibilities.

### **Budget**

The Board should develop and adopt its own budget reflecting revenues, including income earned thereon, and costs associated with each health care field regulated. Revenues, and income earned thereon, from each health care field regulated, should fully support board regulation of that field. The

budget should include allocations for establishing and maintaining a reasonable reserve fund.

### **Setting Fees and Charges**

All Board fees and charges should be set by law or rule. The Board should provide reasonable notice to the regulated healthcare professional and the public of all proposed increases or decreases in fees and charges.

### **Fiscal Year**

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

## **Section VI. Meetings of the Board and Committees of the Board**

### **Location**

The board and its committees should meet in the Board's offices, or other appropriate facilities in the same city as those offices. At its discretion, however, the board may meet from time to time in other areas of the State, or meet virtually, to facilitate their work or to enhance communication with the public and members of the regulated professions.

Teleconference and videoconference are acceptable forms of board meetings if, as per board bylaws and open meetings laws, it is determined the board's business can be properly conducted in this way. The board should be authorized to establish procedures by which its committees may meet by telephone or other telecommunication conference system.

### **Frequency, Duration**

The board should meet at least bimonthly for a period sufficient to complete the work before it at that time. One meeting per quarter may be sufficient . Committees should meet as directed by the board.

### **Emergency and Special Meetings**

Emergency and special meetings of the board may be called at any time by the president/chair, or as provided by board bylaws, if required to enforce the medical practice act. The board may establish procedures by which its committees may call emergency and special meetings in accordance with the state's open meeting laws.

### **Notice**

The board should establish a system for giving its members reasonable notice of all board and committee meetings. The board should comply with the state's open meetings laws.

### **Quorum**

A majority of members constitutes a quorum for the transaction of business by the board or any committee of the board.

### **Conflict of Interest**

No board member shall participate in the deliberation, making of any decision, or taking of any action affecting the member's own personal, professional, or pecuniary interest, or that of a known relative or of

a business or professional associate. With the advice of legal counsel, the board shall adopt and annually review a conflict of interest policy to enforce this section.

### **Minutes**

Minutes of all board and committee meetings and proceedings, and other board and committee materials, shall be prepared and kept in accordance with the board's adopted rules of parliamentary procedure and applicable state laws (e.g., Public Records Act).

### **Open Meetings**

All board and committee meetings should be open to the public in accordance with the state's open meeting laws, with the following exceptions:

1. Meetings to receive testimony or evidence the public disclosure of which the board determines would constitute an unreasonable invasion of personal privacy;
2. Meetings to consult with legal counsel, and to deliberate disciplinary judgments;
3. Meetings regarding investigations;
4. Meetings regarding license applications; and
5. Meetings regarding personnel actions.

The board should ratify all recommendations or decisions made in nonpublic meetings in public, which should be matters of public record.

### **Confidentiality**

The minutes and all records of nonpublic meetings are privileged and confidential and should not be disclosed, except to the board or its designees for the enforcement of the medical practice act, except that all licensing decisions made by the board and all disciplinary orders, with the associated findings of fact and conclusions of law and order, issued by the board should be matters of public record.

The following should be privileged and confidential:

1. Application and renewal forms and any evidence submitted in proof or support of an application to practice, except that the following items of information about each applicant or licensee included on such forms should be matters of public record:
  - a. Full name;
  - b. Name(s) and location(s) of professional schools attended;
  - c. School awarding professional degree, date of award, and designation of degree;
  - d. Site(s) and date(s) of graduate certification(s) held and date(s) granted;
  - e. Specialty certifications;
  - f. Year of initial licensure in the state;
  - g. Other states in which licensed to practice; and
  - h. Current office address and website.
2. All investigations and records of investigations;
3. Any report from any source concerning the fitness of any person to receive or hold a license; and
4. A complaint and the identity of an individual or entity filing an initial complaint with the Board.

Notwithstanding the foregoing provisions, the Board may cooperate with and provide documentation to

other boards, agencies or law enforcement bodies of the state, other states, other jurisdictions, or the United States upon written official request by such entity(s). The Board should share investigative information at any stage of a complaint investigation in order to reduce the likelihood that a licensee may become licensed in one state while under investigation in another state.

## **Section VII. Administration of the State Medical Board**

### **Offices**

The Board should maintain offices it determines are adequate in size, staff, and equipment to effectively carry out the provisions of the medical practice act. At its discretion, it may establish branch offices, staffed and equipped as it finds necessary, in as many areas of the state as it believes require such branch offices to facilitate the work of the Board.

### **Administration**

The Board should establish the function, operation, and administration structure of its offices.

### **Staff, Special Personnel**

To effectively perform its duties under the medical practice act, the Board should be empowered to hire an Executive Director, who will determine its staff needs and to employ, fix compensation for, evaluate, discipline, and remove its own full-time, part-time, temporary, and contract staff in accordance with the statutory requirements of the state. The Board 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. The Board should define the duties of and qualifications for the executive director, if not already defined in statute or in addition to statutory requirements. Staff benefits should be provided in accordance with state statutes.

The Board's staff may include, but need not be limited to, the following:

- An executive director, who, among administrative and other delegated responsibilities, may assist, at the Board's discretion, in the discharge of the duties of the secretary- treasurer and if one exists, the licensing committee, the disciplinary committee, and any other standing or ad hoc committee;
- One or more deputy directors;
- One or more medical consultants or directors, who shall be licensed to practice medicine in the state without restriction;
- One or more licensing staff;
- Office and clerical staff;
- One or more attorneys, who may be full-time employees of the Board, contractors of the Board, or assigned from the Office of the State Attorney General by agreement between the Board and that office, or in private practice to provide legal advice to the Board;
- One or more attorneys on staff to prosecute alleged violations of the medical practice act in administrative hearings and procedures; and/or
- One or more investigators, who shall be trained in and knowledgeable about the investigation of medical and related health care practice.

### **Special Support Personnel**

The Board may enlist, at its discretion, the services of experts, advisors, consultants, and others who are not part of its staff to assist it in more effectively enforcing the medical practice act.

Such persons may serve voluntarily, be reimbursed for expenses in accordance with state law and policy, or be compensated at a level commensurate with services rendered in accordance with state law and policy. When acting for or on behalf of the Board, such persons should benefit from the same immunity and indemnification protections afforded by this statute to the members and staff of the Board.

### **Section VIII. Immunity, Indemnity, Protected Communication**

The medical practice act or other statutes should provide legal protection for the members of the Board and its staff and for those providing information to the Board in good faith.

#### **Qualified Immunity and Indemnity**

The medical practice act or other statute should provide the following:

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 when such person is acting in good faith and in the reasonable belief that the action taken by such person is warranted.
2. If a current or former member, officer, administrator, staff member, committee member, examiner, representative, agent, consultant, or any other person serving or having served the Board requests the State to defend them against any claim or action arising out of any act, omission, proceeding, conduct, or decision related to their duties undertaken or performed in good faith in furtherance of the purposes of the medical practice act and within the scope of the function of the Board, and if such a request is made in writing at a reasonable time before trial, and if the person requesting defense cooperates in good faith in the defense of the claim or action, the State shall provide and pay for such defense and shall pay any resulting judgment, compromise, or settlement.
3. 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.
4. In any suit brought against the Board, its employees or agents, any member of an examining committee appointed by the Board or any individual or person, corporation, or other entity providing services 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.

5. There shall be no liability on the part of and no action for damages against any person, individual, corporation, or entity acting in good faith as an instrumentality of the Board to identify, investigate, counsel, monitor, or assist any licensed physician who suffers or may suffer from any condition that could compromise a physician's fitness and ability to practice medicine with reasonable skill and safety to patients.
6. 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 medical practice act, omission, proceeding, conduct, or decision related to the person's 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.

### **Confidential Communication**

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

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

## **Section IX. Reports of the Board**

### **Annual Report**

The Board should present to the Governor, the Legislature, and the public, at the end of each fiscal year, a formal report summarizing its licensing and disciplinary activity for that year. The report should include, but not be limited to, the following information about each of the Board's regulated professions:

1. The total number of persons fully licensed by the state and the number of those licensees currently practicing in the state;
2. The number of persons who are fully licensed, and practicing, in the state, but are residing in another state;
3. The number of licensees holding each form of limited license authorized by the medical practice act;
4. The number of persons granted a full license by the state for the first time in the past year, the average time to issue the first time license, the number of those licensees currently practicing in the state, and the number of full licenses denied in the past year;
5. The number of licensees currently practicing about whom a complaint, a charge or an adverse item of information required by law was received in the past year;
6. The number and the source, by category, of complaints, charges and adverse items of information required by law received about licensees practicing in the past year and the

- number of these found not to warrant action under this statute and the rules of the Board;
7. The number of disciplinary investigations conducted by the Board or its representatives concerning licensees practicing in the past year and the average time to complete the investigation;
  8. The number of disciplinary actions, by category, taken by the Board in the past year against all licensees and the average time to resolve the initial complaint;
  9. A ranking, by frequency, of primary causes for disciplinary action against all licensees in the past year;
  10. A review of disciplinary activity related to holders of limited forms of license in the past year;
  11. A review of the operations of the Board's current mechanisms for dealing with a licensee dependent on or addicted to alcohol or other addictive substances which have the potential to impair;
  12. A schedule of all current fees and charges;
  13. A revenue and expenditure statement for the past year indicating, but not limited to, the percentage of revenue from and expenditures for each regulated profession, revenue generated from licensing, revenue generated from fines, and expenditures related to investigations;
  14. A summary of other Board activities and a schedule of days met by the Board and each of its committees during the year;
  15. A summary of administrative and legislative activity in the past year;
  16. A summary of the goals and objectives established by the Board for the coming fiscal year;  
and
  17. A copy of the Board's strategic plan.

### **Public Record, Action Reports**

Each of the Board's non-administrative license application withdrawals, license denials and final disciplinary orders, including any associated findings of fact and conclusions of law, should be matters of public record. Voluntary surrenders of or limitations on licenses shall also be matters of public record. The Board should report all denials, orders, surrenders, and limitations to the public, all health care institutions in the state, appropriate state and federal agencies, related professional societies or associations in the state, and any data repository as soon as practical. The Board should make the information readily accessible to the public via the physician's profile as allowed by statute.

The Board should update the profile at least annually and offer the licensee an opportunity to correct erroneous information. A licensee's profile shall contain, but not be limited to:

1. Demographic Information: name and license number, gender, business or practice address, and birth date.
2. Medical Education: medical school(s)' name, address, year of graduation and degree, post-graduate training program(s)' name, address, years attended, and year completed.
3. License and Board Certification Information: license status, license type, original license date, license renewal date, specialty and type of practice, and board certification by a certifying authority recognized by the Board.
4. Criminal Convictions: a description of any conviction in which either the offense, or the facts and circumstances of the circumstances, would violate the ethical standards associated with

the practice of medicine in the state within the last five years, including cases with a deferred adjudication.

5. Malpractice History:
  - a. The number of awards or judgments within the past 10 years;
  - b. When the number exceeds three (3), the number of demands, claims, and/or settlements paid by the licensee or on behalf of the licensee in the past five (5) years; and
  - c. A statement that malpractice payments do not necessarily demonstrate the quality of care provided by a physician, and that the Board independently investigates reports of payment in malpractice cases, which will appear in the licensee's disciplinary history if the Board completed the investigation and took disciplinary action.
6. Disciplinary and Non-Disciplinary History:
  - a. All disciplinary actions taken by the Board;
  - b. All active non-disciplinary board actions such as remedial plans;
  - c. A brief description of the reason for a disciplinary or non-disciplinary action;
  - d. All disciplinary actions taken by other state medical/osteopathic boards and a brief description of the reason for discipline if available;
  - e. All disciplinary actions taken by hospitals;
  - f. An explanation of the types of discipline the Board takes and its effects on the licensee's ability to practice; and
  - g. A statement that hospitals may take disciplinary actions for reasons that do not violate the governing statutes.

## **Section X. 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.

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<sup>6</sup>.

No individual should receive a license to practice medicine in the jurisdiction unless they have successfully completed all components of an examination(s) identified as satisfactory to the Board:

- The currently administered United States Medical Licensing Examination (USMLE) Steps 1, 2, 3 or Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Levels 1, 2, 3; or
- Previously administered examinations such as the Federation Licensing Examination (FLEX), National Board of Medical Examiners (NBME) Parts or National Board of Osteopathic Medical

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<sup>6</sup> 2014 edition jointly developed by the American Educational Research Association (AERA), the American Psychological Association (APA) and the National Council on Measurement in Education (NCME).

- Examiners (NBOME) Parts; or
- A combination of these examinations identified as acceptable by the Board.

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

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.

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.

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 XI. 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:

1. 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:
  - a. The applicant's full name and all aliases or other names ever used, current address, Social Security Number or Individual Taxpayer Identification Number, and date and place of birth;
  - b. All original or electronically verified documents and credentials required by the Board, notarized photocopies, or other verification acceptable to the Board of such documents and credentials;
  - c. A list of all jurisdictions, United States or foreign, in which the applicant has been licensed, denied licensure or authorization to practice medicine or any other health care profession, has voluntarily surrendered a license or an authorization to practice medicine or any other health care profession, or withdrawn any license application;
  - d. 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;
  - e. A detailed educational history, including places, institutions, dates, and program descriptions of all the applicant's education including all college, pre- professional, professional, and professional postgraduate education;
  - f. A detailed employment history for the five years prior to application, including periods of absence from the active practice of medicine;
  - g. A list and current status of all specialty certifications and the name of certifying

- organization; and
- h. Any other information or documentation the Board determines necessary.
2. 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.
  3. 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.
  4. The applicant should have satisfactorily completed at least thirty-six (36) months of progressive postgraduate medical training (also termed graduate medical education, or GME) accredited by the Board, the Accreditation Council for Graduate Medical Education (ACGME), the Commission on Osteopathic College Accreditation (COCA), the Royal College of Physicians and Surgeons of Canada (RCPSC), or the College of Family Physicians of Canada (CFPC).
  5. 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 acceptable by the Board.
  6. The applicant should attest to 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.
  7. The applicant should not be currently suffering from any condition for which they are not being appropriately treated that impairs their judgement or that would otherwise adversely affect their ability to practice medicine in a competent, ethical, and professional manner.
  8. 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.
  9. 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 the applicant's original medical education credentials for inspection at the time of personal appearance.
  10. The applicant should be held responsible for providing to the satisfaction of the Board, or designated staff, the validity of all credentials required for the applicant's 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' Physician Data Center (PDC), which includes its Board Action Data Bank, and Federation Credentials Verification Service (FCVS); the files of the American Medical Association and the American Osteopathic Association; National Practitioner Data

Bank; and other national data banks and information resources.)

11. 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.
12. Applicants should have satisfactorily passed a criminal background check.
13. Applicants should attest that they are not currently suffering from any condition for which they are not being properly treated that impairs their judgement or that would otherwise adversely affect their ability to practice medicine in a competent, ethical, and professional manner.
14. The Board should be authorized to establish regulations for the issuance of a medical license for the intervals between board meetings, including delegating approval to staff if the applicant meets the minimum requirements for licensure.

### **International Medical Graduates**

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:

1. 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.
2. 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.
3. Such applicants should have passed an examination acceptable to the Board that adequately assesses the applicants' medical knowledge.
4. Such applicants should be certified by the Educational Commission for Foreign Medical Graduates (ECFMG) <sup>7</sup> or its Board-approved successor(s), or by an equivalent Board-approved entity.
5. Such applicants should have a demonstrated command of the English language satisfactory to the Board.
6. 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).
7. 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.
8. Such applicants have satisfied or are able to satisfy all applicable requirements of the United States Citizenship and Immigration Services.

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<sup>7</sup> As of July 2023, ECFMG is a division of Intealth.

## **Section XII. Licensure by Endorsement, Expedited Licensure by Endorsement or through Occupational Interstate Licensure Compacts, and Temporary and Special Licensure**

The medical practice act should provide for licensure by endorsement, expedited licensure by endorsement, expedited licensure through occupational interstate licensure compacts, and in certain clearly defined cases, for temporary and special licensure.

### **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 for that 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.

### **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 Commission on Osteopathic College Accreditation (COCA) of the American Osteopathic Association (AOA) approved medical school;
  - b. 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, the National Board of Medical Examiners (NBME) I- III or the Federation Licensing Examination (FLEX);
  - b. Comprehensive Osteopathic Medical Licensure Examination (COMLEX-USA) Levels 1-3 or its predecessor examinations, the National Board of Osteopathic Medical Examiners Levels 1-3 or its predecessor examination(s); and/or
  - c. Medical Council of Canada Qualifying Examinations (MCCQE) or its predecessor examination(s) offered by the 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) the COCA, the RCPSC, or the CFPC; and/or
7. Obtained certification or recertification by a specialty board recognized by the American Board

of Medical Specialties (ABMS) or the Bureau of Osteopathic Specialists (BOS) within the previous ten (10) years.

8. 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 specialty recertification examination. Boards should obtain supplemental documentation including, but not limited to:
  - a. Criminal background check;
  - b. Absence of current/pending investigations in any jurisdiction where licensed;
  - c. Verification of specialty board certification; and
  - d. Professional experience.

Physicians desiring an expedited process for licensure may utilize the Federation Credentials Verification Service (FCVS), or credentials verification meeting equivalent standards for verification of core credentials, or rely on the primary source verification of the state board of first licensure for:

1. Medical school transcript;
2. Examination history;
3. Disciplinary history;
4. Identity (certified birth certificate or original passport);
5. ECFMG certificate, if applicable; and
6. Postgraduate training verification.

### **Expedited Licensure through Occupational Interstate Licensure Compacts**

The Board should be authorized to issue an expedited license through an occupational interstate licensure compact, as long as the governor signed the model compact language into law. An occupational interstate licensure compact is a legally binding agreement between two or more states, depending on the specific requirements of the compact, that establishes a formal, legal relationship among states to significantly streamline the licensing process. Boards that issue licenses through occupational interstate licensure compacts must comply with the rules and regulations of the compact.

### **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;
2. Be granted only to an applicant on a short-term or emergency basis;
3. Automatically terminate within a period specified by the Board.

### **Special Licensure**

The Board should be authorized to issue conditional, restricted, probationary, limited or otherwise circumscribed licenses as it determines necessary. It is up 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 provide medical services to a traveling sports team, coaches, and staff for the duration of the sports event;
2. To provide volunteer medical services to under-insured/uninsured patients;
3. To provide medical services to youth camp enrollees, counselors, and staff for the duration of the youth camp;
4. 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; and
5. To provide medical services in response to disasters, public health emergencies, and mass casualties.

### **Section XIII. 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:

1. 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.
2. Issuance of a limited license specifically for postgraduate training should occur only after the applicant demonstrates that he/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.
3. 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.
4. The limited license should be renewed annually.
5. 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.
6. 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.

#### **Postgraduate Training Program Reporting Requirements**

Program directors responsible for postgraduate training should inform the Board about program participants who have departed or been terminated from the program or have received disciplinary actions within 10 days of said action.

Program directors 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; resignations from the program or nonrenewal of the program contract; dismissals from the program for performance or behavioral reasons; and referrals to substance abuse programs not approved by the Board.

Failure to report such actions 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.

#### **Section XIV: 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:

At the time of periodic renewal, the Board should require the licensee to demonstrate to its satisfaction the licensee's 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 the licensee's 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 law enforcement agency;
  - f. Any health insurance company;
  - g. Any malpractice insurance company;
  - h. Any court; and
  - i. 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 the licensee's 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 is currently suffering from any condition for which they are not being appropriately treated that impairs their judgment or that would otherwise adversely affect their

ability to practice medicine in a competent, ethical and professional manner.

8. 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.

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.

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. The Board should be authorized to collect a fee for renewal of a license.

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.

Failure to report fully and correctly according to timelines specified by the board as outlined above should be grounds for disciplinary action by the Board.

## **Section XV. Disciplinary Process**

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:

### **Range of Actions**

A range of progressive disciplinary and remedial actions should be made available to the Board. 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.

These include, but are not 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. Letters of concern and advisory letters:
8. 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.

9. Monetary redress to another party;
10. A period of free public service, either medical or non-medical;
11. Satisfactory completion of an educational, training and/or treatment program(s), or professional developmental plan;
12. The Board should be authorized, at its discretion, to require professional 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.
13. Levy fines; and
14. Payment of administrative and disciplinary costs.

### **Grounds for Action**

The Board should be authorized to take disciplinary action for unprofessional 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. A misdemeanor related to the practice of medicine and any crime involving moral turpitude; or
  - b. A felony related to the practice of medicine. The Board shall take disciplinary action against a practitioner's license following conviction of a felony as outlined in the medical practice act;
4. Conduct likely to deceive, defraud, or harm the public;
5. Disruptive behavior and/or interaction with physicians, hospital personnel, patients, family 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 the licensee's skill or the efficacy or value of the medicine, treatment, or remedy prescribed by the licensee or at the licensee's 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 the licensee's 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, 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 or any other form of impairment upon Board order;
  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 the licensee themselves;
  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 in 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 of 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 a surrender of a license, a limitation or any restriction to practice medicine in another state or jurisdiction, or a surrender of membership on any medical staff or in any medical or professional association or society resulting in the surrender of the authority to utilize controlled substances issued by any state or federal agency, or any agreement for the limitation 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. Failure to report 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 or conduct unbecoming of the medical profession, including but not limited to, violation of any provision of a national code of ethics acknowledged by the Board and/or failing to uphold the standards of the profession;
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, HBV (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, regardless of the medium;
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. Any conduct that may be harmful to the patient or the public;
52. 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;
53. Conduct likely to deceive, defraud, or harm the public;
54. 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;
55. 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;
56. 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;
57. 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
58. 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.

### **Enforcement and Disciplinary Action Procedures**

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:

**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.

**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 provisions 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.

**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.

**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 an 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.

**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.

**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.

**Board Action Reports:** All of 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 National Practitioner Data Bank and 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.

**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.

### **Section XVI: 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:

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.

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 licensee's 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 state agencies,
8. All law enforcement agencies in the state,
9. All courts in the state,
10. All federal agencies (e.g., Drug Enforcement Administration, Food and Drug Administration, Centers for Medicare and Medicaid Services, Veterans Health Administration, and Department of Defense),

11. All peer review bodies in the state, and
12. All resident training program directors.

A licensee's voluntary resignation from the staff of a health care organization or voluntary limitation of a licensee's 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.

Malpractice insurance carriers, 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).

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.

The Board may reopen previous complaints as it deems necessary to protect the public.

Any person, institution, agency, organization, or licensee who reports in good faith, should not be subject to civil damages or criminal prosecution for so reporting. A person or entity who reports in good faith should be prepared to cooperate with the regulatory authority in the adjudicative process. 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, organization, or licensee for reporting in good faith.

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

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 XVII. Impaired Physicians<sup>8</sup>**

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

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<sup>8</sup> FSMB, *Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health*. April 2021, available at: <https://www.fsmb.org/siteassets/advocacy/policies/policy-on-physician-impairment.pdf>.

with reasonable skill and safety is impaired. The Board should also have the ability to create a safe harbor for applicants to gain a license if they are known to the confidential physician health program approved by the Board.

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 program approved by the Board shall by contract not have any financial relationship or incentive with those evaluation and treatment programs to which they refer practitioners. If available, the impaired physician program shall by contract be accredited by the appropriate national or international accrediting body and maintain those standards throughout the duration of the contract. Per the contract, participants in the program must sign irrevocable disclosure confidentiality waivers, to include federal protections, that allow the program to share information with the Board, evaluators, treatment programs, and other entities as necessary to the monitoring and rehabilitation process.

The Board should be authorized, at its discretion and in accordance with state and federal laws, 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:

1. Direct the licensee to submit to therapy, medical care, counseling, or treatment acceptable to the Board and comply with monitoring to ensure compliance;
2. Suspend, limit, restrict, or place conditions on the licensee's medical license for the duration of the impairment and monitoring or treatment; and/or
3. Revoke the licensee's medical license without further proof, need to establish a pattern, or a demonstration that the licensee is unable to be rehabilitated.

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.

While all impaired licensees should be reported to the Board in accordance 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, 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 licensee impairment from another source or resulting from an investigation of other medical practice violations. 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 XVIII: 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:

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.

The Board should have access to a Board-approved assessment program(s) charged with assessing licensees' clinical competency and fitness for duty.

The Board should be authorized, at its discretion and in accordance with state and federal laws, to require a licensee or an applicant for licensure to undergo a physician competency evaluation conducted by a Board-designated independent evaluator at the 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.

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.

Any licensee or applicant for licensure who is prohibited from practicing medicine, or who has had restrictions or conditions placed upon their license, under the above section, should be afforded, at reasonable intervals, an opportunity to demonstrate to the satisfaction of the Board that he/she can resume or begin the practice of medicine, or can practice without the restrictions or conditions, with reasonable skill and safety.

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. The assessment program shall treat the Board order requiring the assessment of the applicant or licensee as undisputed fact. The assessment program shall notify the Board if the applicant or licensee attempts to submit other materials or alternative narratives that counter the facts from the Board.

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 XIX: Physician Assistants**

The medical practice act should provide for the Board to license and regulate physician assistants.

### **Administration**

Physician assistants appointed to the board should have representation as full voting members to include business, discipline, and hearing decisions on both physician and physician assistant matters.

### **Licensing**

No person should perform or attempt to practice as a physician assistant without first obtaining a license from the Board in accordance with team based or supervision requirements.

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.

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.

The Board may require written notification if a practice agreement is changed or severed for a reason that would have an adverse effect for patient care.

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.

### **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.

### **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 National Practitioner Databank and the Federation of State Medical Boards.

### **Duties and Scope of Practice**

A physician assistant should be permitted to provide those medical services that are within their training and experience and pursuant to a practice agreement.

### **Supervision and Collaborative Practice Arrangements**

The Board should be authorized to allow for individual, alternate, and/or group delegation/supervision/collaboration models for physician assistants. Every physician supervising, collaborating with, or employing a physician assistant should be legally responsible for the delegation of health care tasks to physician assistants and establishing a quality assurance mechanism within the practice agreement to fulfil the responsibilities of supervision or collaboration. Nothing in these provisions, however, should be construed to relieve the physician assistant of any legal liability or 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 or collaborating physician is absent or not in a group supervision or collaboration setting, he or she must provide for appropriate support of the physician assistant by another licensed physician. Each and every relationship should adhere to all statutory requirements for licensure.

### **Renewal**

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

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### **Staff Support**

John Bremer  
Director, State Legislation & Policy, FSMB

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<sup>9</sup> State Medical Board or organizational affiliations are presented for purposes of identification and do not imply endorsement of any draft or final version of this report.