Oregon
Tina Kotek, Governor

Medical Board
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www.oregon.gov/omb

ADMINISTRATIVE AFFAIRS COMMITTEE
MEETING AGENDA
VIDEOCONFERENCE

March 13, 2024, 5:00 p.m.

The mission of the Oregon Medical Board is to protect the health, safety, and wellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.

Committee Members:
Ali Mageehon, PhD, Public Member, Chair
Erin Cramer, PA-C
Niknam Eshraghi, MD
Paula Lee-Valkov, MD
Christoffer Poulsen, DO

	Present	Absent		Present	Absent
CRAMER			**POULSEN**		
ESHRAGHI			**MAGEEGON**		
LEE-VALKOV					

Pursuant to ORS 192.660(2)(f) and ORS 192.660(2)(L), the Administrative Affairs Committee of the Oregon Medical Board (OMB) may convene in Executive Session to consider information or records that are exempt by law from public inspection or information obtained as part of an investigation, including information received in confidence by the Board and Administrative Affairs Committee, information of a personal nature the disclosure of which would constitute an invasion of privacy, and records which are otherwise confidential under Oregon law.

The Administrative Affairs Committee will reconvene in Public Session prior to taking any final action.

Members of the news media may remain in the room during the Executive Session but are directed not to report on the specific information discussed during the Executive Session.

PUBLIC SESSION

APPLICANT REVIEW

1	Pauling, Gregory Robert, PA-C	Entity ID 1065735	CRAMER

2	Annual Board's Best Practices Survey Results	MAGEEHON

3	2025-27 Preliminary Budget Policy Packages	MAGEEHON

4	Quarterly CORE Business Suite Replacement Project Status Report Update	MAGEEHON

OREGON ADMINISTRATIVE RULES (OAR)

5	OAR 847-010-0073 Reporting Requirements; OAR 847-010-0070 Competency Examination	FIRST REVIEW	LEE-VALKOV

6	OAR 847-050-0021 Documents to be Submitted for Licensure OAR 847-070-0022 Documents to be Submitted for Licensure OAR 847-080-0017 Letters and Official Verifications to be Submitted for Licensure	FIRST REVIEW	MAGEEHON

Committee Recommendations Regarding First Review Rules	*MAGEEHON*

- *Division 10, rule 70 and rule 73*
- *Division 50, rule 21*
- *Division 70, rule 22*
- *Division 80, rule 17*

7	OAR 847-001-0005 Rules for Contested Cases	FINAL REVIEW	POULSEN

8	OAR 847-005-0005 Licensure Fees	FINAL REVIEW	CRAMER

9	OAR 847-008-0055 Reactivation Requirements OAR 847-020-0110 Application for Licensure OAR 847-025-0050 Application OAR 847-050-0015 Application OAR 847-070-0015 Application OAR 847-080-0002 Application for Licensure	FINAL REVIEW	ESHRAGHI

10	Public Comment	MAGEEHON

*When called upon, please state your name and organization for the record. We ask that you limit your remarks to **3** minutes. Written comments may also be submitted if you have additional remarks beyond the allotted time.*

DISCUSSION ITEMS

11	Statement of Philosophy Review: Cultural Competency	LEE-VALKOV
12	Statement of Philosophy Review: Telemedicine	ESHRAGHI
13	Federation of State Medical Boards Artificial Intelligence Symposium	CRAMER
14	Statement of Philosophy Review: Artificial Intelligence	CRAMER
15	Updated Personal History Questions	LEE-VALKOV
14	OMB Response to Secretary of State Audit	POULSEN
15	2024 Legislative Session Memo	CRAMER
16	2025 Legislative Concepts Memo	POULSEN
17	Oregon Wellness Program Annual Report	ESHRAGHI

18	OMB Vision Statement Draft	POULSEN

19	Oregon Podiatric Medical Association Letter Regarding HB 2817 FAQs	ESHRAGHI

INFORMATIONAL ITEMS

20	OMB-Submitted Resolutions to the 2024 Federation of State Medical Boards Annual Meeting	CRAMER

21	2023 Public Outreach	ESHRAGHI

22	New Licensure Count	MAGEEHON

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ADMINSTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Discussion Item

Member Assigned: **Mageehon**

Subject: **Annual Board's Best Practices Survey Results**

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March 13, 2024

TO: Administrative Affairs Committee
FROM: Carol Brandt, Business Manager
RE: **Board Responses to Best Practices Self-Assessment**

Recommendation:

Review and forward the results of the Best Practices Self-Assessment Survey to the Full Board for their approval.

Background:

At the January Board meeting, you received information about the Legislative mandate for Board members to conduct an annual assessment of the Agency's governance practices and agency operations.

Board members were given a survey link and a self-assessment guide. The criteria evaluated included the following functions: Executive Director performance expectations and feedback, strategic management, policy development, fiscal oversight and Board management

The self-assessment surveys were completed and the results have been compiled. The Board members' responses were unanimous. An impressive 100% success rate was tallied for the total best practices met by the Board. Analysis of the assessment results and responses will be integrated into the *Annual Performance Progress Report* which is due from applicable Boards and Commissions on September 30th of each year.

Oregon Medical Board
Best Practices Self-Assessment
Fiscal Year 2024

Annually, board members are to self-evaluate their adherence to a set of best practices and report the percent of total best practices met by the board (percent of yes responses in the table below) in the Annual Performance Progress Report as specified in the agency Budget Instructions.

Best Practices Assessment Score Card

Best Practices Criteria	Yes	No
1. Executive Director's performance expectations are current.	13	
2. Executive Director receives annual performance feedback.	13	
3. The agency's mission and high-level goals are current and applicable.	13	
4. The board reviews the Annual Performance Progress Report.	13	
5. The board is appropriately involved in review of agency's key communications.	13	
6. The board is appropriately involved in policy-making activities.	13	
7. The agency's policy option packages are aligned with their mission and goals.	13	
8. The board reviews all proposed budgets.	13	
9. The board periodically reviews key financial information and audit findings.	13	
10. The board is appropriately accounting for resources.	13	
11. The agency adheres to accounting rules and other relevant financial controls.	13	
11. Board members act in accordance with their roles as public representatives.	13	
13. The board coordinates with others where responsibilities and interests overlap.	13	
14. The board members identify and attend appropriate training sessions.	13	
15. The board reviews its management practices to ensure best practices are utilized.	13	
Total number:	195	
Percentage of total:	**100%**	

ADMINSTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Discussion Item

Member Assigned: **Mageehon**

Subject: **2025-27 Preliminary Budget Policy Packages**

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March 13, 2024

TO: Administrative Affairs Committee
FROM: Carol Brandt, Business Manager
RE: **2025-27 Preliminary Budget Policy Packages**

Action Requested:

Review and advise on the agency 2025-27 Budget Policy Packages.

Background:

As a state agency, the Oregon Medical Board (OMB) operates on a well-managed budget that is audited periodically by the Secretary of State's office. The budget anticipates income and limits expenditures for two-year fiscal periods (a "biennium"), beginning July 1 of each odd-numbered calendar year and ending on June 30 of the next odd-numbered calendar year.

Budget preparation starts about one year before each legislative session with the agency beginning to build out it's requested budget for the next biennium. The Agency Request Budget reflects the agency's strategic plan and includes requests for changes in fees (when applicable) and expenditure authority for new items or other changes affecting the agency's budget. These changes are proposed through "Policy Packages" that would enhance the Board's ability to carry out its mission.

The agency works closely with the Oregon Chief Financial Office (within the Department of Administrative Services (DAS)) and the Governor's Office to develop and refine the agency's budget.

The budget process then shifts from the executive branch to the Legislature. The Legislature approves the agency revenue and expenditure budget for the biennium, and the agency enacts this budget.

2025-27 Budget Policy Packages:

The agency is in the early development phase for proposing the following policy packages for the 2025-27 budget:

Fee Adjustments

Agency revenue cycles dictate that the agency begin each biennium with a minimum of six months cash reserves. Due to inflation, anticipated increases in costs for the Health Professionals' Services Program, and growing personal services costs, the Board anticipates that without an increase in revenues, we will have insufficient ending balance at the end of 2025-27 to carry us through the first six months of the 2027-29 biennium.

The Board proposes to increase license registration fees for the professions regulated. This proposal may include a restructure of fees to reflect a pass-through of revenue collected from licensees and disbursed to fund the contracted Health Professionals' Services Program.

Revenue needs are currently under review. The proposed fee increase amount has not yet been determined.

Business Efficiency and Succession Planning

The Board's current staffing includes a Medical Director who provides medical expertise for all OMB programs. With only a single employee with medical expertise, agency business processes are impacted by the volume of work assigned and availability of this individual, which in turn impacts customer service. The individual in this role must have a solid medical background and a thorough understanding of administrative law. When the position becomes vacant, it is challenging to fill.

In keeping with the agency Succession Plan, the Board proposes adding a .5 to 1.0 FTE Associate Medical Director position. This will allow the workload to be shared between two staff members and ensure the position duties are always covered, improving customer service. This will allow the agency to build bench strength and potential career ladder for the Medical Director position.

Health Professionals' Services Program

The Oregon State Board of Nursing has ceased participation in the Health Professionals' Services Program (HPSP). The result is the program costs are now split among the remaining participating boards, increasing the costs for all. The contract for this program expires June 30, 2025 and is in the process of solicitation for a new contract to begin July 1, 2025. Future program expenses are estimated based on the current contract.

The Board proposes to increase expenditure limitation for 2025-27 by $125,000 to cover estimated additional HPSP expenses.

Criminal Background Check Fees

With our 2005-07 Budget, the agency was provided with limitation for criminal background check fees paid to the Oregon State Police. The quantity of criminal background checks performed has been growing over time as our licensee base increases. Our budget limitation for these fees has been insufficient to cover these expenses for several biennia

but has been managed by savings in other areas. We are no longer able to meet our needs with the current budget limitation.

The Board proposes to increase expenditure limitation for 2025-27 by $110,000 to cover these expenses.

Merchant Fees

With our 2009-11 Budget, the agency was provided with limitation for merchant fees associated with online license application and renewals payments made by credit card. Since that time, customer adoption of credit card payments and the number of licensees have grown. Our budget limitation for merchant fees has been insufficient to cover these expenses for several biennia but has been managed by savings in other areas. We are no longer able to meet our needs with the current budget limitation.

The Board proposes to increase expenditure limitation for 2025-27 by $80,000 to cover these expenses.

ADMINSTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Discussion Item

Member Assigned: **Mageehon**

Subject: **Quarterly CORE Business Suite Replacement Project Status Report Update**

Oregon Medical Board
Core Business Suite Replacement Project
Project Status Report
As of February 14, 2024

Project High Level Status

OMB contracted with our systems integration vendor Coastal Cloud Holdings, LLC in December 2022. Throughout 2023, OMB business experts and Coastal Cloud have engaged in discovery sessions to explore the workflows, processes, and business rules that support OMB services. In August and September, OMB began producing user stories and acceptance criteria for the licensing functional area; this work was set aside while agency staff focused on license renewal activities beginning in October, 2023. Meanwhile, Coastal Cloud demonstrated the initial configuration for Board and Committee functionality and spent sprints iterating system configuration to meet agency needs. Coastal Cloud has concluded that configuration and agency users will soon begin testing of this module. Coastal Cloud and OMB have continued to refine the agile process and our partnership as we actively pursue opportunities to produce quality deliverables at a faster pace. We have completed a revised project plan that anticipates project completion in January, 2025.

Milestones & Accomplishments (November 2023 through February 14th, 2024):

- Revised project plan and schedule
- Completed Board and Committee solution configuration
- Configured and deployed user story tracking tool
- Began user testing on Board and Committee configuration

Next Steps:

- Business Administration solution configuration
- Licensing solution configuration
- Continue:
    - Producing user stories
    - Project sprints and solution iteration
    - System demonstrations
    - Data migration activities
    - UAT planning and preparation
    - Training planning and preparation

Schedule Status:

- Schedule is set for a January 2025 Go-live
- Project Roadmap and schedule of discovery sessions is flexible to accommodate business cycles and OMB resource availability

Budget Status:

- Budget through FY2024: $3,776,742
- Total costs to date: $1,764,906
- Budget remaining: $2,011,836 (53%)

ADMINISTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
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Public Session

Rule Review

Member Assigned: **Lee-Valkov**

First Review: **847-010-0073; 847-010-0070**
Reporting Requirements; Competency Examination

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 010 – OREGON MEDICAL BOARD

First Review – April 2024

First, the proposed rule amendment clarifies the timeframe in which a licensee and health care facility must report a voluntary withdrawal from practice, resignation, or limitation of privileges while the licensee is under investigation. ORS 677.415(6) requires "promptly" reporting to the Board. The proposed rule amendment would provide that promptly means within 30 calendar days. The 30-day requirement aligns with the ORS 677.172(1) requirement that all licensees notify the Board of any practice address changes within 30 days.

Second, the proposed rule updates the National Certification Commission for Acupuncture and Oriental Medicine's (NCCAOM) code of ethics. The rule holds Board licensees to recognized standards of ethics and must cite to a specific version that the Board has reviewed and is requiring licensees to follow. The Board must review any updated standards and amend the rule to incorporate the updated standard. The current rule references the NCCAOM's 2016 Code of Ethics. NCCAOM updated their code of ethics in 2022 and issued a revision in November 2023, provided below. In 2023, the Board's Acupuncture Advisory Committee reviewed the updated code of ethics.

Third, the proposed rule amendment updates the definition of "unprofessional conduct" to include within the practice of acupuncture the failure to meet the standard of care.

Fourth, the proposed rule amendment updates the definition of "unprofessional conduct" to include discrimination in the practice of medicine, podiatry, and acupuncture, which would make discrimination a ground for discipline under 677.190(1)(a) and 677.190(17). The proposed amendment is an action item in the Board's Diversity, Equity, and Inclusion Action Plan.

Lastly, the proposed rule amendment in OAR 847-010-0070 updates the Board of Medical Examiners reference the Board.

847-010-0073
Reporting Requirements

(1) Board licensees and health care facilities must report to the Board as required by ORS 676.150, 677.092, 677.190, and 677.415. These reports include, but are not limited to, the following:

(a) A licensee must self-report to the Board:

(A) Any conviction of a misdemeanor or felony or any arrest for a felony crime to the Board within 10 days after the conviction or arrest;

(B) Any adverse action taken by another licensing jurisdiction or any peer review body, health care institution, professional or medical society or association, governmental agency, law enforcement agency or court for acts or conduct similar to acts or conduct that would constitute grounds for disciplinary action as described in ORS chapter 677;

(C) Any official action taken against the licensee within 10 business days of the official action; or

(D) A voluntary withdrawal from practice, voluntary resignation from the staff of a health care facility or voluntary limitation of the licensee's staff privileges at a health care facility if the licensee's voluntary action occurs while the licensee is under investigation by the health care facility or its committee for any reason related to possible medical incompetence, unprofessional conduct or physical incapacity or impairment **within 30 calendar days.**

(b) A licensee who has reasonable cause to believe that another state licensed health care professional has engaged in prohibited or unprofessional conduct must report the conduct within 10 working days to the board responsible for the other professional unless disclosure is prohibited by state or federal laws relating to confidentiality or protection of health information.

(c) A licensee must report within 10 business days to the Board any information that appears to show that a licensee is or may be medically incompetent or is or may be guilty of unprofessional or dishonorable conduct or is or may be a licensee with a physical incapacity.

(d) A health care facility must report to the Board:

(A) Any official action taken against a licensee within 10 business days of the date of the official action; or

(B) A licensee's voluntary withdrawal from practice, voluntary resignation from the staff of a health care facility or voluntary limitation of the licensee's staff privileges at a health care facility if the licensee's voluntary action occurs while the licensee is under investigation by the health care facility or its committee for any reason related to possible medical incompetence, unprofessional conduct or physical incapacity or impairment **within 30 calendar days**.

(2) For purposes of the statutes, reporting to the Board means making a report to the Board's Investigation Unit or the Board's Executive Director or the Board's Medical Director. Making a report to the Board's Health Professionals' Services Program (HPSP) or HPSP's Medical Director does not satisfy the duty to report to the Board.

(3) For the purposes of ORS chapters 676 and 677, the terms medical incompetence, unprofessional conduct, and impaired licensee have the following meanings:

(a) Medical Incompetence: A licensee who is medically incompetent is one who is unable to practice medicine with reasonable skill or safety due to lack of knowledge, lack of ability, or impairment. Evidence of medical incompetence shall include:

(A) Gross or repeated acts of negligence involving patient care.

(B) Failure to achieve a passing score or satisfactory rating on a competency examination or program of evaluation when the examination or evaluation is ordered or directed by the Board or a health care facility.

(C) Failure to complete a course or program of remedial education when ordered or directed to do so by the Board or a health care facility, or a medical education or training program.

(b) Unprofessional conduct: Unprofessional conduct includes the behavior described in ORS 677.188(4), defined as conduct which is unbecoming to a person licensed by the Board or detrimental to the best interest of the public, and which includes:

(A)(i) Any conduct or practice contrary to recognized standards of ethics of the medical, podiatric, or acupuncture professions, or

(ii) Any conduct which does or might constitute a danger to the health or safety of a patient or the public, to include a violation of patient boundaries, or

(iii) Any conduct or practice which does or might adversely affect a provider's ability to safely and skillfully practice medicine, podiatry, or acupuncture; or

(iv) Practicing with a condition that is adversely affecting a provider's ability to safely and skillfully practice medicine, podiatry, or acupuncture.

(B) Willful performance of any surgical or medical treatment which is contrary to acceptable medical standards.

(C)(i) Willful and repeated ordering or performance of unnecessary laboratory tests or radiologic studies; or

(ii) Administration of unnecessary treatment; or

(iii) Employment of outmoded, unproved, or unscientific treatments, except as allowed in ORS 677.190 (1)(b); or

(iv) Failing to obtain consultations when failing to do so is not consistent with the standard of care; or

(v) Otherwise utilizing medical service for diagnosis or treatment which is or may be considered inappropriate or unnecessary.

(D) Fraud in the performance of, or the billing for, medical procedures.

(E) Repeated instances of disruptive behavior in the health care setting that could adversely affect the delivery of health care to patients.

(F) Sexual misconduct: Licensee sexual misconduct is behavior that exploits the licensee-patient relationship in a sexual way. The behavior is non-diagnostic and non-therapeutic, may be verbal, physical or other behavior, and may include expressions of thoughts and feelings or gestures that are sexual or that reasonably may be construed by a patient as sexual. Sexual misconduct includes but is not limited to:

(i) Sexual violation: Licensee-patient sex, whether or not initiated by the patient, and engaging in any conduct with a patient or the patient's immediate family that is sexual or may be reasonably interpreted as sexual, including but not limited to:

(I) Sexual intercourse;

(II) Genital to genital contact;

(III) Oral to genital contact;

(IV) Oral to anal contact;

(V) Genital to anal contact;

(VI) Kissing in a romantic or sexual manner;

(VII) Touching breasts, genitals, or any sexualized body part for any purpose other than appropriate examination or treatment, or where the patient has refused or has withdrawn consent;

(VIII) Encouraging the patient to masturbate in the presence of the licensee or masturbation by the licensee while the patient is present; or

(IX) Offering to provide practice-related services, such as medications, in exchange for sexual favors.

(ii) Sexual impropriety: Behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient or the patient's immediate family, to include:

(I) Sexually exploitative behavior, to include taking, transmitting, viewing, or in any way using photos or any other image of a patient, their family or associates for the prurient interest of others.

(II) Intentional viewing in the health care setting of any sexually explicit conduct for prurient interests.

(III) Having any involvement with child pornography, which is defined as any visual depiction of a minor (a child younger than 18) engaged in sexually explicit conduct.

(IV) Sexually explicit communication in person, by mail, by telephone, or by other electronic means, including but not limited to text message, e-mail, video or social media.

(G) Conduct not otherwise allowed by Oregon law which is contrary to or inconsistent with recognized standards of ethics of the medical, podiatric, or acupuncture professions, specifically conduct that is contrary to or inconsistent with:

(i) Any principle, opinion, or provision of the American Medical Association's 2016 Code of Ethics.

(ii) Ethical standards established by a specialty board as defined in OAR 847-020-0100:

(I) In which the licensee is certified, and

(II) Which were in place at the time the conduct occurred.

(iii) Ethical standards established by the medical college or specialty society:

(I) In which the licensee practices or practiced at the time of the conduct, and

(II) Which were in effect as of April 7, 2022.

(iv) Any provision of the American Osteopathic Association's 2016 Code of Ethics.

(v) Any provision of the American Podiatric Medical Association's 2017 Code of Ethics.

(vi) Any provision of the 2008 (reaffirmed in 2013) American Association of Physician Assistants' Guidelines for Ethical Conduct for the Physician Assistant Profession.

(vii) Any provision of the Oregon Association of Acupuncture and Oriental Medicine's 2008 Code of Ethics.

(viii) Any provision of the National Certification Commission for Acupuncture and Oriental Medicine's ~~**2016**~~ **2023** Code of Ethics.

(H) Intentionally contacting the known complainant or allowing any person authorized to act on behalf of the licensee to contact the known complainant in regard to the complaint or investigation unless and until the licensee has requested a contested case hearing and the Board has authorized the taking of the complainant's deposition pursuant to ORS 183.425.

(I) In the practice of acupuncture, the failure to meet the standard of care of a reasonably prudent, careful, and skillful practitioner of acupuncture under the same circumstances, in the same or similar community. In the practice of acupuncture, errors of such repetition or magnitude that a willful disregard of practice standards or patient safety may be inferred.

(J) In the practice of medicine, podiatry, or acupuncture, discrimination through unfair treatment characterized by implicit and explicit bias, including microaggressions, or indirect or subtle behaviors that reflect negative attitudes or beliefs about a non-majority group. Discrimination is differences in the quality of healthcare delivered that is not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.

(c) Licensee Impairment: A licensee who is impaired is a licensee who is unable to practice medicine with reasonable skill or safety due to factors which include, but are not limited to:

(A) The use of alcohol, drugs, prescribed medication, or other substances while on or off duty which causes impairment when on duty, including taking call or supervising other healthcare professionals, regardless of practice setting.

(B) Mental or emotional illness.

(C) Physical deterioration or long term illness or injury which adversely affects cognition, motor, or perceptive skills.

(4) For the purposes of the reporting requirements of this rule and ORS 677.415, licensees shall be considered to be impaired if they refuse to undergo an evaluation for mental or physical competence or chemical impairment, or if they resign their privileges to avoid such an evaluation, when the evaluation is ordered or directed by a health care facility or by this Board.

(5) For the purposes of the reporting requirements of this rule and ORS 677.415, official action does not include administrative suspensions of seven or fewer calendar days for failure to maintain or complete records. Administrative suspensions described in this section must be reported as an official action when the suspensions occur more than three times in any 12-month period.

(6) A report made by a board licensee or the Oregon Medical Association or other health professional association, to include the Osteopathic Physicians and Surgeons of Oregon, Inc, or the Oregon Podiatric Medical Association to the Board under ORS 677.415 shall include the following information:

(a) The name, title, address and telephone number of the person making the report;

(b) The information that appears to show that a licensee is or may be medically incompetent, is or may be guilty of unprofessional or dishonorable conduct or is or may be a licensee with an impairment.

(7) A report made by a health care facility to the Board under ORS 677.415 (5) and (6) shall include:

(a) The name, title, address and telephone number of the health care facility making the report;

(b) The date of an official action taken against the licensee or the licensee's voluntary action withdrawing from practice, voluntary resignation or voluntary limitation of licensee staff privileges; and

(c) A description of the official action or the licensee's voluntary action, as appropriate to the report, including:

(A) The specific restriction, limitation, suspension, loss or denial of the licensee's medical staff privileges and the effective date or term of the restriction, limitation, suspension, loss or denial; or

(B) The fact that the licensee has voluntarily withdrawn from the practice of medicine or podiatry, voluntarily resigned from the staff of a health care facility or voluntarily limited the licensee's privileges at a health care facility and the effective date of the withdrawal, resignation or limitation.

(8) A report made under ORS 677.415 Section 2 may not include any information that is privileged peer review data, see ORS 41.675.

(9) All required reports shall be made in writing.

(10) Any person who reports or provides information in good faith as required by the statutes is immune from civil liability for making the report.

Statutory/Other Authority: ORS 677.265 & 677.417
Statutes/Other Implemented: ORS 676.150, 677.092, 677.190, 677.205, 677.265 & 677.415

847-010-0070
Competency Examination

(1) Whenever the Board ~~of Medical Examiners~~ orders a medical competency examination pursuant to ORS 677.420, it may require or administer one, all, or any combination of the following examinations:

(a) The Special Purpose Examination (SPEX);

(b) The Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX);

(c) Oral examination;

(d) Any other examination that the Board determines appropriate.

(2) Failure to achieve a passing grade on any examination shall constitute grounds for suspension or revocation of examinee's license on the grounds of Manifest Incapacity to Practice Medicine as provided by ORS 677.190(15).

(3) If an oral examination is ordered by the Board, an Examination Panel shall be appointed. The examination shall include questions which test basic knowledge and also test for knowledge expected of a physician with a practice similar in nature to that of the examinee's. The panel shall establish a system for weighing the score for each question in the examination. After it is prepared, the examination shall be submitted to the Board for review and approval.

(4) Appointment of an Examination Panel is required only when administering an oral examination.

(5) The examinee shall be given no less than two weeks' notice of the date, time and place of any examination to be administered.

(6) The medical competency examination shall be paid for by the licensee.

Statutory/Other Authority: ORS 677.265
Statutes/Other Implemented: ORS 677.110

CODE OF ETHICS

As an NCCAOM® Certified Diplomate, I hereby pledge my aspiration and on-going commitment to the following principles to maintain the highest level of competency and ethical standards of my profession:

- *Respect the rights, privacy and dignity of my patients by maintaining confidentiality and professional boundaries at all times.*
- *Respect my colleagues, employees, students and mentees by maintaining appropriate boundaries.*
- *Treat within my lawful scope of my practice and training and only if I am able to safely, competently and effectively do so.*
- *Assist those seeking my services in a fair, nondiscriminatory and unbiased manner.*
- *Allow my patients to fully participate in decisions related to their healthcare by documenting and keeping them informed of my treatments and outcomes.*
- *Render the highest quality of care and make timely referrals to other health care professionals as may be appropriate.*
- *Continue to advance my knowledge through education, training and collaboration with my colleagues.*
- *Participate in activities that contribute to the betterment and wellness of my community.*
- *Support in the care and access of my medicine to underserved populations.*
- *Promote my profession's access to all people and its growth in the broad spectrum of health care.*

Revised November 2023

ADMINISTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Public Session

Rule Review

Member Assigned: **Mageehon**

First Review: **847-050-0021; 847-070-0022; 847-080-0017**
Subject: **Documents to be Submitted for Licensure; Letters and Official Verifications to be Submitted for Licensure**

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 050, 070, 080 – OREGON MEDICAL BOARD

First Review – April 2024

The rule amendments align recent updates to the MD/DO rule regarding employment verifications submitted for licensure in OAR 847-020-0160. For physician assistant, acupuncture, and podiatric physician applicants, the rule amendments clarify an evaluation of overall performance for an employer verification must include a statement of good standing or a statement regarding eligibility for rehire.

847-050-0021
Documents to be Submitted for Licensure (Physician Assistant)

The documents submitted must be legible and no larger than 8 ½" x 11". All documents and photographs will be retained by the Board as a permanent part of the application file. If original documents are larger than 8 ½″ x 11″, the copies must be reduced to the correct size with all wording and signatures clearly shown. Official translations are required for documents issued in a foreign language. The following documents are required:

(1) Application: Completed formal application provided by the Board. Required dates must include month, day, and year.

(2) Birth Certificate: A copy of birth certificate and a copy of Change of Name documentation, Marriage Certificate, or Divorce Decree if the applicant's name has been changed by court order, adoption, marriage, divorce, etc.

(3) Photograph: A close-up, passport-quality photograph, front view, head and shoulders (not profile), with features distinct, taken within 90 days preceding the filing of the application.

(4) Legible fingerprints as described in OAR 847-008-0068 for the purpose of a criminal records background check.

(5) The results of a Practitioner Self-Query from the National Practitioner Data Bank.

(6) The results of a Physician Data Center Query from the Federation of State Medical Boards.

(7) The applicant must ensure the following required official documents are sent to the Board directly from:

(a) The physician assistant education program:

(A) Proof of completion of a physician assistant education program as specified in OAR 847-050-0020(1) and which includes degree issued, date of degree, dates of attendance, dates and

reason of any leaves of absence or repeated years, and dates, name and location of education program if a transfer student.

(B) A Verification of Education form; which must include information about an applicant's knowledge base, clinical skills, medical judgement, professionalism, and ethics; including any concerns regarding possible impairment in the applicant's ability to safely practice their profession. If the school is unable to complete the form or the Board determines that it is unacceptable, a copy of the transcripts may be acceptable.

(b) Official Examination Certification: An official Examination Certification of the Physician Assistants National Certifying Examination (PANCE), showing the examination score, is required directly from the National Commission on Certification of Physician Assistants (NCCPA).

(c) **If requested by the Board, a**~~A~~ letter verifying licensure in good standing from the state or states of all prior and current health-related licensure. Verification, sent directly from the boards, must show license number, date issued, examination grades if applicable and status.

(d)**(A)** The Director or other official for practice and employment in hospitals, clinics, etc. in the United States and foreign countries: A currently dated original letter (a copy is not acceptable), sent directly from the hospital/clinic, must include ~~an evaluation of overall performance~~**a statement of good standing** and specific beginning and ending dates of practice and employment, for the past five (5) years only.

(B) If the applicant has ~~not~~**ceased** practice~~d~~ for more than two **(2)** years, employment verifications will be required for the past ten (10) years.

(C) If such verification is unavailable or incomplete, provide three reference letters from physicians or physician assistants in the local medical community who are familiar with the applicant's practice and who have known the applicant for more than six months.

(8) Any other documentation or explanatory statements as required by the Board, including but not limited to medical records and criminal or civil records.

Statutory/Other Authority: ORS 677.265 & ORS 677.512
Statutes/Other Implemented: ORS 677.512

847-070-0022
Documents to be Submitted for Licensure (Acupuncture)

The documents submitted must be legible and no larger than 8 ½" x 11". All documents and photographs will be retained by the Board as a permanent part of the application file. If original documents are larger than 8 ½" x 11", the copies must be reduced to the correct size with all wording and signatures clearly shown. Official translations are required for documents issued in a foreign language. The following documents are required:

(1) Application: Completed formal application provided by the Board. Required dates must include month, day and year.

(2) Birth Certificate: A copy of birth certificate and a copy of Change of Name documentation, Marriage Certificate, or Divorce Decree if the applicant's name has been changed by court order, adoption, marriage, divorce, etc.

(3) Acupuncture School Diploma: A copy of a diploma showing graduation from an approved school of acupuncture for those applicants who qualify under OAR 847-070-0016(1).

(4) Photograph: A close-up, passport-quality photograph, front view, head and shoulders (not profile), with features distinct, taken within 90 days preceding the filing of the application.

(5) A letter from the Dean of the applicant's program of acupuncture for those applicants who qualify under OAR 847-070-0016(1).

(6) A letter from the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) verifying current certification in acupuncture by the NCCAOM for those applicants who qualify under OAR 847-070-0016(1) or (2).

(7) **If requested by the Board, a**~~A~~ letter verifying licensure in good standing from the state or states of all prior and current health-related licensure.

(8)**(a)** A letter from the Director or other official for practice and employment to include ~~an evaluation of overall performance~~ **a statement regarding eligibility for rehire** and specific beginning and ending dates of practice and employment, for the past five (5) years only.

(b) If the applicant has ceased practice for more than two (2) years, employment verifications will be required for the past ten (10) years or redacted patient logs from the past five (5) years.

(c) If such verification is unavailable or incomplete, and for acupuncturists who have been or are in solo practice, three reference letters from acupuncturists in the local treatment community who are familiar with the applicant's practice and who have known the applicant for more than six months.

Statutory/Other Authority: ORS 677.265 & 677.759
Statutes/Other Implemented: ORS 677.275 & 677.759

847-080-0017
Letters and Official Verifications to be Submitted for Licensure (Podiatric)

The applicant must ensure that official documents are sent to the Board directly from:

(1) The School of Podiatry:

(a) The Verification of Medical Education form, which includes: degree issued, date of degree, dates of attendance, dates and reason of any leaves of absence or repeated years, and dates, name and location of school of podiatric medicine school if a transfer student.

(b) A Dean's Letter of Recommendation, which includes a statement concerning the applicant's moral and ethical character and overall performance as a podiatric medical student. If the school attests that a Dean's Letter is unavailable or the Board determines that it is unacceptable, a copy of the transcripts may be acceptable.

(2) The Director of Podiatric Education, Chairman or other official of the residency hospital in U.S.: A currently dated original letter (a copy is not acceptable), sent directly from the hospitals in which any post-graduate training was served, which includes an evaluation of overall performance and specific beginning and ending dates of training.

(3)**(a)** The Director or other official for practice and employment in hospitals, clinics, etc., in the U.S. and foreign countries: A currently dated original letter (a copy is not acceptable), sent directly from the hospital/clinic, which includes ~~an evaluation of overall performance~~ **a statement of good standing** and specific beginning and ending dates of practice and employment.

(b) If the applicant has ceased practice for more than two (2) years, employment verifications will be required for the past ten (10) years.

(c) If such verification is unavailable or incomplete, provide three reference letters from physicians in the local medical community who are familiar with the applicant's practice and who have known the applicant for more than six months.

(4) **If requested by the Board,** ~~A~~all health licensing boards in any jurisdiction where the applicant has ever been licensed; regardless of status, i.e., current, lapsed, never practiced there: Verification, sent directly from the boards, must show license number, date issued and status.

(5) Official Examination Certification: An official certification of examination scores for the American Podiatric Medical Licensing Examination (APMLE) Parts I, II and III or the National Board of Podiatric Medical Examiners (NBPME) examination Parts I, II and III is required directly from the NBPME or the Federation of Podiatric Medical Boards.

(6) Federation of Podiatric Medical Boards Disciplinary Report: A Disciplinary Report sent directly from the Federation of Podiatric Medical Boards to the Board.

(7) Any other documentation as required by the Board, including but not limited to medical records and criminal or civil records.

Statutory/Other Authority: ORS 677.265 & 677.820
Statutes/Other Implemented: ORS 677.820, 677.825 & 677.830

ADMINSTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Public Session

Member Assigned: **Mageehon**

Subject: **Committee Recommendations Regarding First Review Rules**

ADMINISTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Public Session

Rule Review

Member Assigned: **Poulsen**

Final Review: **847-001-0005**
Subject: **Rules for Contested Cases**

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 001 – OREGON MEDICAL BOARD

Final Review – March 2024

The rule amendment updates the timeframe by which a party who requests a hearing must file a written answer. The amended timeframe would allow filling within 30 days of a timely hearing request, or 30 days after production, whichever is later.

847-001-0005
Rules for Contested Cases

(1) The Oregon Medical Board adopts the Attorney General's Uniform and Model Rules for Contested Cases of the Attorney General in effect on January 1, (2008), and all amendments thereto are hereby adopted by reference as rules of the Oregon Medical Board.

(2) The Bboard must accept a properly addressed hearing request that was not timely filed if it was postmarked within the time specified for timely filing unless the Bboard receives the request after the entry of the final order by default.

(3) The Bboard may accept a late hearing request other than one described in section (2) above only if:

(a) The failure to timely request a hearing was due to the serious illness of a party lasting 30 days or more, the terminal illness of a member of the party's immediate family, destruction of the party's home or practice site, reasonable reliance on a statement of the agency relating to procedural requirements, or from fraud, misrepresentation, or other misconduct of the agency; and

(b) The Bboard receives the request before the entry of a final order by default.

(4) Due to the complexity of the Board's cases, ~~except for orders of emergency license suspension,~~ a party who requests a hearing must file a written answer within 30 days of a timely hearing request **or, if the party requests discovery, 30 days after production is provided, whichever is later**. **However, in no case shall a party's initial written answer be accepted less than 10 days prior to the first day of any hearing scheduled on the matter.** ~~The written answer must include a statement of each defense the party is raising.~~

~~(5) Regarding an answer filed by a party:~~

(a) **The written answer must include a statement of each defense, including any affirmative defenses, the party is raising**. Failure to raise a particular defense in the answer will be considered a waiver of such defense.

(b) New matters alleged in the answer are presumed to be denied by the Board.

(c) The answer may be amended, but no later than **30 days after the answer response was due**~~60 days after the deadline provided in the notice to request a hearing~~.

(~~6~~d)(A) If the Board amends its notice **without basing its amendment on one or more additional alleged violations**, then a party that requested a hearing may amend its answer up to 30 days after the agency issues the amended notice or **10 days** prior to hearing, whichever is earlier.

(B) If the Board amends its notice based on one or more additional alleged violations, then a party that requested a hearing may amend its answer up to 30 days after the Board issues the amended notice, 30 days after any additional production is provided, or 10 days prior to hearing, whichever is earliest.

(5) Section (4) of this rule does not apply to requests for hearing on orders of emergency license suspension.

[ED. NOTE: The full text of the Attorney General's Model Rules of Procedure is available from the office of the Attorney General or the Medical Board.]

Statutory/Other Authority: ORS 677.265
Statutes/Other Implemented: ORS 183.335, 183.341 & 677.275

ADMINISTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Public Session

Rule Review

Member Assigned: **Cramer**

Final Review: **847-005-0005**
Subject: **Licensure Fees**

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 5 – OREGON MEDICAL BOARD

Final Review – April 2024

The rule amendments implement SB 5522 (2023) policy package 102 to increase Oregon Medical Board (OMB) license registration fees by 25% for all license types, effective July 1, 2024. See the OMB 2023 – 2025 Legislatively Adopted Budget (click link to access) for more information. The rulemaking also removes obsolete fees for the prior PA supervision practice model.

The fee increases ensure that the OMB can continue to fulfill its mission of protecting the public by providing the financial resources necessary to support agency programs. Increased revenue is necessary to provide the OMB with sufficient funding for increasing agency expenses. The last time the OMB exercised the power to increase fees was in 2013.

847-005-0005
Licensure Fees

(1) Doctor of Medicine (MD) and Doctor of Osteopathic Medicine (DO) Licensing Fees:

(a) Initial License Application — $375.

(b) Registration: Active, Administrative Medicine, Inactive, Locum Tenens, Military/Public Health, Telemedicine, Telemonitoring and Teleradiology — $~~253~~**314**/year+*.

(c) Registration: Emeritus — $50/year.

(d) Limited License, SPEX/COMVEX, Visiting Professor, Fellow, Medical Faculty, Postgraduate Application — $185.

(2) Acupuncture Licensing Fees:

(a) Initial License Application — $245.

(b) Registration: Active, Inactive, Locum Tenens and Military/Public Health — $~~161~~**201**/year*.

(c) Registration: Emeritus — $50/year.

(d) Limited License, Visiting Professor, Pending Examination Application — $75.

(3) Physician Assistant Licensing Fees:

(a) Initial License Application — $245.

(b) Registration: Active, Inactive, Locum Tenens, Military/Public Health, and Telemedicine — $~~191~~239/year*.

(c) Registration: Emeritus — $50/year.

(d) Limited License, Pending Examination Application — $75.

(4) Doctor of Podiatric Medicine Licensing Fees:

(a) Initial Application — $340.

(b) Registration: Active, Administrative Medicine, Inactive, Locum Tenens, Military/Public Health, Telemedicine and Telemonitoring — $~~243~~304/year*.

(c) Registration: Emeritus — $50/year.

(d) Limited License, Postgraduate Application — $185.

(5) Other Application or Licensing Fees:

(a) Reactivation Application Fee — $50.

~~(b) Application to Supervise a Physician Assistant — $100.~~

~~(c) Application to Supervise a Physician Assistant in a Volunteer Capacity — $50.~~

(~~d~~b) Electronic Prescription Drug Monitoring Program — $35/year**.

(~~e~~c) Workforce Data Fee — $2/year***.

(~~f~~d) Criminal Records Check Fee — $52****.

(6) Delinquent Registration Renewals:

(a) Delinquent MD/DO Registration Renewal — $195.

(b) Delinquent Acupuncture Registration Renewal — $80.

(c) Delinquent Physician Assistant Registration Renewal — $80.

(d) Delinquent Doctor of Podiatric Medicine Registration Renewal — $195.

(7) All Board fees and fines are non-refundable and non-transferable.

+Per ORS 677.290(3), fee includes $10.00 for the Oregon Health and Science University Library.

*Collected biennially excepted where noted in the Administrative Rules.

**Per ORS 431A.850-431A.895, fee is assessed to licensees authorized to prescribe or dispense controlled substances in Oregon for the purpose of creating and maintaining the Prescription Drug Monitoring Program administered by the Oregon Health Authority.

***Per ORS 676.410, fee is assessed for the purpose of creating and maintaining a healthcare workforce data base administered by the Oregon Health Authority.

****Per ORS 181A.195(9)(e), fee is the actual cost of acquiring and furnishing criminal offender information.

Statutory/Other Authority: ORS 677.265, 181A.195, 431A.880 & 676.410
Statutes/Other Implemented: ORS 677.265, 181A.195, 431A.880, 676.410 & 677.290

ADMINISTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Public Session

Rule Review

Member Assigned: **Eshraghi**

Final Review: **847-008-0055; 847-020-0110; 847-025-0050; 847-050-0015; 847-070-0015; 847-080-0002**

Subject: **Reactivation Requirements; Application for Licensure**

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 8, 20, 25, 50, 70, 80 – OREGON MEDICAL BOARD

Final Review – April 2024

The rule amendments add payment of any civil penalties and costs due to the Oregon Medical Board as an application requirement. This would apply to applicants with a surrendered, retired, or revoked license seeking to be relicensed. Applicants would have to pay in full any civil penalties and costs due to the Oregon Medical Board before being relicensed.

847-008-0055
Reactivation Requirements (all OMB licensees)

(1) A licensee of the Board who wishes to reactivate must provide the Board with the following:

(a) Completed reactivation application;

(b) Appropriate fees as listed in 847-005-0005 **and any civil penalties or hearing costs that may be due**;

(c) An evaluation of overall performance and specific beginning and ending dates of training, practice, or employment sent directly to the Board from the director, administrator, dean, or other official of each hospital, clinic, office, or training institute where the licensee was employed, practiced, had hospital privileges, or trained in any state, country, or territory since the time of licensee's last renewal or as directed by the Board.

(2) The Board may require the licensee applying for reactivation to:

(a) Provide other documentation or explanatory statements;

(b) Personally appear before the Board;

(c) Demonstrate clinical competency per 847-020-0182, 847-020-0183, 847-050-0043, 847-070-0045, or 847-080-0021.

(3) The Board may deny reactivation based on grounds for denial of licensure provided in Oregon Revised Statutes chapter 677 or Oregon Administrative Rules chapter 847.

Statutory/Other Authority: ORS 677.265
Statutes/Other Implemented: ORS 677.172, ORS 677.190, ORS 677.265, ORS 677.512, ORS 677.759, ORS 677.825 & ORS 677.830

847-020-0110
Application for Licensure (MD/DO)

(1) Any person who wishes to practice medicine in this state beyond the first post-graduate training year must apply for an Oregon license to practice medicine.

(2) When applying for licensure, the applicant must submit to the Board the completed application, fees, documents, ~~and~~ letters**, and any civil penalties or hearing costs that may be due**.

(3) A person applying for licensure under these rules who has not completed the licensure process within a 12 month consecutive period must file a new application, documents, letters and pay a full filing fee as if filing for the first time.

(4) The applicant may be required to appear before the Board for a personal interview regarding information received during the processing of the application. Unless excused in advance, failure to appear before the Board for a personal interview violates ORS 677.190(17) and may subject the applicant to disciplinary action.

Statutory/Other Authority: ORS 677.265
Statutes/Other Implemented: ORS 677.100 & 677.190

847-025-0050
Application (Telemedicine Status License)

(1) When applying for a license to practice medicine across state lines, the applicant must submit to the Board:

(a) The completed application, fees, documents, letters, **any civil penalties or hearing costs that may be due**, and any other information required by the Board for physician licensure as stated in OAR 847, division ~~0~~20 or physician assistant licensure as stated in OAR 847, division 50; and

(b) A description of the applicant's intended practice of medicine across state lines in the state of Oregon.

(2) An applicant applying for a license to practice medicine across state lines is subject to the requirements in OAR 847-008-0010.

Statutory/Other Authority: ORS 677.265 & 677.139
Statutes/Other Implemented: ORS 677.100, 677.139 & 677.265

847-050-0015 (PA)
Application

(1) Each application for the licensure of a physician assistant must meet the licensing requirements as set forth in ORS 677.512.

(2) When applying for licensure, the applicant must submit to the Board the completed application, fees, documents, letters, and any civil penalties or hearing costs that may be due.

(~~2~~3) No applicant is entitled to licensure who:

(a) Has failed an examination for licensure in the State of Oregon;

(b) Has had a license or certificate revoked or suspended in this or any other state unless the said license or certificate has been restored or reinstated and the applicant's license or certificate is in good standing in the state which had revoked the same;

(c) Has been refused a license or certificate in any other state on any grounds other than failure in a medical licensure examination; or

(d) Has been guilty of conduct similar to that which would be prohibited by or to which ORS 677.190 would apply.

(~~3~~4) A person applying for licensure under these rules who has not completed the licensure process within a 12 month consecutive period from date of receipt of the application must file a new application, documents, letters and pay a full filing fee as if filing for the first time.

Statutory/Other Authority: ORS 677.265
Statutes/Other Implemented: ORS 677.265 & 677.512

847-070-0015
Application (Acupuncture)

(1) Every applicant must satisfactorily complete an application and document evidence of qualifications listed in OAR 847-070-0016 to the satisfaction of the Board. Such application and documentation must be complete before an applicant may be considered eligible for licensure.

(2) When applying for licensure, the applicant must submit to the Board the completed application, fees, documents, letters, and any civil penalties or hearing costs that may be due.

(~~2~~3) False documentation is grounds for denial of licensure or disciplinary action by the Board.

(~~3~~4) An applicant applying for licensure under these rules who has not completed the licensure process within a 12 month consecutive period must file a new application, documents, letters and pay a full filing fee as if filing for the first time.

(~~4~~5) No applicant is entitled to licensure who:

(a) Has had his/her license or certificate revoked or suspended in this or any other state unless the said license or certificate has been restored or reinstated and the applicant's license or certificate is in good standing in the state which had revoked the same;

(b) Has been refused a license or certificate in any other state on any grounds other than failure in an acupuncture licensure examination; or

(c) Has been guilty of conduct similar to that which would be prohibited by or to which ORS 677.190 would apply.

Statutory/Other Authority: ORS 677.265 & 677.759
Statutes/Other Implemented: ORS 677.759

847-080-0002
Application for Licensure (DPM)

(1) When applying for licensure the applicant must submit to the Board the completed application, fees, documents, ~~and~~ letters**, and any civil penalties or hearing costs that may be due**.

(2) A person applying for licensure under these rules who has not completed the licensure process within a 12 month consecutive period must file a new application, documents, letters and pay a full filing fee as if filing for the first time.

(3) The applicant may be required to appear before the Board for a personal interview regarding information received during the processing of the application. Unless excused in advance, failure to appear before the Board for a personal interview violates ORS 677.190(17) and may subject the applicant to disciplinary action.

Statutory/Other Authority: ORS 677.265
Statutes/Other Implemented: ORS 677.100, 677.190, 677.265, 677.810 & 677.840

ADMINSTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Public Session

Discussion Item

Member Assigned: **Mageehon**

Subject: **Public Comment**

ADMINSTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Discussion Item

Member Assigned: **Lee-Valkov**

Subject: **Statement of Philosophy Review: Cultural Competency**

OREGON MEDICAL BOARD

Statement of Philosophy

Diversity, Equity, and Inclusion in Medical Practice ~~Cultural Competency~~

The Oregon Medical Board's mission is to regulate the practice of medicine in a way to promote access to safe, quality care for all Oregon citizens. Oregonians are growing increasingly diverse, and inequities in access to quality health care are apparent. Achieving equity of health outcomes requires that we first acknowledge that current inequities are not acceptable, that we gain a better understanding of what contributes to ~~inequity~~**inequities**, and that we commit to addressing inequities.

Discrimination in the practice of medicine, podiatry, or acupuncture violates the standard of care and presents a risk of harm to patients. The Oregon Medical Board recommends the following as a basis for inspiring positive change for the benefit of all patients:

1. Focus on self-reflection and culturally competent practice

Licensees are encouraged to engage in self-reflection, understand their own conscious and unconscious biases, and consider the impact on the provider-patient relationship. The extent to which providers engage in self-reflection, consider how their own cultural view and biases influence patient care, and then adjust their practice, depends heavily on provider self-motivation to make change. Initiatives to embed cultural competency into all areas of practice, professional development, policies, and processes are essential.

2. Acknowledge systemic racism

Some patients may have difficulty engaging with health professionals or with the treatment prescribed due to systemic issues. It is important to acknowledge that systemic racism and privilege exist in the health sector in order to meaningfully address this problem. Providers can reflect on their own cultural views and biases as a first step, then work to influence and support positive changes in their institutions and organizations.

3. Collect and use data for equity monitoring

Health care providers need access to robust and accurate data to identify inequities and address problematic structures and processes.

4. Overcome structural barriers to individualize care

Short clinical visits focused on only the patient's immediate needs results in a relationship which is largely transactional. To strengthen the provider-patient relationship and provide culturally competent care, providers must consider the individual patient's practices, values, and beliefs. Tailoring the clinical visit to the individual can ensure the patient's input is respected and valued.

All Oregon Medical Board licensees are required to complete cultural competency continuing education to care effectively for patients from diverse cultures, groups, and communities. **~~Participating~~ Engaging** in cultural competency continuing education **and experiences** is a way to gain a better understanding of Oregon's socially and culturally diverse communities and to foster a commitment to addressing health care inequities.

The Oregon Medical Board is committed to addressing inequities in access to care, ensuring equitable licensure and disciplinary processes for all applicants and licensees, and confronting systemic disparities in health outcomes.

- Adopted October 2013
- Amended, April 1, 2021
- Amended April 4, 2024 (DRAFT)

The Oregon Medical Board holds licensees to recognized standards of ethics of the medical profession, specifically for this philosophy: American Medical Association's Code of Medical Ethics: Opinion 9.121 Racial and Ethnic Health Care Disparities; American Association of Physician Assistants' Guidelines for Ethical Conduct for the PA Profession: The PA and Individual Professionalism-Competency; and Oregon Association of Acupuncturists' Code of Ethics: 1.1 Competence. ORS 677.190(1)(a) and ORS 677.188(4)(a).

ADMINSTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Discussion Item

Member Assigned: **Eshraghi**

Subject: **Statement of Philosophy Review: Telemedicine**

OREGON MEDICAL BOARD
Statement of Philosophy

Telemedicine

The Oregon Medical Board supports a consistent standard of care and scope of practice for **physicians, physician assistants, and acupuncturists**~~licensees~~, regardless of the delivery tool or business method enabling provider-patient communication. Telemedicine is not a separate form of medicine, but rather a delivery tool. It is the practice of medicine, **podiatry, or acupuncture** through means of electronic communication, information technology, or other means of interaction between a **provider**~~licensee~~ at one location and a patient in another location.

Licensure Requirements

Telemedicine generally involves using secure videoconferencing or other appropriate technology to replicate the interaction of an in-person encounter. The practice of medicine, **podiatry, or acupuncture** occurs at the patient's location when technology is used to provide care. The provider must possess appropriate licensure in all jurisdictions where the patient receives care. Therefore, with a few exceptions provided in ORS 677.060 and 677.137 and detailed below, providers practicing via telemedicine on patients located in Oregon must be licensed in Oregon.

A physician or physician assistant licensed in another state may provide care via telemedicine without obtaining Oregon licensure if they have an established provider-patient relationship with a person who is in Oregon temporarily for the purpose of business, education, vacation, or work and who requires the direct medical treatment by that physician or physician assistant as provided in ORS 677.060 or 677.137.

A physician or physician assistant licensed in another state may consult directly with another physician or physician assistant licensed in Oregon if they do not undertake the primary responsibility for diagnosing or rendering treatment to a patient located in Oregon as provided in ORS 677.060 or 677.137.

A physician or physician assistant licensed in another state may provide temporary or intermittent follow up care via telemedicine without obtaining Oregon licensure if they have an established provider-patient relationship with a person located in Oregon **as described in ORS 677.060 or 677.137.** ~~Although not specifically addressed by a statutory exemption, the Oregon Medical Board has chosen not to enforce the licensure requirement for the out of state physician or physician assistant to provide this temporary or intermittent continuity of care.~~ The **OMB understands that the** patient**'s** needs are **often** best served by ~~having~~ **allowing continuity of care with** the physician or physician assistant who knows the patient and has access to the patient's medical records provide ~~this~~ follow up care **under these circumstances**.

A physician, physician assistant, or acupuncturist licensed in Oregon with an Active status license may be temporarily located outside of Oregon to provide care via telemedicine for a patient located in Oregon.

How to Conduct a Visit

The Board recognizes that delivery of services through telemedicine conveys potential benefits and potential challenges for patients, and that the delivery method does not alter the scope of practice, the professional obligations, the setting, or the manner of practice of any ~~licensee~~**provider**, beyond that authorized by law. **Physicians, physician assistants, and acupuncturists**~~Licensees~~ are always obligated to maintain the highest degree of professionalism, place the welfare of patients first, meet the same standards of professional practice and ethical conduct, and protect patient confidentiality. As such, some situations and presentations are appropriate to provide care via telemedicine, while some are not.

A physician, PA, or acupuncturist is expected to:

- Maintain an appropriate provider-patient relationship. At each telemedicine encounter, the **provider**~~licensee~~ should:
    - Verify the location and identity of the patient,
    - Provide the identity and credentials of the provider to the patient, and
    - Obtain appropriate informed consents from the patient after disclosures regarding the limitations of telemedicine.
- Document relevant clinical history and evaluation of the patient's presentation. Treatment based solely on an online questionnaire without individualized review and assessment does not constitute an acceptable standard of care.
- Provide continuity of care for patients, including follow-up care, information, and documentation of care provided to the patient or suitably identified care providers of the patient.
- Immediately direct the patient to the appropriate level of care when referral to acute or emergency care is necessary for the safety of the patient.
- Meet or exceed applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention rules. Written policies and procedures should be maintained at the same standard as in-person encounters for documentation, maintenance, and transmission of the records.
- Be transparent in:
    - Specific services provided;
    - Contact information;
    - Licensure and qualifications;
    - Fees for services and how payment is to be made;

- Financial interests;[1]
- Appropriate uses and limitations of the site, including emergency health situations;
- Uses and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;
- To whom patient health information may be disclosed and for what purpose;
- Rights of patients with respect to patient health information; and
- Information collected and any passive tracking mechanisms utilized.

- Provide patients a clear mechanism to:
  - Access, supplement, and amend patient-provided personal health information;
  - Provide feedback regarding the site and the quality of information and services; and
  - Register complaints, including information regarding filing a complaint with the Oregon Medical Board.

- Adopted January 2012
- Amended October 2, 2020; April 7, 2022, **(DRAFT) April 4, 2024**

The Oregon Medical Board holds **providers** ~~*licensees*~~ *to recognized standards of ethics of the medical profession, specifically for this philosophy: American Medical Association's Code of Medical Ethics: Opinion 1.2.12 Ethical Practice in Telemedicine; American Association of Physician Assistants' Guidelines for Ethical Conduct for the PA Profession: The PA and Patient; and Oregon Association of Acupuncturists' Code of Ethics: 1.2 Communication with Patients.*
- ORS 677.190(1)(a) and ORS 677.188(4)(a)

[1] A health practitioner must inform patients when referring the patient to a facility in which the health practitioner or an immediate family member has a financial interest. See ORS 441.098.

ADMINSTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Discussion Item

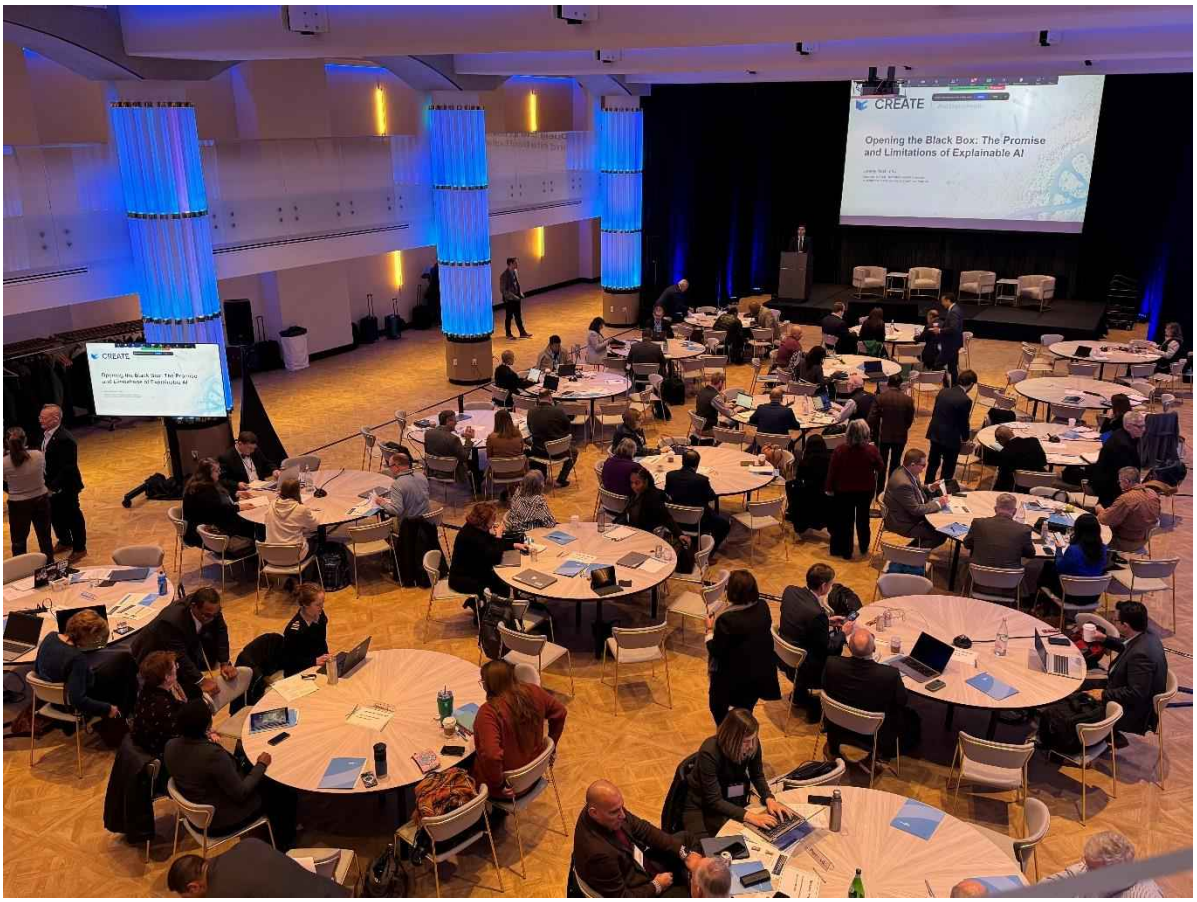
Member Assigned: **Cramer**

Subject: **Federation of State Medical Boards Artificial Intelligence Symposium**

Executive Summary: FSMB Symposium on Artificial Intelligence in Health Care and Medical Regulation
Washington, DC
January 17, 2024

The Federation of State Medical Boards' (FSMB) Symposium on Artificial Intelligence in Health Care and Medical Regulation was held on Wednesday, January 17, 2024, at the Hamilton Hotel, Washington, DC.

The meeting was attended by 133 individuals, including members and staff of state and territorial medical and osteopathic boards, representatives of the health technology sector, the legal profession, venture capital, government (including HRSA and the Office for the Advancement of Telehealth at HHS, and a legislative fellow for the U.S. Senate Artificial Intelligence Caucus), and several partner organizations – such as AACOM, AAOE, ACCME, AMA, AOA, ATA, CMSS, FSMB Foundation, Intealth, NABP, NBME and NBOME. .



Humayun "Hank" Chaudhry, DO, President and CEO of the FSMB, and Jeffrey Carter, MD, Chair of the FSMB's Board of Directors and member of the Missouri Board of Registration, opened the meeting. Dr. Carter reminded attendees that this was not FSMB's first public discussion of the subject. Working with the law firm of McDermott Will and Emery, the FSMB sponsored a symposium in 2018 about the role of artificial intelligence and technology in health care. Dr. Carter also noted that a significant reason for the symposium this time is to better inform the ongoing work of the FSMB's Ethics and Professionalism

Committee. The Committee, chaired by FSMB Board Member Mark Woodland, MS, MD, of Pennsylvania Board of Medicine, is drafting guidance and recommendations related to artificial intelligence in health care for consideration by the FSMB's House of Delegates in three months in Nashville, Tennessee.

Opening Keynote Speaker

Jeffery Smith, MPP, the Deputy Division Director within the Certification and Testing Division in the Office of Technology at the Office of the National Coordinator (ONC) for Health Information Technology in the U.S. Department of Health and Human Services, was the opening keynote speaker. Mr. Smith previously served as Vice President of Public Policy at the American Medical Informatics Association. He shared a brief primer about the ONC and its statutory role in the federal government, noting that "ONC-certified Health IT is the foundation of the U.S. Digital Health infrastructure" and that the Government Accountability Office (GAO) had looked at clinical applications and administrative applications of AI as early as 2020.

Mr. Smith said that ONC is optimistic on the use of AI in healthcare but recognizes there are challenges, including the possibility of widespread harm by misuse or misapplication of AI. He cited several examples, including racial bias in algorithms and an EPIC sepsis model that looked at 180 million covered lives and was found to be flawed. He also said that ONC focuses "on equity and fairness when it comes to quantitative measures of performance of IT." The ONC's view, he said, is that "transparency is a requisite for trustworthy AI."

He also spoke at length about the Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing (HTI-1) Final Rule, which will become effective on January 1, 2025. The rule defines Predictive DSI (Decision Support Intervention) as "technology that supports decision-making based on algorithms or models that derive relationships from training data and then produce an output that results in prediction, classification, recommendation, evaluation, or analysis." Predictive DSI certification requirements (1) enable users to access information about the design, development, training, and evaluation of Predictive DSIs; (2) require developers to apply "intervention risk management" practices for all Predictive DSIs; and (3) make information regarding these practices available to the public. The ONC's focus on transparency was characterized as a fundamental first step towards governance of AI in healthcare.

Mr. Smith also discussed the alignment of this rule with President Biden's Executive Order on The Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence, issued October 30, 2023. The order defines AI as "a machine-based system that can, for a given set of human-defined objectives, make predictions, recommendations, or decisions influencing real or virtual environments." The order also called for an AI Task Force to develop a strategic plan on the responsible deployment and use of AI and AI-enabled technologies in the health and human services sector. The Task Force will be developing policies addressing safety and performance monitoring of AI in health care and incorporating equity principles into AI-enabled technologies used in the health and human services.

Mr. Smith suggested medical regulators, educators and accreditors need to be focused on incorporating basic AI education at the medical student level, and ensuring basic AI literacy for all practitioners.

Perspectives Panel

The opening panel featured a discussion with Marc Paradis, MS, Vice President of Data Strategy at Northwell Health, Marc Succi, MD, a radiologist at Massachusetts General Hospital-Harvard Medical School and Associate Chair of Innovation and Commercialization at Mass General Brigham, and Alya Sulaiman, JD, a Partner at McDermott Will & Emery. Frank Meyers, JD, FSMB's Deputy Legal Counsel, served as moderator.

Panelists outlined current AI usage for ambient clinical documentation, diagnostic assistance, patient communication and care coordination. Challenges include physician reluctance to adopt recommendations, determining accountability, and avoiding introducing biases. The panelists highlighted both risks and benefits associated with greater incorporation of AI into the clinical setting, such as acceleration of diagnoses and individualized treatment models.

Collectively, the panelists urged developing regulatory approaches focused on addressing those harms we are most interested in avoiding, rather than adopting vague principles. Multiple panelists argued the pace of AI advancement necessitates rapid adoption while addressing ethical concerns. Action items center on further testing of current AI tools in clinical settings and developing education accompanied by incentives to drive responsible clinician usage.

The panel also addressed the challenges of attributing liability across developers, organizations, and clinicians with AI usage, and discussed potential exploration of shared responsibility models. Ms. Sulaiman commented that distributive responsibility models of regulation tend to be less favorable than those focusing on shared responsibility. Such models would require clear measures on intended functionality, performance degradation risks and appropriate human oversight. Ms. Sulaiman remarked that the key question for development of future regulatory policies is "What are we comfortable delegating to AI?"

Mr. Paradis observed that generative artificial intelligence could be the solution to the balance we all seek between losing physicians and other health care practitioners to burnout and developing improvements in our ability to assess clinical risk and improve care. He suggested approaching artificial intelligence with a focus less on the impact of technology on today's healthcare delivery models and instead on how technology will transform society, suggesting AI would "rewire society in 5-10 years" at every level. Human intelligence, he argued, is a "flawed form of intelligence" replete with biases (e.g., recency bias, experiential bias, etc.) and attempting to guarantee bias-free AI systems, when the same cannot be said for human intelligence, would slow down or halt the beneficial application of AI in the healthcare setting. Dr. Succi believed the transformative impact of AI on healthcare will take longer, stating "I think 90% adoption of AI in health care in 5-10 years is not realistic because it takes 2-3 times longer to change anything in healthcare." Dr. Succi said he is looking not only at AI that improves quality of health care but also improves access to care, as with rural health care.

The panel also commented on recently introduced legislation in Georgia that would require a licensed physician to oversee and review all uses of AI in healthcare. More than one panelist suggested such legislation may be too draconian and limit the innovation and power of AI to improve health care.

Key Ethical Challenges for Medical Regulation

Jeremy Petch, PhD, Director of Digital Health Innovation at Hamilton Health Sciences and an Assistant Professor at the University of Toronto and McMaster University, reviewed what is meant by "Black Box" AI models, noting that a "black box" is an engineering term that refers to algorithms that are sufficiently complex that they are not easily interpretable by humans (and sometimes not interpretable at all). Black boxes, he said, are often cited as a barrier to the adoption of AI in medicine, given that they impact clinician ability to trust the models. He reviewed the differences between interpretability and explainability in black box models, and between global and local explanations for how such models work.

Dr. Petch reviewed limitations of explainability: explanations are approximations, so they may produce only an imitative understanding of the functioning of black box AI. Interpretability, on the other hand, implies that a human can understand exactly how a model arrived at a specific output. He proposed a

guideline for deciding when to require interpretable models, as opposed to merely explainable ones, suggesting that the decision should be based on the stakes of the clinical decision and how significant a tradeoff it offers in terms of interpretability and performance. If there are no meaningful differences in performance or accuracy between interpretable and explainable models, then an interpretable model should be used. However, if there is a significant improvement in performance with an explainable model, then its use may be justified. As the stakes of a decision are raised, the improvement in performance should also rise significantly for ongoing acceptance of an explainable black box model to be justified. If significant improvement in performance is not offered, then interpretability should be required.

Sara Gerke, JD, an Assistant Professor of Law at Penn State Dickinson Law School, discussed the potential liability for physicians using AI. Ms. Gerke analyzed scenarios where physicians face liability risks by not following current standard of care, even if AI recommendations are correct. She also discussed a recent study in the *Journal of Nuclear Medicine* which concluded that a juror may not be more inclined to assign liability if a clinician rejects AI-generated advice that causes harm in comparison to a situation where a clinician follows a non-standard of care approach that causes patient harm. She further discussed that beyond physicians, the law also creates liability risks for hospital systems purchasing and implementing AI tools, and developers involved in creating them.

Both panelists agreed that *as AI becomes more widely adopted and complex, the standard of care itself may shift to incorporate AI recommendations.* Legal frameworks could also change through case law or legislation like EU directives regulating AI as a product. Analysis of the European Union's AI Act, effective in 2023, illustrates the following points: (1) broad directive gaps exist for healthcare AI; (2) legal causation issues are present; (3) there are unique software product challenges; and (4) evidentiary rule changes on algorithmic opacity are needed.

The panel also commented that AI learning creates opacity posing trust issues for physicians and informed consent questions for patients. Full lifecycle improvements to training data controls, explainability and clinical trials could help address these AI challenges.

FSMB Ethics and Professionalism Committee

FSMB Board Member Mark Woodland, MS, MD, who chairs FSMB's Ethics and Professionalism Committee, provided insight into the Committee's deliberations on the issue of ethical use of artificial intelligence. He noted that the committee discussion reinforced the importance of key traditional ethical principles, such as beneficence, nonmaleficence, autonomy and justice. He noted that these principles will manifest in a policy to help state medical boards and physicians navigate the responsible and ethical incorporation of AI and stressed a need for (1) greater incorporation of AI knowledge in medical education, (2) increased emphasis on human accountability, (3) improved policies on informed consent and data privacy, (4) recommendations to proactively address responsibility and liability concerns, and (5) collaboration with experts. Dr. Woodland concluded by stating that by thoughtfully addressing the opportunities and challenges posed by AI in healthcare, state medical boards can promote the safe, effective, and ethical use of AI as a tool to enhance, but not replace, human judgment and accountability.

Small Group Breakout Sessions

Attendees broke out into small groups to discuss the following topics and issues related to AI adoption and use by licensed health care professionals: (1) What strategies should state medical boards use to keep pace with the rapid advancements in AI technology and its application in medical practice? (2) What steps can state medical boards take to ensure that AI tools trained on biased algorithms cannot be used by licensees? (3) Which use of AI tools in health care can result in patient harm and what are appropriate regulatory responses?

Among the observations reported at the end of the breakout sessions was that it is essential that the FSMB continue to track developments in AI and raise awareness among licensees and members of the public about its potential use. Discussions noted that in the near future state medical boards are going to see complaints about the misuse of AI and potential harms caused because a licensee either followed or did not follow the advice of an AI tool or algorithm. Addressing expert opinions in such cases was identified as an area where medical boards may need improved education and guidance. Attendees suggested that the FSMB could develop educational modules to keep licensees and member boards aware of AI from their perspective. Attendees also identified that requirements for AI-focused CME could be a means of helping licensees keep pace with AI.

Panel: Perspectives on AI in Healthcare and Reflections on the Day

The final panel, moderated by Eric Eskioglu, MD, MBA, discussed generative AI and its role in health care and medical regulation. Panelists included Sarvam TerKonda, MD, Past Chair of the FSMB and Associate Professor of Plastic Surgery at the Mayo Clinic College of Medicine and Science, Jade Dominique James-Halbert, MD, MPH, a specialist in Obstetrics-Gynecology in Bridgeton, Missouri, who is Chair of SSM Health DePaul Hospital in St. Louis, MO, Alexis Gilroy, JD, partner at Jones Day, and Shannon Curtis, JD, Assistant Director of Federal Affairs for the American Medical Association.

Dr. TerKonda noted that the evolution of AI has been rapid and that many medical professionals and medical boards are deficient in their knowledge of AI and how it is impacting the future of healthcare. He commented that AI is already being used every day in our daily lives and will play a different role for different specialists and specialties. Dr. Eskioglu agreed, noting that a recent survey of a large health system found that only the radiology department was openly using and studying AI to assist in diagnosis and treatment.

The panelists debated whether it is best to think about regulating the technology, or use cases where AI plays a role in the practice of medicine. As a corollary, panelists shared their perspectives on whether the current regulatory framework is sufficient to address AI. Ms. Gilroy noted that the existing legal standard of care cited in existing regulations may suffice, with parallels to how a medical board handles liability in a physician that requests and obtains expert consultation from a specialist. Ms. Curtis shared the results of an AMA member survey, which indicated that 62% of respondents were not yet engaged with using AI but were aware of its potential. The survey also suggested that 20% of respondents were AI evangelists. She noted that liability in the use of AI is a real fear among physicians, and that the AMA is looking at risk mitigation efforts. Ms. Curtis offered some pushback on the notion that we already have the regulations we need in place. While she does not support “over-regulation,” she recognized that there are regulatory gaps that will need to be filled.

ADMINSTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Discussion Item

Member Assigned: **Cramer**

Subject: **Statement of Philosophy Review: Artificial Intelligence**

OREGON MEDICAL BOARD

Statement of Philosophy

Artificial Intelligence

Artificial Intelligence (AI) is a tool, or set of tools, residing on a spectrum. AI may be as simple as a chatbot on a smartphone, something more technical like a clinical decisionmaking tool, or something as complex as a whole language algorithmic black box capable of suggesting treatment pathways for cancer. AI is developing rapidly in reach, capability, and quality, and medical providers and regulators must prepare for the ubiquity of AI, which is sure to envelop medical care with astonishing speed.

AI has tremendous promise. It will undoubtedly advance the standard of care, and clinicians who carefully embrace AI tools will ultimately detect pathologic subtlety, improve accuracy, and spend more quality time in face-to-face patient care than those who do not. AI can improve patient access and empathetic engagement even while shifting administrative tasks away from the clinician in the midst of growing health care provider shortages.

As clinicians adopt these tools of innovation and automation, the Oregon Medical Board will continue to hold licensees responsible for the care they provide to patients and expects licensees to use technology – including AI – responsibly and ethically. Regardless of who introduces AI into the practice, OMB licensees are expected to possess basic AI literacy in order to understand the technology and how to use it, explain its capabilities and limitations, assess the quality of AI outputs, and identify and guard against bias in AI algorithms. OMB licensees must be intelligent consumers of AI, and must not be complacent nor compromise their own medical decision making by becoming overly reliant on AI.

The Oregon Medical Board recommends that clinicians become “tech-fluent” in relevant AI tools and incorporate them into their practice responsibly to keep pace with the increasing standard of care.

- DRAFT April 4, 2024

MEMORANDUM

TO:	Oregon Medical Board
SUBJECT:	Artificial Intelligence Resources
DATE:	February 21, 2024

For the development of the Board's statement on Artificial Intelligence, information from other medical boards and organizations.

The Washington Medical Commission's Policy Statement Telemedicine includes a section on artificial intelligence:

> A practitioner who uses artificial intelligence (AI) tools as part of telemedicine to diagnose or treat a patient in Washington should:
>
> (a) Understand that use of an AI tool and acceptance of suggested diagnosis or related treatment plan is at the discretion of the treating practitioner;
>
> (b) Understand the limitations of using an AI tool, including the potential for bias against populations that are not adequately represented in testing the tool.
>
> A practitioner who uses AI should complete a self-directed CME (category II-V) on bias and underrepresented populations in health care technology applications such as AI.

The North Carolina Medical Board's Position Statement 5.1.4: Telemedicine includes a paragraph on artificial intelligence:

> A licensee who incorporates artificial intelligence ("AI") tools as part of telemedicine to diagnose or treat a patient in North Carolina should (a) understand that the use of an AI tool and acceptance of suggested diagnosis or related treatment plan is at the discretion of the treating practitioner; and (b) understand the limitations of using an AI tool, including the potential bias against populations that were not adequately represented in original testing of the tool.

The American Medical Association's Code of Ethics Opinion 11.2.1, Professionalism in Health Care Systems notes that, "[f]ormularies, clinical practice guidelines, decision support tools that rely on augmented intelligence, and other mechanisms intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented."

Additional AMA resources:

- AMA's Augmented intelligence in medicine
- AMA's Advancing health care AI through ethics, evidence and equity
- AMA's Principles for Augmented Intelligence Development, Deployment, and Use

Additional Resources:

- World Medical Association, Statement on Augmented Intelligence in Medical Care
- Kaiser Permanente, Less desktop, more bedside: Using augmented intelligence to accelerate health care innovation

ADMINSTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Discussion Item

Member Assigned: **Lee-Valkov**

Subject: **Updated Personal History Questions**

MEMORANDUM

TO: Administrative Affairs Committee
SUBJECT: Personal History Questions Update
DATE: February 21, 2024

Applicants for initial licensure and licensees renewing or reactivating a license must answer personal history questions. The answers to these questions assist the Board in determining whether the applicant is qualified and competent for an Oregon medical license. Currently, the questions are similar – but not identical – for each of the OMB's licensed professions.

In planning for the agency's new IT database, OMB staff proposes the following revisions that will create one set of questions across all professions. The revised language is also streamlined and refined to only solicit information relevant to licensure.

Does the AAC recommend revising the personal history questions as proposed?

Current Question	Proposed Revision
Question 1: Other Health Care License	
Do you hold, or have you ever held, any licenses to practice another health care profession?	Do you hold, or have you ever held, any licenses to practice another health care profession?
Question 2: Exam Failures	
Have you ever failed a state or national examination or any portion, step, part, or component of an examination to qualify for a state license to practice a health care profession? If you ever failed a portion of a licensing examination you must answer "yes" even if you later passed the examination.	Have you ever failed a step or part of a state or national examination to qualify for a license to practice a health care profession? If you ever failed a portion or component of a licensing examination, you must answer "yes" even if you later passed the examination.
Question 3: Withdrawn Applications	
Have you ever been asked to and/or permitted to withdraw an application for licensure, for credentialing, or for certification with any board, agency or institution?	Have you ever been asked to and/or permitted to withdraw an application for licensure, credentialing, or certification with any board, agency or institution?

Current Question	Proposed Revision
Question 4: Other License Denied	
Has any state licensing board refused to issue, refused to renew, or denied you a license to practice?	Has any state licensing board refused to issue/renew or denied you a license to practice?
Question 5: Investigations or Discipline	
Have you ever had any disciplinary or adverse action imposed against any professional license or certification, or were you ever denied a professional license or certification, or have you entered into any consent agreement, stipulated order or settlement with any regulatory Board or certification agency; or have you ever been notified of any complaints or investigations related to any license or certification?	Have you ever been notified of ANY complaints or investigations or had ANY actions imposed against a professional license or certification? This includes entering a consent agreement, corrective action, stipulated order, or settlement with any board or agency.
Question 6: DEA Registration Issues	
Regardless of the outcome, have you been denied approval to prescribe controlled substances, or been subject to an inquiry or charged with a violation of federal or state controlled substance laws, or been asked to surrender your DEA number?	Regardless of the outcome, have you ever been: denied approval to prescribe controlled substances, subject to an inquiry or charged with a violation of federal or state controlled substance laws, or asked to surrender your DEA number?
Question 7: Arrest or Conviction	
Have you ever been arrested, convicted of, or pled guilty or "nolo contendere" (no contest) to ANY offense in any state in the United States or any foreign country, other than minor traffic violations? Matters in which you were pardoned and/or diverted, or the conviction was deferred, set aside or expunged must be disclosed.	Have you ever been arrested, convicted of, or pled guilty or "nolo contendere" (no contest) to ANY offense in any state in the United States or any foreign country, other than minor traffic violations? Matters in which you were pardoned and/or diverted, or the conviction was deferred, set aside or expunged must be disclosed.
Question 8: Government Investigation	
Have you ever been contacted by or asked to make a response to any governmental agency in any jurisdiction regarding any criminal or civil investigation of which you are the subject, whether or not a charge, claim or filing with a court actually occurred?	Have you ever been contacted by or asked to make a response to any governmental agency in any jurisdiction regarding a criminal or civil investigation of which you are the subject, whether or not a charge, claim, or filing with a court actually occurred?

Current Question	Proposed Revision
Question 9: Civil Actions	
Are there any current, proposed, impending or threatened civil or criminal actions against you, which includes, but is not limited to malpractice claims? This includes whether or not a claim, charge or filing was actually made with a court.	Are there any current, proposed, or impending civil actions against you, which includes, but is not limited to malpractice claims? This includes whether or not a claim or filing was actually made with a court.
Question 10: Civil Claims, Malpractice	
Have you ever entered into any formal, informal, out-of-court, or confidential settlement to deter, prevent, or settle a claim, lawsuit, letter of intent to sue, and/or criminal action? This includes whether or not a claim, charge, or filing was actually made with a court.	Have you ever had a civil claim, including malpractice, against you regardless of the outcome? This includes whether or not a claim or filing was actually made with a court and confidential resolutions. Include any payment made by you or on your behalf, even if it was not reported to the National Practitioner Data Bank (NPDB).
Question 11: Malpractice Claims	
Has any award, settlement or payment of any kind ever been made by you or on your behalf to resolve a malpractice claim, even if it was not required to be reported to the National Practitioner Data Bank (NPDB); or have you ever been notified in any manner that any such claim is proposed, pending or threatened, whether or not a claim, charge or filing was actually made with a court?	Delete, question covered in #10.
Question 12: Training Issues	
During any training program related to your health care profession, including medical school or any medical, acupuncture or postgraduate training, have you ever been subject to an action for any academic, clinical or professional concerns, including actions such as warning, remediation, probation, restriction, suspension, termination, or request to voluntarily resign?	During any education or training program related to your health care profession, have you ever been subject to an action for an academic, clinical, or professional concerns, including actions such as warning, remediation, probation, restriction, suspension, termination, or request to voluntarily resign?

Current Question	Proposed Revision
Question 13: Employment Issues	
Regarding employment related to your health care profession, have you ever had an employment agreement or privileges denied, reduced, restricted, suspended, revoked or terminated; or have you ever been subject to disciplinary action including but not limited to probation; or have you been terminated from employment or subject to non-renewal of an employment agreement with or without cause; or have you been asked to voluntarily resign or voluntarily suspend your privileges; or have you been under investigation by a hospital, clinic, surgical center, or other medically related entity; or have you been notified that such action or request is pending or proposed?	Have you ever been subject to an employment action related to your health care profession? This includes denial, reduction, restriction, suspension, revocation, or termination of an employment agreement or privileges; disciplinary actions; probation; termination or non-renewal of an employment agreement with or without cause; voluntary resignation or suspension of privileges while under investigation by a hospital, clinic, surgical center, or other medically related entity; or received notification that any of these actions or requests is pending or proposed.
Question 14: Interrupted Practice	
Have you interrupted the practice of your health care profession for one year or more, or ceased the practice of your specialty?	Have you interrupted the practice of your health care profession for one year or more, or ceased the practice of your specialty?
Question 15: Substance Use	
Do you currently engage in the excessive or habitual use of alcohol or drugs or are you dependent on the use of alcohol or drugs which impair your ability to practice your health care profession safely and competently? "Excessive" as used in this question includes, but is not limited to, the use of alcohol or drugs that leads to disturbances, fights, arrest, DUII, injury, accident, illness, loss of consciousness, .08% BAC or above on a required chemical substance screening test, or other adverse consequences. If you are currently enrolled in the Oregon Health Professionals' Services Program (HPSP), you may answer "no."	Do you currently engage in the excessive or habitual use of alcohol or drugs or are you dependent on the use of alcohol or drugs which impair your ability to practice your health care profession safely and competently? "Excessive" as used in this question includes, but is not limited to, the use of alcohol or drugs that leads to disturbances, fights, arrest, DUII, injury, accident, illness, loss of consciousness, .08% BAC or above on a required chemical substance screening test, or other adverse consequences. If you are currently enrolled in the Oregon Health Professionals' Services Program (HPSP), you may answer "no."

ADMINSTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Discussion Item

Member Assigned: **Poulsen**

Subject: **OMB Response to Secretary of State Audit**

Oregon
Tina Kotek, Governor

Medical Board
1500 SW 1st Avenue, Suite 620
Portland, OR 97201-5847
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January 16, 2024

Kip Memmott, Director
Secretary of State, Audits Division
225 Capitol Street NE, Suite 500
Salem, OR 97310

Dear Mr. Memmott,

This letter serves as the Oregon Medical Board's written response to the Audits Division's final draft audit report titled "To Protect Patients and Maintain Public Trust, the Oregon Medical Board Should Further its Efforts to Address the Risk of Inequitable Disciplinary Decisions."

The OMB is committed to consistent and equitable outcomes in our investigations. Therefore, we agree with the report's findings and the four recommendations which directly align with the OMB's mission and values, specifically integrity, accountability, excellence, customer service, and equity.

Below is our detailed response to each of the four recommendations in the audit.

Recommendation 1 Implement sanctioning guidelines and/or a sanction matrix to help reduce the risk of inconsistent and inequitable case decisions.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	July 1, 2025 and ongoing	Nicole Krishnaswami 971-673-2700

Narrative for Recommendation 1: The OMB agrees with this recommendation and the audit's acknowledgment that, "[OMB] cases can be complex, with unique circumstances and factors that can affect how a licensee is sanctioned."

In 2018, the OMB identified DUII cases and opioid prescribing cases as high-volume, single-issue allegations, and the agency developed internal advisory guidelines to assist the board in resolving these categories of cases. By the end of this fiscal biennium, the OMB will build upon this work to develop additional disciplinary guidelines to efficiently, consistently, and equitably review cases with consideration of aggravating factors (e.g. licensee has a pattern of similar conduct, has violated prior board orders, etc.) and mitigating factors (e.g. licensee has no history of similar issues, is actively engaged in remediation, etc.).

Importantly, while the goal of disciplinary guidelines is to ensure equity and consistency, the OMB understands that systemic and institutional biases raise the possibility that any matrix or algorithm may actually result in inequitable outcomes as has been a concern with Oregon's Measure 11 and many three-strikes laws across the country. The OMB will aim to write guidelines that attempt to control for inherent, systemic biases so that they do not result in disparate outcomes for historically disadvantaged licensees.

The guidelines will be used as internal advisory communications to support board members in their deliberations, and the board will retain discretion to craft an appropriate resolution in each unique case – ranging from closure with no discipline to license revocation – after carefully considering each investigation's specific circumstances.

Recommendation 2 Add the ability to categorize cases by primary or most serious complaint type, or another effective categorization system, to the agency's forthcoming new data system.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	July 1, 2025	Nicole Krishnaswami 971-673-2700

Narrative for Recommendation 2: The OMB agrees with this recommendation and appreciates the audit's recognition of the limitations of the agency's existing database. The OMB is currently developing a new database that will replace its legacy system. Therefore, this is an ideal time to reevaluate and revise the current categorization system for complaints.

The OMB's new database is projected to deploy in early 2025. Because changing the categorization system may be deemed an "enhancement" by the vendor developing the database and because of the propensity for IT projects to be delayed, we anticipate completing this recommendation by July 1, 2025. If additional funding is needed to add such an enhancement to the project currently underway, the OMB may seek additional expenditure limitation in the agency budget.

Recommendation 3 Use complaint data to conduct regular, systematic reviews of past cases to help monitor for and ensure equity and consistency.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	July 1, 2026	Nicole Krishnaswami 971-673-2700

Narrative for Recommendation 3: The OMB agrees with this recommendation and that regular, systematic reviews of cases will be helpful in monitoring for disparate outcomes. The OMB also appreciates the audit's recognition that such a review is complicated because "two complaint allegations can appear to be similar but have completely different case details that may contribute to different board disciplinary outcomes."

The OMB's Strategic Plan and its Diversity, Equity, and Inclusion Action Plan both include performing a retrospective analysis similar to this recommendation, and the agency looks forward to the increased reporting and data analysis capabilities that will be possible with the new database. We estimate a full year's data will be necessary for meaningful analysis; therefore, we will spend the time between now and July 1, 2026, determining the key data collection points, performing quality assurance on the data, and developing a framework for analysis of the data that aims to explore equity and consistency of disciplinary outcomes.

Recommendation 4 Develop and implement written policies and procedures for analyzing board disciplinary decisions for equity and consistency.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	January 1, 2026	Nicole Krishnaswami 971-673-2700

Narrative for Recommendation 4: The OMB agrees with this recommendation and will develop policies and procedures for conducting the regular, systematic reviews of disciplinary cases (Recommendation 3) to evaluate the board's equity and consistency in disciplinary decisions. The OMB maintains robust procedures for completing its work, and the agency will ensure that policies and procedures are in place to solidify this analysis as part of our routine process improvement activities.

Finally, the Oregon Medical Board thanks the audit team from the Secretary of State Audits Division for their detailed and comprehensive audit of the OMB's investigative processes and for their professionalism and consideration throughout the review. We are extremely proud of the dedicated and thorough work of the board members and staff, and we are pleased that the audit provides tangible recommendations for continuing to strengthen our agency.

Please contact Nicole Krishnaswami at Nicole.Krishnaswami@omb.oregon.gov or 971-673-2700 with any questions.

Sincerely,

Nicole Krishnaswami
Executive Director

cc: Christoffer Poulsen, DO, Board Chair 2024
Erin Cramer, PA-C, Board Member (Chair 2023)
Olivia Recheked, MPA, Secretary of State Audits Division, Audit Manager
Stephen Winn, MPP, Secretary of State Audits Division, Principal Auditor
Christina Nichols, Secretary of State Audits Division, Staff Auditor

Oregon Medical Board

To Protect Patients and Maintain Public Trust, the Oregon Medical Board Should Further its Efforts to Address the Risk of Inequitable Disciplinary Decisions

January 2024
Report 2024-02

OREGON SOS
Secretary of State
LaVonne Griffin-Valade

OREGON AUDITS DIVISION
Audits Director
Kip Memmott

Audit Highlights

Oregon Medical Board

To Protect Patients and Maintain Public Trust, the Oregon Medical Board Should Further its Efforts to Address the Risk of Inequitable Disciplinary Decisions

Why this audit is important

- The Oregon Medical Board (OMB) regulates doctors, physician assistants, podiatric physicians, and acupuncturists, with the mission to protect and promote the health, safety, and well-being of Oregonians.
- In addition to licensing and education, OMB also investigates and disciplines licensees for violating Oregon's Medical Practice Act. The board receives roughly 700 to 800 complaints a year.
- To protect patients and maintain public trust, OMB's role in investigating and disciplining licensees requires an assurance of consistency and equity in the resulting outcomes of these investigations.
- If licensees are disciplined inconsistently or inequitably, especially as the result of racial bias or discrimination, it can have the effect of limiting the representation of people of color in medical professions. This can contribute to continued disparities in medical treatment and health outcomes for these communities.

What we found

1. Medical complaint cases can be complex, often containing specific circumstances within the case or the licensee's history. In some instances, two complaint allegations can appear to be similar, but have completely different case details that may contribute to different board disciplinary outcomes. For example, the same procedure performed on two patients with different levels of overall health can have very different results. (pg. 11)
2. While OMB's investigation process includes many formal policies and procedures staff and managers are supposed to follow, its process for comparing disciplinary decisions is generally informal and intermittent. There is no formal process to help ensure these reviews are performed in a standardized way each time. (pg. 12)
3. Many medical boards in other states, including Washington and California, utilize sanctioning guidelines or disciplinary matrices to ensure disciplinary decisions are consistent and equitable. Other types of health care boards, and other regulatory organizations, also use some form of disciplinary guidelines to help improve equity and consistency. While OMB utilizes a disciplinary matrix for two specific types of complaints, it does not do so for any other complaint types. (pg. 12)
4. OMB's current data system does not capture complaint information in a way that permits the agency to easily analyze its disciplinary decisions. While OMB has done qualitative reviews to try to ensure consistency, the database hinders OMB's ability to conduct routine, systematic data analysis to help assure the public and licensees that similar cases result in consistent and equitable disciplinary outcomes. (pg. 14)

What we recommend

We made four recommendations to OMB. The board agreed with all of our recommendations. The response can be found at the end of the report.

OREGON SOS

OREGON AUDITS DIVISION

Introduction

The Oregon Medical Board (OMB) was created by the Legislature in 1889. OMB's mission is to protect the health, safety, and well-being of Oregonians by regulating the practice of medicine in a manner that promotes access to quality care. OMB licenses and regulates multiple health care professions in Oregon. In addition to its licensing functions, OMB supports education and research to support licensees in delivering quality medical care. Lastly, and the focus of this audit, OMB is responsible for investigating and deciding whether to take action on complaints against licensees that violate the state's Medical Practice Act.

The Oregon Medical Board regulates the practice of medicine to help protect the health and safety of Oregonians

OMB licenses and regulates several different groups of health professionals. To help ensure Oregonians' health, safety, and well-being, the board is at the forefront of evaluating, revising, and enforcing medical practice standards, scope, and regulatory oversight while also ensuring the Medical Practice Act remains reflective of any changes in health care and regulatory standards.

Nearly all of OMB's funding comes from licensee fees

OMB is an Other-Funded Agency, with 97% of its funds coming from fees for licensure and registration. The board's 2023-25 budget was approved in the amount of $18,442,127. For the two-year licensing period, renewal fees for active, practicing licensees range from $326 for acupuncturists up to $580 for physicians.[1]

Figure 1: OMB is funded solely through Other Funds and does not receive funding from the Legislature

	2019-21 Legislatively Approved	2021-23 Legislatively Approved	2023-25 Legislatively Adopted
Other Funds	$ 14,079,904	$ 17,346,295	$18,442,127
Positions	41	42	42
FTE	41.00	42.00	42.00

Source: 2023-25 Budget Highlights, Oregon Legislative Fiscal Office, September 2023

The board is composed of 14 members, which includes seven Doctors of Medicine, two Doctors of Osteopathic Medicine, one Doctor of Podiatric Medicine, one Physician Assistant, and three public members. A bill passed in the 2023 legislative session added an additional Physician Assistant representative and reduced the number of Doctors of Medicine representatives from seven to six.

All board members are appointed by the Governor and confirmed by the Senate. They can serve up to two three-year terms. Under the governance of the board, there are 42 positions in several departments, including the executive director and medical director. OMB's departments consist of Business, Licensing, Investigations and Compliance, and Administration.

[1] Renewal fee amounts include fees sent to the Oregon Health Authority for prescription monitoring and maintaining a workforce database and fees to support the Oregon Health and Science University Library.

OMB has many roles and responsibilities in regulating and enforcing the Medical Practice Act

Since its creation in 1889, the Oregon Medical Board has expanded its regulatory oversight to include several health care professions. OMB currently licenses and regulates:

- Doctors of Medicine (MDs);
- Doctors of Osteopathic Medicine (DOs);
- Doctors of Podiatric Medicine (DPMs);
- Physician Assistants (PAs); and,
- Acupuncturists (LAcs).

In addition to licensing and regulating, OMB establishes practice standards, education, and scope, including for Emergency Medical Services (EMS) providers. OMB oversees licensee monitoring, probation, discipline, education, wellness, and remediation.

Figure 2: In 2022, OMB had over 25,000 licensees under its purview

	MD	DO	DPM	PA	LAc
Active	16,621	2,003	215	2,701	1,503
Inactive	1,103	115	8	134	57
Limited[2]	786	217	13	3	1
Total	**18,510**	**2,335**	**236**	**2,838**	**1,561**

Source: Oregon Medical Board

Licenses are renewed every two years. At the time of an initial or renewal application, the licensing unit reviews the applicant's qualifications and any prior investigations or complaints they may have on their record. They also review any information available through the National Practitioner Data Bank (NPDB) administered by the U.S. Department of Health and Human Services, the Physician Data Center (PDC) administered by the Federation of State Medical Boards, as well as conducting a criminal background check. If there are any issues discovered during this process, an investigation may be opened into the licensee or an initial applicant. During the application process, licensees have the option of inputting their demographic information, as required by the Oregon Health Authority per ORS 676.410, which enables the board to conduct equity analysis.

OMB also enforces the state's Medical Practice Act as outlined in Oregon law.[3] When there is potential or evident violation of the state's Medical Practice Act, OMB opens an investigation into the licensee or applicant. The board is required to make public certain actions taken against licensees who violate the state's Medical Practice Act, such as license suspensions, license revocations, or corrective action agreements. OMB is also required to report disciplinary actions to the National Practitioner Data Bank. Public board orders and actions against licensees are published and viewable on OMB's website or available via a public records request.[4]

[2] Limited licenses include scenarios such as postgraduates entering medical training programs, non-practicing providers employed as medical school faculty, or visiting out-of-state providers, such as during a declared state of emergency.
[3] Oregon Revised Statutes, Chapter 677
[4] Oregon Medical Board | Board Actions

Oregon's Medical Practice Act

Oregon's Medical Practice Act consists of 27 separate grounds for discipline or denial of a license. Most of these grounds are very specific. Some examples include gross or repeated acts of negligence, chemical substance abuse, conviction of a criminal offense, and sexual misconduct.

Medical board laws and structures vary from state to state

Each state determines their own Medical Practice Act. Some state legislation requires clear and convincing evidence of a medical practice violation, while other states, like Oregon, require a preponderance of evidence. Some states have one regulatory organization in charge of regulating medical practitioners. In Oregon, OMB solely regulates its licensees, within the scope of its authority under state law. Some other states have separate departments, agencies, boards, or commissions with different roles and authority. A licensee may commit a medical practice act violation in one state and face discipline, but in another state, their actions may not result in any discipline. These state-by-state variations can lead to varied disciplinary outcomes for licensees.

Other than federal requirements for reporting certain disciplinary actions to the National Practitioner Data Bank, there is no substantive federal oversight or policy requirements for medical boards. The Federation of State Medical Boards provides a framework, support, policy recommendations, relevant medical and regulatory studies, state comparisons, as well as another data hub for medical board action reporting. However, state medical boards are not required to be members of the Federation of State Medical Boards.

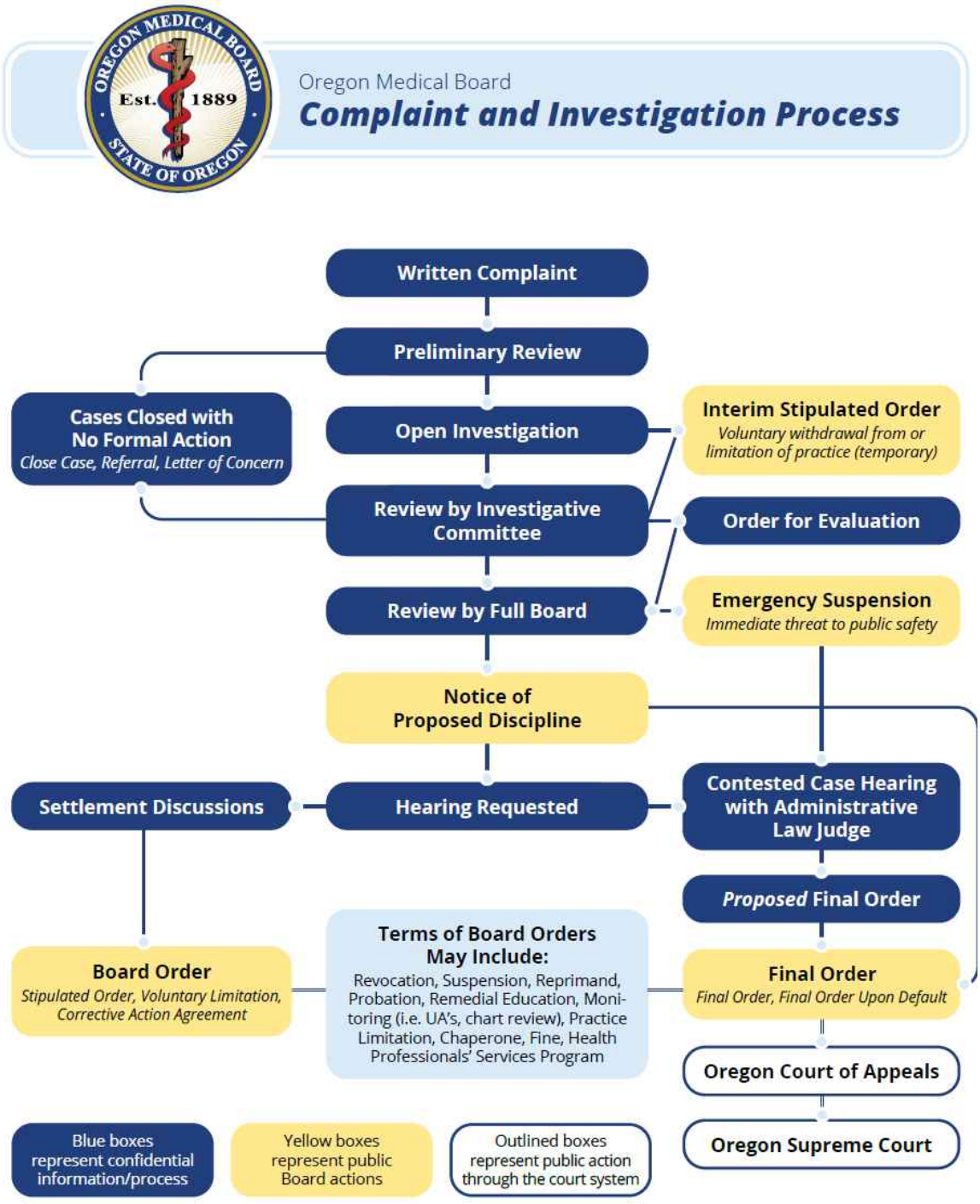
Many state boards have joined the Interstate Medical Licensure Compact (IMLC). IMLC has explicit rules and requirements in regulating licensees, some of which may override state-created laws and rules. When one participating state suspends a licensee, it has an automatic, mandated effect on that licensee in other participating states in which they practice. Currently, 37 states and two territories participate in the compact, with several pending completion of their participation application. Eleven states and territories do not participate, including Oregon. According to OMB, Oregon is not a part of the compact because some of the IMLC requirements are not as stringent as Oregon's licensing requirements.

Board composition also varies in each state. Most have one or more public members, who are individuals not licensed or regulated by the medical board. The Federation of State Medical Boards recommends at least 25% representation of public members. Currently, OMB has 21% public member representation.

OMB enforces Oregon medical laws by investigating complaints against licensees

Another critical OMB function is to investigate complaints against individuals licensed by the board. Complaints are reviewed and, if applicable, assigned for investigation. While licensees are required to report violations, most investigations come from complaints by patients and people associated with patients, such as relatives or patient advocates. An investigation is conducted when there is a potential violation of Oregon's Medical Practice Act.

Figure 3: Each written complaint OMB receives follows a defined process



Source: Oregon Medical Board, January 2024

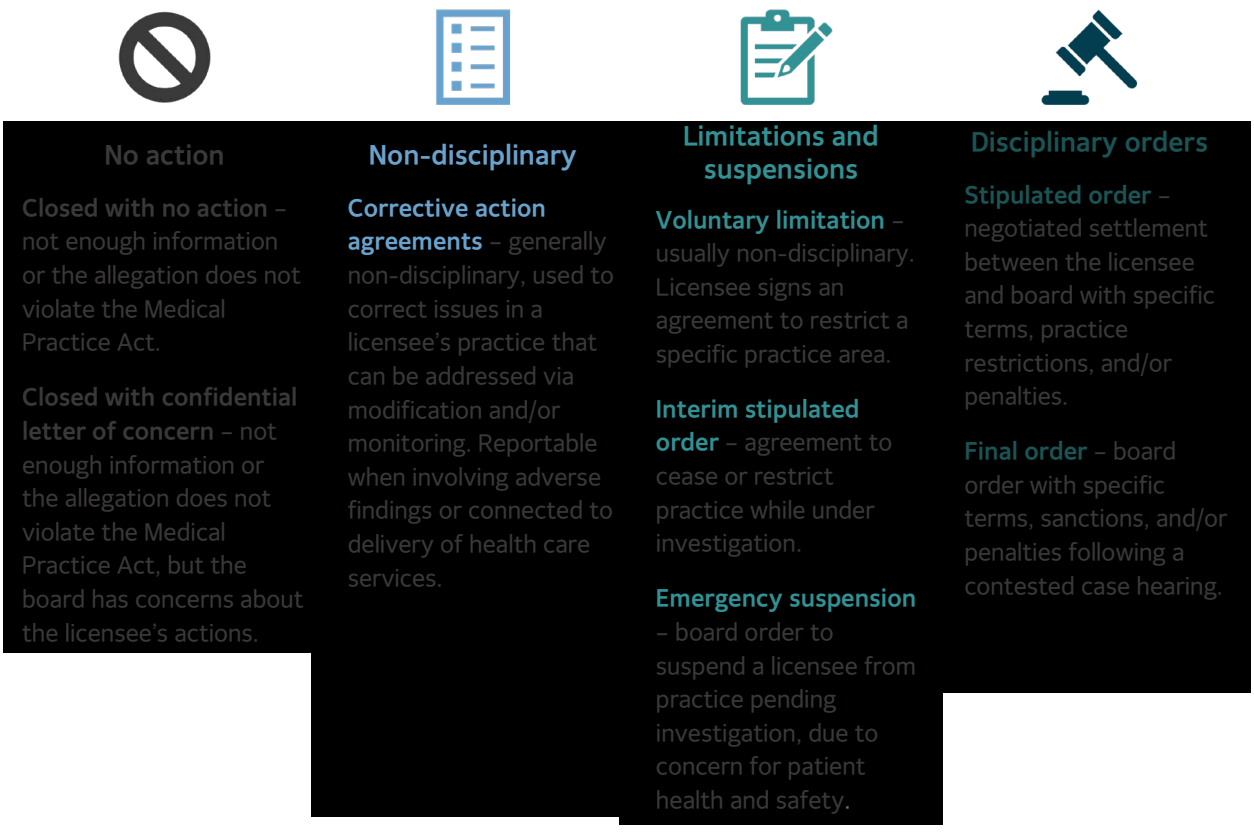
There are many stages and potential outcomes of OMB's investigated cases

OMB's investigation unit includes eight investigators, several administrative specialists, an investigations supervisor, and the investigations manager. The board receives about 700 to 800 written complaints annually. According to OMB's Winter 2023 Newsletter, the board opened 757 investigations and closed 792 investigated cases in 2022.

Complaints submitted to the board are reviewed weekly by a complaint intake committee, which determines whether there is potential for a violation. If a complaint is of an egregious nature, it will be reviewed with management upon receipt, then assigned to an investigator and prioritized; the complaint may require immediate action by the board. If there is an immediate concern for patient safety, the board may issue an Interim Stipulated Order to temporarily suspend or restrict a licensee's practice while under investigation. If the licensee refuses to agree to this order, the board can vote to suspend their license through an Order of Emergency Suspension. According to OMB, 55 cases opened from 2019 to 2022 (about 1.8%) included either an interim stipulated order or emergency suspension.

By statute, an investigator has 120 days to complete their investigation before submitting an investigation report to leadership, though the board can approve extensions to this timeline. While the investigation is open, the assigned investigator collects evidence, interviews those with potential knowledge of the violation, and then compiles an investigative case report when the investigation has concluded. This case summary report does not include any determinations on whether a violation occurred or recommend any disciplinary actions. Claims related to malpractice, incompetence, or unprofessional conduct are also reviewed by OMB's medical director, and the board often contracts with medical consultants to review medical-related cases and provide an expert opinion. The report goes through a quality assurance process that includes several reviews and then goes to the board for review and action.

Figure 4: Complaint cases can be resolved with a variety of outcomes, from case closure with no action up to a stipulated or final disciplinary order that may include sanctions and penalties.



Source: Oregon Medical Board

When the case report goes to the board, it is first reviewed by the Investigative Committee. This committee consists of five to six board members, including one public member. The committee reviews evidence and investigative case reports and proposes potential action for the board to take. This proposed action is then discussed by the full board. All disciplinary decisions are made by vote of the full board.

If the board finds that a violation occurred, it issues a Notice of Proposed Disciplinary Action. The licensee under investigation can either contest the proposed action through an administrative hearing or enter into a settlement with OMB, waiving their right to a hearing. If a settlement is reached, the board will issue a corrective action agreement, voluntary limitation, or stipulated order. Stipulated orders can include penalties, additional educational requirements, limitations on practice, monitoring requirements, or other sanctions, potentially including license surrender. Notably, the board considers corrective action agreements to be non-disciplinary actions, so they are generally not reported to the National Practitioner Data Bank, unless there are adverse findings or a connection to the delivery of health care services.

Figure 5: From 2020-2022, most of OMB's investigated cases that closed with an order were settled with stipulated orders

	2020	%	2021	%	2022	%*
Automatic Suspensions	1	1%	2	3%	3	3%
Corrective Action Agreements	13	15%	14	19%	12	13%
Stipulated Orders	62	74%	58	78%	71	78%
Voluntary Limitations	0	0%	0	0%	2	2%
Final Orders	8	10%	0	0%	3	3%
Total	84	100%	74	100%	91	100%

*Due to rounding, percentages may may not add up to 100%.

Source: Oregon Medical Board

When a licensee decides to contest a Notice of Proposed Disciplinary Action, the case goes to a hearing before an Administrative Law Judge. At the conclusion of a contested case hearing, the Administrative Law Judge will issue a Proposed Final Order. OMB can revise the terms and conditions of this order before issuing a Final Order. The licensee can further contest the Final Order at the Oregon Court of Appeals.

OMB generally learns about licensee misconduct, negligence, or noncompliance through complaints by patients and those associated with patients

Most complaints that lead to investigations come from patients or someone associated with a patient, such as a family member or advocate. In fact, more investigations came from complaints by patients and their associates than from all other sources. OMB licensees and some health care organizations are also required by statute to report potential violations of the Medical Practice Act. OMB reports that when it discovers a licensee has not reported a violation, it investigates and may take disciplinary action.

Malpractice lawsuits against OMB licensees are required to be reported to the board, as well. However, based on federal regulations and related court decisions, if a malpractice suit is filed against an organization, not a specific provider, it is not reportable to the National Practitioner Data Bank or the

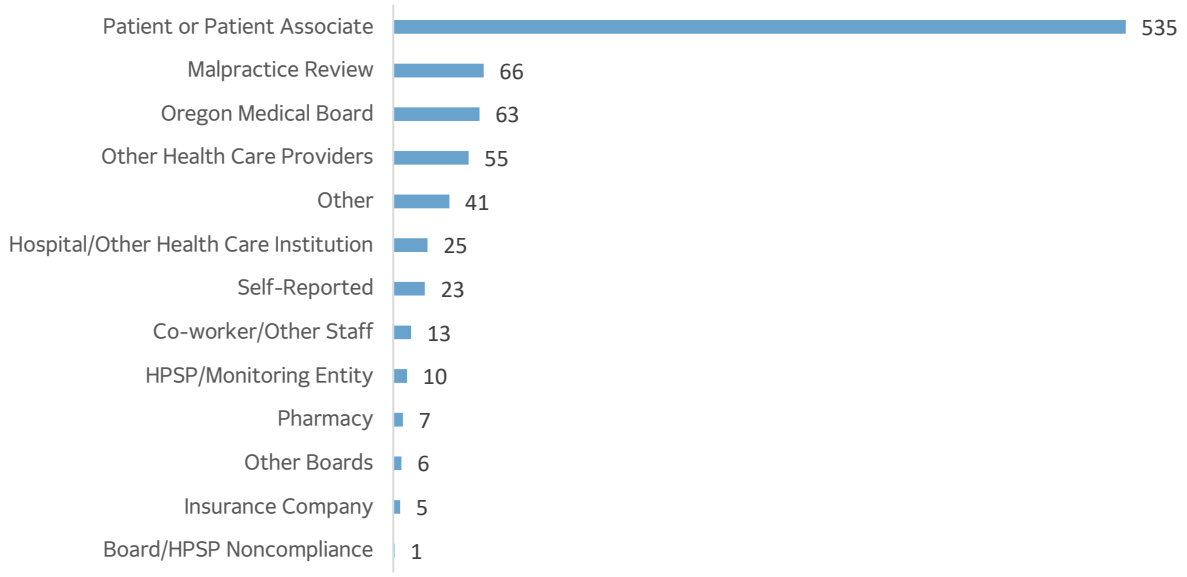
board. If a provider pays out a negotiated settlement from their own personal funds without reimbursement from an insurer, it is also not reportable to the data bank or the board.

The data bank requires hospitals and health care groups to report formal actions taken against a licensee if:

- the licensee's conduct impacted or could have impacted patient care; and,
- the formal action against them is more than 30 days in duration; or,
- the organization accepts the practitioner's surrender of clinical privileges or practice restriction while under investigation or in lieu of an investigation.

OMB requires health care facilities to report official actions taken against licensees within 10 days of the action. OMB defines an official action as "a restriction, limitation, loss or denial of privileges of a licensee to practice medicine, or any formal action taken against a licensee by a government agency or a health care facility based on a finding of medical incompetence, unprofessional conduct, physical incapacity or impairment."

Figure 6: In 2022, more investigations came from complaints by patients or people associated with patients than all other sources combined



Source: Oregon Medical Board, Winter 2023 Newsletter

At a set cost to state medical boards, the National Practitioner Data Bank offers what it calls "Continuous Query" notification reports. These reports are sent to enrolled medical boards within 24 hours of the data bank receiving adverse information about a practitioner. Information reported to the data bank can consist of malpractice lawsuit payments and certain adverse actions against licensees, such as a state medical board revoking a doctor's license. Notifications come to the data bank from several types of entities, such as hospitals, malpractice insurers, accreditation organizations, and state medical boards. Currently, OMB utilizes this feature for new applicants, licensees under investigation, and licensees who have been investigated for sexual misconduct. OMB enrolls such licensees for a 1-year period with the exception of licensees investigated for sexual misconduct, who are enrolled for a 2-year timeframe.

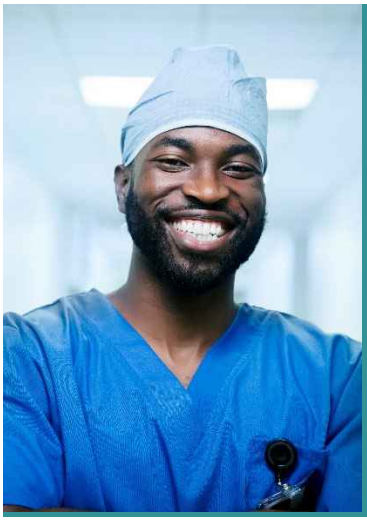
Contested case hearings can be expensive and are often avoided through negotiated agreements between licensees and the board. By the end of fiscal year 2022, OMB had two board orders appealed, two appeals upheld, one appeal closed without opinion, and three appeals still pending.

The Health Professionals' Services Program monitors licensees with substance use or mental health disorders

In addition to receiving complaints, the board may also learn about licensees' conduct by other means and decide to open an investigation. They may learn of a licensee's misconduct through other reporters, or through a confidential monitoring program called Health Professionals' Services Program (HPSP).

This confidential monitoring program is for licensees with substance use disorders, mental health disorders, or both. The board may order a licensee to enroll in this program after completing an investigation. The board establishes the program's requirements for the licensee to follow. During their enrollment period, the licensee is required to meet the criteria established by the board to maintain their license to practice. If a licensee fails to meet a requirement, such as failing a urine drug test, the program will alert the board, which will then potentially open a new investigation for noncompliance.

The HPSP also permits licensees to voluntarily self-enroll. The program will evaluate the licensee and create an individualized monitoring agreement. When licensees self-refer into this program, OMB will not be notified, unless the licensee becomes noncompliant with their monitoring agreement.



The Oregon Wellness Program

OMB has partnered in pioneering a free provider wellness program to help support practitioners facing personal and professional challenges. Called the Oregon Wellness Program, it was formally launched in 2018 after OMB partnered with health care institutions and a network of professional societies.

The program offers licensees resources through education and research and free, confidential counseling and wellness services. This initiative was driven by trends in provider burnout, suicides, and impairment. Providers facing these challenges with the difficult work they do are not always at their best, and it can affect their delivery of care, potentially compromising the health, well-being, and safety of Oregonians.

Racism threatens public health, impacting health outcomes and representation in the medical and scientific community

In recent years, the Centers for Disease Control (CDC) has declared racism a serious public health threat. According to the CDC, racism obstructs social and economic opportunities, affecting one's housing, education, career, well-being, and health. Health outcomes of underserved communities are affected by their community's representation in health care. The state of Oregon is working toward evaluating, revising, and implementing operational strategies and services with a focus on diversity, equity, and inclusion; all in a concerted effort to remove entrenched racism and discrimination within agencies and to the public they serve.

Racism is a serious public health threat

In 2021, when the CDC declared racism a serious public health threat, it emphasized the pervasive impacts of structured and interpersonal racism that has been rooted in this country for centuries. Racism affects an individual's ability to obtain housing, education, employment, and wealth — factors which experts refer to as the social determinants of health.

CDC also stresses racism's impact on the health care industry, in part by reducing the number of people of color employed in medical professions. This lack of representation for people of color "deprives our nation and the scientific and medical community of the full breadth of talent, expertise, and perspectives needed to best address racial and ethnic health disparities."[5]

When health care professionals are disciplined unfairly, including through implicit or explicit bias, it can impact both licensees and the larger community. If a sanction is more lenient than typical for a violation, it could potentially jeopardize patients receiving care from that licensee. If the board's discipline is harsher than is typical, it can result in the licensee facing undue hardship and, potentially, the suspension or cancellation of their license. When this comes as the result of racial discrimination or bias, it can have the effect of limiting the representation of people of color in medical professions. Ultimately, this can contribute to continued disparities in medical treatment and health outcomes for communities of color.[6]

Racism and representation in the medical field

In its declaration of racism as a public health threat, the CDC referenced a report titled *Missing Persons: Minorities in the Health Professions, a Report of the Sullivan Commission on Diversity in the Healthcare Workforce*. This report details the impacts and barriers effected by embedded racism and how it hinders individuals from underserved communities from attaining education in a health care occupation and employment in a medical or scientific field. The report stresses that research shows a community's health outcomes are correlated with that community's representation in the health care workforce.

Oregon is focused on DEI action planning, strategies, and initiatives

In recent years, Oregon has encouraged state agencies to incorporate Diversity, Equity, and Inclusion (DEI) in their operations and service delivery. In 2021, the State of Oregon's DEI Action Plan was published. It has a specific initial focus on anti-racism and outlines recommendations and resources for state agencies to utilize. In early 2023, Governor Tina Kotek issued a letter of expectations for state agencies which included a requirement for agencies to create and submit strategic DEI action plans, making specific reference to the 2021 DEI Action Plan as a guide to agencies in their development and implementation.

Additionally, the Secretary of State's Audits Division conducts performance audits with an equity lens. Federal performance auditing standards, set by the US Government Accountability Office, compel state auditors to include an equity focus when conducting performance audits of government agencies, with

[5] Racism and Health | Minority Health, CDC 2021
[6] Missing Persons: Minorities in the Health Professions, the Sullivan Commission

specific criteria for assessing if an auditee's "services are provided effectively, efficiently, economically, ethically, and equitably."[7]

The Oregon Medical Board has a strategic plan for incorporating DEI in the board's operations and how it regulates licensees. Following the Governor's request in early 2023 for state agencies to submit a strategic DEI plan, OMB completed and submitted its plan in May 2023. The plan includes strategies to incorporate DEI in the investigation process, including:

- Collecting complainant demographics at the conclusion of an investigation;
- Creating a new complaint category for discrimination; and,
- Amending board rule to include discrimination as a form of unprofessional conduct.

In addition to OMB's new DEI action plan, OMB had previously implemented a continuing education requirement for licensees on cultural competency, as required by statute. The board also established a cultural competency philosophy statement, which is a detailed explanation of its expectations of licensees related to providing culturally competent care to their patients. In 2017, OMB published a booklet, "Cultural Competency: A Practical Guide for Medical Professionals," which was adopted as required reading for many educational and training programs and was given the 2018 "Best of Boards Award" by the national organization Administrators in Medicine for education and outreach. Furthermore, OMB has an established, detailed Affirmative Action policy for hiring and maintaining a diverse and inclusive workforce.

[7] Government Accountability Office, GAO-21-368G, Government Auditing Standards: 2018 Revision

Audit Results

Although OMB has some processes in place to try to ensure consistent board decisions, the board does not have formal, written procedures or processes for achieving consistent and equitable decisions on investigated complaints against licensees.

OMB has taken steps to reduce the risk of making inconsistent or inequitable sanctioning decisions, including implementing sanctioning guides for two specific complaint types. The board also uses an informal process to review prior investigated case outcomes in an effort to ensure consistency. However, OMB does not conduct routine, systematic analyses of board decisions. Without this, or established sanctioning guidelines, OMB and the public cannot be sure investigated cases are decided consistently and equitably. The board would benefit from developing and implementing sanctioning guidelines for all other types of complaints the board investigates, as well as creating a formal process for routine, systematic analysis of their case decisions.

Due to how complaint information is captured in OMB's data system, it is difficult to analyze decisions for equity and consistency across all cases. For example, many cases include more than one type of complaint, but the data system is not configured to identify the primary or main complaint type. This impedes OMB's ability to easily use its data to sort and compare cases with similar complaint types.

Implementing formal guidelines and case reviews would help OMB ensure equity and consistency

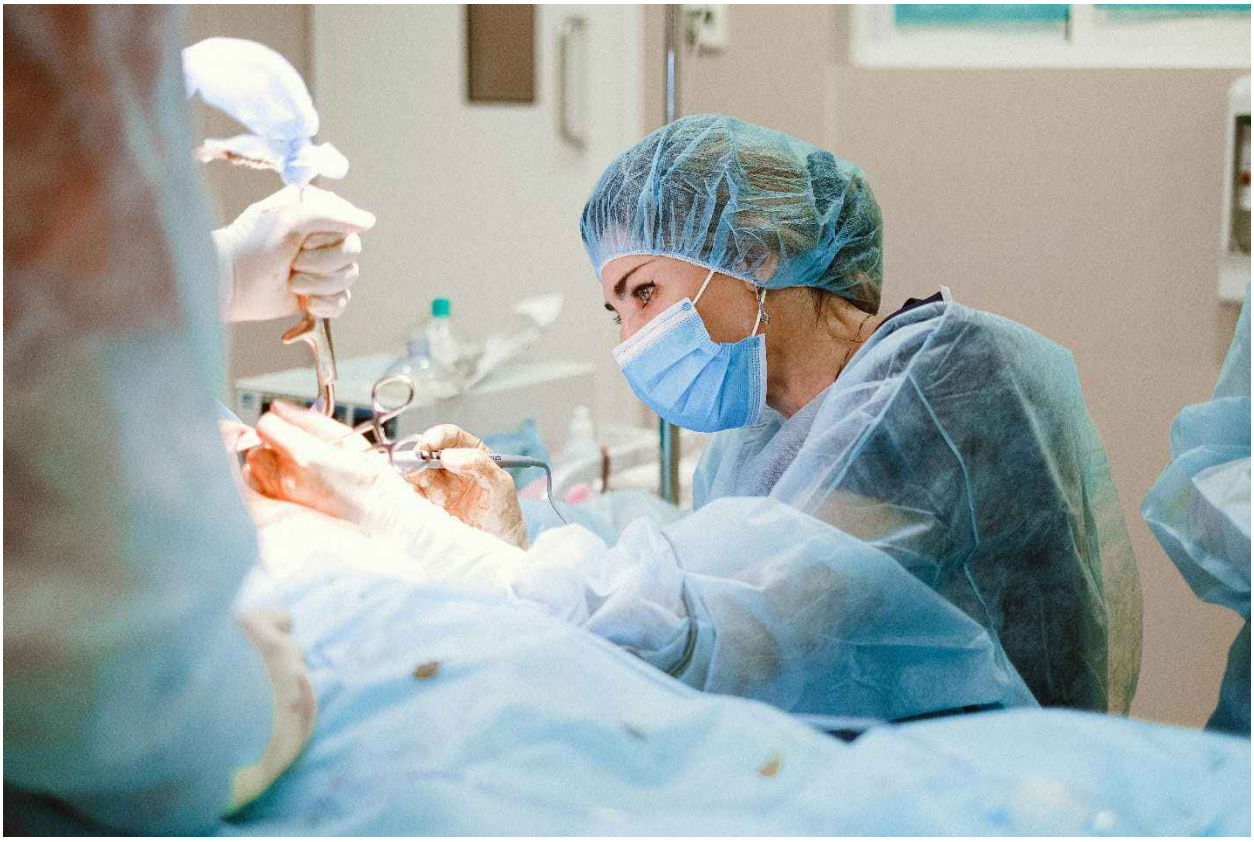
While OMB utilizes some informal procedures for trying to ensure consistency and equity in board decisions, as well as using sanctioning guides for two different types of complaints, OMB could provide more assurance of consistency and equity by implementing sanctioning guidelines for all types of complaints.

Complaint cases can be complex, with unique circumstances and factors that can affect how a licensee is sanctioned

Medical complaint cases can be thorny, potentially containing specific circumstances within the case or the licensee's history that can make it challenging to compare with other cases. There are many factors that can affect the outcome of an investigation. These factors can reduce or increase the level of board action.

For example, the location of a practitioner and type of license can play a part in the board's decision making. If a provider is practicing in a rural or frontier region, the board will consider the community standard of care in determining whether the licensee was practicing appropriately. Similarly, an acupuncturist licensee may receive a lower monetary penalty for a violation than a physician licensee, as their income may be less, so a higher penalty could cause more financial hardship.

Another possible consideration is whether a licensee is new in their career or has a history of previous similar issues. If a licensee is new to their profession and is actively seeking additional experience and support, the board may decide to place the licensee on a corrective action agreement to help them learn and grow their skills through education or mentoring.



In some instances, two complaint allegations can appear to be similar, but the dynamics of the cases are completely different and may contribute to different board disciplinary outcomes. For example, the same procedure performed on two patients with different levels of overall health can have very different results. Similarly, the same surgery performed by two different surgeons can also end with different results depending on the experience of the surgeon, the available resources, the patient's condition, and other factors. As a result, these cases could have very different disciplinary outcomes.

While OMB has formal procedures in many areas, implementing disciplinary guidelines and routinely analyzing case decisions would help further equity and consistency

OMB's investigation process includes many formal policies and procedures staff and managers are expected to follow. These include policies on how the intake committee receives and initially evaluates complaints; how investigations should be conducted; and how investigation case summaries should be compiled, among other areas.

All investigation case reports go through multiple reviews, including by the investigation manager, medical director, and executive director, before going to the board. Initial recommendations for discipline are made by the Investigative Committee — comprised solely of board members — and not by investigators or other OMB staff or managers. Although auditors did not test each of these procedures, taken together, they appear to provide a useful starting point for promoting equitable and consistent decisions.

In contrast to these formal policies and procedures, OMB's current process for comparing disciplinary decisions is generally informal and intermittent. For example, OMB management indicated the board sometimes requests information on past disciplinary outcomes to inform its decision on a current case.

OMB managers will then identify similar cases using a combination of keyword searches in the data system and staff or manager recall of prior cases.

However, there are no formal policies or procedures governing this process or specific guidance for how to determine case precedence, to help ensure these reviews are performed in a standard way. Additionally, they are generally only done when requested by the board, or when OMB managers or staff anticipate the board might want this information. Without a formal process for these tasks, as well as policies and procedures for routinely conducting systematic reviews of disciplinary decisions, it is difficult to be sure the board's decisions are consistent and equitable.

To further promote the consistency and equity of disciplinary decisions, many medical boards in other states utilize sanctioning guidelines or disciplinary matrices. States with guidelines or matrices include Connecticut, North Carolina, Ohio, Virginia, and Oregon's neighbors Washington and California, among others. Like sentencing guidelines used by courts, disciplinary guidelines generally establish the minimum and maximum disciplinary sanctions a board will apply for a specific violation or category of violations.

California and Washington Utilize Sanctioning Guides

California uses a detailed, prescriptive disciplinary guidance document that details minimum and maximum sanctioning and various conditions to consider for each type of complaint. In contrast, Washington uses a disciplinary matrix that determines minimum and maximum sanctioning based on the severity of the violation and the risk of or actual harm to patients.

Many other health care-related boards also use disciplinary guidelines or matrices, as well as other types of regulatory boards. Auditors found examples of nursing, dental, physical therapy, and other health care boards using disciplinary guidelines or matrices in states like Maryland, North Carolina, Texas, and Virginia. Other regulatory boards and organizations that use or recommend using disciplinary guidelines include the Association of Marital & Family Therapy Boards, National Center for State Courts, Transportation Security Administration, and Financial Industry Regulatory Authority. Additionally, the Federation of State Medical Boards has noted the importance of efforts to "identify best practices for ensuring fairness and incorporating the principles of equity and inclusion in board decision making related to licensing and disciplinary action."[8]

While OMB uses sanctioning guidelines for two specific types of complaints, it does not use them for any other complaint types. When auditors asked OMB about this, management indicated a concern that guidelines could not adequately account for the unique circumstances and complexity of each case. Disciplinary guidelines we saw in other states included provisions in which the board can deviate from the guidelines if necessary. Some boards also set mitigating or aggravating factors that, if present in a case, may warrant either a lighter or more stringent disciplinary sanction. Providing this flexibility helps preserve a board's authority and autonomy in making disciplinary decisions and protects against potential injustices for cases that may not fit well within disciplinary guidelines.

[8] Federation of State Medical Boards (FSMB) Diversity, Equity, and Inclusion Workgroup Interim Report, 2022.

Without a disciplinary matrix or guidelines to help guide the board's disciplinary discussions and a regular and systematic process for reviewing past cases, OMB cannot provide convincing assurance to the public and licensees that its disciplinary decisions are equitable and consistent. However, the board has taken some action to look for potential inequities. OMB's strategic plan includes an item to evaluate equity in "investigative case reviews and final outcomes," with an expected completion date of December 2023. However, according to OMB management, the expected completion date of that evaluation has been revised to December 2025 due to other work demands. The board also utilized a legal student extern in 2013 to review past cases for consistency of disciplinary outcomes. While that review found no significant inconsistencies, the limited nature of this review is not an adequate substitute for a regular, robust review process.

A new data system with robust categorization of complaints will help OMB conduct routine, systematic equity analysis of case outcomes

While OMB is in the process of developing a new data system that will have more data capabilities, the board's current system, TechMed, does not effectively capture complaint detail to allow for consistency and equity analysis.

The data system contains over 50 complaint categories, with most cases containing several different types of complaints. Moreover, all complaint types applicable to a case are captured in one data field, with no delineation in the data system to identify a primary complaint type or to organize complaint types by the most serious or most pertinent allegation included in the case. In the data provided to the audit team, there were over 600 combinations of complaint types in the complaint category field, making it difficult for auditors to analyze the data in a useful way. Without an effective complaint categorization mechanism in its data system, OMB cannot objectively and systematically evaluate consistency and equity across all cases.

Due in part to the limitations with OMB's complaint data, auditors reviewed a targeted selection of 28 case files that appeared similar in nature, or which included serious allegations. While no substantial discrepancies were found in these cases, the difficulty of identifying cases with similar complaint types in the data limited the number of cases auditors could realistically review and impaired the usefulness of both the analysis and any conclusions that could be drawn from it.

OMB is in the process of building and rolling out a new data system to capture licensing and case information, which will replace its current system. This process is expected to be finished in 2024. OMB management has indicated that while this system is intended to provide similar functionality to their current system, it will have the capability to capture different data points. Management has also indicated its willingness to make changes to the new system based on this audit's findings and recommendations.

Recommendations

To help ensure investigated cases result in consistent and equitable board decisions, OMB should:

1. Implement sanctioning guidelines and/or a sanction matrix to help reduce the risk of inconsistent and inequitable case decisions;
2. Add the ability to categorize cases by primary or most serious complaint type, or another effective categorization system, to its forthcoming new data system;
3. Use complaint data to conduct regular, systematic reviews of past cases to help monitor for and ensure equity and consistency;
4. Develop and implement written policies and procedures for analyzing board disciplinary decisions for equity and consistency.

Objective, Scope, and Methodology

Objective

How does the Oregon Medical Board ensure its disciplinary decisions are consistent and equitable for cases with similar circumstances and violations?

Scope

Complaint cases closed with a disciplinary action, corrective action agreement, or letter of concern for the five-year period of January 1, 2017, to December 31, 2021.

Methodology

To meet our objective, we performed the following procedures:

- Analyzed OMB complaint case data and licensee demographic data;
- Reviewed the board's policies, procedures, and processes related to investigations and disciplinary decisions;
- Interviewed OMB managers, staff, and Investigative Committee board members, as well as stakeholders and other outside groups, such as the Oregon Society of Physician Assistants and malpractice attorneys;
- Reviewed a targeted selection of 28 complaint case files;
- Obtained audits, reports, and/or documents from other states' medical or health licensing boards, as well as other boards and commissions in Oregon; and
- Reviewed research, reports, or other documents from related professional organizations and outside groups, such as the Federation of State Medical Boards and the National Practitioners Data Bank.

Internal control review

We determined that the following internal controls were relevant to our audit objective.[9]

- Risk Assessment
  - We reviewed policies and procedures, interviewed OMB managers and staff, and sent questions related to the board's strategic goal of consistent disciplinary outcomes.
- Control activities
  - We interviewed OMB managers and evaluated policies and procedures related to disciplinary decisions.
- Monitoring activities
  - We evaluated whether the board regularly analyzes its disciplinary outcomes for equity and consistency.

Deficiencies with these internal controls were documented in the results section of this report.

[9] Auditors relied on standards for internal controls from the U.S. Government Accountability Office, report GAO-14-704G.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We sincerely appreciate the courtesies and cooperation extended by officials and employees of the Oregon Medical Board during the course of this audit.

Audit team
Olivia Recheked, MPA, Audit Manager
Stephen Winn, MPP, Principal Auditor
Christina Nichols, Staff Auditor

About the Secretary of State Audits Division

The Oregon Constitution provides that the Secretary of State shall be, by virtue of the office, Auditor of Public Accounts. The Audits Division performs this duty. The division reports to the Secretary of State and is independent of other agencies within the Executive, Legislative, and Judicial branches of Oregon government. The division has constitutional authority to audit all state officers, agencies, boards and commissions as well as administer municipal audit law.

OREGON SOS

Secretary of State
LaVonne Griffin-Valade

OREGON AUDITS DIVISION

Audits Director
Kip Memmott

This report is intended to promote the best possible management of public resources.
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WAC 246-16-800

Sanctions—General provisions.

(1) Applying these rules.

(a) The disciplining authorities listed in RCW **18.130.040**(2) will apply these rules to determine sanctions imposed for unprofessional conduct by a license holder in any active, inactive, or expired status. The rules do not apply to applicants.

(b) The disciplining authorities will apply the rules in:

(i) Orders under RCW **18.130.110** or **18.130.160**; and

(ii) Stipulations to informal disposition under RCW **18.130.172**.

(c) Sanctions will begin on the effective date of the order.

(2) Selecting sanctions.

(a) The disciplining authority will select sanctions to protect the public and, if possible, rehabilitate the license holder.

(b) The disciplining authority may impose the full range of sanctions listed in RCW **18.130.160** for orders and RCW **18.130.172** for stipulations to informal dispositions.

(i) Suspension or revocation will be imposed when the license holder cannot practice with reasonable skill or safety.

(ii) Permanent revocation may be imposed when the disciplining authority finds the license holder can never be rehabilitated or can never regain the ability to practice safely.

(iii) Surrender of a credential may be imposed when the license holder is at the end of his or her effective practice and surrender alone is enough to protect the public. The license holder must agree to retire and not resume practice.

(iv) Indefinite suspension may be imposed in default and waiver of hearing orders. If indefinite suspension is not imposed in a default or waiver of hearing order, the disciplining authority shall impose sanctions determined according to these rules.

(v) "Oversight" means a period of time during which respondent must engage in on-going affirmative conduct intended to encourage rehabilitation and ensure public safety. It also includes active compliance monitoring by the disciplining authority. The passage of time without additional complaints or violations, with or without payment of a fine or costs, is not, by itself, oversight.

(c) The disciplining authority may deviate from the sanction schedules in these rules if the schedule does not adequately address the facts in a case. The disciplining authority will acknowledge the deviation and state its reasons for deviating from the sanction schedules in the order or stipulation to informal disposition.

(d) If the unprofessional conduct is not described in a schedule, the disciplining authority will use its judgment to determine appropriate sanctions. The disciplining authority will state in the order or stipulation to informal disposition that no sanction schedule applies.

(3) Using sanction schedules.

(a) Step 1: The findings of fact in an order or the allegations in an informal disposition describe the unprofessional conduct. The disciplining authority uses the unprofessional conduct described to select the appropriate sanction schedule contained in WAC **246-16-810** through **246-16-860**.

(i) If the act of unprofessional conduct falls in more than one sanction schedule, the greater sanction is imposed.

(ii) If different acts of unprofessional conduct fall in the same sanction schedule, the highest sanction is imposed and the other acts of unprofessional conduct are considered aggravating factors.

(b) Step 2: The disciplining authority identifies the severity of the unprofessional conduct and identifies a tier using the sanction schedule tier descriptions.

(c) Step 3: The disciplining authority identifies aggravating or mitigating factors using the list in WAC **246-16-890**. The disciplining authority describes the factors in the order or stipulation to informal disposition.

(d) Step 4: The disciplining authority selects sanctions within the identified tier. The starting point for duration of the sanctions is the middle of the tier range.

(i) Aggravating factors move the appropriate sanctions towards the maximum end of the tier range.

(ii) Mitigating factors move the appropriate sanctions towards the minimum end of the tier range.

(iii) Mitigating or aggravating factors may result in determination of a sanction outside the range in the tier. The disciplining authority will state its reasons for deviating from the tier range in the sanction schedule in the order or stipulation to informal disposition. The disciplining authority has complied with these rules if it acknowledges the deviation and states its reasons for deviating from the sanction schedules in the order or stipulation to informal disposition.

[Statutory Authority: RCW **18.130.390**. WSR 09-15-190, § 246-16-800, filed 7/22/09, effective 8/22/09.]

WAC 246-16-810

Sanction schedule—Practice below s

PRACTICE BELOW STANDARD OF CARE				
Severity	Tier / Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least	**A** – Caused no or minimal patient harm or a risk of minimal patient harm	Conditions that may include reprimand, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 3 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	0-3 years
	B – Caused moderate patient harm or risk of moderate to severe patient harm	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 5 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. OR revocation.	2 years - 5 years unless revocation
greatest	**C** – Caused severe harm or death to a human patient	Oversight for 3 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. In addition - demonstration of knowledge or competency.	Permanent conditions, restrictions or revocation.	3 years - permanent

[Statutory Authority: RCW . WSR 09-15-190, 8/22/09.]

WAC 246-16-820

Sanction schedule—Sexual misconduc

SEXUAL MISCONDUCT OR CONTACT (including convictions for sexual misconduct)				
Severity	Tier / Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least	**A** –Inappropriate conduct, contact, or statements of a sexual or romantic nature	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, etc.	Oversight for 3 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	0-3 years
	B – Sexual contact, romantic relationship, or sexual statements that risk or result in patient harm	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 5 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. OR revocation.	2 years - 5 years unless revocation
greatest	**C** – Sexual contact, including but not limited to contact involving force and/or intimidation, and convictions of sexual offenses in RCW 9.94A.030.	1 year suspension AND oversight for 5 additional years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. AND demonstration of successful completion of evaluation and treatment.	Permanent conditions, restrictions, or revocation.	6 years - permanent

[Statutory Authority: RCW . WSR 09-15-190, 8/22/09.]

WAC 246-16-830

Sanction schedule—Abuse—Physica

ABUSE -- Physical and/or Emotional				
Severity	Tier / Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least	**A** – Verbal or nonverbal intimidation, forceful contact, or disruptive or demeaning behavior, including general behavior not necessarily directed at a specific patient or patients	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, etc.	Oversight for 3 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	0-3 years
	B – Abusive unnecessary or forceful contact or disruptive or demeaning behavior causing or risking moderate mental or physical harm, including general behavior not directed at a specific patient or patients.	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 5 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. OR revocation.	2 years - 5 years unless revocation
greatest	**C** – Severe physical, verbal, or forceful contact, or emotional disruptive behavior, that results in or risks significant harm or death	1 year suspension AND oversight for 5 additional years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. AND demonstration of successful completion of evaluation and treatment.	Permanent conditions, restrictions, or revocation.	6 years - permanent

[Statutory Authority: RCW . WSR 09-15-190, 8/22/09.]

WAC 246-16-840

Sanction schedu

DIVERSION OF CONTROLLED SUBSTANCES OR LEGEND DRUGS				
Severity	**Tier/Conduct**	**Sanction Range In consideration of Aggravating & Mitigating Circumstances**		**Duration**
		Minimum	Maximum	
least	**A** – Diversion with no or minimal patient harm or risk of harm	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, treatment, etc.	Oversight for 5 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, treatment etc.	0-5 years
	B – Diversion with moderate patient harm or risk of harm or for distribution	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, treatment, etc.	Oversight for 7 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, treatment, etc. OR revocation.	2 - 7 years unless revocation
greatest	**C** – Diversion with severe physical injury or death of a patient or a risk of severe physical injury or death or for substantial distribution to others	1 year suspension AND oversight for 5 additional years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. AND demonstration of successful completion of evaluation and treatment.	Permanent conditions, restrictions OR revocation.	6 years - permanent

[Statutory Authority: RCW . WSR 09-15-190, 8/22/09.]

WAC 246-16-850

Sanction schedule—Substance abuse.

SUBSTANCE ABUSE				
Severity	Tier / Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least  greatest	A – Misuse of drugs or alcohol with no to minimal patient harm or risk of harm	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, treatment, etc.	Oversight for 5 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, treatment, etc.	0-5 years
	B –Misuse of drugs or alcohol with moderate patient harm or risk of harm	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, treatment, etc.	Oversight for 7 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, treatment, etc. OR revocation.	2 - 7 years unless revocation
	C –Misuse of drugs or alcohol with severe physical injury or death of a patient or a risk of significant physical injury or death	1 year suspension AND oversight for 5 additional years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. AND demonstration of successful completion of evaluation and treatment.	Permanent conditions, restrictions OR revocation.	6 years - permanent

[Statutory Authority: RCW [illegible]. WSR 09-15-190, 8/22/09.]

WAC 246-16-860

Sanction schedule—Criminal convictions.

CRIMINAL CONVICTIONS (excluding sexual misconduct)				
Severity	Tier / Conviction	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least	**A** – Conviction of a Gross Misdemeanor except sexual offenses in RCW 9.94A.030	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, etc.	Oversight for 5 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	0-5 years
	B – Conviction of a Class B, C, OR Unclassified Felony, except sexual offenses in RCW 9.94A.030	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 5 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. OR revocation.	2 years - 5 years unless revocation
greatest	**C** – Conviction of a Class A Felony, except sexual offenses in RCW 9.94A.030	5 years suspension	Permanent revocation	5 years - permanent revocation

[Statutory Authority: RCW [illegible]. WSR 09-15-190, 8/22/09.]

State of California

Business, Consumer Services, and Housing Agency

MEDICAL BOARD OF CALIFORNIA

MANUAL OF MODEL DISCIPLINARY ORDERS AND DISCIPLINARY GUIDELINES

12th Edition
2016

STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA

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MANUAL OF MODEL DISCIPLINARY ORDERS
AND DISCIPLINARY GUIDELINES
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STATE OF CALIFORNIA
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The Board produced this Manual of Model Disciplinary Orders and Disciplinary Guidelines, 12th Edition for the intended use of those involved in the physician disciplinary process: Administrative Law Judges, defense attorneys, physician-respondents, trial attorneys from the Office of the Attorney General, and the Board's disciplinary panel members who review proposed decisions and stipulations and make final decisions. These guidelines are not binding standards.

The Federation of State Medical Boards and other state medical boards have requested and received this manual. All are welcome to use and copy any part of this material for their own work.

To view this document visit http://www.mbc.ca.gov/Enforcement/disciplinary_guide.pdf

Revisions to the Manual of Model Disciplinary Orders and Disciplinary Guidelines are made periodically.

STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
MANUAL OF MODEL DISCIPLINARY ORDERS AND DISCIPLINARY GUIDELINES

Business and Professions Code section 2229 mandates protection of the public shall be the highest priority for the Medical Board and for the Administrative Law Judges of the Medical Quality Hearing Panel. Section 2229 further specifies that, to the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of licensees. To implement the mandates of section 2229, the Board has adopted the Manual of Model Disciplinary Orders and Disciplinary Guidelines (guidelines), 12th Edition. Consistent with the mandates of section 2229, these guidelines set forth the discipline the Board finds appropriate and necessary for the identified violations. In addition to protecting the public and, where not inconsistent, rehabilitating the licensee, the Board finds that imposition of the discipline set forth in the guidelines will promote uniformity, certainty and fairness, and deterrence, and, in turn, further public protection.

The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board- ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

The Model Disciplinary Orders contain three sections: three (3) Disciplinary Orders; twenty-three (23) Optional Conditions whose use depends on the nature and circumstances of the particular case; and eleven (11) Standard Conditions that generally appear in all probation cases. All orders should place the Disciplinary Order(s) first, Optional Condition(s) second, and Standard Condition(s) third.

MODEL DISCIPLINARY ORDERS
TABLE OF CONTENTS

RECOMMENDED RANGE OF PENALTIES FOR VIOLATIONS

MODEL DISCIPLINARY ORDERS

1. Revocation - Single Cause

Certificate No._____ issued to respondent _____ is revoked.

2. Revocation - Multiple Causes

Certificate No. _____ issued to respondent _____ is revoked pursuant to determination of Issues (e.g. I, II, and III), separately and for all of them.

3. Standard Stay Order

However, revocation stayed and respondent is placed on probation for (e.g., ten) years upon the following terms and conditions.

OPTIONAL CONDITIONS

4. Actual Suspension

As part of probation, respondent is suspended from the practice of medicine for (e.g., 90 days) beginning the sixteenth (16th) day after the effective date of this decision.

5. Controlled Substances - Total Restriction

Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined in the California Uniform Controlled Substances Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5.

If respondent forms the medical opinion, after an appropriate prior examination and a medical indication, that a patient's medical condition may benefit from the use of marijuana, respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and a medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, respondent shall inform the patient or the patient's primary caregiver that respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

6. Controlled Substances - Surrender of DEA Permit

Respondent is prohibited from practicing medicine until respondent provides documentary proof to the Board or its designee that respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any state prescription forms and all controlled substances order forms. Thereafter, respondent shall not reapply for a new DEA permit without the prior written consent of the Board or its designee.

7. Controlled Substances - Partial Restriction

Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedule(s)_____(e.g., IV and V) of the Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, respondent shall inform the patient or the patient's primary caregiver that respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

Note: Also use Condition 8, which requires that separate records be maintained for all controlled substances prescribed.

(Option)
Respondent shall immediately surrender respondent's current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, respondent shall submit proof that respondent has surrendered respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, respondent shall submit a true copy of the permit to the Board or its designee.

8. Controlled Substances- Maintain Records and Access to Records and Inventories

Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section

11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

9. Controlled Substances - Abstain From Use

Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drugs as defined by Business and Professions Code section 4022, and any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed to respondent by another practitioner for a bona fide illness or condition.

Within 15 calendar days of receiving any lawfully prescribed medications, respondent shall notify the Board or its designee of the: issuing practitioner's name, address, and telephone number; medication name, strength, and quantity; and issuing pharmacy name, address, and telephone number.

If respondent has a confirmed positive biological fluid test for any substance (whether or not legally prescribed) and has not reported the use to the Board or its designee, respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine. The respondent shall not resume the practice of medicine until the final decision on an accusation and/or a petition to revoke probation is effective. An accusation and/or petition to revoke probation shall be filed by the Board within 30 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. If the case is heard by an Administrative Law Judge alone, he or she shall forward a Proposed Decision to the Board within 15 days of submission of the matter. Within 15 days of receipt by the Board of the Administrative Law Judge's proposed decision, the Board shall issue its Decision, unless good cause can be shown for the delay. If the case is heard by the Board, the Board shall issue its decision within 15 days of submission of the case, unless good cause can be shown for the delay. Good cause includes, but is not limited to, non-adoption of the proposed decision, request for reconsideration, remands and other interlocutory orders issued by the Board. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 30 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

10. Alcohol - Abstain From Use

Respondent shall abstain completely from the use of products or beverages containing alcohol.

If respondent has a confirmed positive biological fluid test for alcohol, respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine. The respondent shall not resume the practice of medicine until the final decision on an accusation

and/or a petition to revoke probation is effective. An accusation and/or petition to revoke probation shall be filed by the Board within 30 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. If the case is heard by an Administrative Law Judge alone, he or she shall forward a Proposed Decision to the Board within 15 days of submission of the matter. Within 15 days of receipt by the Board of the Administrative Law Judge's proposed decision, the Board shall issue its Decision, unless good cause can be shown for the delay. If the case is heard by the Board, the Board shall issue its decision within 15 days of submission of the case, unless good cause can be shown for the delay. Good cause includes, but is not limited to, non-adoption of the proposed decision, request for reconsideration, remands and other interlocutory orders issued by the Board. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 30 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

11. Biological Fluid Testing

Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon request of the Board or its designee. "Biological fluid testing" may include, but is not limited to, urine, blood, breathalyzer, hair follicle testing, or similar drug screening approved by the Board or its designee. Prior to practicing medicine, respondent shall contract with a laboratory or service approved in advance by the Board or its designee that will conduct random, unannounced, observed, biological fluid testing. The contract shall require results of the tests to be transmitted by the laboratory or service directly to the Board or its designee within four hours of the results becoming available. Respondent shall maintain this laboratory or service contract during the period of probation.

A certified copy of any laboratory test result may be received in evidence in any proceedings between the Board and respondent.

If respondent fails to cooperate in a random biological fluid testing program within the specified time frame, respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine. The respondent shall not resume the practice of medicine until the final decision on an accusation and/or a petition to revoke probation is effective. An accusation and/or petition to revoke probation shall be filed by the Board within 30 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. If the case is heard by an Administrative Law Judge alone, he or she shall forward a Proposed Decision to the Board within 15 days of submission of the matter. Within 15 days of receipt by the Board of the Administrative Law Judge's proposed decision, the Board shall issue its Decision, unless good cause can be shown for the delay. If the case is heard by the Board, the Board shall issue its decision within 15 days of submission of the case, unless good cause can be shown for the delay. Good cause includes, but is not limited to, non-adoption of the proposed decision, request for reconsideration, remands and other interlocutory orders issued by the Board. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 30 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

12. Community Service - Free Services

[Medical community service shall only be authorized in cases not involving quality of care.]

Within 60 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval a community service plan in which respondent shall within the first 2 years of probation, provide_____ hours of free services (e.g., medical or nonmedical) to a community or non-profit organization. If the term of probation is designated for 2 years or less, the community service hours must be completed not later than 6 months prior to the completion of probation.

Prior to engaging in any community service respondent shall provide a true copy of the Decision(s) to the chief of staff, director, office manager, program manager, officer, or the chief executive officer at every community or non-profit organization where respondent provides community service and shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall also apply to any change(s) in community service.

Community service performed prior to the effective date of the Decision shall not be accepted in fulfillment of this condition.

13. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

14. Prescribing Practices Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the

Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

15. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

16. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

17. Professional Boundaries Program

Within 60 calendar days from the effective date of this Decision, respondent shall enroll in a professional boundaries program approved in advance by the Board or its designee. Respondent, at the program's discretion, shall undergo and complete the program's assessment of respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24 hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the Decision(s), Accusation(s) and any other information that the Board or its designee deems relevant. The program shall evaluate respondent at the end of the training and the program shall provide any data from the assessment and training as well as the results of the evaluation to the Board or its designee.

Failure to complete the entire program not later than six (6) months after respondent's initial enrollment shall constitute a violation of probation unless the Board or its designee agrees in writing to a later time for completion. Based on respondent's performance in and evaluations from the assessment, education, and training, the program shall advise the Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that respondent can practice medicine safely. Respondent shall comply with program recommendations. At the completion of the program, respondent shall submit to a final evaluation. The program shall provide the results of the evaluation to the Board or its designee. The professional boundaries program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

The program has the authority to determine whether or not respondent successfully completed the program.

A professional boundaries course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

(Option # 1: Condition Precedent)
Respondent shall not practice medicine until respondent has successfully completed the program and has been so notified by the Board or its designee in writing.

(Option # 2: Condition Subsequent)
If respondent fails to complete the program within the designated time period, respondent shall cease the practice of medicine within three (3) calendar days after being notified by the Board or its designee that respondent failed to complete the program.

18. Clinical Competence Assessment Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require respondent's on-site participation for a minimum of 3 and no more than 5 days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

[Note: The following language shall be included in this condition unless Option #1 is included: If respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the respondent did not successfully complete the clinical competence assessment program, the respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.]

(Option #1: Condition Precedent)
Respondent shall not practice medicine until respondent has successfully completed the program and has been so notified by the Board or its designee in writing.

(Option #2)
Within 60 days after respondent has successfully completed the clinical competence assessment program, respondent shall participate in a professional enhancement program approved in advance by the Board or its designee, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at

respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

19. Written Examination

[**NOTE:** This condition should **only** be used where a clinical competence assessment program is not appropriate.]

Within 60 calendar days of the effective date of this Decision, respondent shall take and pass the Special Purpose Examination (SPEX) or an equivalent examination as determined by the Board or its designee.

Failure to pass the required written examination within 180 calendar days after the effective date of this Decision is a violation of probation. Respondent shall pay the costs of all examinations.

[**Note:** The following language shall be included in this condition unless Option #1 is included: If respondent fails to pass the written examination, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not practice medicine until respondent successfully passes the examination, as evidenced by written notice to respondent from the Board or its designee.]

(Option 1: Condition Precedent)
Respondent shall not practice medicine until respondent has passed the required examination and has been so notified by the Board or its designee in writing. This prohibition shall not bar respondent from participating in a clinical competence assessment program approved by the Board or its designee.
Note: The condition precedent option is particularly recommended in cases where respondent has been found to be incompetent, repeatedly negligent, or grossly negligent.

20. Psychiatric Evaluation

Within 30 calendar days of the effective date of this Decision, and on whatever periodic basis thereafter may be required by the Board or its designee, respondent shall undergo and complete a psychiatric evaluation (and psychological testing, if deemed necessary) by a Board-appointed board certified psychiatrist, who shall consider any information provided by the Board or designee and any other information the psychiatrist deems relevant, and shall furnish a written evaluation report to the Board or its designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not be accepted towards the fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations and psychological testing.

Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the Board or its designee.

(Option: Condition Precedent)
Respondent shall not engage in the practice of medicine until notified by the Board or its designee that respondent is mentally fit to practice medicine safely. The period of time that respondent is not practicing medicine shall not be counted toward completion of the term of probation.

21. Psychotherapy

Within 60 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval the name and qualifications of a California-licensed board certified psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the Board or its designee deems that no further psychotherapy is necessary.

The psychotherapist shall consider any information provided by the Board or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the Board or its designee. Respondent shall cooperate in providing the psychotherapist any information and documents that the psychotherapist may deem pertinent.

Respondent shall have the treating psychotherapist submit quarterly status reports to the Board or its designee. The Board or its designee may require respondent to undergo psychiatric evaluations by a Board-appointed board certified psychiatrist. If, prior to the completion of probation, respondent is found to be mentally unfit to resume the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Board determines that respondent is mentally fit to resume the practice of medicine without restrictions.

Respondent shall pay the cost of all psychotherapy and psychiatric evaluations.

Note: This condition is for those cases where the evidence demonstrates that the respondent has had impairment (impairment by mental illness, alcohol abuse and/or drug self-abuse) related to the violations but is not at present a danger to respondent's patients.

22. Medical Evaluation and Treatment

Within 30 calendar days of the effective date of this Decision, and on a periodic basis thereafter as may be required by the Board or its designee, respondent shall undergo a medical evaluation by a Board-appointed physician who shall consider any information provided by the Board or designee and any other information the evaluating physician deems relevant and shall furnish a medical report to the Board or its designee. Respondent shall provide the evaluating physician any information and documentation that the evaluating physician may deem pertinent.

Following the evaluation, respondent shall comply with all restrictions or conditions recommended by the evaluating physician within 15 calendar days after being notified by the Board or its designee. If respondent is required by the Board or its designee to undergo medical treatment, respondent shall within 30 calendar days of the requirement notice, submit to the Board or its designee for prior approval the name and qualifications of a California licensed treating physician of respondent's choice. Upon approval of the treating physician, respondent shall within 15 calendar days undertake medical treatment and shall continue such treatment until further notice from the Board or its designee.

The treating physician shall consider any information provided by the Board or its designee or any other information the treating physician may deem pertinent prior to commencement of treatment. Respondent shall have the treating physician submit quarterly reports to the Board or its designee indicating whether or not the respondent is capable of practicing medicine safely.

Respondent shall provide the Board or its designee with any and all medical records pertaining to treatment, the Board or its designee deems necessary.

If, prior to the completion of probation, respondent is found to be physically incapable of resuming the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Board determines that respondent is physically capable of resuming the practice of medicine without restrictions. Respondent shall pay the cost of the medical evaluation(s) and treatment.

(Option- Condition Precedent)
Respondent shall not engage in the practice of medicine until notified in writing by the Board or its designee of its determination that respondent is medically fit to practice safely.

Note: This condition is for those cases where the evidence demonstrates that medical illness or disability was a contributing cause of the violations.

23. Monitoring - Practice/Billing

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a _____[**insert:** practice, billing, or practice and billing] monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's _____ [**insert:** practice, billing, or practice and billing] shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of _____[**insert:** medicine or billing, or both], and

whether respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

24. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the respondent's practice setting changes and the respondent is no longer practicing in a setting in compliance with this Decision, the respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

25. Third Party Chaperone

During probation, respondent shall have a third party chaperone present while consulting, examining or treating _____[**insert:** male, female, or minor] patients. Respondent shall, within 30 calendar days of the effective date of the Decision, submit to the Board or its designee for prior approval name(s) of persons who will act as the third party chaperone.

If respondent fails to obtain approval of a third party chaperone within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified.

Respondent shall cease the practice of medicine until a chaperone is approved to provide monitoring responsibility.

Each third party chaperone shall sign (in ink or electronically) and date each patient medical record at the time the chaperone's services are provided. Each third party chaperone shall read the Decision(s) and the Accusation(s), and fully understand the role of the third party chaperone.

Respondent shall maintain a log of all patients seen for whom a third party chaperone is required. The log shall contain the: 1) patient initials, address and telephone number; 2) medical record number; and 3) date of service. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

Respondent is prohibited from terminating employment of a Board-approved third party chaperone solely because that person provided information as required to the Board or its designee.

If the third party chaperone resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name of the person(s) who will act as the third party chaperone. If respondent fails to obtain approval of a replacement chaperone within 30 calendar days of the resignation or unavailability of the chaperone, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement chaperone is approved and assumes monitoring responsibility.

(Option)

Respondent shall provide written notification to respondent's patients that a third party chaperone shall be present during all consultations, examination, or treatment with [**insert:** male, female or minor] patients. Respondent shall maintain in the patient's file a copy of the written notification, shall make the notification available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the notification for the entire term of probation.

26. Prohibited Practice

During probation, respondent is prohibited from _____ [**insert:** practicing, performing, or treating] _____[**insert:** a specific medical procedure; surgery; on a specific patient population]. After the effective date of this Decision, all patients being treated by the respondent shall be notified that the respondent is prohibited from _____ [**insert:** practicing, performing or treating] _____ [**insert:** a specific medical procedure; surgery; on a specific patient population]. Any new patients must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep

this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

STANDARD CONDITIONS

27. Notification

Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

28. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

29. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

30. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

31. General Probation Requirements

Compliance with Probation Unit
Respondent shall comply with the Board's probation unit.

Address Changes
Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice
Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal
Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California
Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

32. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

33. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

34. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

35. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

36. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his or her license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

37. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

RECOMMENDED RANGE OF PENALTIES FOR VIOLATIONS

DISCIPLINARY ACTION TAKEN BY OTHERS [B&P 141(a) & 2305]
Minimum penalty: Same for similar offense in California
Maximum penalty: Revocation

MISLEADING ADVERTISING (B&P 651 & 2271)
Minimum penalty: Stayed revocation, 1 year probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education Course [13]
3. Professionalism Program (Ethics Course) [16]
4. Monitoring-Practice/Billing [23]
5. Prohibited Practice [26]

EXCESSIVE PRESCRIBING (B&P 725), or
PRESCRIBING WITHOUT AN APPROPRIATE PRIOR EXAMINATION (B&P 2242)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Controlled Substances-Total DEA restriction [5],
   Surrender DEA permit [6] or
   Partial DEA restriction [7]
3. Maintain Records and Access to Records and Inventories [8]
4. Education Course [13]
5. Prescribing Practices Course [14]
6. Medical Record Keeping Course [15]
7. Professionalism Program (Ethics Course) [16]
8. Clinical Competence Assessment Program [18]
9. Monitoring-Practice/Billing [23]

EXCESSIVE TREATMENTS (B&P 725)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education Course [13]
3. Medical Record Keeping Course [15]
4. Professionalism Program (Ethics Course) [16]
5. Clinical Competence Assessment Program [18]
6. Monitoring-Practice/Billing [23]
7. Prohibited Practice [26]

SEXUAL MISCONDUCT (B&P 726)
Minimum penalty: Stayed revocation, 7 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education Course [13]
3. Professionalism Program (Ethics Course) [16]
4. Professional Boundaries Program [17]
5. Psychiatric Evaluation [20]
6. Psychotherapy [21]
7. Monitoring-Practice/Billing [23]
8. Third Party Chaperone [25]
9. Prohibited Practice [26]

SEXUAL EXPLOITATION (B&P 729)
Minimum penalty: Revocation
Effective January 1, 2003, Business and Professions Code 2246 was added to read, "Any proposed decision or decision issued under this article that contains any finding of fact that the licensee engaged in any act of sexual exploitation, as described in paragraphs (3) to (5), inclusive, of subdivision (b) of Section 729, with a patient shall contain an order of revocation. The revocation shall not be stayed by the administrative law judge."

MENTAL OR PHYSICAL ILLNESS (B&P 820)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Written Examination [19]
2. Psychiatric Evaluation [20]
3. Psychotherapy [21]
4. Medical Evaluation and Treatment [22]
5. Monitoring-Practice/Billing [23]
6. Solo Practice Prohibition [24]
7. Prohibited Practice [26]

REGISTRATION AS A SEX OFFENDER (B&P 2232)
Minimum penalty: Revocation
Section 2232(a) of the Business and Professions Code provides that "Except as provided in subdivisions (b), (c), and (d), the board shall promptly revoke the license of any person who, at any time after January 1, 1947, has been required to register as a sex offender pursuant to the provisions of section 290 of the Penal Code."

GENERAL UNPROFESSIONAL CONDUCT (B&P 2234), or
GROSS NEGLIGENCE [B&P 2234 (b)], or
REPEATED NEGLIGENT ACTS [B&P 2234(c)], or
INCOMPETENCE [B&P 2234(d)], or
FAILURE TO MAINTAIN ADEQUATE RECORDS (B&P 2266)
Minimum penalty: Stayed revocation, 5 years probation
NOTE: In cases charging repeated negligent acts with one patient, a public reprimand may, in appropriate circumstances, be ordered.
Maximum penalty: Revocation
1. Education course [13]
2. Prescribing Practices Course [14]
3. Medical Record Keeping Course [15]
4. Professionalism Program (Ethics Course) [16]
5. Clinical Competence Assessment Program [18]
6. Monitoring-Practice/Billing [23]
7. Solo Practice Prohibition [24]
8. Prohibited Practice [26]

DISHONESTY - Substantially related to the qualifications, functions or duties of a physician and surgeon and *arising from* or occurring during patient care, treatment, management or billing [B&P 2234(e)]
Minimum penalty: Stayed revocation, one year suspension at least 7 years probation
Maximum penalty: Revocation
1. Professionalism Program (Ethics Course) [16]
2. Psychiatric Evaluation [20]
3. Medical Evaluation [22]
4. Monitoring-Practice/Billing [23]
5. Solo Practice Prohibition [24]
6. Prohibited Practice [26]
7. Victim Restitution

DISHONESTY - Substantially related to the qualifications, function or duties of a physician and surgeon but *not arising from* or occurring during patient care, treatment, management or billing [BP 2234 (e)]
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Community Service [12]
3. Professionalism Program (Ethics Course) [16]
4. Psychiatric Evaluation [20]
5. Medical Evaluation [22]
6. Monitoring-Practice/Billing (if financial dishonesty or conviction of financial crime) [23]
7. Victim Restitution

PROCURING LICENSE BY FRAUD (B&P 2235)
1. Revocation [1] [2]

CONVICTION OF CRIME - Substantially related to the qualifications, functions or duties of a physician and surgeon and *arising from* or occurring during patient care, treatment, management or billing (B&P 2236)
Minimum penalty: Stayed revocation, one year suspension, at least 7 years probation
Maximum penalty: Revocation
1. Community Service [12]
2. Professionalism Program (Ethics Course) [16]
3. Psychiatric Evaluation [20]
4. Medical Evaluation and Treatment [22]
5. Monitoring-Practice/Billing [23]
6. Solo Practice Prohibition [24]
7. Prohibited Practice [26]
8. Victim Restitution

CONVICTION OF CRIME - Felony conviction substantially related to the qualifications, functions or duties of a physician and surgeon but *not arising from* or occurring during patient care, treatment, management or billing (B&P 2236)
Minimum penalty: Stayed revocation, 7 years probation
Maximum penalty: Revocation
1. Suspension of 30 days or more [4]
2. Community Service [12]
3. Professionalism Program (Ethics Course) [16]
4. Psychiatric Evaluation [20]
5. Medical Evaluation and Treatment [22]
6. Monitoring-Practice/Billing (if dishonesty or conviction of a financial crime) [23]
7. Victim Restitution

CONVICTION OF CRIME - Misdemeanor conviction substantially related to the qualifications, functions or duties of a physician and surgeon but *not arising from* or occurring during patient care, treatment, management or billing (B&P 2236)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Community Service [12]
2. Professionalism Program (Ethics Course) [16]
3. Psychiatric Evaluation [20]
4. Medical Evaluation and Treatment [22]
5. Victim Restitution

CONVICTION OF DRUG VIOLATIONS (B&P 2237), or
VIOLATION OF DRUG STATUTES (B&P 2238), or
EXCESSIVE USE OF CONTROLLED SUBSTANCES (B&P 2239), or
PRACTICE UNDER THE INFLUENCE OF NARCOTIC (B&P 2280)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Controlled Substances - Total DEA restriction [5],
   Surrender DEA permit [6], or
   Partial DEA restriction [7]

3. Maintain Drug Records and Access to Records and Inventories [8]
4. Controlled Substances - Abstain From Use [9]
5. Alcohol-Abstain from Use [10]
6. Biological Fluid Testing [11]
7. Education Course [13]
8. Prescribing Practices Course [14]
9. Medical Record Keeping Course [15]
10. Professionalism Program (Ethics Course) [16]
11. Psychiatric Evaluation [20]
12. Psychotherapy [21]
13. Medical Evaluation and Treatment [22]
14. Monitoring-Practice/Billing [23]
15. Prohibited Practice [26]

ILLEGAL SALES OF CONTROLLED SUBSTANCES (B&P 2238)
Revocation [1] [2]

EXCESSIVE USE OF ALCOHOL (B&P 2239) or
PRACTICE UNDER THE INFLUENCE OF ALCOHOL (B&P 2280)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Controlled Substances-Abstain From Use [9]
3. Alcohol-Abstain from Use [10]
4. Biological Fluid Testing [11]
5. Professionalism Program (Ethics Course) [16]
6. Psychiatric Evaluation [20]
7. Psychotherapy [21]
8. Medical Evaluation and Treatment [22]
9. Monitoring-Practice/Billing [23]

PRESCRIBING TO ADDICTS (B&P 2241)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Controlled Substances- Total DEA restriction [5],
   Surrender DEA permit [6], or
   Partial restriction [7]
3. Maintain Drug Records and Access to Records and Inventories [8]
4. Education Course [13]
5. Prescribing Practices Course [14]
6. Medical Record Keeping Course [15]
7. Professionalism Program (Ethics Course) [16]
8. Clinical Competence Assessment Program [18]
9. Monitoring-Practice/Billing [23]
10. Prohibited Practice [26]

ILLEGAL CANCER TREATMENT (B&P 2252 and 2258)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education course [13]
3. Prescribing Practices Course [14]
4. Professionalism Program (Ethics Course) [16]
5. Clinical Competence Assessment Program [18]
6. Monitoring-Practice/Billing [23]
7. Prohibited Practice [26]

MAKING FALSE STATEMENTS (B&P 2261), or
ALTERATION OF MEDICAL RECORDS (B&P 2262)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Medical Record Keeping Course [15]
3. Professionalism Program (Ethics Course) [16]
4. If fraud involved, see “Dishonesty” guidelines

AIDING AND ABETTING UNLICENSED PRACTICE (B&P 2264)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education Course [13]
3. Professionalism Program (Ethics Course) [16]
4. Monitoring-Practice/Billing [23]
5. Prohibited Practice [26]

FICTITIOUS NAME VIOLATION (B&P 2285)
Minimum penalty: Stayed revocation, one year probation
Maximum penalty: Revocation

IMPERSONATION OF APPLICANT IN EXAM (B&P 2288)
1. Revocation [1] [2]

PRACTICE DURING SUSPENSION (B&P 2306)
1. Revocation [1] [2]

BUSINESS ORGANIZATION IN VIOLATION OF CHAPTER (B&P 2417)
Minimum penalty: Revocation
Effective January 1, 2002, Business and Professions Code section 2417 was added to read, in part, "(b) A physician and surgeon who practices medicine with a business organization knowing that it is owned or operated in violation of Section 1871.4 of the Insurance Code, Section 14107 or 14107.2 of the Welfare and Institutions Code, or Section 549 or 550 of the Penal Code shall have his or her license to practice permanently revoked."

VIOLATION OF PROBATION
Minimum penalty: 30 day suspension
Maximum penalty: Revocation
The maximum penalty should be given for repeated similar offenses or for probation violations revealing a cavalier or recalcitrant attitude. A violation of any of the following conditions of probation should result in, at minimum, a 60 day suspension:

1. Controlled Substances -Maintain Records and Access to Records and Inventories [8]
2. Biological Fluid Testing [11]
3. Professional Boundaries Program [17]
4. Psychiatric Evaluation [20]
5. Psychotherapy [21]
6 Medical Evaluation and Treatment [22]
7 Third Party Chaperone [25]

It is the expectation of the Medical Board of California that the appropriate penalty for a physician who did not successfully complete a clinical competence assessment program ordered as part of his or her probation is revocation.

Sanctioning Reference Points Instruction Manual

Board of Medicine

Guidance Document 85-11
Adopted July 2004
Revised August 2011

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June 2011

Dear Interested Parties:

In the spring of 2001, the Virginia Department of Health Professions approved a workplan to study sanctioning in disciplinary cases for Virginia's 13 health regulatory boards. The purpose of the study was to "*...provide an empirical, systematic analysis of board sanctions for offenses and, based on this analysis, to derive reference points for board members...*" The purposes and goals of the study were consistent with state statutes which specify that the Board of Health Professions (BHP) periodically review the investigatory and disciplinary processes to ensure the protection of the public and the fair and equitable treatment of health professionals.

The Board of Medicine was chosen as the first board to test a set of sanction reference points. After interviewing Board of Medicine members and staff, a committee of board members, staff, and research consultants assembled a research agenda involving the most exhaustive statistical study of sanctioned physicians ever conducted in the United States. The analysis included collecting over 100 factors on all Board of Medicine sanctioned cases in Virginia over a 6 year period. These factors measured case seriousness, respondent characteristics, and prior disciplinary history. After identifying the factors that were consistently associated with sanctioning, it was decided that the results provided a solid foundation for the creation of sanctioning reference points. Using both the data and collective input from the Board of Medicine and staff, analysts developed a usable set of sanction worksheets as a way to implement the reference system.

In 2010, BHP recommended that the SRPs be evaluated to determine if the program had met the objectives set forth in 2001. The result was several changes to the Board of Medicine's Sanctioning Reference Points worksheets. This manual is the product of those adopted changes.

Sincerely yours,

D. Reynolds-Cane, M.D.

Dianne L. Reynolds-Cane, M.D.
Director
Virginia Department of Health Professions

Cordially,

Elizabeth A. Carter, Ph.D.

Elizabeth A. Carter, Ph.D.
Executive Director
Virginia Board of Health Professions

Table Of Contents

General information

Overview

The Virginia Board of Health Professions has spent the last 10 years studying sanctioning in disciplinary cases. The study has examined all of the Department of Health Professions' (DHP) 13 health regulatory Boards. Focusing on the Board of Medicine (BOM), this manual contains background on the project, the goals and purposes of the Sanctioning Reference Points (SRP) system, and three revised offense-based worksheets and grids used to help Board members determine how similarly situated respondents have been treated in the past.

This SRP system is based on a specific sample of cases, and thus only applies to those persons sanctioned by the Virginia Board of Medicine. Moreover, the worksheets and grids have not been tested or validated on any other groups of persons. Therefore, they should not be used to sanction respondents coming before other health regulatory boards, other states, or other disciplinary bodies.

The current SRP system is comprised of a series of worksheets which score a number of offense and respondent factors identified using statistical analysis and built upon the Department's effort to maintain standards of practice over time. The original BOM SRP Manual was adopted in June 2004, and has been applied to cases closed in violation for a period of 7 years.

These instructions and the use of the SRP system fall within current DHP and BOM policies and procedures. Furthermore, all sanctioning recommendations are those currently available to and used by the Board and are specified within existing Virginia statutes. If an SRP worksheet recommendation is more or less severe than a Virginia statute or DHP regulation, the existing laws or policy supersedes the worksheet recommendation.

Background

In 2010, the Board of Health Professions (BHP) recommended that the SRPs be evaluated to determine if the program had met the objectives set forth in 2001. The purpose of this study was to evaluate the SRP system against its own unique set of objectives. The SRPs were designed to aid board members, staff and the public in a variety of ways. This Effectiveness Study seeks to examine whether or not the SRPs were successful, and if not, which areas require improvement.

The Effectiveness Study relied heavily on the completed coversheets and worksheets which record the offense score, respondent score, recommended sanction, actual sanction and any reasons for departure (if applicable). The study resulted in changes to the manual for the BOM. This manual is the result of those adopted changes.

Goals

In 2001, The Board of Health Professions and the Board of Medicine cited the following purposes and goals for establishing SRPs:

- Making sanctioning decisions more predictable
- Providing an education tool for new Board members
- Adding an empirical element to a process/system that is inherently subjective
- Providing a resource for BOM and those involved in proceedings
- "Neutralizing" sanctioning inconsistencies
- Validating Board member or staff recall of past cases
- Reducing the influence of undesirable factors—e.g., Board member ID, overall Board makeup, race or ethnic origin, etc.
- Helping predict future caseloads and need for probation services and terms

Methodology

The fundamental dilemma when developing a sanctioning reference system is deciding whether the supporting analysis should be grounded in historical data (a descriptive approach) or whether it should be developed normatively (a prescriptive approach). A normative approach reflects what policymakers feel sanction recommendations should be, as opposed to what they have been. SRPs can also be developed using historical data analysis with normative adjustments. This approach combines information from past practice with policy adjustments, in order to achieve a more balanced outcome. The SRP manual adopted in 2004, was based on a descriptive approach with a limited number of normative adjustments. The Effectiveness Study was conducted in a similar manner, drawing from historical data to inform worksheet modification.

Qualitative Analysis

Researchers conducted in-depth personal interviews with BOM members and Board staff, as well as holding informal conversations with representatives from the Attorney General's office and the Executive Director of the Board of Health Professions. The interview results were used to build consensus regarding the purpose and utility of SRPs and to further frame the Effectiveness Study's analysis. Additionally, interviews helped ensure the factors that Board members consider when sanctioning continued to be included during the quantitative phase of the study. Previous scoring factors were examined for their continued relevance and sanctioning influence.

Quantitative Analysis

In 2002, researchers collected detailed information on all BOM disciplinary cases ending in a violation between 1996 and 2001; approximately 250 sanctioning "events" covering close to 500 cases. Over 100 different factors were collected on each case to describe the case attributes Board members identified as potentially impacting sanction decisions. Researchers used data available through the DHP case management system combined with primary data collected from hard copy files. The hard copy files contained investigative reports, Board notices, Board orders, and all other documentation made available to Board members when deciding a case sanction.

A comprehensive database was created to analyze the offense and respondent factors which were identified as potentially influencing sanctioning decisions. Using statistical analysis to construct a "historical portrait" of past sanctioning decisions, the significant factors along with their relative weights were derived. Those factors and weights were formulated into sanctioning worksheets and grids, which became the SRPs.

During the Effectiveness Study, researchers used the 130 SRP worksheets and coversheets previously completed by Board members to create a database. The worksheets' factors, scores, sanction recommendations, sanctions handed down, and departure reasons (if any) were coded and keyed over the course of several weeks, creating a database. That database was then merged with DHP's data system L2K, adding more unique variables for analysis. The resulting database was analyzed to determine any changes in Board sanctioning that may have had an effect on the worksheet recommendations.

The original Medicine SRP manual made use of 5 offense based worksheets. This manual eliminated 2 worksheets by combining their unique characteristics into other existing worksheets. The first change was made by adding Unlicensed Activity circumstances to the Fraud/Deception/Misrepresentation worksheet. The next change was adding Inappropriate Relationship/Sexual Abuse to the Patient Case worksheet.

Offense factors such as patient harm, patient vulnerability and case severity (priority level) were analyzed, as well as respondent factors such as substance abuse, impairment at the time of offense, initiation of self-corrective action, and prior history of the respondent. Researchers re-examined factors previously deemed "extralegal" or inappropriate for the SRP system. For example, respondent's attorney representation, physical location (region), age, gender, and case processing time were considered "extra-legal" factors.

Although, both "legal" and "extra-legal" factors can help explain sanction variation, only those "legal" factors the Board felt should consistently play a role in a sanction decision continued to be included on the worksheets. By using this method, the hope is to achieve more neutrality in sanctioning, by making sure the Board considers the same set of "legal" factors in every case.

Characteristics of the SRP System

Wide Sanctioning Ranges

The SRPs consider and weigh the circumstances of an offense and the relevant characteristics of the respondent, providing the Board with a sanctioning model that encompasses roughly 70% of historical practice. This means that approximately 30% of past cases receive sanctions either higher or lower than what the reference points indicate, recognizing that aggravating and mitigating factors play a role in sanctioning. The wide sanctioning ranges allow the Board to customize on a particular sanction within the broader SRP recommended range.

Two Dimensional Sanctioning Grid

The Board indicated early in the SRP study that sanctioning is not only influenced by circumstances directly associated with the case, but also by the respondent's past history. The empirical analysis supported the notion that both offense and respondent factors impacted sanction outcomes. Subsequently, the SRPs make use of a two-dimensional scoring grid; one dimension scores factors related to the current violation(s), while the other dimension scores factors related to the respondent.

In addition, the first dimension assigns points for circumstances related to the violation that the Board is currently considering. For example, the respondent may receive points for inability to safely practice due to impairment at the time of the offense or, if there were multiple patients involved. The second dimension assigns points for factors that relate to the respondent. For example, a respondent before the Board for an unlicensed activity case may also receive points for having a history of disciplinary violations for other types of cases. That same respondent would receive more points if the prior violation was similar to the current one being heard.

Voluntary Nature

The SRP system should be viewed as a decision-aid to be used by the Board of Medicine. Sanctioning within the SRP ranges is "totally voluntary"- , meaning that the system is viewed strictly as a tool and the Board may choose any sanction outside the recommendation. The Board maintains complete discretion in determining the sanction handed down. However, a structured sanctioning system is of little value if the Board is not provided with the appropriate coversheet and worksheet in every case eligible for scoring. A coversheet and worksheet should be completed in cases resolved by Informal Conferences or Pre-Hearing Consent Orders. The coversheet and worksheets will be referenced by Board members during executive session only after a violation has been determined.

Using the SRP System

Case Types Covered by the SRPs

The revised SRP worksheets are grouped into 3 offense types: Impairment, Patient Care, and Fraud/Unlicensed Activity. This organization is based on the most recent historical analysis of Board sanctioning. The SRP factors found on each worksheet are those which proved important in determining sanctioning outcomes.

When multiple cases have been combined for disposition by the Board into one order, only one coversheet and worksheet is completed that encompasses the entire event. If a case has more than one offense type, one coversheet and worksheet is selected according to the type of worksheet which appears furthest to left on the following table. For example, a licensee found in violation of both an advertising and a treatment-related offense would have their case scored on a Patient Care worksheet, since Patient Care is to the left of Fraud/Unlicensed Activity on the table. The table also assigns the various case types brought before the Board to one of 3 worksheets. If a case type is not listed, the most analogous offense type is found and use the appropriate scoring worksheet is used.

Case Types Covered Within Worksheets

Impairment Worksheet		Patient Care Worksheet		Fraud/Unlicensed Activity Worksheet	
Drug Related	Drug adulteration	Abuse	Any sexual assault	Advertising	Claim of Superiority
	Obtaining Drugs by Fraud		Mistreatment of a patient		Deceptive/Misleading
	Patient deprivation	Inappropriate Relationship	Dual, sexual or other boundary issue		Fail to Disclose Full Fee when Advertising
	Personal use		Inappropriate touching		Improper Use of Trade Name
	Prescription forgery		Inappropriate written or oral communications		Omission of Required Wording/Ad Element
Impairment	due to use of alcohol, illegal substances, or prescription drugs	Patient Care - Diagnosis/ Treatment	Alternative Treatment		Other
			Delayed or unsatisfactory diagnose/treat	Business Practice Issues	Default on guaranteed student loan
Incapacitation	due to mental, physical or medical conditions		Failure to diagnose/treat		Disclosure
			Improper diagnose/treat		Inappropriate Use of Specialty or Board Certification
			Other diagnosis/treatment issues		
		Patient Care - Drug Related	Failure to provide counseling	Fraud	Falsification/alteration of patient records
			Improper management of patient regimen		
			Inappropriate or Excessive Prescribing/ Dispensing		Falsification of licensing/renewal documents
			Improper patient management		Improper patient billing
		Patient Care - Surgery	Improper/unnecessary performance of surgery		Performing unwarranted/unjust services
			Other surgery-related issues	Unlicensed Activity	Aiding/abetting unlicensed activity
			Inspection Deficiencies/Facility Violation		No valid license - not qualified to practice
		Patient Care - Other	Medical Record Keeping		No valid license - qualified to practice
			Records release		Practicing beyond the scope of license
		Supervision/ Neglect	Failure to do what a reasonable person would		Practicing on a revoked, suspended, or expired license
			Leaving a patient unattended in a health-care environment		

Worksheets Not Used in Certain Cases

The SRPs are not applied in any of the following circumstances:

- Action by Another Board - When a case which has already been adjudicated by a Board from another state appears before the Virginia Board of Medicine, the Board often attempts to mirror the sanction handed down by the other Board. The Virginia Board of Medicine usually requires that all conditions set by the other Board are completed or complied with in Virginia. The SRPs do not apply to cases previously heard and adjudicated by another Board.
- Compliance/Reinstatement - The SRPs should be applied to new cases only.

- Confidential Consent Agreement (CCA) - SRPs will not be used in cases settled by CCA.
- Formal Hearings - SRPs will not be used in cases that reach a Formal Hearing level.
- Mandatory Suspensions - Virginia law requires that under certain circumstances (conviction of a felony, declaration of legal incompetence or incapacitation, license revocation in another jurisdiction) the license of a physician must be suspended. The sanction is defined by law and is therefore excluded from the Sanctioning Reference Point system.

Completing the SRP Coversheet & Worksheet

Ultimately, it is the responsibility of the BOM to complete the SRP coversheet and worksheet in all applicable cases.

The information relied upon to complete a coversheet and worksheet is derived from the case packet provided to the Board and the respondent. It is also possible that information discovered at the time of the informal conference may impact worksheet scoring. The SRP coversheet and worksheet, once completed, are confidential under the Code of Virginia. Additionally, the manual, including blank coversheets and worksheets, can be found on the Department of Health Professions web site: www.dhp.state.va.us (paper copy also available on request).

Worksheets

Scoring instructions are contained adjacent to each of the 3 worksheets in subsequent sections of this manual. Detailed instructions are provided for each factor on a worksheet and should be referenced to ensure accurate scoring. When scoring, the scoring weights assigned to a factor on the worksheet cannot be adjusted. The scoring weights can only be applied as 'yes or no' with all or none of the points applied. In instances where a scoring factor is difficult to interpret, the Board has final authority in how a case is scored.

Coversheet

The coversheet (shown on page 12) is completed to ensure a uniform record of each case and to facilitate recordation of other pertinent information critical for continued system monitoring, evaluation and improvement.

If the Board feels the sanctioning grid does not recommend an appropriate sanction, the Board should depart either high or low when handing down a sanction. If the Board disagrees with the sanction grid recommendation and imposes a sanction greater or less than the recommended sanction, a short explanation should be recorded on the coversheet. The explanation could identify the factors and reasons for departure (see examples below). This process ensures worksheets are revised to reflect current Board practice and to maintain the dynamic nature of the system. For example, if a particular reason is continually cited, the Board can examine the issue more closely to determine if the worksheets should be modified to better reflect Board practice.

Aggravating and mitigating circumstances that may influence Board decisions can include, but should not be limited to, such things as:

- Age of prior record
- Dishonesty/Obstruction
- Motivation/Intent
- Remorse
- Extreme patient vulnerability
- Restitution/Self-corrective action
- Multiple offenses/Isolated incident

A space is provided on the coversheet to record the reason(s) for departure. Due to the uniqueness of each case, the reason(s) for departure may be varied. Sample scenarios are provided below:

Departure Example #1
Sanction Grid Result: Recommend Formal/Accept Surrender
Imposed Sanction: Probation with Terms - practice restriction
Reason(s) for Departure: Respondent was particularly remorseful and had already begun corrective action.

Departure Example #2
Sanction Grid Result: Reprimand
Imposed Sanction: Probation with Terms - practice monitoring
Reason(s) for Departure: Respondent may be trending towards future violations, implement oversight now to avoid future problems.

Determining a Specific Sanction

The Sanction Grid has four separate sanctioning outcomes: Recommend Formal or Accept Surrender, Treatment/ Monitoring, Reprimand and No Sanction. The table below lists specific sanction types under the four SRP grid recommendations. After considering the sanction grid recommendation, the Board should fashion a more detailed sanction(s) based on the individual case circumstances.

Expanded Sanctioning Grid Outcomes

SRP Sanction Outcome	Eligible Sanction Types
Recommend Formal/ Accept Surrender	Recommend Formal Hearing Accept Surrender C.O. for Suspension C.O. for Revocation
Treatment/Monitoring	Stayed Suspension Probation Terms: Mental or Physical Evaluation Continuing education Audit of practice Chart/record review Special examine (SPEX) Prescribing log Evaluation HPMP Chaperone Oversight by monitor/supervisor Therapy Other
Reprimand	Monetary Penalty Reprimand
No Sanction	No Sanction

Coversheet, Worksheets and Instructions

Sanctioning Reference Points Coversheet

1. Choose the appropriate worksheet
2. Complete the Offense Score and Respondent Score sections.
3. Determine the Recommended Sanction based on the scoring results and grid.
4. Complete this coversheet, noting a reason for departure if applicable.

Case Number(s): | | | | | | | | | | | | | | | | | | |

Respondent Name: _____ Last _____ First _____ Title

License Number: _____

Worksheet Used:
____Impairment
____Patient Care
____Fraud/Unlicensed Activity

Sanction Grid Result:
____No Sanction - Reprimand
____Reprimand - Treatment/Monitoring
____Treatment/Monitoring
____Treatment/Monitoring - Recommend Formal/Accept Surrender
____Recommend Formal/Accept Surrender

Imposed Sanction(s):
____No Sanction
____Reprimand
____Monetary Penalty: $_____ enter amount
____Probation: _____ duration in months
____Stayed Suspension: _____ duration in months
____Recommend Formal
____Accept Surrender
____Revocation
____Suspension
____Other sanction: _____
____Terms: _____

Reasons for Departure from Sanction Grid Result (if applicable): _____

_____

_____

Worksheet Preparer's Name: _____ Date Worksheet Completed: _____

Confidential pursuant to § 54.1-2400.2 of the Code of Virginia.

Impairment Instructions

Board of Medicine
Adopted 5/11/11

Offense Score

Step 1: Case Circumstances (score all that apply)

a. Enter "30" if the offense involves multiple patients.
b. Enter "25" if the respondent was unable to safely practice at the time of the offense due to illness related to substance abuse, or mental/physical impairment.
c. Enter "20" if the patient is especially vulnerable. Patients in this category must be at least one of the following: under age 18, over age 65, or mentally/ physically handicapped.
d. Enter "20" if there was financial or other material gain from the offense.

Step 2: Patient Injury Level (score only if applicable)
If a is scored, b and c cannot be scored; if a is not scored, b and/or c may be scored; skip if none are applicable. Score injury level for the patient with the most serious injury.

a. Enter "100" if a death occurred. Score if death was the result of an action by the respondent.
b. Enter "50" if physical injury occurred. Physical injury includes any injury requiring medical care, ranging from first-aid treatment to hospitalization.
c. Enter "50" if mental injury occurred. Mental injury includes any mental health care, such as psychiatric, psychological or any type of counseling provided by a bona fide health care professional.

Step 3: Priority Level (must score one)
A priority level must be scored. If more than one case is being sanctioned at the same time, score the case with the highest priority level.

a. Enter "75" in cases where an individual may have committed an act or is highly likely to commit an act that constitutes significant and substantial danger to the health and safety of any person (Priority A).
b. Enter "30" in cases where an individual may have committed a harmful act to another person but does not pose an imminent threat to public safety (Priority B) or where an individual may have committed an act that could be harmful or is considered substandard (Priority C).
c. Enter "20" in cases where an individual has committed an act that does not harm the patient but may result in the loss of property or chattel, misleads or causes inconvenience (Priority D).

Step 4: Obtain a Total Offense Score
Combine the scores from Steps 1, 2, and 3 for a Total Offense Score. This score is used to locate the correct horizontal row on the sanctioning recommendation grid.

Respondent Score

Step 5: Respondent Circumstances and Prior Board History (score all that apply)

a. Enter "60" if the respondent has a concurrent civil, malpractice, or criminal action related to the current case.
b. Enter "60" if the respondent has had one or more prior Board violations.
c. Enter "50" if the respondent has had any "similar" violations prior to this case. Similar violations include any cases that are also classified as "Impairment," which include Drug Related, Impairment and Incapacitation (see pg. 5 for a complete list).
d. Enter "50" if the respondent has been diagnosed or treated for mental health problems by a bona fide health care professional in the past for a condition affecting his/her ability to function safely or properly.
e. Enter "50" if the respondent has been diagnosed or treated for inappropriate relationship or sexual boundary problems by a bona fide health care professional in the past.
f. Enter "25" if the respondent has been diagnosed or treated for alcohol problems by a bona fide health care professional in the past.
g. Enter "25" if the respondent has been diagnosed or treated for drug problems by a bona fide health care professional in the past.

Note: Items d through g can be scored if the Board has evidence that another entity had determined that the respondent has had problems with substance abuse, mental health or sexual boundaries.

Step 6: Combine all for Total Respondent Score
Combine the scores from Steps 5 for a Total Respondent Score which will be used to locate the correct vertical column on the sanctioning recommendation grid.

Sanctioning Grid

Step 7: Identify SRP Recommendation
Locate the Offense and Respondent scores within the correct ranges on the top and left sides of the grid. The cell where row and column scores intersect displays the sanctioning recommendation.

Example: If the Offense Score is 70 and the Respondent Score is 90, the recommended sanction is shown in the center grid cell - "Treatment/Monitoring-Recommend Formal or Accept Surrender".

Step 8: Coversheet
Complete the coversheet, including the grid sanction, the imposed sanction and the reasons for departure if applicable.

Impairment Worksheet

Board of Medicine
Adopted 5/11/11

Offense Score	Points	Score
Case Circumstances (score all that apply)		
a. Multiple patients involved	30	
b. Impaired - Inability to practice	25	
c. Patient especially vulnerable	20	
d. Financial or material gain from offense	20	
Patient Injury Level (score only if applicable)		
a. Physical Injury - death	100	
b. Physical Injury - medical care	50	
c. Mental Injury	50	
Priority Level (must score one)		
a. Priority A	75	
b. Priority B or C	30	
c. Priority D	20	
Total Offense Score		

Respondent Score		
Respondent Circumstances and Prior Board History (score all that apply)		
a. Concurrent action	60	
b. One or more prior board violations	60	
c. Any prior "similar" board violations	50	
d. Past mental health problems	50	
e. Past inappropriate relationship/sexual problems	50	
f. Past alcohol problems	25	
g. Past drug problems	25	
Total Respondent Score		

Offense Score

Respondent Score	0-50	51-100	101 or more
0-50	No Sanction / Reprimand	Reprimand / Treatment/ Monitoring	Treatment/ Monitoring / Recommend Formal/ Accept Surrender
51-100	Treatment/Monitoring	Treatment/ Monitoring / Recommend Formal/ Accept Surrender	Treatment/ Monitoring / Recommend Formal/ Accept Surrender
101 or more	Treatment/ Monitoring / Recommend Formal/ Accept Surrender	Recommend Formal/ Accept Surrender	Recommend Formal/ Accept Surrender

Offense Score

Step 1: Case Type (score only one; score "0" if not applicable)

a. Enter "50" if the case involves sexual abuse.
b. Enter "25" if the case involves physician performance. Cases of this type include patient treatment such as Patient Care - Diagnosis/ Treatment, Patient Care - Drug Related and Patient Care - Surgery.
c. Enter "25" if the case involves an inspection deficiency or facility violation.

Step 2: Case Circumstances (score all that apply)

a. Enter "20" if the patient is especially vulnerable. Patients in this category must be at least one of the following: under age 18, over age 65, or mentally/physically handicapped.
b. Enter "20" if there was financial or other material gain from the offense.
c. Enter "30" if the case involves multiple patients.

Step 3: Patient Injury Level (score only if applicable)
If a is scored, b and c cannot be scored; if a is not scored, b and/or c may be scored; skip if none are applicable. Score injury level for the patient with the most serious injury.

a. Enter "100" if a death occurred. Score if death was the result of action by the respondent.
b. Enter "50" if physical injury occurred. Physical injury includes any injury requiring medical care ranging from first-aid treatment to hospitalization.
c. Enter "50" if mental injury occurred. Mental injury includes any mental health care such as psychiatric, psychological or any type of counseling provided by a bona fide health care professional.

Step 4: Priority Level (must score one)
A priority level must be scored. If more than one case is being sanctioned at the same time, score the case with the highest priority level.

a. Enter "75" in cases where an individual may have committed an act or is highly likely to commit an act that constitutes significant and substantial danger to the health and safety of any person (Priority A).
b. Enter "30" in cases where an individual may have committed a harmful act to another person but does not pose an imminent threat to public safety (Priority B) or where an individual may have committed an act that could be harmful or is considered substandard (Priority C).
c. Enter "20" in cases where an individual has committed an act that does not harm the patient but may result in the loss of property or chattel, misleads or causes inconvenience (Priority D).

Step 5: Obtain a Total Offense Score
Combine the scores from Steps 1, 2, 3, and 4 for a Total Offense Score. This score is used to locate the correct horizontal row on the sanctioning recommendation grid.

Respondent Score

Step 6: Respondent Circumstances and Prior Board History (score all that apply)

a. Enter "60" if the respondent has a concurrent civil, malpractice, or criminal action related to the current case.
b. Enter "60" if the respondent has had one or more prior Board violations.
c. Enter "50" if the respondent has had any "similar" violations prior to this case. Similar violations include any cases that are also classified as "Patient Care," which includes Abuse, Inappropriate Relationship, Neglect, Patient Care - Diagnosis/Treatment, Patient Care - Drug Related, Patient Care - Surgery and Patient Care - Other (see pg. 5 for a complete list).
d. Enter "50" if the respondent has been diagnosed or treated for mental health problems by a bona fide health care professional in the past for a condition affecting his/her ability to function safely or properly.
e. Enter "50" if the respondent has been diagnosed or treated for inappropriate relationship or sexual boundary problems by a bona fide health care professional in the past.
f. Enter "25" if the respondent has been diagnosed or treated for alcohol problems by a bona fide health care professional in the past.
g. Enter "25" if the respondent has been diagnosed or treated for drug problems by a bona fide health care professional in the past.

Note: Items d through g can be scored if the Board has evidence that another entity had determined that the respondent has had problems with substance abuse, mental health or sexual boundaries.

Step 7: Combine all for Total Respondent Score
Combine the scores from Steps 6 for a Total Respondent Score which will be used to locate the correct vertical column on the sanctioning recommendation grid.

Sanctioning Grid

Step 8: Identify SRP Recommendation
Locate the Offense and Respondent scores within the correct ranges on the top and left sides of the grid. The cell where row and column scores intersect displays the sanctioning recommendation.

Example: If the Offense Score is 70 and the Respondent Score is 90, the recommended sanction is shown in the center grid cell - "Treatment/Monitoring."

Step 9: Coversheet
Complete the coversheet, including the grid sanction, the imposed sanction and the reasons for departure if applicable.

Patient Care Worksheet

Board of Medicine
Adopted 5/11/11

Offense Score	Points	Score
Case Type (score only one)		
a. Sexual abuse	50	
b. Physician performance, patient related	25	
c. Inspection deficiency/facility violation	25	
Case Circumstances (score all that apply)		
a. Multiple patients involved	30	
b. Patient especially vulnerable	20	
c. Financial or material gain from offense	20	
Patient Injury Level (score only if applicable)		
a. Physical Injury - death	100	
b. Physical Injury - medical care	50	
c. Mental Injury	50	
Priority Level (must score one)		
a. Priority A	75	
b. Priority B or C	30	
c. Priority D	20	
Total Offense Score		

Respondent Score		
Respondent Circumstances and Prior Board History (score all that apply)		
a. Concurrent action	60	
b. One or more prior board violations	60	
c. Any prior "similar" board violations	50	
d. Past mental health problems	50	
e. Past inappropriate relationship/sexual problems	50	
f. Past alcohol problems	25	
g. Past drug problems	25	
Total Respondent Score		

Respondent Score \ Offense Score	0-50	51-100	101 or more
0-50	No Sanction / Reprimand	Reprimand / Treatment/ Monitoring	Treatment/ Monitoring / Recommend Formal/ Accept Surrender
51-100	Treatment/Monitoring	Treatment/Monitoring	Treatment/ Monitoring / Recommend Formal/ Accept Surrender
101 or more	Treatment/ Monitoring / Recommend Formal/ Accept Surrender	Treatment/ Monitoring / Recommend Formal/ Accept Surrender	Recommend Formal/ Accept Surrender

Fraud/Unlicensed Activity Instructions

Board of Medicine
Adopted 5/11/11

Offense Score

Step 1: Case Circumstances (score all that apply)

a. Enter "30" if the case type is "Claim of Superiority".
b. Enter "20" if the case involves one of the following "Financial Offenses": Fraud, Patient billing issues, Student loan default or tax related cases.
c. Enter "20" if there was financial or other material gain from the offense.
d. Enter "20" if the patient is especially vulnerable. Patients in this category must be at least one of the following: under age 18, over age 65, or mentally/physically handicapped.

Step 2: Patient Injury Level (score only if applicable)
If a is scored, b and c cannot be scored; if a is not scored, b and/or c may be scored; skip if none are applicable. Score injury level for the patient with the most serious injury.

a. Enter "100" if a death occurred. Score if death was the result of an action by the respondent.
b. Enter "50" if physical injury occurred. Physical injury includes any injury requiring medical care ranging from first-aid treatment to hospitalization.
c. Enter "50" if mental injury occurred. Mental injury includes any mental health care such as psychiatric, psychological or any type of counseling provided by a bona fide health care professional.

Step 3: Priority Level.
A priority level must be scored. If more than one case is being sanctioned at the same time, score the case with the highest priority level.

a. Enter "100" in cases where an individual may have committed an act or is highly likely to commit an act that constitutes significant and substantial danger to the health and safety of any person (Priority A).
b. Enter "40" in cases where an individual may have committed a harmful act to another person but does not pose an imminent threat to public safety (Priority B) or where an individual may have committed an act that could be harmful or is considered substandard (Priority C).
c. Enter "20" in cases where an individual has committed an act that does not harm the patient but may result in the loss of property or chattel, misleads or causes inconvenience (Priority D).

Step 4: Obtain a Total Offense Score
Combine the scores from Steps 1, 2, and 3 for a Total Offense Score. This score is used to locate the correct horizontal row on the sanctioning recommendation grid.

Respondent Score

Step 5: Respondent Circumstances and Prior Board History (score all that apply)

a. Enter "60" if the respondent has a concurrent civil, malpractice, or criminal action related to the current case.
b. Enter "60" if the respondent has had one or more prior Board violations.
c. Enter "50" if the respondent has had any "similar" violations prior to this case. Similar violations include any cases that are also classified as Fraud/Unlicensed Activity" which include Advertising, Business Practice Issues, Fraud, and Unlicensed Activity (see pg. 5 for a complete list)
d. Enter "50" if the respondent has been diagnosed or treated for mental health problems by a bona fide health care professional in the past to care for a condition affecting his/her ability to function safely or properly.
e. Enter "50" if the respondent has been diagnosed or treated for inappropriate relationship or sexual boundary problems by a bona fide health care professional in the past.
f. Enter "25" if the respondent has been diagnosed or treated for alcohol problems by a bona fide health care professional in the past.
g. Enter "25" if the respondent has been diagnosed or treated for drug problems by a bona fide health care professional in the past.

Note: Items d through g can be scored if the Board has evidence that another entity had determined that the respondent has had problems with substance abuse, mental health or sexual boundaries.

Step 6: Combine all for Total Respondent Score
Combine the scores from Steps 5 for a Total Respondent Score which will be used to locate the correct vertical column on the sanctioning recommendation grid.

Sanctioning Grid

Step 7: Identify SRP Recommendation
Locate the Offense and Respondent scores within the correct ranges on the top and left sides of the grid. The cell where row and column scores intersect displays the sanctioning recommendation.

Example: If the Offense Score is 70 and the Respondent Score is 90, the recommended sanction is shown in the center grid cell - "Treatment/Monitoring".

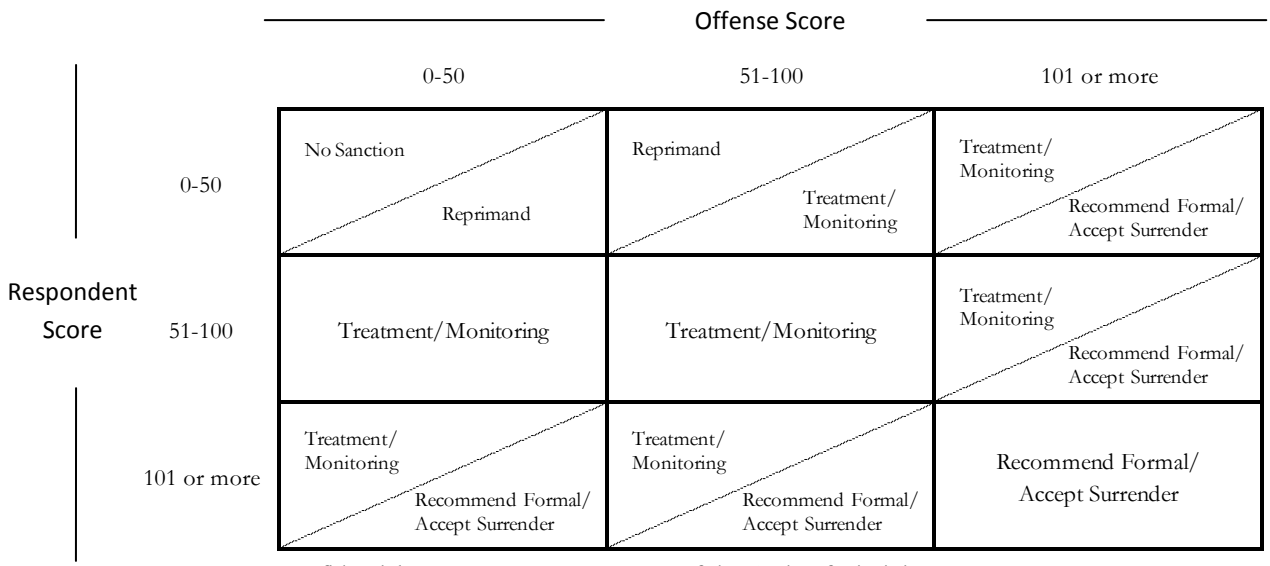
Step 8: Coversheet
Complete the coversheet including the grid sanction, the imposed sanction and the reasons for departure if applicable.

Fraud/Unlicensed Activity Worksheet

Board of Medicine
Adopted 5/11/11

Offense Score	Points	Score
Case Circumstances (score all that apply)		
a. Claim of Superiority	30	
b. Financial Offenses (see list)	20	
c. Financial or material gain from offense	20	
d. Patient especially vulnerable	20	
Patient Injury Level (score only if applicable)		
a. Physical Injury - death	100	
b. Physical Injury - medical care	50	
c. Mental Injury	50	
Priority Level (must score one)		
a. Priority A	100	
b. Priority B or C	40	
c. Priority D	20	
Total Offense Score		

Respondent Score		
Respondent Circumstances and Prior Board History (score all that apply)		
a. Concurrent action	60	
b. One or more prior board violations	60	
c. Any prior "similar" board violations	50	
d. Past mental health problems	50	
e. Past inappropriate relationship/sexual problems	50	
f. Past alcohol problems	25	
g. Past drug problems	25	
Total Respondent Score		



THE NORTH CAROLINA MEDICAL BOARD
DISCIPLINARY GUIDELINES

These disciplinary guidelines have been devised to promote consistency in sanctions imposed by the Board, to lend credibility to the disciplinary process and to aid the Board in their ultimate goal of public protection. They are used for reference and guidance only and are not binding on the Board. The Board recognizes that each case has individual facts and circumstances that distinguish it from other cases of the same nature and the Board agrees to consider all mitigating and aggravating factors specific to a case before determining the appropriate sanction. These guidelines will be used to neutralize unwarranted inconsistencies and improve the efficiency of the Board.

VIOLATIONS

1. Improper Prescribing, Dispensing, or Administering of Controlled Substances
2. A Violation of a Law Involving the Practice of Medicine
3. Criminal Acts or Convictions
4. Practicing Below the Minimum Standard of Care
5. Boundary Violations
6. Inadequate Record Keeping
7. Ethics Violations
8. Out of State Adverse Actions
9. Inability to Practice Due to an Addiction
10. Violation of Consent Order
11. Fraud, Misrepresentation, or Deception
12. Failure to file the Appropriate Paperwork with the Board.
13. Failure to comply with a Board Order.

IMPROPER PRESCRIBING, DISPENSING OR ADMINISTERING CONTROLLED SUBSTANCES.

Presumptive Maximum Discipline: Revocation of license

Presumptive Minimum Discipline: Private Letter of Concern

A VIOLATION OF A LAW INVOLVING THE PRACTICE OF MEDICINE

FELONY
Presumptive Maximum Discipline: Revocation of license

Presumptive Minimum Discipline: Indefinite Suspension of license

MISDEMEANOR
Presumptive Maximum Discipline: Revocation of license

Presumptive Minimum Discipline: Public Reprimand

CRIMINAL ACTS AND CONVICTIONS

FELONY
Presumptive Maximum Discipline: Revocation of license

Presumptive Minimum Discipline: Indefinite suspension of license

MORAL TURPITUDE
Maximum Penalty: Revocation of medical license

Minimum Penalty: Reprimand

MISDEMEANOR

Presumptive Maximum Discipline: Revocation of license

Presumptive Minimum Discipline: Private Letter of Concern

PRACTICING BELOW THE MINIMUM STANDARD OF CARE

Presumptive Maximum Discipline: Revocation of license

Presumptive Minimum Discipline: Stayed suspension of license

BOUNDARY VIOLATIONS

Presumptive Maximum Discipline: Revocation of license

Presumptive Minimum Discipline: Stayed Suspension of license

INADEQUATE RECORDKEEPING

Presumptive Maximum Discipline: Indefinite Suspension of license

Presumptive Minimum Discipline: Private Letter of Concern

ETHICS VIOLATIONS

Presumptive Maximum Discipline: Indefinite Suspension of license

Presumptive Minimum Discipline: Private Letter of Concern

OUT OF STATE ADVERSE ACTIONS

Presumptive Maximum Discipline: Revocation of license

Presumptive Minimum Discipline: Private Letter of Concern

INABILITY TO PRACTICE DUE TO AN ADDICTION

Presumptive Maximum Discipline: Revocation of license

Presumptive Minimum Discipline: Suspension of license

VIOLATION OF A CONSENT ORDER

Presumptive Maximum Discipline: Revocation of license

Presumptive Minimum Discipline: Stayed Suspension of license

FRAUD, MISREPRESENTATION OR DECEPTION

Presumptive Maximum Discipline: Revocation of license

Presumptive Minimum Discipline: Public Reprimand

FAILURE TO FILE THE APPROPRIATE PAPERWORK WITH THE BOARD

Presumptive Maximum Discipline: Public Reprimand

Presumptive Minimum Discipline: Private Letter of Concern

FAILURE TO COMPLY WITH A BOARD ORDER

Presumptive Maximum Discipline: Revocation of license

Presumptive Minimum Discipline: Public Reprimand

After a violation of the North Carolina Medical Practice Act has been established, the Board may consider aggravating and mitigating circumstances in deciding the appropriate discipline. The aggravating and mitigating factors set forth below are some of the factors the Board may consider. The Board may take into consideration other factors in aggravation or mitigation offered by the parties.

AGGRAVATING FACTORS

1. Prior disciplinary actions
2. Patient harm
3. Dishonest or selfish motive
4. Submission of false evidence, false statements, or other deceptive practices during the disciplinary process
5. Vulnerability of victim
6. Refusal to admit wrongful nature of conduct
7. Willful or reckless misconduct
8. Pattern of misconduct (repeated instances of the same misconduct)
9. Multiple offenses (more than one instance of different misconduct)

MITIGATING FACTORS

1. Absence of a prior disciplinary record
2. No direct patient harm
3. Absence of a dishonest or selfish motive
4. Full cooperation with the Board
5. Physical or mental disability or impairment
6. Rehabilitation or remedial measures
7. Remorse
8. Remoteness of prior discipline

Texas Administrative Code

TITLE 22	EXAMINING BOARDS
PART 9	TEXAS MEDICAL BOARD
CHAPTER 190	DISCIPLINARY GUIDELINES
SUBCHAPTER C	SANCTION GUIDELINES
RULE §190.14	Disciplinary Sanction Guidelines

These disciplinary sanction guidelines are designed to provide guidance in assessing sanctions for violations of the Medical Practice Act. The ultimate purpose of disciplinary sanctions is to protect the public, deter future violations, offer opportunities for rehabilitation if appropriate, punish violators, and deter others from violations. These guidelines are intended to promote consistent sanctions for similar violations, facilitate timely resolution of cases, and encourage settlements.

(1) The standard sanctions outlined in paragraph (9) of this section provide a range from "Low Sanction" to "High Sanction" based upon any aggravating or mitigating factors that are found to apply in a particular case. The board may impose more restrictive sanctions when there are multiple violations of the Act. The board may impose more or less severe or restrictive sanctions, based on any aggravating and/or mitigating factors listed in §190.15 of this chapter (relating to Aggravating and Mitigating Factors) that are found to apply in a particular case.

(2) The minimum sanctions outlined in paragraph (9) of this section are applicable to first time violators. In accordance with §164.001(g)(2) of the Act, the board shall consider revoking the person's license if the person is a repeat offender.

(3) The sanctions outlined in paragraph (9) of this section are based on the conclusion stated in §164.001(j) of the Act that a violation related directly to patient care is more serious than one that involves only an administrative violation. An administrative violation may be handled informally in accordance with §187.14(7) of this title (relating to Informal Resolutions of Violations). Administrative violations may be more or less serious, depending on the nature of the violation. Administrative violations that are considered by the board to be more serious are designated as being an "aggravated administrative violation."

(4) The maximum sanction in all cases is revocation of the licensee's license, which may be accompanied by an administrative penalty of up to $5,000 per violation. In accordance with §165.003 of the Act, each day the violation continues is a separate violation.

(5) Each statutory violation constitutes a separate offense, even if arising out of a single act.

(6) If the licensee acknowledges a violation and agrees to comply with terms and conditions of remedial action through an agreed order, the standard sanctions may be reduced.

(7) Any panel action that falls outside the guideline range shall be reviewed and voted on individually by the board at a regular meeting.

(8) For any violation of the Act that is not specifically mentioned in this rule, the board shall apply a sanction that generally follows the spirit and scheme of the sanctions outlined in this rule.

(9) The following standard sanctions shall apply to violations of the Act:

Attached Graphic

Figure: 22 TAC §190.14(9)

Violation Description	Statutory/Rule Citation	Low Sanction	High Sanction
Abusive or Disruptive Behavior	§164.052(a)(5) (unprofessional conduct likely to injure public); Rule §190.8(2)(K), (P)	Remedial Plan: Anger management and communications CME, JP exam, medical ethics	Agreed Order with IME or Public Referral to PHP; CME in medical ethics, anger management, communications with colleagues, JP exam. For multiple orders or egregious actions- -interfering with patient care: public reprimand, suspension with terms and conditions
Aiding in unlicensed practice	§164.052(a)(17) (directly or indirectly aids or abets unlicensed practice)	Remedial Plan: Directed CME in supervision or delegation if applicable; 8 hours CME in medical ethics, 8 hours CME in risk management; must pass JP within 1 year	Agreed Order: Public reprimand, all sanctions in low category, plus $2,000 admin penalty
Bad faith mediation by a licensee in relation to an out-of-network health benefit claim	§1467.101 and 1467.102 of the Texas Insurance Code (bad faith in out-of-network claim dispute resolution)--"except for good cause shown, the regulatory agency shall	Good cause shown: Remedial Plan: 8 hours of medical ethics; otherwise, admin penalty is statutorily required	Agreed Order: Public reprimand; $5,000 admin penalty, "except for good cause shown" per §1467.102; plus all

	impose an administrative penalty"		sanctions in low category
Boundary Violation: Engaging in sexual contact with a patient or engaging in sexually inappropriate behavior or comments directed towards a patient	§164.052(a)(5) (unprofessional conduct likely to injure public); Rule §190.8(2)(E)-(F)	**RP is statutorily prohibited** Verbal remarks, or inappropriate behavior, but not involving touching: Agreed Order: Public reprimand; Vanderbilt or PACE boundaries course; JP exam; CME in ethics; chaperone	Cases involving physical contact: Agreed Order: Low sanctions plus IME, Replace chaperone with may not treat patient of the affected gender; or suspension or revocation
Boundary Violation: Becoming financially or personally involved with a patient in an inappropriate manner	§164.052(a)(5)(unprofessional conduct likely to injure public); Rule §190.8(2)(G)	**RP is statutorily prohibited** Single incident: Agreed Order: CME in ethics, JP exam; if financial involvement, restitution if appropriate; and/or admin penalty	More than one incident (more than one patient, or occasion): Agreed Order: Low Sanctions plus: Public reprimand; Vanderbilt or PACE boundaries course; JP exam; CME in ethics; administrative penalty; or suspension or revocation
Breach of Confidentiality	§164.052(a)(5) (unprofessional conduct likely to injure public); Rule §190.8(2)(N)	Remedial Plan: 8 hours risk management CME to include HIPAA, $500 administration fee	Agreed Order: Public reprimand, CME in risk management and in HIPAA requirements; $3,000 per occurrence; JP exam
Cease and desist order--issuance	§164.002 (Board's general authority to dispose of "any		

of: See "Unlicensed practice of medicine"	complaint or matter" unless precluded by another statute) §165.052 (power to issue cease and desist orders against unlicensed persons)		
Cease and desist order (existing), violation of	§165.052(b) (violation of (c) and (d) is grounds for imposing admin penalty)	Administrative penalty $2,000 - $5,000 per offense	Referral to Attorney General for civil penalty and costs or criminal prosecution. §165.101 (civil)and §165.152 (criminal)
Change in practice or mailing address, failure to notify the board of	§164.051(a)(3) Rule §166.1(d) (notify Board within 30 days of change of mailing or practice address or professional name on file)	Remedial Plan: 4 hours of ethics/risk management and $500 administration fee	Agreed Order: 8 hours of ethics/risk management; $2,000 admin penalty; JP exam
CME - Failure to obtain or document CME	§164.051(a)(3) (forbids breaking or attempting to break a Board rule); Rule §166.2 (48 credits each 24 months + other requirements and accreditation of CME req'ts)	Remedial Plan: All missing hours of CME and 4 hours of ethics/risk management and $500 administration fee	Agreed Order: 8 hours of CME in ethics/risk management plus complete all missing hours; $1,000 admin penalty; JP exam
Crime: Abortion - performing a criminal abortion. Health and Safety Code §170.002 and Chapter 171 (§170.002 prohibits third-trimester abortions, with exceptions;	§164.052(a)(16) (prohibits performing, procuring, aiding, or abetting in procuring a criminal abortion); §164.055 (requires "appropriate disciplinary action" against a physician who violates Health and Safety Code §170.002 or	Agreed Order: Public Reprimand; must pass JP within 1 year; $5,000 admin penalty	Agreed Order: Suspension, probated with terms, or revocation

Chapter 171 requires physicians to make available certain materials to abortion patients and restricts how informed consent is obtained; the criminal offense (§171.018) is an unspecified class of misdemeanor punishable only by a $10,000 fine)	Chapter 171)		
Crime: Arrest for offense under Penal Code §§21.02; 21.11; 22.011(a)(2); 22.021(a)(1)(B); (assaultive offenses against children)	§164.0595 (Temporary suspension or restriction of license for certain arrests)	Agreed Order: Restriction of license, chaperone; may not treat pediatric patients	Agreed Order: Suspension of license, no probation
Crime: Deferred adjudication community supervision for offense under Penal Code §§21.11; 22.011(a)(2); 22.021(a)(1)(B); (assaultive offenses against children)	§164.057(c) (mandates revocation upon proof of deferred adjudication community supervision)		Revocation is statutorily required
Crime: Felony conviction	§204.303(a)(2) of the Physician Assistant Act; §205.351(a)(7) of the Acupuncture Act; §164.057(a)(1)(A) of the Medical Practice Act	Initial conviction: Statutorily required §190.8(6)(A)(iv) and §164.057(a)(1)(A); suspension to	Revocation is statutorily required on final conviction - §164.057(b)

	(requires suspension on initial conviction for a felony)	occur by operation of law pursuant to §187.72	
Crime: Felony deferred adjudication; Misdemeanor involving moral turpitude deferred adjudication	§204.303(a)(2) & (3) of the Physician Assistant Act; Board Rule 185.17(7)& (11); §205.351(a)(7) of the Acupuncture Act; §164.051(a)(2)(A) of the Medical Practice Act (authorizes sanctions for initial convictions and deferred adjudications for felonies and misdemeanors involving moral turpitude)	Agreed Order: Appropriate sanction such as referral to PHP, anger management, IME, restrictions on practice, CME in appropriate area	Suspension or Revocation; §164.001(a); Revocation is statutorily required on final conviction of a felony- §164.057(b)
Crime: Misdemeanor conviction of crime involving moral turpitude	§204.303(a)(2) of the Physician Assistant Act; §205.351(a)(7) of the Acupuncture Act; §164.051(a)(2)(B) of the Medical Practice Act (authorizes suspension on initial conviction for misdemeanor of moral turpitude, and revocation upon final conviction)	If the offense is not related to the duties and responsibilities of the licensed occupation, the standard sanction shall require: (-a-) Suspension of license, which may be probated; (-b-) compliance with all restrictions, conditions and terms imposed by any order of probation or deferred adjudication; (-c-) public reprimand; and (-d-) administrative penalty of $2,000	If the offense is related to the duties and responsibilities of the licensed occupation, the standard sanction shall be revocation of the license.

		per violation.	
Crime: Misdemeanor conviction **not** involving moral turpitude that is connected with the physician's practice of medicine	Texas Occupations Code §53.021; Rule §190.8(6)(B)(iv) stating Chapter 53 of applies to misdemeanor convictions not involving moral turpitude but connected with the physicians practice of medicine and setting out factors showing connection to practice of medicine	Suspension	Revocation
Crime: Misdemeanor initial conviction under Penal Code Chapter 22 (assaultive offenses - **see also: arrest or deferred adjudication for assaultive offenses against children**) of crime punishable by more than a fine; **OR** Penal Code §25.07 (violation of court order re: family violence); **OR** §25.071 (violation of court order re: crime of bias or prejudice); **OR** one requiring registration as a sex offender under	§164.057(a)(1)(B), (C), (D), and (E) (when misdemeanor conviction requires suspension)	Suspension is statutorily required per §164.057(a)(1)(B)	Revocation is statutorily required on final conviction - §164.057(b)

Code of Criminal Procedures Chapter 62			
Death certificate, failure to sign electronically	§164.053(a)(1) (authorizes sanctions via §164.052(a)(5) for breaking any law that "is connected with the physician's practice of medicine"); Health and Safety Code Chapter 193 (requires electronic filing of death certificates)	Remedial Plan: 4 hours of ethics/risk management and $500 administration fee	Agreed Order: CME – 8 hours of risk management, 4 – 8 hours medical ethics; $2,000 admin penalty; JP exam
Delegation of professional medical responsibility or acts to person if the physician knows or has reason to know that the person is not qualified by training, experience, or licensure to perform the responsibility or acts	§164.053(a)(9) (describes the violation as unprofessional conduct, allows sanctions)	Remedial Plan: 12 hours CME in supervision and delegation, 8 hours in risk management, 8 hours in medical ethics; JP exam	Agreed Order: Low sanctions plus no delegation or supervision authority; administrative penalty of $2,000 per violation
Discipline by peers, may be either an administrative violation or SOC	§164.051(a)(7) (describes offense: includes being subjected to disciplinary action taken by peers in a local, regional, state, or national professional medical ass'n or being disciplined by a licensed hospital or medical staff of a hospital, including removal, suspension, limitation of privileges, or other action IF	Agreed Order: See the applicable sanction for the violation of the Texas Medical Practice Act that most closely relates to the basis of the disciplinary action by peers. In addition, the licensee shall	Agreed Order: Public reprimand; comply with all restrictions, conditions and terms imposed by the disciplinary action by peers to the extent possible; and administrative penalty of $3,000 per

	the board finds the action was based on unprofessional conduct or professional incompetence that was likely to harm the public and "was appropriate and reasonably supported by evidence submitted to the board." Expert panel report provides such evidence)	comply with all restrictions, conditions and terms imposed by the disciplinary action by peers to the extent possible.	violation, plus directed CME and, if SOC case, a chart monitor. If not SOC: IME; anger management; CME in communications
Disciplined by another state or military may be either an administrative violation or a patient care violation	§164.051(a)(9) (describes the violation, requires that acts for which discipline imposed be the same or similar to acts in §164.052 or acts that are the same or similar to acts described in 164.051(a), for example rule violations, SOC violations, and all forms of impairment) Issue is only whether there was an order--no relitigation of prior facts, e.g., no new expert panel required	If no standard of care concerns, Remedial Plan with appropriate CME and $500 administration fee; OR reciprocal Agreed Order as appropriate.	If out-of-state order is revocation, revocation is statutorily required.
Drug logs - Failure to maintain (see also, violation of state or federal law connected with practice)	§164.053(a)(2) (describes offense and refers to Chapter 481 Health and Safety Code and 21 USC §801 et seq.)	Remedial Plan: 8 hours of ethics/risk management and $500 administration fee	Agreed Order: Public reprimand; 8 hours of ethics/risk management; $2,000 admin penalty; JP exam
Employing a revoked/cancelled / or suspended physician (see also aiding and	§164.052(a)(14) (describes offense: "directly or indirectly employs . . .); §164.052(a)(15) (forbids associating in the practice of medicine with such a person)	Agreed Order: Public reprimand; $3,000 admin penalty; take and pass JP exam	Agreed Order: Public reprimand; $5,000 admin penalty; JP exam; no delegation authority

abetting the unlicensed practice)			
Failing to adequately supervise subordinates and improper delegation	§164.053(a)(8); §164.053(a)(9) - These sections describe the respective violations and define them as unprofessional conduct	Remedial Plan: 12 hours CME in supervision and delegation; consider ordering Rsp to furnish ED copies of delegation orders of develop and furnish delegation orders to ED; $500 admin fee	Agreed Order: Low category sanctions plus: monitoring of practice; no delegation or supervision authority; administrative penalty of $2,000 per violation; JP exam
Fails to keep proper medical records	§164.051(a)(3) (authorizes sanctioning rule violations); §164.051(a)(6) (authorizes sanctioning failure to practice acceptably consistent with public welfare); Rule §165.1 describes contents of an adequate medical record	Remedial Plan: CME in appropriate area; $500 administration fee	Agreed Order: 8 or more hours of medical record-keeping, require in-person attendance if practical; chart monitor 8 – 12 cycles; $2,000 admin penalty; JP exam; PACE course in medical record-keeping if prior order for inadequate record-keeping
Failure to Communicate with patient or other providers	§164.052(a)(5) (prohibits conduct that is "likely to deceive or defraud the public" and unprofessional conduct as defined by §164.053)	Single incident: Remedial Plan--8 hours risk management CME to include patient communications, $500 administration	Multiple instances: Agreed Order: Public reprimand, risk management and communications CME, fine, counseling, IME

		fee	
Failure to display a "Notice Concerning Complaints" sign	Rule §178.3(a)(1) (requires display of sign)	Remedial Plan: 4 hours of ethics/risk management and $500 administration fee	Agreed Order: 8 hours of ethics/risk management, $1,000 admin penalty; JP exam
Failure to report dangerous behavior to governmental body	§164.052(a)(5) (prohibits conduct that is "likely to deceive or defraud the public" and unprofessional conduct as defined by §164.053)	Single incident: Agreed Order: Admin penalty; CME in medical ethics; JP exam	Multiple or egregious: Agreed Order: Low category sanctions plus public reprimand and $5,000 admin penalty
Failure to Pay/CS	Gov't Code; Family Code Chapter 232 (authorizes suspending licenses of any kind granted by the state to persons who do not pay support payments)	Suspension until such time as the licensee is no longer in default is required – statutorily required	Suspension until such time as the licensee is no longer in default - statutorily required
Failure to Pay Student Loan	§56.003 of the Texas Occupations Code	Agreed Order: public reprimand; within a certain time frame, provide proof of entering into an agreement with the loan servicing agent and/or default has been cured. Auto-suspend if violate order	Suspension until such time as the licensee is no longer in default
Failure to report suspected abuse of a patient by a third party, when the report of that abuse	§164.052(a)(5)(prohibits conduct that is “likely to deceive or defraud the public” and unprofessional conduct as defined by §164.053); Rule §190.8(2)(O)	Remedial Plan; CME- 8 hrs risk management; JP Exam	Agreed Order: Low sanctions plus public reprimand; administrative penalty

is required by law			$3,000 per violation
Fees, failure to provide explanation of	§101.203 (prohibits overbilling via ref to Health and Safety Code §311.025); §101.351 (establishes requirement and excludes application of §101.351 to physicians who post a billing practice sign in their waiting room)	Remedial Plan: 8 hours of ethics/risk management/billing practices and $500 administration fee	Agreed Order: 8 - 16 hours of CME in ethics, risk management, billing practices, and CPT coding, $2,000 admin penalty
Fraud on a diploma/in an exam	§164.052(a)(2); §164.052(a)(3) (describes offense as presenting an illegally or fraudulently obtained credential and cheating on exams)	Misrepresentations that do not make licensee/applicant ineligible: Remedial Plan - 8 hours of ethics/risk management and $500 administration fee	If misrepresentation makes the licensee ineligible, then revocation.
Fraudulent, improper billing practices - requires that Respondent knows the service was not provided or knows was improper, unreasonable, or medically or clinically unnecessary. Should not sanction for an unknowing and isolated episode.	§101.203 (prohibits overbilling via ref to Health and Safety Code §311.0025); §164.053(a)(7) (prohibits violation of Health and Safety Code §311.0025)	Agreed order: Including, but not limited to: monitoring of billing practices; directed CME; restitution; and administrative penalty of $1,000, but not to exceed the amount of improper billing	Agreed Order: Public reprimand, monitoring of practice, including billing practices; directed CME; restitution; and administrative penalty of $3,000 per violation
Health care liability claim, failure to	§160.052(b) (requires reporting health care liability claims to Board) Rule §176.2	Remedial Plan: 4 hours of ethics/risk management	Agreed Order: 8 hours of ethics/risk management;

report	and §176.9 (prescribes form for such reporting)	and $500 administration fee	$2,000 admin penalty; JP exam
Impairment (no history and no aggravating factors such as SOC, boundary violation, or felony)	§164.051(a)(4) (authorizes sanctions for practicing by those unable because of illness, drunkenness, excessive use of substances, or a mental or physical condition); §164.052(a)(4) (forbids use of alcohol or drugs in an intemperate manner that could endanger a patient's life)	Refer to PHP--Public referral via agreed order required if case involves discharge from PHP, otherwise private referral is OK if appropriate	Voluntary surrender or temporary suspension
Impairment (with history or SOC violation or boundary violation or felony)	§164.051(a)(4) (authorizes sanctions for practicing by those unable because of illness, drunkenness, excessive use of substances, or a mental or physical condition); §164.052(a)(4) (forbids use of alcohol or drugs in an intemperate manner that could endanger a patient's life)	Agreed Order: IME with report to ED or to panel at re-convened ISC, restrict practice or voluntary suspension pending report; if impairment is found at ISC, suspension of license until such time as the licensee can demonstrate that the licensee is safe and competent to practice medicine, with conditions to be determined by a subsequent panel	Agreed Order: Suspension of license until such time as the licensee can demonstrate that the licensee is safe and competent to practice medicine OR Suspension probated for 10 years with terms and conditions including but not necessarily limited to: drug testing; restrictions on practice; AA or NA attendance evidenced by logs; IME for psychiatric/ psychological

			evaluation and treatment; proficiency testing OR revocation.
Intimidation of Complainant	§164.052(a)(5) (prohibits unprofessional conduct as defined by §164.053 or that is "likely to deceive or defraud the public")	Single Incident: Public reprimand and fine	Multiple/Egregious: Suspension and/or revocation; significant admin penalty; CME in ethics; JP exam
Medical Records: failure to release/ Overcharging for	§159.006 of the Act (information furnished by licensee); §164.051(a)(3) (prohibits rule violations); Rule §165.2 (requires release to proper person as described therein unless release would harm the patient and prescribes allowable charges	Remedial Plan: 4 hours of ethics/risk management and $500 administration fee	Agreed Order: 8 hours of ethics/risk management, $2,000 admin penalty; JP exam. Also, §159.006 (Board may appoint temp or permanent custodian of patient records held by a physician)
Misleading advertising	§164.051(a)(3); §164.052(6) (prohibits false advertising); Rule §164.3, §164.	Remedial Plan: 8 hours of ethics/risk management, correct the advertisement and $500 administration fee	Agreed Order: 16 hours of ethics/risk management in person, correct the advertisement, $5,000 admin penalty, JP exam
Operating an unlicensed pharmacy	§158.001(b) (requires physicians to comply with Occupations Code Chapter 558 to operate a retail pharmacy)	Agreed Order: Must pass JP within 1 year, $2,000 penalty, CME – medical ethics	Agreed Order: JP exam; cease operating pharmacy; CME – ethics and risk management
Overbilling: See fraudulent, improper billing			

Peer review action: See Discipline by peers			
Physician-patient relationship, Improper termination of	Rule §190.8(1)(J) (requires reasonable notice to patient of termination)	Single incident: Remedial Plan: 8 hours CME - 4 risk management and 4 ethics, $500 administration fee	Multiple instances: Public reprimand, risk management, fine, CME - in physician-patient communications
Pill mills, unregistered pain clinics, overprescribing – See Delegation, Supervision, Prescribing			Revocation
Prescribing controlled substances to oneself, family members, or others in which there is a close personal relationship absent immediate need, without taking an adequate history, performing a proper physical examination, or creating and maintaining adequate records	§164.051(a)(6); Rule §190.8(1)(L), (M)	Agreed Order CME 8 hours medical recordkeeping, or risk management; 8 hours appropriate prescribing of controlled substances; JP Exam If only one prescription and no evidence of pattern, the ISC Panel may consider a remedial plan.	Agreed Order Low sanctions plus public reprimand; restrictions on prescribing to self, family, and others in which there is a close personal relationship, restrictions on practice including restrictions on prescribing and administering controlled substances and dangerous drugs, administrative penalty of $3,000 per violation
Prescribing dangerous drugs to oneself, family members, or	§164.051(a)(6); Rule §190.8(1)(L), (M)	Remedial Plan: CME - 8 hours medical recordkeeping or	Agreed Order: Low sanctions plus restrictions on

others in which there is a close personal relationship without taking an adequate history, performing a proper physical examination, or creating and maintaining adequate records		risk management; JP Exam	prescribing to self, family, and others in which there is a close personal relationship and administrative penalty of $2,000 per violation
Prescribing, writes false or fictitious prescriptions OR prescribes or dispenses drugs to a person who is known to be an abuser of narcotic drugs, controlled substances, or dangerous drugs OR writes prescriptions for or dispenses to a person who the physician should have known was an abuser of narcotic drugs, controlled substances, or dangerous drugs	§164.053(a)(3),(a)(4) (defines the violations under unprofessional conduct)	Agreed Order: CME - 8 hours drug-seeking behavior, 8 hours risk management; chart monitor at least 8 cycles; if Respondent does not use one, order to develop a pain management contract with specific provisions for termination of physician-patient relationship on a maximum of 3 violations by the patient including a positive test for a controlled substance not prescribed by Respondent, drug screens required by contract; JP Exam; admin penalty of $3,000 per violation	Agreed Order Low sanctions plus: restrictions on practice including restrictions on prescribing and administering controlled substances and dangerous drugs; proficiency testing; directed CME; and increase administrative penalty to $5,000 per violation. If evidence of false or fictitious prescriptions, surrender DEA registration certificate for all controlled substance schedules.

Prescribing, nontherapeutic--or dispensing, or administering of drugs nontherapeutically, one patient, no prior board disciplinary history related to standard of care or care-related violations OR prescribing, administering, or dispensing in a manner inconsistent with public health and welfare, one patient, no prior board disciplinary history related to standard of care or care-related violations	§164.053(a)(5),(a)(6) (prohibits prescribing or administering any drug or treatment that is nontherapeutic per se or because of the way it is administered or prescribed)	Remedial Plan CME in appropriate area; $500 administration fee per year.	Agreed Order: Proficiency testing, CME in appropriate area; chart monitor for 8 cycles; administrative penalty of $3,000 per violation
Prescribing, nontherapeutic--or dispensing, or administering of drugs nontherapeutically More than one patient or prior history of	§164.053(a)(5),(a)(6) (prohibits prescribing or administering any drug or treatment that is nontherapeutic per se or because of the way it is administered or prescribed)	Agreed Order: Proficiency testing; CME in appropriate area; chart monitor 12 cycles; administrative penalty $3,000 per violation	Agreed Order: Low sanctions plus restrictions on practice, including prescribing and administering controlled substances and dangerous drugs;

disciplinary action for standard of care or care-related violations OR prescribing, administering, or dispensing in a manner inconsistent with public health and welfare, more than one patient or prior history of disciplinary action for standard of care or care-related violations			and administrative penalty of $5,000 per violation. If there are aggravating factors, revocation should be considered.
Referring a patient to a facility, laboratory, or pharmacy without disclosing the existence of the licensee's ownership interest in the entity to the patient	§164.052(a)(5) (prohibits conduct that is "likely to deceive or defraud the public" and unprofessional conduct as defined by §164.053); Rule §190.8(2)(H)	Remedial Plan: CME 8 hrs ethics, 8 hrs risk management; within 30 days of order's entry, provide proof of implement of form used to disclose ownership to interest	Agreed Order: Low sanctions plus public reprimand; JP Exam; administrative penalty $3,000 per violation
Refusal to respond to board subpoena or request for information or action	§160.009 of the Act and Rule §179.4 (relating to Request for Information and Records from Physicians); §164.052(a)(5), as further defined by Board Rule 190.8(2)(B) (prohibits Unprofessional conduct as defined by §164.053 or that is "likely to deceive or defraud the	If records eventually received, Remedial Plan of 8 hours of ethics/risk management and $500 administration fee	If records never received and intentionally withheld, Agreed Order: public reprimand; JP exam; admin penalty; CME in medical ethics

	public")		
Reporting false or misleading information on an initial application for licensure or for licensure renewal	§164.052(a)(1) (forbids submission of false or misleading statements of documents in an application for a license)	Misrepresentations that do not make licensee/applicant ineligible: Remedial Plan - 8 hours of ethics/risk management and $500 administration fee	If misrepresentation makes the licensee ineligible, then revocation.
Reporting false or misleading Board (non-licensing matter)	§164.052(a)(5), as further defined by Rule §190.8(2)(C)	Remedial Plan - 8 hours of ethics/risk management and $500 administration fee	Agreed Order: 8 hours of ethics/risk management JP Exam administrative penalty of $3,000
Self-Prescribing: See "Prescribing to self."			
Solicitation of patients/Drumming	§165.155 (provides a Class A misdemeanor penalty)	Agreed Order (if no conviction): 8 hours of ethics/risk management and $500 administration fee	Egregious: Agreed Order: Public reprimand, chart sign off, $5,000 fine, JP exam, CME in medical ethics OR referral to county attorney for prosecution as Class A misdemeanor under §165.155(e)
Standard of Care - one patient, no prior SOC or care-related violations	§164.051(a)(6) (fails to practice medicine in an acceptable, professional manner consistent with public health and welfare)	Remedial Plan*: CME in appropriate area; $500 administration fee per year. *No RP if case concerns a patient death	Agreed Order: Proficiency testing; directed CME; chart monitor for 8 cycles; administrative penalty

			of $3,000 per violation
Standard of care - one patient, one prior SOC or care-related violation	§164.051(a)(6) (fails to practice medicine in an acceptable, professional manner consistent with public health and welfare)	Agreed Order: Chart monitor for 8 cycles; directed CME, administrative penalty of $3,000 per violation	Agreed Order: Limiting the practice of the person or excluding one or more specified activities of medicine; proficiency testing; directed CME; monitoring of the practice (either chart monitor for 12 cycles or supervising physician for a number of cases or specified period of time); public reprimand; and administrative penalty of $5,000 per violation.
Standard of care - one patient, more than one prior SOC or care-related violation	§164.051(a)(6) (fails to practice medicine in an acceptable, professional manner consistent with public health and welfare); §164.051(a)(8) (recurring meritorious healthcare liability claims that evidence professional incompetence likely to injure the public); Rule §190.8(5) (defines	Agreed Order: Limiting the practice of the person or excluding one or more specified activities of medicine; proficiency testing; directed CME; monitoring of the practice (either chart monitor for 12 cycles or supervising	Agreed Order: K-STAR or PACE or equivalent proficiency testing; directed CME; chart monitoring (either chart monitor for 16 cycles or supervising physician for a number of cases or specified period of time), restricting

	"recurring" as 3 or more claims awarded or settled for $50,000 in a 5-year period)	physician for a number of cases or specified period of time); administrative penalty of $ 3,000 per violation	the practice; withdrawal of prescribing privileges or delegating privileges; public reprimand; administrative penalty of $5,000 per violation
Standard of care - more than one patient, no prior SOC or care-related violation	§164.051(a)(6) (fails to practice medicine in an acceptable, professional manner consistent with public health and welfare); §164.051(a)(8) (recurring meritorious healthcare liability claims that evidence professional incompetence); Rule §190.8(5) (defines "recurring" as 3 or more claims awarded or settled for $50,000 in a 5-year period)	Agreed Order: Chart Monitor for 8 cycles; CME in appropriate area; administrative penalty of $3,000 per violation	Agreed Order: Proficiency testing; directed CME; chart monitor 12 cycles; public reprimand; and administrative penalty of $5,000 per violation
Standard of care - more than one patient, prior SOC or care-related violations	§164.051(a)(6) (fails to practice medicine in an acceptable, professional manner consistent with public health and welfare); §164.051(a)(8) (recurring meritorious healthcare liability claims that evidence professional incompetence); Rule §190.8(5) (defines "recurring" as 3 or	Agreed Order: Proficiency testing; directed CME; monitoring for 12 cycles; requiring oversight or restricting of the practice; public reprimand; and administrative penalty of $5,000 per violation.	Suspension or revocation

	more claims awarded or settled for $50,000 in a 5-year period)		
Supervision of midlevels, failure to perform: See "Failing to adequately supervise subordinates and improper delegation."			
Unlicensed practice of medicine	§165.052(a)(see definition of "practice of medicine" at §151.002(a)(13))	Cease and Desist Order and referral of Order to District Attorney or Attorney General	Cease and Desist Order; referral to Attorney General's office for injunction or civil penalties
Unsound Mind - adjudicated (See also "Impairment')	§164.051(a)(5) (enables Board to take action if a licensee or applicant "is found by a court to be of unsound mind")	Suspension of license until such time as the licensee can demonstrate that the licensee is safe and competent to practice medicine; IME and return to ISC panel with results	Temporary suspension prior to seeking revocation; show cause hearing under §164.056
Violation of Board Order	§164.052(a)(5) (enables sanctioning of unprofessional or dishonorable conduct as defined by §164.053 or conduct that injures the public)	Administrative in nature- Agreed Order: Administrative Penalty of $1,000; Substantive in nature-extension of order and increase the terms of the original order	Agreed Order: Low sanctions plus: public reprimand; admin penalty of $3,000 - $5,000
Violation of state or federal law	§164.053(a)(1) (authorizes sanctions via §164.052(a)(5)	If criminal law, see above under	Agreed Order: public

connected with physician's practice	for breaking any law that "is connected with the physician's practice of medicine")	"Crime." If civil law, Agreed Order: must pass JP exam and 8 hours of risk management/ethics	reprimand; restriction of license; surrender of controlled substance privileges; plus low sanctions

December 23, 2005

MANUAL OF PENALTY GUIDELINES FOR LICENSED PHYSICIANS AND SURGEONS

The Connecticut Medical Examining Board
The Connecticut Department of Public Health

2005

STATE OF CONNECTICUT

The Connecticut Medical Examining Board and the Department of Public Health play separate and distinct roles in disciplining physicians. The Practitioner Investigations Unit (PIU) of the Department of Public Health is responsible for receiving and investigating complaints concerning licensed physicians. As part of the investigative process, the PIU obtains all relevant records, interviews necessary witnesses, and obtains an expert opinion from a physician having the same specialty as the licensee who is being investigated. At the conclusion of the investigation, the supervisor of the PIU determines which cases will proceed to a hearing, and which cases will be dismissed. If the supervisor of the PIU determines that the evidence is sufficient to warrant disciplinary action, the matter is referred to the Department's Legal Office for prosecution. A formal disciplinary action is initiated by a Statement of Charges. Prior to issuing a Statement of Charges, however, the physician is afforded an opportunity to show compliance with the governing statutes.

The Board is responsible for presiding over disciplinary hearings and rendering final decisions. Hearings are presided over by a three-person panel consisting of the following: at least one member of the Medical Examining Board; one public member who may be either a board member or hearing panelist (who is not a board member and is appointed to a list of panelists by the Commissioner of the Department); and, one physician or physician assistant who is on the list of non-board hearing panelists. See, P.A. 05-275, §18, revising §20-8a(c) of the Connecticut General Statutes. The panel receives advice from an Assistant Attorney General. At the conclusion of the hearing, the panel meets to determine its findings on the allegations, and a Proposed Memorandum of Decision is written. The parties are provided with a copy of the Proposed Memorandum of Decision, and are given an opportunity to request oral argument before a final decision is rendered by the entire Board. At any time prior to issuance of the final Decision, the parties may choose to settle the case. Settlement documents are referred to as "Consent Orders," and must be approved by the Board.

This Manual consists of two parts:

- Part One - Disciplinary Guidelines: This section consists of (1) the terms used by the Board to impose a penalty on a license, and (2) the recommended minimum and maximum penalties for each type of violation, with reference to the specific terms.

- Part Two - Non-Disciplinary Terms: This section includes additional standard terms, of a non-disciplinary nature, that may be included in final Decisions.

Additional copies of this document are available on the Department's web page at: www.dph.state.ct.us under "Boards and Commissions" with specific reference to the Medical Examining Board. Copies are also available upon written request to:

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PART ONE

DISCIPLINARY GUIDELINES

PART ONE – DISCIPLINARY GUIDELINES

INDEX

DISCIPLINARY GUIDELINES

[1] All references are to the Connecticut General Statutes unless otherwise stated.

PART ONE – DISCIPLINARY GUIDELINES

INTRODUCTION

These disciplinary guidelines have been devised to promote consistency in sanctions imposed by the Board, to lend credibility to the disciplinary process, and to aid the Board in its ultimate goal of protecting the public. These Guidelines are used for reference and guidance only and are not binding regulations of the Board or Department. The Board recognizes that individual matters present unique sets of circumstances which merit individual consideration.

Upon a finding of good cause following a hearing, §19a-17(a) of the General Statutes authorizes the Board to order one or more of the following (in order of increasing severity): (1) assess a civil penalty; (2) issue a letter of reprimand or censure a licensee (3) place a practitioner on a probationary status and require regular reports on the matters that are the basis of probation and/or require that the practitioner pursue further professional education in those areas that are the basis for the probation; (4) place limitations on the practitioner's practice; (5) suspend the license; and, (6) revoke the license. The "Disciplinary Terms" set forth herein, includes the language used to impose these disciplinary terms.

After a violation has been established, in determining the penalty, the Board will consider whether the physician's continued practice without restriction and/or probation will pose a danger to the public.

- If the Board determines that a restriction and/or probation is not required to protect the public health and safety, a civil penalty and/or reprimand or censure may be ordered.
- If the Board determines that a restriction and/or probation is required to protect the public health and safety, the restriction and/or probation shall address the matters which are the basis of the disciplinary action.
- If the Board determines that the physician's continued immediate practice would pose a danger to the public health and safety, a suspension or revocation shall be ordered. Revocation may be ordered when the Board determines that the public health and safety would be endangered if the physician continues to practice and a restriction and/or probation is insufficient to ensure the public health and safety.

During the penalty determination phase of its deliberations, the Board may consider factors including but not limited to:

- Whether the physician's conduct was a unique event or part of a pattern of misconduct
- Whether the physician's conduct reflects a lack of judgment that poses a risk in other situations
- Whether the physician has a history of prior disciplinary actions
- Whether the physician's conduct was based in whole or in part upon dishonest or selfish motives

- Whether the physician in the course of the investigation or proceeding submitted false evidence, false statements, or engaged in other deceptive practices during the disciplinary process
- Whether the physician refused to acknowledge the wrongful nature of the conduct
- Whether the physician engaged in willful or reckless misconduct
- The extent of the patient's or victim's vulnerability
- Whether and the extent to which the public health and safety would be endangered if the physician continues to practice

During the penalty determination phase of its deliberations, the Board will also consider mitigating and other factors in determining whether to deviate from these guidelines. Mitigating and other factors may include, but are not limited to:

- The extent to which the physician takes responsibility for his or her actions
- The physician's willingness to cooperate in rehabilitation
- Whether a procedure was an emergency or was scheduled in advance
- The remoteness of prior discipline
- Interim rehabilitation or remedial measures
- The absence of a prior disciplinary record
- Full cooperation with the Board and/or Department
- Physical or mental disability or impairment
- Absence of a dishonest or selfish motive
- Restitution for victims

These Guidelines establish minimum and maximum penalties for violations of the standard of practice. Any deviation from these Guidelines shall be accompanied by a statement of the reason for the deviation, including any mitigating or other facts.

In lieu of proceeding through a hearing resulting in a Memorandum of Decision, licensees may enter into a Consent Order. Since Consent Orders are settlement documents with negotiated terms, the Guidelines do not apply to Consent Orders. *See*, P.A. 05-275.

Licensees may also enter into a voluntary surrender of a license or an agreement not to renew or reinstate a license. Since these documents do not require a Board-issued order, they are not described in this document. Additionally, in lieu of the Department requesting that the Board summarily suspend a license, a physician may voluntarily agree to cease practicing for a designated period of time by executing an "Interim Consent Order" (ICO). Since an ICO is not a final order of the Board, it is also not described herein.

These guidelines may be revised, from time to time, as the Board and Department deem appropriate.

DISCIPLINARY TERMS

1. Civil Penalty

Respondent shall pay a civil penalty of _____ dollars ($_____) by certified or cashier's check payable to "Treasurer, State of Connecticut." The check shall reference the Petition Number on the face of the check, and shall be payable within thirty days of the effective date of this Decision.

2. Reprimand

Respondent's license number _____ to practice as a physician and surgeon in the State of Connecticut is hereby reprimanded.

3. Censure

Respondent's license number _____ to practice as a physician and surgeon in the State of Connecticut is hereby censured.

4. Revocation

Respondent's license number _____ to practice as a physician and surgeon in the State of Connecticut is hereby revoked.

5. Suspension

Commencing on _____, respondent's license shall be suspended for a period of **[with said suspension immediately stayed/stayed after a period of _____]**. **[If actual suspension is three months or longer:** All three originals of respondent's license shall be provided to the Department's Legal Office within ten days of the effective date of this Order.]

6. Probation

[Concurrently,/Following said suspension,] [R/r]espondent's license shall be placed on probation, commencing on _____, for a period of _____ under the following terms and conditions:

a. <u>Therapy</u>

Within two weeks of the commencement of probation, respondent shall submit to the Department for its pre-approval, the name of a licensed psychiatrist or psychologist ("the therapist") who has agreed to provide therapy to respondent, and respondent shall participate in regularly scheduled therapy with the therapist at **[his/her]** own expense.

(1) Respondent shall provide a copy of this Decision to the therapist.

(2) The therapist shall furnish written confirmation to the Department of his or her engagement in that capacity and receipt of a copy of this Decision within fifteen (15) days of receipt.

(3) If the therapist determines that therapy is no longer necessary, that a reduction in frequency of therapy sessions is warranted, or that respondent should be transferred to another therapist, the therapist shall advise the Department, and the Department shall pre-approve said termination of therapy, reduction in frequency of therapy sessions, and/or respondent's transfer to another therapist.

(4) The therapist shall submit reports _____ for the _____ of probation; _____ for the _____ of probation; and, _____ for the _____ of probation, which shall address, but not necessarily be limited to, respondent's ability to practice medicine **[in an alcohol and substance free state]** safely and competently. Said reports shall continue until the therapist determines that therapy is no longer necessary or the period of probation has terminated.

(5) The therapist shall immediately notify the Department in writing if the therapist believes respondent's continued practice poses a danger to the public, or if respondent discontinues therapy and/or terminates his or her services.

b. <u>Alcohol/Drug Screens</u>

Commencing no later than _____, and during the entire probationary period, respondent shall refrain from the ingestion of illegal substances and alcohol in any form, and the ingestion, inhalation, injection or other use of any controlled substance and/or legend drug unless prescribed or recommended for a legitimate purpose by a licensed health care professional authorized to prescribe medications. In the event a medical condition arises requiring treatment utilizing controlled substances, legend drugs, or alcohol in any form, respondent shall notify the Department and, upon request, provide such written documentation of the treatment as is deemed necessary by the Department.

(1) During the first two years of the probationary period, respondent shall submit to two random observed urine screens weekly for alcohol, illegal drugs, controlled substances, and legend drugs; during the third and fourth years, **[she/he]** shall submit to such screens on a weekly basis; and, during the fifth year, **[she/he]** shall submit to such screens on a monthly basis. Respondent shall submit to such screens on a more frequent basis if requested to do so by the therapist, the Department, or the Board. Said screens shall be administered by a facility approved by the Department. All such random screens shall be legally defensible in that the specimen donor and chain of custody shall be identified throughout the screening process. All laboratory reports shall state that the chain of custody procedure has been followed.

(2) Respondent shall cause to have the facility provide monthly reports to the Department on the urine screens for alcohol, illegal substances, controlled substances and legend drugs. All such screens shall be

negative for alcohol, controlled substances, and legend drugs, except for medications prescribed by respondent's physician. If respondent has a positive urine screen, the facility shall immediately notify the Department. All positive random drug and alcohol screens shall be confirmed by gas chromatograph/mass spectrometer testing.

(3) Respondent understands and agrees that if respondent fails to submit a urine sample when requested to do so, such missed screen shall be deemed a positive screen.

(4) Respondent shall notify each of his or her health care professionals of all medications prescribed for **[him/her]** by any and all other health care professionals.

(5) The Department shall immediately notify the Board if respondent fails to comply with the screening requirements or has a positive screen.

c. AA/NA Meetings

Commencing on _____, respondent shall attend "anonymous" or support group meetings on an average of _____ times per month, and shall provide monthly reports to the Department concerning **[his/her]** record of attendance.

d. Reporting Arrests

During the period of probation, respondent shall report to the Department any arrest under the provisions of Connecticut General Statutes section 14-227a. Such report shall occur within fifteen (15) days of such event.

e. Employer Reports

Respondent shall provide **[his/her]** chief of service, employer, partner and/or associate at any hospital, clinic, partnership and/or association at which **[she/he]** practices, is employed or with which **[she/he]** is affiliated or has privileges, with a copy of this Decision within fifteen (15) days of its effective date; and, respondent shall cause to have his/her chief of service, employer, partner and/or associate provide confirmation to the Department of receipt of the Decision within 15 days thereafter. If respondent changes employment at any time during the probationary period, respondent shall provide **[his/her]** new chief of service, employer, partner and/or associate as described herein with a copy of this Decision, within fifteen (15) days of commencement of **[employment/_____]** at a new facility, and shall cause the new employer to provide the Department with confirmation of **[his/her]** receipt of the Decision within fifteen days thereafter. Respondent agrees to provide _____reports from any and all of **[his/her] [employer/_____]** for the _____ of probation; and, _____ for the remainder of the probationary period, stating that respondent is practicing with reasonable skill and safety **[and in an alcohol and substance-free state]**.

f. No Solo Practice

During the period of probation, respondent shall only practice as a physician and surgeon in an office and practice setting that includes other physicians.

g. Approval of Employment

Respondent shall obtain written approval from the Board prior to any change in employment.

h. Physical Health

Respondent shall, at **[his/her]** own expense, undergo a physical examination by a physician pre-approved by the Department ("the initial examination").

(1) No later than _____ , respondent shall submit to the Department for its pre-approval, the name of a physician licensed in Connecticut ("the physician") who will perform the initial examination to assess respondent's physical health.

(2) Within seven days of the Department's approval of the physician, respondent shall provide the physician with a copy of this Order.

(3) The initial examination shall be completed no later than 30 days after the Department has approved the physician. The initial examination shall include any additional testing the physician deems necessary. Respondent shall fully cooperate with all requests made by the physician.

(4) Respondent shall continue in treatment by the physician on a ___ basis (or more frequently at the discretion of said physician) for purposes of assessing respondent's physical health; and, respondent shall undergo any further examinations the physician deems necessary.

(5) Respondent shall ensure that the complete results of the initial examination and any subsequent examinations are submitted by the physician directly to the Department within fourteen days of completion of the examination. The report of the initial examination shall also document that respondent timely provided the physician with a copy of this Order.

(6) The physician shall submit written reports to the Department on a ___ basis stating that respondent can practice as a physician and surgeon with reasonable skill and safety. If the physician reaches any other conclusion, such finding shall constitute a violation of this Order.

i. **Psychiatric Evaluation**

Respondent shall, at **[his/her]** own expense, undergo a psychiatric evaluation by a psychiatrist pre-approved by the Department ("the psychiatrist").

(1) No later than _____, respondent shall submit to the Department for its pre-approval, the name of a psychiatrist licensed in Connecticut who will perform a complete psychiatric evaluation of respondent.

(2) Within seven days of the Department's approval of the psychiatrist, respondent shall provide the psychiatrist with a copy of this Order, any and all previous psychiatric evaluations of respondent, any reports received by the Drug Control Division of the Department of Consumer Protection, any prior therapist reports, any relevant employer reports, and any reports received from the police or any other authority.

(3) The psychiatric evaluation shall be completed no later than 90 days after the Department has approved the psychiatrist. The psychiatric evaluation shall include psychological testing and, if requested by the psychiatrist, a complete neuropsychological testing. Respondent shall fully cooperate with all requests made by the psychiatrist.

(4) Respondent shall ensure that the complete results of the evaluation are submitted by the psychiatrist directly to the Department within fourteen days of completion. The results shall also document that respondent provided the psychiatrist with a copy of this Order, and any other documents identified herein. The evaluator shall conclude that respondent can safely practice as a physician without having any further restrictions on **[his/her]** license. If the psychiatrist reaches any other conclusion, such finding shall constitute a violation of this Order.

j. **Psychiatric evaluation prior to termination of probation**

Within the final six months of the probationary period, respondent shall, at **[his/her]** own expense, undergo a psychiatric evaluation by a psychiatrist pre-approved by the Department ("the psychiatrist").

(1) Respondent shall fully cooperate with all requests made by the psychiatrist. The psychiatric evaluation shall include psychological testing and, if requested by the psychiatrist, a complete neuropsychological testing.

(2) Respondent shall provide the psychiatrist with a copy of this Order, any and all previous psychiatric evaluations of respondent, reports received by the Drug Control Division of the Department of Consumer Protection, the Department's monitoring file including all therapist and employer reports, and any reports received from the police or any other

authority. The evaluation report provided to the Department by the psychiatrist shall include a confirmation of the psychiatrist's receipt of the foregoing documents to the extent that they exist.

(3) Respondent shall ensure that the evaluation report is provided by the psychiatrist directly to the Department at least thirty days before the probationary period terminates.

(4) The psychiatrist shall conclude that respondent can safely practice medicine without having any further restrictions on **[his/her]** license. If the psychiatrist reaches any other conclusion, such finding shall constitute a violation of this Order.

k. Monitoring of Records

No later than _____, respondent shall submit to the Department for its pre-approval, the name of a physician licensed in Connecticut ("monitor") who, at respondent's expense, will conduct a **[monthly/quarterly]** random review of __ percent or ___of respondent's patient records, created or updated during the probationary period, whichever is the larger number. Within fifteen days of the Department's approval, respondent shall provide the monitor with a copy of this Decision. Respondent shall cause the monitor to confirm receipt of this Decision within fifteen days after **[she/he]** has received the Decision. In the event respondent has ___ or fewer patients, the monitor shall review all of respondent's patient records.

(1) Respondent's monitor shall meet with respondent not less than once every _____ for the _____ of the probationary period **[and _____ for the remainder of the probationary period].**

(2) The monitor shall have the right to monitor respondent's practice by any other reasonable means which he or she deems appropriate. Respondent shall fully cooperate with the supervisor in providing such monitoring.

(3) Respondent shall be responsible for providing written monitor reports directly to the Department _____ for the _____ of the probationary period **[and _____ for the remainder of the probationary period]**. Such monitor reports shall include documentation of dates and durations of meetings with respondent, number and a general description of the patient records and patient medication orders and prescriptions reviewed, additional monitoring techniques utilized, and statement that respondent is practicing with reasonable skill and safety.

l. Practice Monitor

No later than _____, respondent shall submit to the Department for its pre-approval, the name of a physician licensed in Connecticut ("practice monitor"). Within fifteen days of the Department's approval, respondent shall

provide the monitor with a copy of this Decision. Respondent shall cause the monitor to confirm receipt of this Decision within fifteen days after **[she/he]** has received the Decision. Respondent's practice shall be supervised at all times by the practice monitor.

(1) Respondent's practice monitor shall meet with **[him/her]** not less than ____ for the _____ of the probationary period **[and _____ for the remainder of the probationary period]**.

(2) The practice monitor shall have the right to monitor respondent's practice by any other reasonable means which he or she deems appropriate. Respondent shall fully cooperate with the practice monitor in providing such monitoring.

(3) Respondent shall be responsible for providing written practice monitor reports directly to the Department _____ for the _____ of the probationary period **[and _____ for the remainder of the probationary period]**. Such reports shall include documentation of dates and durations of meetings with respondent, number and a general description of the patient records and patient medication orders and prescriptions reviewed, additional monitoring techniques utilized, and a statement that respondent is practicing with reasonable skill and safety.

m. <u>Chaperone present during exams</u>

Respondent shall have **[a female/another]** employee ("chaperone") present during any examination or treatment of a **[female/male]** patient.

(1) For each such appointment, respondent shall maintain as part of the patient's medical record, the name of the chaperone, and the patient's and chaperone's signatures attesting to the presence of the chaperone on said date.

(2) Respondent shall permit the Department to conduct random, unannounced reviews of all records identified in paragraph ___ above, as well as the patient log of appointments, to ensure compliance with this provision.

n. <u>Training and Education</u>

(1) Within the first _____ of the probationary period, respondent shall attend and successfully complete a course in _____, pre-approved by the Board. Within _____ of the completion of such coursework, respondent shall provide the Department with proof, to the Department's satisfaction, of the successful completion of such course(s).

(2) Respondent shall not perform _____ until **[she/he]** has provided proof to the satisfaction of the Department of completion of such coursework required in paragraph ___ above.

(3) Within thirty days of the effective date of this Decision, respondent shall have **[his/her]** ability to perform _____ evaluated at _____ by a _____ approved by the Board ("the evaluator").

(4) If the evaluator recommends retraining, respondent shall successfully comply with all such recommendations within the timeframe established by the evaluator.

(5) Respondent shall not perform any _____ until such time as the evaluator either reports to the Department that (1) there are no deficiencies in respondent's ability to perform _____, or (2) respondent has successfully completed the retraining.

o. <u>Direct Practice Supervision</u>

[Within 14 days after completing the coursework required in paragraph _____ above/No later than ___], respondent shall submit to the Department for pre-approval, the name of a physician who will be present for and observe the first **<u>[number]</u> <u>[procedure]</u>** respondent performs. After observing ___ such procedures, the supervisor shall, within _____days, report to the Department that he or she has personally observed ____ such procedures, and that such procedures were performed with reasonable skill and safety. Thereafter, respondent may perform _____ without direct supervision. If the supervisor reports that such procedures were not performed with reasonable skill and safety, respondent shall continue to be barred from performing such procedure without supervision until the supervisor reports that he or she has personally observed respondent perform _____ such procedures, and that such procedures were performed with reasonable skill and safety.

p. <u>Taking of the SPEX examination</u>

During the ____ of the probationary period, respondent shall successfully complete the Special Purpose Examination of the Federation of State Medical Boards, and provide proof of successful completion of the examination to the Department.

q. <u>Skill assessment</u>

During the _____ of the probationary period, respondent shall successfully obtain and complete an individual evaluation of her/his medical skills from a facility or institution (*i.e*., Institute for Physician Evaluation, Philadelphia, Pennsylvania or Center for Personalized Education for Physicians, Aurora, Colorado), pre-approved by the Department (hereinafter "Evaluating Facility"). Respondent shall cause the Evaluating Facility to submit its evaluation report directly to the Department.

7. Cease and desist order

The Board orders respondent to immediately cease and desist from practicing as a physician and surgeon.

8. Permanent restriction

Respondent's license to practice medicine is hereby permanently restricted in that respondent shall permanently refrain from _____.

9. Action taken by another state's licensing authority

a. In the event respondent fully complies with and completes the terms and conditions of the disciplinary action ordered by the _____ Board, in Order No. _____ before beginning practice in Connecticut, respondent's license number _____ to practice medicine and surgery in Connecticut is hereby placed on probation for a period of _____ from the date **[she/he]** commences practicing in this State.

b. In the event respondent begins practice in Connecticut before **[she/he]** has fully complied with and/or completed the terms and conditions of the ____ Order, the term of respondent's probation in Connecticut shall be _____, plus the uncompleted term of the _____ Order **[as well as any unfulfilled community service requirements]**.

c. During the period of probation, respondent's Connecticut license shall be subject to the following terms and conditions:

[Insert terms.]

10. Surrender of Drug Registrations (use if license suspended at least one year)

Within ten days of the effective date of this Order, respondent agrees to surrender to the issuing authorities, **[his/her]** state and federal Controlled Substance Registrations.

11. Surrender/Reinstatement of Controlled Substance Registrations

Within ten days of the effective date of this Order, respondent shall surrender to the issuing authorities, **[his/her]** state and federal Controlled Substance Registrations. Respondent shall not reapply for **[his/her]** state or federal controlled substance registrations for the first ___ years of the probationary period. If during the first _ years of the probationary period, the Drug Control Division of the Department of Consumer Protection (hereinafter "Drug Control") approves respondent to reapply for **[his/her]** state controlled substance registration, respondent may then request that the Board modify this Order to permit **[him/her]** to submit such application to Drug Control. If the Board agrees to so modify this Order, and respondent obtains said registrations, respondent's controlled substance prescribing, ordering, and dispensing practices shall be monitored _____ by a licensed physician pre-approved by the

Department (hereinafter "supervisor") for a period of ___, upon issuance of said registrations, as set forth below. If the probationary period has already terminated at the time respondent obtains such registrations, the probationary period shall be extended or reinstated to ensure that the _____ period of monitoring is completed. If the probationary period is extended or reinstated to comply with this provision, no other terms of probation shall be extended or reinstated. During this period of monitoring, respondent shall:

a. Maintain a log of all controlled substances dispensed to patients as well as all prescriptions for controlled substances, both written and authorized by phone.

b. Maintain copies of all orders placed to wholesalers for controlled substances, as well as records of receipts.

c. Monitoring of records (6k above)

DISCIPLINARY GUIDELINES

The following Guidelines identify general types of violations with reference to the statutory citation, and the minimum and maximum penalties for each type of violation. The numbers in the parentheses refer to the paragraph numbers of the terms found on pages 10 through 19 of this Manual. Actual penalties may fall anywhere *between* the recommended minimum and maximum.

PHYSICAL ILLNESS OR LOSS OF MOTOR SKILL, INCLUDING BUT NOT LIMITED TO, DETERIORATION THROUGH THE AGING PROCESS (§20-13c(1))

Minimum: Probation (6)
Maximum: Revocation (4)

EMOTIONAL DISORDER OR MENTAL ILLNESS (§20-13c(2))

Minimum: Probation (6)
Maximum: Revocation (4)

ABUSE OR EXCESSIVE USE OF DRUGS, INCLUDING ALCOHOL, NARCOTICS, OR CHEMICALS (§20-13c(3))

Minimum: Probation (6)
Maximum: Revocation (4)

NEGLIGENT CONDUCT IN THE PRACTICE OF MEDICINE (§20-13c(4))

Minimum: Civil penalty (1)
Maximum: Revocation (4)

ILLEGAL CONDUCT IN THE PRACTICE OF MEDICINE (§20-13c(4))

Minimum: Civil penalty (1)
Maximum: Revocation (4)

INCOMPETENT CONDUCT IN THE PRACTICE OF MEDICINE (§20-13c(4))

Minimum: Probation (6)
Maximum: Revocation (4)

ALTERATION OF MEDICAL RECORDS (§20-13c(4))

Minimum: Civil penalty (1)
Maximum: Revocation (4)

SEXUAL MISCONDUCT (§20-13c(4))

Minimum: Probation (6)
Maximum: Revocation (4)

POSSESSION, USE, PRESCRIPTION FOR USE, OR DISTRIBUTION OF CONTROLLED SUBSTANCES OR LEGEND DRUGS, EXCEPT FOR THERAPEUTIC OR OTHER MEDICALLY PROPER PURPOSES (§20-13c(5))

Minimum: Civil penalty (1)
Maximum: Revocation (4)

MISREPRESENTATION OR CONCEALMENT OF A MATERIAL FACT IN OBTAINING OR REINSTATING A LICENSE TO PRACTICE MEDICINE (§20-13c(6))

Minimum: Civil penalty (1)
Maximum: Revocation (4)

FAILURE TO ADEQUATELY SUPERVISE A PHYSICIAN ASSISTANT (§20-13c(7))

Minimum: Civil penalty (1)
Maximum: Reprimand (2) and/or censure (3)

FAILURE TO FULFILL ANY OBLIGATION RESULTING FROM PARTICIPATION IN THE NATIONAL HEALTH SERVICE CORPS (§20-13c(8))

Minimum: Civil penalty (1)
Maximum: Reprimand (2) and/or censure (3)

FAILURE TO MAINTAIN PROFESSIONAL LIABIITY INSURANCE OR OTHER INDEMNITY AGAINST LIABILITY FOR PROFESSIONAL MALPRACTICE AS PROVIDED IN §20-11b(a) (§20-13c(9))

Minimum: Civil penalty (1)
Maximum: Revocation (4)

FAILURE TO PROVIDE INFORMATION REQUESTED BY THE DEPARTMENT FOR PURPOSES OF COMPLETING A HEALTH CARE PROVIDER PROFILE, AS REQUIRED BY §20-13j (§20-13c(10))

Minimum: Civil penalty (1)
Maximum: Probation until information is provided (6 with modification)

ENGAGING IN ANY ACTIVITY FOR WHICH ACCREDITATION IS REQUIRED UNDER §19a-690 OR §19a-691 (MRI AND ANESTHESIA ACCREDITATION) WITHOUT THE APPROPRIATE ACCREDITATION REQUIRED BY §19a-690 OR §19a-691(§20-13c(11))

Minimum: Civil penalty (1)
Maximum: Revocation (4)

FAILURE TO PROVIDE EVIDENCE OF ACCREDITATION REQUIRED UNDER §19a-690 OR §19a-691 (MRI AND ANESTHESIA ACCREDITATION) AS REQUESTED BY THE DEPARTMENT PURSUANT TO §19a-690 or §19a-691 (§20-13c(12))

Minimum: Civil penalty (1)
Maximum: Probation until evidence is provided (6, with modification)

VIOLATION OF ANY PROVISION OF CHAPTER 370 OR ANY REGULATION ESTABLISHED UNDER CHAPTER 370 (§20-13c(13))

Minimum: Civil penalty (1)
Maximum: Revocation (4)

AIDING AND ABETTING THE UNLICENSED PRACTICE OF MEDICINE (§20-13c(4) in conjunction with §20-9)

Minimum: Cease and desist (7)
Maximum: Revocation (4)

THE UNLICENSED PRACTICE OF MEDICINE (§20-13c(13) in conjunction with §20-9)

Minimum: Cease and desist (7)
Maximum: Cease and desist (7)

ACTION BASED ON DISCIPLINARY ACTION TAKEN IN ANOTHER JURISDICTION (§19a-17a(7)(B) in conjunction with appropriate section from §20-13c, based on nature of the violations that formed the basis of the action taken in the other jurisdiction)

Minimum: Civil penalty (1)
Maximum: Revocation (4)

FAILURE TO REPORT TO THE DEPARTMENT ANY DISCIPLINARY ACTION SIMILAR TO AN ACTION SPECIFIED IN §19a-17(a) TAKEN AGAINST THE LICENSEE BY ANOTHER JURISDICTION (§20-13d(d))

Minimum: Reprimand (2) and/or censure (3)
Maximum: Revocation (4)

FAILURE TO TIMELY RENEW A LICENSE (§20-14b))

Minimum: Civil penalty (1)
Maximum: Revocation (4)

UNLAWFUL DELEGATION TO UNLICENSED PERSONS (§20-13c(4) in conjunction with §20-9)

Minimum: Civil penalty (1)
Maximum: Revocation (4)

FAILURE TO REPORT A PHYSICIAN WHO HAS ENGAGED IN CONDUCT THAT MAY ENDANGER THE PUBLIC HEALTH AND SAFETY (§20-13d(a))

Minimum: Civil penalty (1)
Maximum: Revocation (4)

PRACTICING WHILE UNDER SUSPENSION (§20-13c(4))

Minimum: Revocation (4)
Maximum: Revocation (4)

VIOLATION OF PROBATION (§20-13c(4))

Minimum: Extension of probation (6, with modification)
Maximum: Revocation (4)

FAILURE TO COMPLY WITH MEDICAL EDUCATION REQUIREMENTS (P.A. 05-275, sec. 24)

Minimum: Civil penalty (1)
Maximum: Probation (6)

PART TWO

NON-DISCIPLINARY TERMS

PART TWO - NON-DISCIPLINARY TERMS

INDEX

PART TWO – NON-DISCIPLINARY TERMS

In addition to disciplinary terms, Decisions also include a number of non-disciplinary provisions concerning, *e.g*., costs, effective date, *etc*., as set forth herein.

1. Address for submission of reports

All correspondence and reports are to be addressed to:

Bonnie Pinkerton, Nurse Consultant
Department of Public Health
Division of Health Systems Regulation
410 Capitol Avenue, MS #12HSR
P.O. Box 340308
Hartford, CT 06134-0308

Ms. Pinkerton may also be contacted at the following email address: bonnie.pinkerton@po.state.ct.us

2. Schedule for submission of reports

All reports required by the terms of this Decision shall be due according to a schedule to be established by the Department of Public Health.

3. Comply with all state and federal laws

Respondent shall comply with all state and federal statutes and regulations applicable to **[his/her]** licensure.

4. Costs

Respondent shall pay all costs necessary to comply with this Decision.

5. Periods of unemployment or practice out of state

For standard of care cases, having a probationary period: In the event respondent is not employed as a physician for periods of thirty (30) consecutive days or longer, or is employed as a physician for less than twenty (20) hours per week, or is employed outside of the State of Connecticut, respondent shall notify the Department in writing. Such periods of time shall not be counted in reducing the probationary period covered by this Decision.

6. Legal Notice

Legal notice shall be sufficient if sent to respondent's last known address of record reported to the Office of Practitioner Licensing and Certification of the Healthcare Systems Branch of the Department.

7. Bearing on criminal liability

This document has no bearing on any criminal liability without the written consent of the Director of the Medicaid Fraud Control Unit or the Bureau Chief of the Division of Criminal Justice's Statewide Prosecution Bureau.

8. Compliance with regulations re closure of office

Respondent shall comply with the provisions of §19a-14-44 of the Regulations of Connecticut State Agencies governing the closure of **[his/her]** office and the discontinuance of practice.

State Medical Board of Ohio

DISCIPLINARY & FINING GUIDELINES

(Revised January 2020)

Disciplinary & Fining Guidelines are primarily for the Board's reference and guidance. They are subject to revision at the Board's discretion without notice to the public. The Guidelines are intended to promote consistency in Board-imposed sanctions but are not binding on the Board. The Board recognizes that individual matters present unique sets of circumstances which merit individual consideration by the Board.

CATEGORIES OF VIOLATIONS

APPENDICES

CATEGORY I: IMPROPER PRESCRIBING, DISPENSING, OR ADMINISTERING OF DRUGS

A. Prescribing, dispensing, or administering of any drug for excessive periods of time and/or in excessive amounts.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Definite suspension, min. 90 days; discretionary probation as appropriate, to include prescribing course

Fining Range: $3,000 - $20,000

B. (Reserved)

C. (Reserved)

D. Failing to keep patient records of substances prescribed, dispensed or administered; and/or failing to perform appropriate prior examination and/or failure to document in the patient record performance of appropriate prior examination.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Reprimand; discretionary probation as appropriate, to include medical-recordkeeping course

Fining Range: $1,000 - $10,000

E. (Reserved)

F. Inappropriate purchasing, controlling, dispensing, and/or administering of any drug.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Definite suspension, min. 60 days; discretionary probation, as appropriate

Fining Range: $3,500 - $20,000

G. Failure to use acceptable methods in selection of drugs or other modalities.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 180 days, with conditions for reinstatement; discretionary probation, as appropriate

Fining Range: $2,500 - $18,000

H. (Reserved)

I. Selling, prescribing, dispensing, giving away, or administering any drug for other than a legal and legitimate therapeutic purpose and/or selling, prescribing, dispensing, giving away, or administering any drug in exchange for sexual favors.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Permanent revocation of certificate or permanent denial of application

Fining Range: $17,000 - $20,000

J. (Reserved)

K. (Reserved)

L. Plea of guilty to, judicial finding of guilt of, or judicial finding of eligibility for intervention in lieu of conviction for, a drug related felony, except where the underlying criminal conduct was directly related to a substance-related impairment of the respondent and was committed to obtain substance(s) solely for self-use.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Permanent revocation of certificate or permanent denial of application

Fining Range: $14,000 - $20,000

M. Plea of guilty to, judicial finding of guilt of, or judicial finding of eligibility for intervention in lieu of conviction for, a drug-related misdemeanor, except where the underlying criminal conduct was directly related to a substance-related impairment of the respondent and was committed to obtain substance(s) solely for self-use.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application.

Minimum Penalty: Indefinite suspension, min. 180 days, with conditions for reinstatement; discretionary probation, as appropriate

Fining Range: $2,000 - $5,000

N. Plea of guilty to, judicial finding of guilt of, or judicial finding of eligibility for intervention in lieu of conviction for, a drug related felony where the underlying criminal conduct was directly related to a substance-related impairment of the respondent and was committed to obtain substance(s) solely for self-use.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application.

Minimum Penalty: 90 days of suspension in addition to the minimum penalty for the applicable guideline section under Category IX.

Fining Range: $4,000 - $20,000

O. Plea of guilty to, judicial finding of guilt of, or judicial finding of eligibility for intervention in lieu of conviction for, a drug-related misdemeanor where the underlying criminal conduct was directly related to a substance-related impairment of the respondent and was committed to obtain substance(s) solely for self-use.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application.

Minimum Penalty: 30 days of suspension in addition to the minimum penalty for the applicable guideline section under Category IX.

Fining Range: $2,000 - $5,000

P. Utilizing a controlled substance in the treatment of a family member or self in violation of Section 4731-11-08, Ohio Administrative Code.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Reprimand; discretionary probation, as appropriate, to include appropriate medical-education course

Fining Range: $1,500 - $10,000

Review/Revision History:
Sections I.M, I.O, and I.P: 12/2010
Sections I.A through I.K: 10/2010
Sections I.L and I.N: 7/2010
Sections I.A, I.D, I.F, I.G, I.M, and I.P: 6/2018
Fining Range incorporated: 01/2020

CATEGORY II: MINIMAL STANDARDS OF CARE

A. Departure from or failure to conform to minimal standards of care.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Discretionary probation, as appropriate

Fining Range: $3,500 - $20,000

B. Sexual misconduct within practice that included "sexual interaction" and/or "sexual contact" as defined by Rule 4731-26-01, O.A.C.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 1 year, with conditions for reinstatement; discretionary probation, as appropriate, to include a boundaries course

Fining Range: $6,000 - $20,000

C. Sexual misconduct within practice that is limited to "sexual impropriety" as defined by Rule 4731-26-01, O.A.C.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Reprimand; discretionary probation, as appropriate, to include a boundaries course

Fining Range: $1,000 - $5,000

NOTE: WHERE APPROPRIATE, PERMANENT LIMITATIONS AND RESTRICTIONS MAY ALSO BE IMPOSED.

Review/Revision History:
Sections II.A and II.B: 1/2011
Sections II.A and II.B: 6/2018
Sections II.B. and II.C: 07/2019
Fining Range incorporated: 01/2020

CATEGORY III: FRAUD, MISREPRESENTATION, OR DECEPTION

A. Fraud in passing examination.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Revocation of certificate or denial of application (minimum required by statute)

Fining Range: $18,000 - $18,000

B. (Reserved)

C. (Reserved)

D. Publishing a false, fraudulent, deceptive, or misleading statement.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Suspension for 30 days; discretionary probation, as appropriate

Fining Range: $1,000 - $18,000

E. (Reserved)

F. Obtaining, or attempting to obtain, anything of value by fraudulent misrepresentations in the course of practice.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 1 year, with conditions for reinstatement; discretionary probation, as appropriate

Fining Range: $8,000 - $18,000

G. Deceptive advertising.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Suspension for 30 days; discretionary probation, as appropriate

Fining Range: $1,500 - $17,000

H. Representing, with purpose of obtaining compensation or advantage, that incurable disease can be cured.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 3 years, with conditions for reinstatement to include SPEX and personal/professional ethics courses; discretionary probation, as appropriate, including requirements for a practice plan and monitoring physician prior to resuming practice

Fining Range: $18,000 - $20,000

NOTE: SEE APPENDIX A IF VIOLATION BY LICENSURE APPLICANT.

Review/Revision History:
Sections III.A through III.H: 2/2011
Sections III.D and III.F through III.H: 6/2018
Fining Range incorporated: 01/2020

CATEGORY IV: ETHICS VIOLATIONS

A. Division of fees for referral of patients, or receiving a thing of value for specific referral of patient to utilize particular service or business.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 1 year, with conditions for reinstatement; discretionary probation, as appropriate

Fining Range: $9,000 - $18,000

B. Code of ethics violation.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Reprimand

Fining Range: $3,000 - $18,000

C. Willfully betraying a professional confidence.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Suspension for 30 days; discretionary probation, as appropriate, to include condition of successfully completing appropriate ethics course(s)

Fining Range: $4,000 - $20,000

NOTE: SEE CATEGORY II PENALTIES FOR SEXUAL MISCONDUCT WITHIN PRACTICE, AND CATEGORY III PENALTIES FOR FRAUDULENT ACTS.

Review/Revision History:
Sections IV.A through IV.C: 5/2011
Sections IV.A and IV.C: 6/2018
Fining Range incorporated: 01/2020

CATEGORY V: ACTIONS BY OTHER STATES OR ENTITIES

Limitation, revocation, suspension, acceptance of license surrender, denial of license, refusal to renew or reinstate a license, imposition of probation, or censure or other reprimand, by another jurisdiction; action against clinical privileges by Department of Defense or Veterans Administration; or termination or suspension from Medicare or Medicaid.

Maximum Penalty: Correspond to maximum penalty in Ohio for type of violation committed

Minimum Penalty: Correspond to minimum penalty in Ohio for type of violation committed

Fining Range: No fine. Fine may be levied based upon the underlying negative conduct.

Review/Revision History:
Category V: 5/2011
Fining Range incorporated: 01/2020

CATEGORY VI: UNAUTHORIZED PRACTICE

A. Practice during suspension imposed by Board order.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Permanent revocation of certificate or permanent denial of application

Fining Range: $18,000 - $20,000

B. Applicant's prior practice without license or registration as physician assistant, anesthesiologist assistant, or radiologist assistant.

Maximum Penalty: Denial of licensure or P.A./A.A./R.A. registration with conditions for any future application

Minimum Penalty: Denial of licensure or P.A./A.A./R.A. registration

Fining Range: No fine applies to applicants for licensure.

C. Aiding and abetting unlicensed practice or practice by unregistered physician assistant, anesthesiologist assistant, or radiologist assistant.

Maximum Penalty: One-year suspension; discretionary probation, as appropriate, including requirement of annual report of utilization of employee or P.A./A.A./R.A.

Minimum Penalty: Suspension for 30 days; discretionary probation, as appropriate, including requirement of annual report of utilization of employee or P.A./A.A/R.A.

Fining Range: $5,000 - $20,000

D. Practice outside scope of license or registration.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: 30-day suspension

Fining Range: $3,500 - $20,000

E. Supervising a physician assistant, anesthesiologist assistant, or radiologist assistant in the absence of an approved supervisory plan and approved supervision agreement.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Suspension for 90 days

Fining Range: $3,000 - $20,000

F. Practice of a physician assistant, anesthesiologist assistant, or radiologist assistant in the absence of an approved supervisory plan and an approved supervision agreement.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Suspension for 90 days

Fining Range: $2,000 - $20,000

G. Permitting a physician assistant, anesthesiologist assistant, or radiologist assistant to perform services as a P.A., A.A., or R.A. in a manner that is inconsistent with the supervisory plan or special services plan under which that P.A./A.A./R.A. practices.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Discretionary probation, as appropriate

Fining Range: $3,000 - $20,000

H. Practice of a physician assistant, anesthesiologist assistant, or radiologist assistant in a manner that is inconsistent with the supervisory plan or special services plan under which that P.A./A.A./R.A. practices.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Discretionary probation, as appropriate

Fining Range: $3,000 - $20,000

I. Permitting a physician assistant to perform services as a physician assistant in a manner that is not in accordance with Chapter 4730 or other applicable chapter of the Revised Code and/or the rules adopted thereunder.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 180 days, with conditions for reinstatement; discretionary probation, as appropriate

Fining Range: $3,500 - $20,000

J. Practice of a physician assistant in a manner that is not in accordance with Chapter 4730 or other applicable chapter of the Revised Code and/or the rules adopted thereunder.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 180 days, with conditions for reinstatement; discretionary probation, as appropriate

Fining Range: $3,500 - $20,000

K. (Reserved)

L. Limited Practitioner Holding Self Out as Doctor or Physician in Violation of Rule 4731-1-03(D) and/or 4731-1-03(E), Ohio Admin. Code.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 180 days; conditions for reinstatement to include eliminating the offending references from any advertising, internet sites, signs, business cards, stationery, and similar locations; discretionary probation, as appropriate

Fining Range: $10,000 - $20,000

M. Practicing as a physician assistant without holding concurrent NCCPA certification.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: If the P.A. has regained NCCPA certification and the period of practice without certification was 30 days or less: Reprimand

If the P.A. has regained NCCPA certification and the period of practice without certification was 31+ days: Definite suspension for a period of 30 days or more

If the P.A. has not regained NCCPA certification: Indefinite suspension of at least 90 days; reinstatement conditions to include current NCCPA certification; and discretionary probation, as appropriate, to include approval of a practice plan

Fining Range: $4,500 - $20,000

NOTE: SEE CATEGORY VII PENALTIES FOR PRACTICE IN VIOLATION OF CONDITIONS OF LIMITATION PLACED BY THE BOARD

Review/Revision History:
Sections VI.A through VI.K: 5/2011
Section VI.L: 12/2011
Section VI.M: 8/2016
Sections VI.C, VI.G through VI.J, and VI.L through IV.M: 6/2018
Fining Range incorporated and VI.K: 01/2020

CATEGORY VII: VIOLATION OF CONDITIONS OF LIMITATION

A. Violation of practice or prescribing limitations placed by the Board.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. one year, with conditions for reinstatement; discretionary probation, as appropriate

Fining Range: $18,000 - $20,000

B. Violation of conditions of limitation, other than practice prohibitions, placed by the Board.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: A fine; subsequent probation, minimum for at least the period of time established by the prior existing Order or Consent Agreement

Fining Range: $1,000 - $5,000

Review/Revision History:
Section VII.A: 8/2011
Section VII.B: 4/2017
Section VII.A: 6/2018
Fining Range incorporated: 01/2020

CATEGORY VIII: CRIMINAL ACTS OR CONVICTIONS

A. Plea of guilty to, judicial finding of guilt of, or judicial finding of eligibility for intervention in lieu of conviction for, a felony committed in course of practice, except where the underlying criminal conduct was directly related to a substance-related impairment of the respondent and was committed to obtain substance(s) solely for self-use.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Permanent revocation of certificate or permanent denial of application

Fining range: $18,000 - $20,000

B. Plea of guilty to, judicial finding of guilt of, or judicial finding of eligibility for intervention in lieu of conviction for, a felony not committed in course of practice.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 30 days, with conditions for reinstatement; discretionary probation, as appropriate

Fining range: $8,000 - $20,000

C. Commission of act constituting a felony in this state, regardless of where committed, if related to practice, except where the underlying criminal conduct was directly related to a substance-related impairment of the respondent and was committed to obtain substance(s) solely for self-use.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Permanent revocation of certificate or permanent denial of application

Fining Range: $18,000 - $20,000

D. Commission of act constituting a felony in this state, regardless of where committed, if unrelated to practice.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 30 days, with conditions for reinstatement; discretionary probation, as appropriate

Fining Range: $8,000 - $20,000

E. Plea of guilty to, judicial finding of guilt of, or judicial finding of eligibility for intervention in lieu of conviction for, a misdemeanor committed in course of practice or involving moral turpitude.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 180 days, with conditions for reinstatement; discretionary probation, as appropriate

Fining Range: $4,000 - $20,000

F. Commission of act constituting a misdemeanor committed in course of practice or involving moral turpitude.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Suspension for 30 days; discretionary probation, as appropriate

Fining Range: $4,500 - $20,000

G. Plea of guilty to, judicial finding of guilt of, or judicial finding of eligibility for intervention in lieu of conviction for, a felony committed in course of practice, where the underlying criminal conduct was directly related to a substance-related impairment of the respondent and was committed to obtain substance(s) solely for self-use.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application.

Minimum Penalty: 90 days of suspension in addition to the minimum penalty for the applicable guideline section under Category IX.

Fining Range: $4,000 - $20,000

H. Commission of act constituting a felony in this state, regardless of where committed, if related to practice, where the underlying criminal conduct was directly related to a substance-related impairment of the respondent and was committed to obtain substance(s) solely for self-use.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application.

Minimum Penalty: 90 days of suspension in addition to the minimum penalty for the applicable guideline section under Category IX.

Fining Range: $4,000 - $20,000

I. Commission of act constituting a felony in this state, regardless of where committed, if related to practice of massage therapy with an expired license.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Definite suspension of 90 days, with completion of a professional ethics course within one year; discretionary probation, as appropriate

Fining Range: $500 - $20,000

NOTE: SEE CATEGORY I PENALTIES FOR DRUG RELATED CONVICTIONS

Review/Revision History:
Sections VIII.B and VIII.D: 8/2011
Sections VIII.E and VIII.F: 9/2010
Sections VIII.A, VIII.C, VIII.G, and VIII.H: 7/2010
Section VIII.I: 10/2015
Sections VIII.B, and VIII.D through VIII.F: 6/2018
Fining Range incorporated and VIII.I: 01/2020

CATEGORY IX: IMPAIRMENT OF ABILITY TO PRACTICE

A. Initial Impairment and/or Less than One Year of Sobriety: Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances (including the inability to practice in accordance with such standards without appropriate treatment, monitoring, or supervision).

This section applies to:

(1) All licensees holding an active certificate,
(2) All licensees holding a previously active certificate that is currently expired/inactive/lapsed for any reason,
(3) All applicants for licensure/reinstatement/restoration who have not demonstrated continuous current sobriety for at least one year since the date of the applicant's discharge from treatment where the treatment was completed and conformed with board requirements.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, no minimum, with conditions for reinstatement; subsequent probation, minimum 5 years

Fining Range: No fine. Fine may be levied based upon a licensee's negative underlying conduct (not applicable to an applicant for initial licensure).

B. "Slip Rule": Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances (including the inability to practice in accordance with such standards without appropriate treatment, monitoring, or supervision), where all conditions set forth in Rule 4731-16-02(D), Ohio Administrative Code, have been met.

The Respondent will not be subjected to suspension or other formal discipline. No fine.

C. First Relapse: Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances (including the inability to practice in accordance with such standards without appropriate treatment, monitoring, or supervision); first relapse during or following treatment, and/or where all conditions set forth in Rule 4731-16-02(D), Ohio Administrative Code, have not been met.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 90 days following date of license suspension (mandated by administrative rule), with conditions for reinstatement; subsequent probation, min. 5 years

Fining Range: No fine. Fine may be levied based upon underlying negative conduct.

D. Second Relapse: Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances (including the inability to practice in accordance with such standards without appropriate treatment, monitoring, or supervision); second relapse during or following treatment.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 1 year following date of license suspension (mandated by administrative rule), with conditions for reinstatement; subsequent probation, min. 5 years

Fining Range: No fine. Fine may be levied based upon underlying negative conduct.

E. Third Relapse: Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances (including the inability to practice in accordance with such standards without appropriate treatment, monitoring, or supervision); third relapse during or following treatment.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 3 years following date of license suspension (mandated by administrative rule), with conditions for reinstatement; subsequent probation, min. 5 years

Fining Range: No fine. Fine may be levied based upon underlying negative conduct.

F. Impairment, 1 - 5 Years of Sobriety: Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances (including the inability to practice in accordance with such standards without appropriate treatment, monitoring, or supervision).

This section applies to all applicants for licensure/reinstatement/restoration who have demonstrated continuous current sobriety for more than one year, but less than five years, since the date of the applicant's discharge from treatment where the treatment was completed and conformed with board requirements.

Maximum Penalty: Permanent denial of application

Minimum Penalty: Application granted; subject to probation for a minimum term that, when added to the applicant's demonstrated period of continuous current sobriety, shall not be less than 5 years

Fining Range: No fine. Fine may be levied based upon a licensee's negative underlying conduct (not applicable to an applicant for initial licensure).

G. Impairment, 5+ Years of Sobriety: Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances (including the inability to practice in accordance with such standards without appropriate treatment, monitoring, or supervision).

This section applies to all applicants for licensure/reinstatement/restoration who have demonstrated continuous current sobriety for more than five years since the date of the applicant's discharge from treatment where the treatment was completed and conformed with board requirements.

Maximum Penalty: Permanent denial of application

Minimum Penalty: License may be granted/reinstated/restored without probation or other disciplinary action

Fining Range: No fine. Fine may be levied based upon a licensee's negative underlying conduct (not applicable to an applicant for initial licensure).

H. Mental/Physical Illness, Currently Unable To Practice: Inability to practice according to acceptable and prevailing standards of care by reason of mental or physical illness (including any mental disorder, mental illness, physical illness, or physical deterioration that adversely affects cognitive, motor, or perceptive skills).

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: If applicant: Granting of license subject to indefinite suspension, min. as appropriate; conditions for reinstatement; discretionary probation, as appropriate

If licensee: Indefinite suspension, min. as appropriate; conditions for reinstatement; discretionary probation, as appropriate

Fining Range: No fine. Fine may be levied based upon a licensee's negative underlying conduct (not applicable to an applicant for initial licensure).

I. Mental/Physical Illness, Currently Able To Practice Subject To Appropriate Treatment, Monitoring, Or Supervision: Inability to practice according to acceptable and prevailing standards of care by reason of mental or physical illness (including any mental disorder, mental illness, physical illness, or physical deterioration, that adversely affects cognitive, motor, or perceptive skills) without appropriate treatment, monitoring, or supervision.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: If applicant: Granting of license, discretionary probation, as appropriate

If licensee: Discretionary probation, as appropriate

Fining Range: No fine. Fine may be levied based upon a licensee's negative underlying conduct (not applicable to an applicant for initial licensure).

Review/Revision History:
Sections IX.A through IX.I: 9/2011
Sections IX.H through IX.I: 6/2018
Fining Range incorporated: 01/2020

CATEGORY X: C.M.E. REQUIREMENTS

A. Failure to respond timely to C.M.E. audit, but requisite C.M.E. completed.

Maximum Penalty: Reprimand; subject to mandatory audits of compliance with CME requirements for the current CME acquisition period and for two full CME acquisition periods thereafter.

Minimum Penalty: Reprimand.

Fining Range: $4,000 - $5,000
(Maximum of $5,000 fine for CME violations pursuant to Section 4731.282)

B. Failure to complete C.M.E. as certified on renewal application.

Maximum Penalty: Reprimand; $5,000.00 fine; indefinite suspension until any outstanding shortage of CME credits has been rectified; subject to mandatory audits of compliance with CME requirements during suspension (if any), for the current CME acquisition period at the time of reinstatement (or for current CME acquisition period if no suspension), and for two full CME acquisition periods thereafter.

Minimum Penalty: Reprimand; $1,000.00 fine; indefinite suspension until any outstanding shortage of CME credits has been rectified; subject to mandatory audits of compliance with CME requirements during suspension (if any), for the current CME acquisition period at the time of reinstatement (or for current CME acquisition period if no suspension), and for two full CME acquisition periods thereafter.

Fining Range: $4,500 - $5,000
(Maximum of $5,000 fine for CME violations pursuant to Section 4731.282)

C. Failure to complete C.M.E. as certified on renewal application; repeat offense.

Maximum Penalty: $5,000.00 fine; indefinite suspension, min. 90 days, with conditions for reinstatement; subject to mandatory audits of compliance with CME requirements during suspension, for the current CME acquisition period at the time of reinstatement, and for two full CME acquisition periods thereafter.

Minimum Penalty: $3,000.00 fine; indefinite suspension, min. 60 days, with conditions for reinstatement; subject to mandatory audits of compliance with CME requirements during suspension, for the current CME acquisition period at the time of reinstatement, and for two full CME acquisition periods thereafter.

Fining Range: (Maximum of $5,000 fine for CME violations pursuant to Section 4731.282)

NOTE: IF FRAUDULENT MISREPRESENTATIONS (OTHER THAN FALSE CERTIFICATION OF COMPLETION) ARE MADE WITH RESPECT TO C.M.E., CATEGORY III PENALTY MAY BE APPROPRIATE IN ADDITION TO THE STANDARD C.M.E. PENALTY. A BIFURCATED ORDER MAY BE USED.

Review/Revision History:
Sections X.A through X.C: 10/2011
Fining Range incorporated: 01/2020

CATEGORY XI: MISCELLANEOUS VIOLATIONS

A. Violating or attempting to violate, directly or indirectly, or assisting in or abetting violation of, or conspiring to violate, the Medical Practices Act or any rule promulgated by the Board.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Correspond to minimum penalty for actual offense

Fining Range: $4,500 - $20,000

B. Violation of any abortion law or rule.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Reprimand

Fining Range: $5,000 - $20,000

C. Permitting name or certificate to be used when not actually directing treatment.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Suspension, 1 year; discretionary probation, as appropriate

Fining Range: $9,500 - $20,000

D. Failure to cooperate in an investigation conducted by the Board.

Maximum Penalty: Indefinite suspension of license with conditions for reinstatement to include, at a minimum, full cooperation in the underlying investigation.

Minimum Penalty: Reprimand, as long as respondent has fully cooperated in the underlying investigation.

Fining Range: $3,000 – 5,000

Review/Revision History:
Sections XI.A through XI.D: 10/2011
Section XI.C: 6/2018
Fining Range incorporated: 01/2020

APPENDIX A: APPLICABILITY OF GUIDELINES TO LICENSURE AND TRAINING CERTIFICATE APPLICANTS

The penalties specified in Categories I through XI are generally tailored to apply to violations of the Medical Practices Act by licensees. When applicants for licensure or training certificates are found to have committed like violations, the appropriate penalties will be formulated in terms of either grant, denial, or permanent denial of the application. A grant of a license or training certificate may be accompanied by limitation, suspension, requirements for reinstatement, probation, and/or reprimand, as appropriate, and should be proportionate to penalties imposed for licensees.

Review/Revision History:
11/2011

APPENDIX B: AGGRAVATING AND MITIGATING FACTORS

After a violation has been established, the Board may consider aggravating and mitigating circumstances in deciding what penalty to impose. If the Board deems such circumstances sufficient to justify a departure from disciplinary guidelines, they should be specified during the Board's deliberations.

AGGRAVATION

Aggravation or aggravating circumstances are any considerations or factors which might justify an increase in the degree of discipline to be imposed. Aggravating factors may include, but are not limited to:

(a) Prior disciplinary actions
(b) Dishonest or selfish motive
(c) A pattern of misconduct
(d) Multiple violations
(e) Submission of false evidence, false statements, or other deceptive practices during the disciplinary process
(f) Refusal to acknowledge wrongful nature of conduct
(g) Adverse impact of misconduct on others
(h) Vulnerability of victim
(i) Willful or reckless misconduct
(j) Use/abuse of position of trust, or of licensee status, to accomplish the deception, theft, boundaries violation, or other misconduct
(k) Where an individual has a duty to disclose information to the Board, the extent of delay in disclosing all or part of the information, including the failure to self-report relapse immediately to the Board as required
(l) Failure to correct misconduct after recognizing the existence of the problem/violation

MITIGATION

Mitigation or mitigating circumstances are any considerations or factors which might justify a reduction in the degree of discipline to be imposed. Mitigating factors may include, but are not limited to:

(a) Absence of a prior disciplinary record
(b) Absence of a dishonest or selfish motive
(c) Isolated incident, unlikely to recur
(d) Full and free disclosure to Board, when done in a timely manner (such as before discovery is imminent)

(e) Physical or mental disability or impairment
(NOTE: IT IS THE BOARD'S STATED POLICY THAT IMPAIRMENT SHALL NOT EXCUSE ACTS WHICH RESULT IN CONVICTION OR WHICH POTENTIALLY HAVE AN ADVERSE IMPACT ON OTHER INDIVIDUALS.)
(f) Interim rehabilitation or remedial measures
(g) Remorse
(h) Absence of adverse impact of misconduct on others
(i) Remoteness of misconduct, to the extent that the passage of time between the misconduct and the Board's determination of the sanction is not attributable to the respondent's delay, evasion, or other acts/omissions
(j) Absence of willful or reckless misconduct
(k) Prompt correction of misconduct/problem after recognizing its existence.

Review/Revision History:
11/2011

STANDARD PROTOCOLS FOR VIOLATIONS OF THE DENTAL PRACTICE ACT AND GENERAL CONSENT ORDERS

In keeping with its obligation and mission to promote quality oral health care and protect all communities in the State of Oregon by equitably and ethically regulating dental professionals, the Oregon Board of Dentistry (OBD/Board) has updated the following recommended protocols for the most common violations of the Dental Practice Act.

The Board carefully considers the totality of the facts and circumstances in each individual case, with the safety of the public being paramount. To the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of the licensee.

These protocols serve as guidelines, and the Board acknowledges that there may be departures in individual cases depending upon mitigating or aggravating circumstances.

CIVIL PENALTIES

Licensee shall pay a $(**XX**) civil penalty, by a single payment, in the form of a cashier's, bank, or official check, made payable to the Oregon Board of Dentistry and delivered to the Board offices within (**XX**) days of the effective date of the Order.

> **NOTE:** The Board will allow licensed dentists a 30-day payment period for each civil penalty increment of $2,500.00.
>
> **NOTE:** The Board will allow licensed dental therapists a 30-day payment period for each civil penalty increment of $500.00.
>
> **NOTE:** The Board will allow licensed dental hygienists a 30-day payment period for each civil penalty increment of $500.00.

REFUND AND/OR RESTITUTION PAYMENTS

Licensee shall pay $(**XX**) *refund or restitution*, by a single payment, in the form of a cashier's, bank, or official check made payable to patient (PATIENT INITIALS) and delivered to the Board offices within (**XX**) days of the effective date of the Order.

> **NOTE:** The Board will allow licensed dentists a 30-day payment period for each restitution and/or refund increment of $2,500.00.
>
> **NOTE:** The Board will allow licensed dental therapists a 30-day payment period for each civil penalty increment of $500.00.
>
> **NOTE:** The Board will allow licensed dental hygienists a 30-day payment period for each civil penalty increment of $500.00.
>
> REFUND: To restore money paid by patient for treatment.
>
> RESTITUTION: Money to repair unacceptable treatment.

REIMBURSEMENT PAYMENTS

Licensee shall provide the Board with documentation verifying reimbursement payment made to (COMPANY NAME), patient (PATIENT INITIALS) insurance carrier, within (**XX**) days of the effective date of the Order.

> **NOTE:** The Board will allow licensed dentists a 30-day payment period for each reimbursement increment of $2,500.00.
>
> **NOTE:** The Board will allow licensed dental therapists a 30-day payment period for each reimbursement increment of $500.00.
>
> **NOTE:** The Board will allow licensed dental hygienists a 30-day payment period for each reimbursement increment of $500.00.

RESTRICTIONS

Licensee shall abide by any practice restriction(s) imposed by the Board until the Licensee receives written notice from the Board that the restriction(s) have been removed.

> **NOTE:** If a license becomes inactive (expired, retired, etc.) while restriction(s) are in place, and the license is subsequently reinstated, the restriction(s) shall remain in place pending further order of the Board.

REMEDIAL CONTINUING EDUCATION (CE) – BOARD ORDERED

Licensee shall submit documentation to the Board verifying successful completion of (**XX**) hours of (**XX**) (OPTIONS: Board approved, hands-on, mentored), CE in the area of (**XX**) within (**XX**) (OPTIONS: years, months) of the effective date of the Order, unless the Board grants an extension, and advises Licensee in writing. This ordered CE is in addition to the CE required for the licensure period(s) (**XX**) (i.e. April 1, XXXX to March 31, XXXX, or October 1, XXXX to September 30, XXXX).

FALSE/INACCURATE CERTIFICATION OR STATEMENTS ON DOCUMENTS OR RECORDINGS

Licensee may be disciplined and required to pay a $(**XX**) civil penalty, by a single payment in the form of a cashier's, bank, or official check made payable to the Oregon Board of Dentistry and delivered to the Board offices within (**XX**) days of the effective date of the Order.

> **NOTE:** The civil penalties are $2,000.00 for dentists, $1,000.00 for dental therapists, and $1,000.00 for dental hygienists.

FAILURE TO MEET CONTINUING EDUCATION (CE) STANDARDS

> **NOTE:** If Licensee completes <100% of the required CE, the Board will request a letter of explanation, review extenuating circumstances, and audit an additional two-year cycle. Discipline may be recommended after review of circumstances.
>
> **NOTE (ANESTHESIA PERMIT HOLDERS):** If Licensee fails to provide the CE required to maintain their anesthesia permit (i.e. for a CE audit), the Licensee will be notified that the permit has been removed from their license and will not be added back onto their license until documentation is provided to and accepted by the Board.

FAILURE TO MAINTAIN BASIC LIFE SUPPORT BASIC LIFE SUPPORT (BLS) FOR HEALTHCARE PROVIDERS

If Licensee fails to maintain BLS for Healthcare Providers for any period of time, the Board will request a letter of explanation and review extenuating circumstances. Licensee may be disciplined and may be required to pay a $(**XX**) civil penalty, by a single payment, in the form of a cashier's, bank, or official check made payable to the Oregon Board of Dentistry and delivered to the Board offices within (**XX**) days of the effective date of the Order.

> **NOTE:** If Licensee fails to maintain BLS for Healthcare Providers for one day to three months, discipline may be recommended after review of circumstances.
>
> **NOTE:** If Licensee fails to maintain BLS for Healthcare Providers for three months to six months, the Licensee may be reprimanded and required to pay a $500.00 (DENTIST) civil penalty, a $250.00 (DENTAL THERAPIST) civil penalty, or a $250.00 (DENTAL HYGIENIST) civil penalty.
>
> **NOTE:** If Licensee fails to maintain BLS for Healthcare Providers for longer than six months, the Licensee may be reprimanded and required to paya $1,000.00 (DENTIST) civil penalty, a $500.00 (DENTAL THERAPIST) civil penalty, or a $500.00 (DENTAL HYGIENIST) civil penalty.
>
> **NOTE (ANESTHESIA PERMIT HOLDERS):** If an anesthesia permit holder fails to maintain BLS for Healthcare Providers for longer than six months, the Licensee may be reprimanded and pay a $1,500.00 (DENTIST) civil penalty or a $1,000.00 (DENTAL HYGIENIST) civil penalty. If Licensee fails to provide or maintain a current BLS for Healthcare Providers, the licensee will be notified that the permit has been removed from their license and will not be added back onto their license until documentation is provided to and accepted by the Board.

FAILURE TO MAINTAIN ADVANCED CARDIOVASCULAR LIFE SUPPORT (ACLS) AND/OR PEDIATRIC ADVANCED LIFE SUPPORT (PALS) CERTIFICATION.

If Licensee who is required to maintain an ACLS and/or PALS certification fails to maintain ACLS and/or PALS for any period of time, the Board will request a letter of explanation and review extenuating circumstances. Licensee may be disciplined and may be required to pay a $(**XX**) civil penalty, by a single payment, in the form of a cashier's, bank, or official check made payable to the Oregon Board of Dentistry and delivered to the Board offices within (**XX**) days of the effective date of the Order.

> **NOTE:** If Licensee fails to provide or maintain ACLS and/or PALS for one day to three months, discipline may be recommended after review of circumstances.
>
> **NOTE:** If Licensee fails to provide or maintain ACLS and/or PALS for longer than three months, Licensee may be reprimanded and required to pay at minimum a $1,500.00 civil penalty.

NOTE: (ANESTHESIA PERMIT HOLDERS): If an anesthesia permit holder who is required to maintain an ACLS and/or PALS certification fails to provide or maintain a current ACLS and/or PALS, the licensee will be notified that the permit has been removed from their license and will not be added back on until documentation is provided to and accepted by the Board.

PRACTICING WITHOUT A CURRENT LICENSE

Licensee may be disciplined and required to pay a $(**XX**) civil penalty, by a single payment, in the form of a cashier's, bank, or official check, made payable to the Oregon Board of Dentistry and delivered to the Board offices within (**XX**) days of the effective date of the Order.

NOTE: A licensed dentist, who practiced any number of days without an active license will be issued a Notice of Proposed Disciplinary Action and offered a Consent Order incorporating a reprimand and a requirement to pay at minimum a $2,000.00 civil penalty.

NOTE: A licensed dental therapist who practiced any number of days without an active license or without a valid Collaborative Agreement, will be issued a Notice of Proposed Disciplinary Action and offered a Consent Order incorporating a reprimand and a requirement to pay at minimum a $1,000.00 civil penalty.

NOTE: A licensed dental hygienist who practiced any number of days without an active license will be issued a Notice of Proposed Disciplinary Action and offered a Consent Order incorporating a reprimand and requirement to pay at minimum a civil penalty of $1,000.00.

ALLOWING A PERSON TO PERFORM DUTIES FOR WHICH THE PERSON IS NOT LICENSED OR CERTIFIED

Licensee shall be disciplined and required to pay a $(**XX**) civil penalty, by a single payment, in the form of a cashier's, bank, or official check, made payable to the Oregon Board of Dentistry and delivered to the Board offices within (**XX**) days of the effective date of the Order.

NOTE: The civil penalties are $2,000.00 for the first offense. Increased civil penalties may be assessed in the event of repeated or egregious offenses.

FAILURE TO RESPOND WITHIN TEN DAYS TO A BOARD REQUEST FOR INFORMATION

Licensee may be disciplined and required to pay a $(**XX**) civil penalty, by a single payment, in the form of a cashier's, bank, or official check, made payable to the Oregon Board of Dentistry and delivered to the Board offices within (**XX**) days of the effective date of the Order.

> **NOTE:** The Board may issue a Notice of Proposed Disciplinary Action and offer a Consent Order, incorporating a reprimand and a $1,000.00 civil penalty, to a licensed dentist, who fails to respond within ten days to a Board request for information.
>
> **NOTE:** The Board may issue a Notice of Proposed Disciplinary Action and offer a Consent Order, incorporating a reprimand and a $500.00 civil penalty, to a licensed dental therapist, who fails to respond within ten days to a Board request for information.
>
> **NOTE:** The Board may issue a Notice of Proposed Disciplinary Action and offer a Consent Order, incorporating a reprimand and a $500.00 civil penalty, to a licensed dental hygienist, who fails to respond within ten days to a Board request for information.

FAILURE TO CONDUCT WEEKLY BIOLOGICAL TESTING OF STERILIZATION DEVICES

Failures are calculated as a percentage of required biological monitoring, based on the number of weeks per calendar year that patients were scheduled, multiplied by the number of testing devices in use.

Licensee may be disciplined and required to pay a $(**XX**) civil penalty, by a single payment, in the form of a cashier's, bank, or official check made payable to the Oregon Board of Dentistry and delivered to the Board offices within (**XX**) days of the effective date of the Order.

Licensee may be required to submit documentation to the Board verifying successful completion of (**XX**) hours of Board approved continuing education in the area of infection control within (**XX**) (OPTIONS: years, months) of the effective date of the Order. This ordered continuing education is in addition to the continuing education required for the licensure period(s) (**XX**) (i.e. April 1, XXXX to March 31, XXXX or October 1, XXXX to September 30, XXXX).

For a period of one year of the effective date of the Order, Licensee may be required to submit, on a quarterly basis, the results of the previous month's weekly biological monitoring testing of sterilization devices. Periods of time Licensee is not practicing in Oregon shall not apply to reduction of the one-year requirement.

NOTE: Failure to complete ≤5% of required biological monitoring testing within the previous calendar year and current year-to-date will result in a Letter of Concern.

NOTE: Failure to complete >5% to 10% of required biological monitoring testing within a calendar year will result in the issuance of a Notice of Proposed Disciplinary Action and an offer of a Consent Order incorporating a reprimand.

NOTE: Failure to complete >10% to 20% of required biological monitoring testing within a calendar year will result in the issuance of a Notice and an offer of a Consent Order incorporating a reprimand, a $3,000.00 civil penalty, two hours of Board approved continuing education in the area of infection control within (**XX**), and quarterly submission of spore testing results for a period of one year from the effective date of the Order.

NOTE: Failure to complete >20% of required biological monitoring testing within a calendar year will result in the issuance of a Notice and an offer of a Consent Order incorporating a reprimand, a $6,000.00 civil penalty, four hours of Board approved continuing education in the area of infection control within (**XX**), and quarterly submission of spore testing results for a period of one year from the effective date of the Order.

FAILURE TO REGISTER WITH THE PRESCRIPTION DRUG MONITORING PROGRAM (PDMP). Effective July 1, 2020.

Licensee may be disciplined and required to pay a $(**XX**) civil penalty, by a single payment, in the form of a cashier's, bank, or official check made payable to the Oregon Board of Dentistry and delivered to the Board offices within 30 days of the effective date of the Order.

> **NOTE:** Required date means the date that the rule became effective (July 1, 2020), the date of initial licensure in Oregon, or the date the licensee obtains a DEA number, whichever comes latest.
>
> **NOTE:** Failure to be registered with the PDMP for one day to three months from the required date may result in a Letter of Concern.
>
> **NOTE:** Failure to be registered with the PDMP for three months to six months from the required date may result in a reprimand.
>
> **NOTE:** Failure to be registered with the PDMP for longer than six months from the required date may result in a reprimand and a $1000.00 civil penalty.

STANDARD PROTOCOLS FOR CONSENT ORDERS
RELATED TO DIAGNOSED SUBSTANCE USE DISORDER

Licensee shall, for an indefinite length of time, be subject to the following conditions of this Consent Order:

Licensee shall voluntarily enter the State's Health Professionals' Services Program (HPSP) and abide by all of the terms and conditions established by the HPSP vendor, per Oregon law ORS 676.

Licensee shall contact and initiate procedures to enter HPSP within one (1) business day of the effective date of this Order. Business days are defined as days Monday through Friday excluding holidays. Licensee understands that failure to enroll in HPSP will result in notification to the Board.

Licensee shall not apply for relief from these conditions within five years of the effective date of the Order, and must do so in writing. Periods of time Licensee is not practicing dentistry as a dentist in Oregon, or dental hygiene as a dental hygienist in Oregon, shall not apply to reduction of the five-year requirement.

Licensee shall not use alcohol, marijuana, illegal drugs, stimulants, narcotics, sedatives, or any other mind altering substances at any place or time unless prescribed by a licensed practitioner for a bona fide medical condition and upon prior notice to the Board and care providers, except that prior notice to the Board and care providers shall not be required in the case of a bona fide medical emergency.

Licensee shall undergo an evaluation by a Board approved evaluator or treatment provider within 30 days of the effective date of the Order and make the written evaluation and treatment recommendations available to the Board.

Licensee shall adhere to, participate in, and complete all aspects of any and all residential care programs, continuing care programs and recovery treatment plans recommended by Board approved care providers and arrange for a written copy of all plans, programs, and contracts to be provided to the Board within 30 days of the effective date of this Order.

Licensee shall advise the Board, in writing, of any change or alteration to any residential care programs, continuing care programs, and recovery treatment plans 14 days before the change goes into effect.

Licensee shall instruct all health care providers participating in the residential, continuing care, and recovery programs to respond promptly to any Oregon Board of Dentistry inquiry concerning Licensee's compliance with the treatment plan and to immediately report to the Board, any positive test results or any substantial failure to fully participate in the programs by the Licensee. Licensee shall instruct the foregoing professionals to make written quarterly reports to the Board of Licensee's progress and compliance with the treatment programs.

Licensee shall waive any privilege with respect to any physical, psychiatric, or psychological evaluation or treatment in favor of the Board for the purposes of determining

compliance with this Order, or the need to modify this Order, and shall execute any waiver or release upon request of the Board.

Licensee shall submit to a Board approved, random, supervised, urinalysis, hair, or blood testing program, at Licensee's expense, with the frequency of the testing to be determined by the Board, but initially at a minimum of 36 random tests per year. Licensee shall arrange for the results of all tests, both positive and negative, to be provided promptly to the Board.

Licensee shall advise the Board, within 72 hours, of any alcohol, illegal or prescription drug, or mind altering substance related relapse, any positive urinalysis test result, or any substantial failure to participate in any recommended recovery program.

Licensee shall personally appear before the Board, or its designated representative(s), at a frequency to be determined by the Board, but initially at a frequency of three times per year.

Licensee shall, within three days, report the arrest for any misdemeanor or felony and, within three days, report the conviction for any misdemeanor or felony.

Licensee shall assure that, at all times, the Board has the most current addresses and telephone numbers for residences and offices.

IF APPROPRIATE –

Licensee, agree to not order, store, inventory, audit, access, draw, administer, dispense, waste, or have unilateral access to any Scheduled controlled drugs for any clinic setting.

Licensee shall immediately begin using pre-numbered triplicate prescription pads for prescribing controlled substances. Said prescription pads will be provided to the Licensee, at his/her expense, by the Board. Said prescriptions shall be used in their numeric order. Prior to the 15th day of each month, Licensee shall submit to the Board office, one copy of each triplicate prescription used during the previous month. The second copy to the triplicate set shall be maintained in the file of the patient for whom the prescription was written. In the event of a telephone prescription, Licensee shall submit two copies of the prescription to the Board monthly. In the event any prescription is not used, Licensee shall mark all three copies void and submit them to the Board monthly.

Licensee shall maintain a dental practice environment in which nitrous oxide is not present or available for any purpose, or establish a Board approved plan to assure that Licensee does not have singular access to nitrous oxide. The Board must approve the proposed plan before implementation.

Licensee shall immediately surrender his/her Drug Enforcement Administration Registration.

STANDARD PROTOCOLS FOR CONSENT ORDERS
SPECIFICALLY RELATED TO SEXUAL VIOLATIONS

SEX RELATED VIOLATIONS

Licensee shall, for an indefinite length of time, be subject to the following conditions of this Consent Order:

Licensee shall not apply for relief from these conditions within five years of the effective date of the Order, and must do so in writing. Periods of time Licensee is not practicing dentistry as a dentist in Oregon, shall not apply to reduction of the five-year requirement.

Licensee shall undergo an assessment by a Board approved evaluator, within 30 days of the effective date of the Order, and make the written evaluation and treatment recommendations available to the Board.

Licensee shall adhere to, participate in, and complete all aspects of any and all residential care programs, continuing care programs and recovery treatment plans recommended by Board approved care providers and arrange for a written copy of all plans, programs, and contracts to be provided to the Board within 30 days of the effective date of the Order.

Licensee shall advise the Board, in writing, of any change or alteration to any residential care programs, continuing care programs, and recovery treatment plans 14 days before the change goes into effect.

Licensee shall instruct all health care providers participating in the residential, continuing care, and recovery programs to respond promptly to any Oregon Board of Dentistry inquiry concerning Licensee's compliance with the treatment plan and to immediately report to the Board, any substantial failure to fully participate in the programs by the Licensee. Licensee shall instruct the foregoing professionals to make written quarterly reports to the Board of Licensee's progress and compliance with the treatment programs.

Licensee shall waive any privilege with respect to any physical, psychiatric, or psychological evaluation or treatment in favor of the Board for the purposes of determining compliance with this Order, or the need to modify this Order, and shall execute any waiver or release upon request of the Board.

Licensee shall report all arrests or interaction with law enforcement within 72 hours.

Licensee shall advise the Board, within 72 hours, of any substantial failure to participate in any recommended recovery program.

Licensee shall personally appear before the Board, or its designated representative(s), at a frequency to be determined by the Board, but initially at a frequency of three times per year.

IF APPROPRIATE –

Require Licensee to advise his/her dental staff or his/her employer of the terms of the Consent Order at least on an annual basis. Licensee shall provide the Board with documentation attesting that each dental staff member or employer reviewed the Consent Order. In the case of a Licensee adding a new employee, the Licensee shall advise the individual of the terms of the Consent Order on the first day of employment and shall provide the Board with documentation attesting to that advice.

STANDARD PROTOCOLS FOR CONSENT ORDERS
REQUIRING CLOSE SUPERVISION

CLOSE SUPERVISION

For a period of at least (XX) months, Licensee shall only practice dentistry in Oregon under the close supervision of a Board approved, Oregon licensed dentist (Supervisor), in order to demonstrate that clinical skills meet the acceptable level of patient care. Periods of time Licensee does not practice dentistry as a dentist in Oregon, shall not apply to reduction of the (six) month requirement

Licensee will submit the names of any other supervising dentists for Board approval. Licensee will immediately advise the Board of any change in supervising dentists.

Licensee shall only treat patients when another Board approved Supervisor is physically in the office and shall not be solely responsible for emergent care.

The Supervisor will review and co-sign Licensee's treatment plans, treatment notes, and prescription orders.

Licensee will maintain a log of procedures performed by Licensee. The log will include the patient's name, the date of treatment, and a brief description of the procedure. The Supervisor will review and co-sign the log. Prior to the 15th of each month, Licensee will submit the log of the previous month's treatments to the Board.

For a period of two weeks, or longer if deemed necessary by the Supervisor, the Supervisor will examine the appropriate stages of dental work performed by Licensee in order to determine clinical competence.

After two weeks, and for each month thereafter for a period of six months, the Supervisor will submit a written report to the Board describing Licensee's level of clinical competence. At the end of six months, the Supervisor, will submit a written report attesting to the level of Licensee's competency to practice dentistry in Oregon.

At the end of the restricted license period, the Board will re-evaluate the status of Licensee's dental license. At that time, the Board may extend the restricted license period, lift the license restrictions, or take other appropriate action.

STANDARD PROTOCOLS – DEFINITIONS

Group practice: On 10/10/08, the Board defined "group practice" as two or more Oregon licensed dentists, one of which may be a respondent, practicing in the same business entity and in the same physical location.

STANDARD PROTOCOLS – PARAGRAPHS

WHEREAS, based on the results of an investigation, the Board has filed a Notice of Proposed Disciplinary Action, dated (**XX**), and hereby incorporated by reference; and

Licensee shall successfully complete the Board/OAGD Mentor Program at Licensee's expense. Licensee will remain in the Mentor Program until such time as the mentor advises the Board that Licensee achieved an acceptable level of skill in the listed areas of XXX and the Board advises Licensee in writing that he met the provisions of this Order. Participation in the Mentor Program requires that Licensee successfully complete continuing education and/or engage in a study club, as recommended by the Mentor and move to adopt the Mentor's recommendations on treatment. In the event Licensee's mentor agreement ends prematurely, the Board may require an alternative education program for Licensee.

FEDERATION OF STATE BOARDS OF PHYSICAL THERAPY

Model Board Action Guidelines

Ethics & Legislation Committee
5/22/2018

fsbpt

Promoting Safety & Competence

Contents

Steps to Use Disciplinary Guidelines

Step 1: Determine Grounds for Disciplinary Action

- Determine the “Color” Category

Step 2: Determine if type I, type II, or type III infraction

Step 3: Determine if isolated event or multiple events

- Can be multiple events of same grounds in one investigation
- Can be prior disciplinary actions for same grounds

Step 4: Use matrix to determine the applicable classes of punitive and/or remedial actions

Step 5: Assign punitive and/or remedial actions

Step 6: Identify any mitigating/aggravating factors

Step 7: Modify punitive and/or remedial actions within the class (if applicable)

Step 8: Repeat with any additional ground for disciplinary action

Step 9: Determine final punitive and/or remedial actions to be taken. Report to NPDB/ELDD

- Use Basis for Action codes suggested

Grounds for Action Categorization

Grounds for Action Categorization Coding	Basis for Action Code
An offense of failing to act	
Failing to adhere to the recognized standards of ethics of the physical therapy profession as established by rule.	D3,D7, E4,81,E5,5, FA
Failing to complete continuing competence requirements as established by rule.	A2
Failing to maintain adequate patient records. For the purposes of this paragraph, adequate patient records means legible records that contain at minimum sufficient information to identify the patient, an evaluation of objective findings, a diagnosis, a plan of care, a treatment record and a discharge plan.	50, 45
Failing to maintain patient confidentiality without documented authorization of the patient or unless otherwise required by law.	C3
Failing to report to the board, where there is direct knowledge, any unprofessional, incompetent, or illegal acts that appear to be in violation of this [act] or any rules established by the board.	A3, 23, E4
Failing to supervise physical therapist assistants or physical therapy aides in accordance with this [act] and board rules.	G1, G2
Failure to Comply With Health and Safety Requirements	31
Non-Sexual dual relationship or boundary violation	D2
Practicing with an expired license	24
An offense of action - potential for harm is expected to be primarily financial or ethical	
Attempting to engage in conduct that subverts or undermines the integrity of the examination or the examination process including, but not limited to, a violation of security and copyright provisions related to the national licensure exam, utilizing in any manner recalled or memorized examination questions from or with any person or entity, failing to comply with all test center security procedures, communicating or attempting to communicate with other examinees during the test, or copying or sharing examination questions or portions of questions.	E4
Charging fraudulent fees for services performed or not performed.	55, 56, E1,E3
Directly or indirectly requesting, receiving or participating in the dividing, transferring, assigning, rebating or refunding of an unearned fee, or profiting by means of a credit or other valuable consideration such as an unearned commission, discount or gratuity in connection with the furnishing of physical therapy services. This does not prohibit the members	71, E6

of any regularly and properly organized business entity recognized by law and comprising physical therapists from dividing fees received for professional services among themselves as they determine necessary.	
Drug screening violation	35
Having had a license [or certificate] revoked or suspended, other disciplinary action taken, or an application for licensure [or certification] refused, revoked or suspended by the proper authorities of another jurisdiction, territory, or country.	39
Interfering with an investigation or disciplinary proceeding by failure to cooperate, by willful misrepresentation of facts, or by the use of threats or harassment against any patient or witness to prevent that patient or witness from providing evidence in a disciplinary proceeding or any legal action.	23
Making misleading, deceptive, untrue or fraudulent representations in violation of this [act] or in the practice of the profession.	55, 56, E3, E4, 81, E5, E6
Misappropriation of patient property or other property	16
Obtaining or attempting to obtain a license [or certificate] by fraud or misrepresentation.	E4, E3, 81
Participating in underutilization or overutilization of physical therapy services for personal or institutional financial gain.	E2, E5, E6, D3
Promoting any unnecessary device, treatment intervention, or service resulting in the financial gain of the practitioner or of a third party.	D3, E5, E6
Providing treatment intervention unwarranted by the condition of the patient or continuing treatment beyond the point of reasonable benefit.	E2
Violating any provision of this [act], board rules or a written order of the board.	A5
An offense of action - potential for harm is expected to be related to clinical issue	
Acting in a manner inconsistent with generally accepted standards of physical therapy practice, regardless of whether actual injury to the patient is established.	F6, C1, C2
Aiding and abetting the unlicensed practice of physical therapy	G2
Error in Prescribing, Dispensing or Administering Medication	H5
Failure to consult or delay in seeking consultation with supervisor/proctor	F8
Inadequate or improper infection control practices	17
Negligence	13
Patient abandonment	F9
Practicing or offering to practice beyond the scope of the practice of physical therapy	29
Practicing without a license	25
An offense of action - implications or consequences of licensee action potentially extend beyond limits of the clinic	

Diversion of controlled substance	H6
Engaging in sexual misconduct.	D1
Having been convicted of or pled guilty to a felony in the courts of this jurisdiction or any other jurisdiction, territory or country. Conviction, as used in this paragraph, shall include a deferred conviction, deferred prosecution, deferred sentence, finding or verdict of guilt, an admission of guilt, an Alfred plea, or a plea of *nolo contendere*.	19, B1, 18, I1
Narcotics violation or other violation of drug statutes	H1
Patient abuse	14
Practicing after having been adjudged mentally incompetent by a court of competent jurisdiction.	F1, F3
Practicing as a physical therapist or working as a physical therapist assistant when physical or mental abilities are impaired by the use of controlled substances or other habit-forming drugs, chemicals or alcohol, or by other causes.	F2
Practicing physical therapy with a mental or physical condition that impairs the ability of the licensee to practice with skill and safety.	F3, F4
Unauthorized administration of medication	H4
Unauthorized dispensing of medication	H3
Unauthorized prescribing of medication	H2
Violation of Federal or State Statutes, Regulations or Rules	A6, 36, 37, 44, 84

Infraction Types

Use the factors below to determine where the licensee's action fit best.

Type I Factors to Consider- all may not apply	Type II Factors to Consider- all may not apply	Type III Factors to Consider- all may not apply
•Unintentional error •Licensee believes acting in patient's best interest; no self-serving intent •Honest mistake •Safety not compromised •Little to no intended risk	•Poor judgement demonstrated •Acting in licensee's own best interest •Conscious awareness act is improper •Faulty decision-making is evident •Potentially unsafe choice •Risk believed to be insignificant or justified	•Harmful intent with or without direct harm to the patient including but not limited to: financial, emotional, physical •Acted with recklessness •Disregard for interest of patient or others •Dangerous or unsafe choice •Decision with conscious disregard of substantial and unjustifiable risk to the patient, others, or licensee

Guidelines Matrix

An offense of failing to act

An offense of action - potential for harm is expected to be primarily financial or ethical

An offense of action - potential for harm is expected to be related to clinical issue

An offense of action – implications or consequences of licensee action potentially extend beyond limits of the practice setting

*Cost of investigation and administration of violations may be assessed in any/all cases

Type I		Type II		Type III	
Isolated	**Multiple**	**Isolated**	**Multiple**	**Isolated**	**Multiple**
A	B	1 & A	2 & A	2 & A	2 & B
1 & A	2 & A	2 & B	3 & B	3 & B	3 & C
1 & B	2 & B	2 & C	3 & C	3 & C	4 & C
2 & C	2 & C	3 & B	3 & C	3 & C	4 & C

Isolated- means one incident occurring one time
Multiple- means more than one incident of the same violation (either same patient or different patients)

May 2018

Classes of Punitive & Remedial Actions

Punitive Actions		Remedial Actions	
Class 1	Civil Penalty + Censure	**Class A**	Advisory letter → Continuing Competence Activity
Class 2	Civil Penalty + Censure → Denial of License	**Class B**	Periodic Monitoring → Supervised Clinical Practice
Class 3	Civil Penalty + Restricted License → Revocation	**Class C**	Continuing Competence Activity → Treatment Program
Class 4	Civil Penalty + Denial of License → Revocation		

Punitive & Remedial Actions Ranked in Severity (low to high)		
Punitive		**Remedial**
Censure		Advisory letter
Civil Penalty (monetary)		Periodic monitoring
Community Service		Continuing competence activity
Restrict a license		Examinations/assessments
Suspension		Supervised clinical practice
Denial of a license		Examination of fitness to practice
Voluntary surrender		Treatment program
Summary suspension		
Revocation		

May 2018

Mitigating and Aggravating Factors

*Aggravating and mitigating circumstances are specific to the individual case, but factors that may influence Board decisions can include such things as (not all-inclusive list):

Mitigating:
Licensee implemented remedial measures on their own- from knowledge of infraction up to prior to Board action
Personal circumstances
Remorse
Self-reporting- prior to a complaint
Voluntary admission of misconduct-post complaint

Aggravating:
Age and vulnerability of the patient
Obstruction
Personal circumstances
Total number of offenses
Time span over which offenses occurred

*Note that multiple events, recidivism, and harm to the patient are somewhat accounted for in the matrix

Mitigating and Aggravating Factors should be considered and influence the assessment of the remediation or disciplinary action. The Board may consider the mitigating and aggravating factors and determine whether or not these should influence the severity of the remediation or disciplinary action.

Application of mitigating/aggravating factors: Influences the severity of the action (within Class 1-4 and Class A-C) or number of actions applied; the class does not change.

Definitions

Advisory Letter- a non-disciplinary, private, written notification to the licensee [or certificate holder] that, while there is no evidence to merit disciplinary action, the board believes that the licensee [or certificate holder] should become educated about the requirements of the [act] and board rules

Censure- a disciplinary, written expression of formal disapproval to the licensee [or certificate holder] that does not impose any further conditions and is a matter of public record

Civil Penalty (monetary) - impose a sanction of a monetary nature. Civil penalty does not include, but is in addition to, administrative costs, including, but not limited to: investigative costs, attorney costs, and staff time, assigned to the licensee [or certificate holder]

Community Service- mandated performance of a number of hours of unpaid work by the licensee [or certificate holder] for the benefit of the public

Continuing Competence Activity-

1. require licensee [or certificate holder] to attend a continuing competence activity on a specific topic related to practice/work, and/or
2. require licensee [or certificate holder] to demonstrate or complete continued competence requirements required during a period of suspended or revoked licensure

Denial of License- refuse to issue or renew a license [or certificate]

Examination of fitness to practice- licensee [or certificate holder] must be examined in order to determine his or her mental or physical ability to practice as a physical therapist or work as a physical therapist assistant

Examinations/Assessments- licensee [or certificate holder] is required to complete examinations or assessment tools approved by the board

Isolated- means one incident occurring one time

Multiple- more than one incident of the same violation (either same case or different cases)

Periodic Monitoring- method of holding a licensee [or certificate holder] accountable by observing practice/work at regular intervals for a specified period of time

Restriction[1]

1. Any condition placed upon the licensee [or certificate holder] as to scope of practice, place of practice, supervision of practice, periodic monitoring, duration of licensed status, or type or condition of individual to whom the licensee [or certificate holder] may provide services. May include a restriction of a licensee's [or certificate holder's] employment pending proceedings by the board.
2. The licensee [or certificate holder] may enter into a written agreement with the board for a restricted license [or certificate] when entering into a substance abuse program.

Revocation- formal action to terminate a license, which cannot thereafter be renewed or restored, but only replaced upon application for a new license

Summary Suspension- immediately suspends a license [or certificate] **without** a hearing or the opportunity for the licensee [or certificate holder] to defend his or her license. The licensee [or certificate holder] is immediately precluded from practicing as a physical therapist or working as a physical therapist assistant

Supervised clinical practice- formal process of professional support to enable a licensee [or certificate holder] to develop knowledge and competence, assume responsibility for their own practice, and enhance public protection in a clinical situation[2]

Suspension- suspend a license [or certificate] for a period prescribed by the board which temporarily precludes a licensee's [or certificate holder's] ability to practice as a physical therapist or work as a physical therapist assistant

Treatment program- as part of the agreement established between the licensee [or certificate holder] and the board, the licensee [or certificate holder] signs a waiver allowing the substance abuse program to release information to the board if the licensee [or certificate holder], does not comply with the requirements of the Board laws or rules, or is unable to practice or work with reasonable skill or safety.

Voluntary Surrender-action initiated by the licensee [or certificate holder] based on an order of consent from the board to terminate a license, which can only be replaced upon application for a new license

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[1] Probation is not one of the options for discipline in the model practice act as it is considered simply one form of a restricted license. Probation is the specified period of time to assure compliance by the licensee [or certificate holder] with the restrictions established in the Board's order to continue to practice.

[2] "Clinical supervision." A Dictionary of Nursing. *Encyclopedia.com.* 27 Feb. 2017 <http://www.encyclopedia.com>

OREGON BOARD OF PSYCHOLOGIST EXAMINERS
Disciplinary Guidelines – Adopted 11/4/17

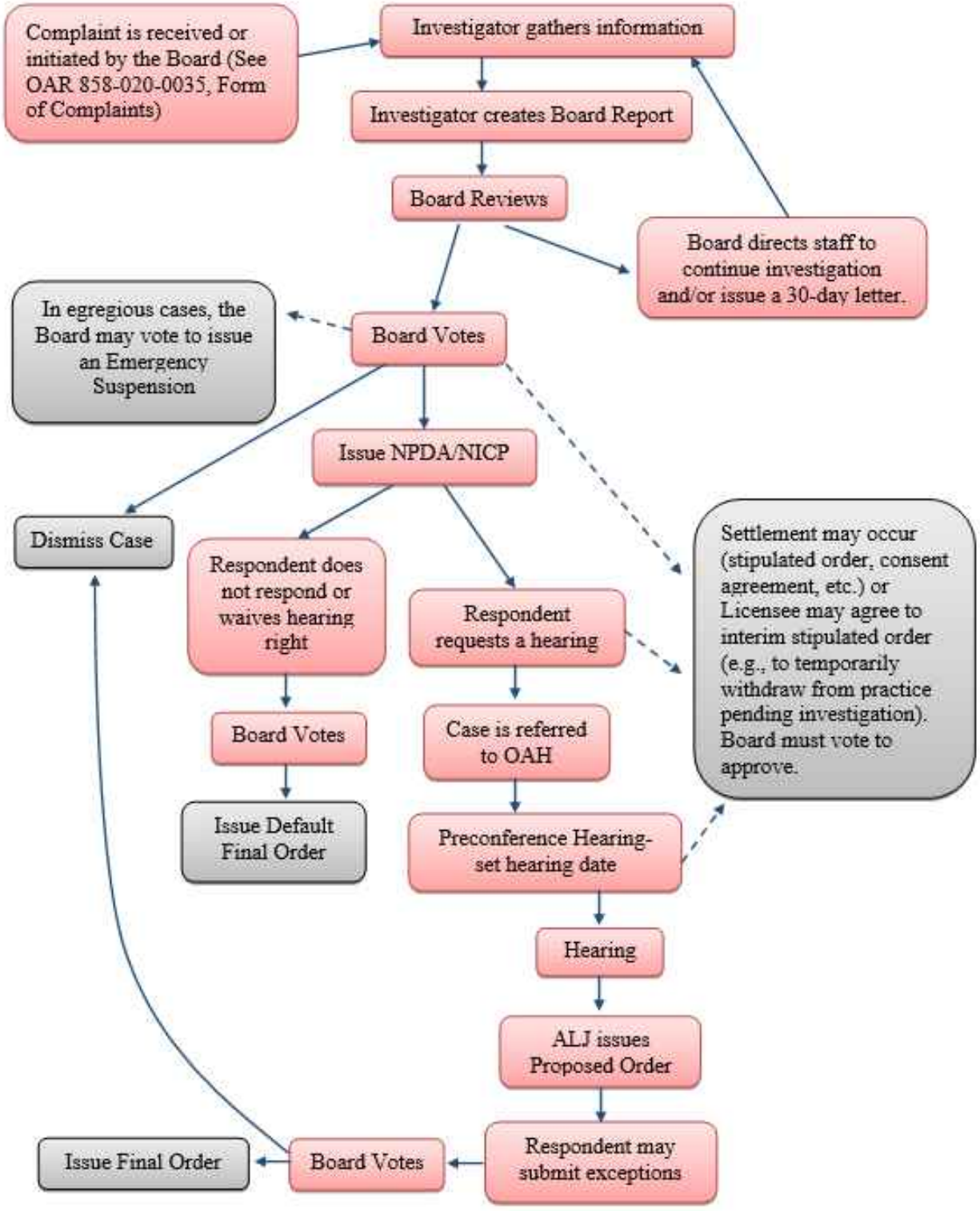
Types of Board Action

- ***Non-Disciplinary Actions.*** Complaints are confidential and may not be disclosed to the public.
  - **Dismissal**- No violation found, case is closed.
  - **Dismiss with Letter of Concern**- No violation found, but the Board finds sufficient concerns raised in the course of the investigation and deliberation of the case to warrant a communication to provide feedback to the person. The purpose is to educate the person as to the requirements of the law/ethical principle(s), and warn the person that if the situation is true and repeated, formal action could result.

- ***Disciplinary Actions.*** Notices and orders are public documents, and include one or more of the following:
  - **Reprimand**- The reprimand is a viable option if the violations alleged are relatively minor and no patient harm occurred. This action alone is a less punitive course of action, but may also be combined with other discipline.
  - **Revocation of License**- Loss of license. The Board may specify that the licensee may reapply after a certain period of time, or never. If the document is silent as to reapplication, then the Board will not review a subsequent application for licensure until at least one year has elapsed from the effective date of the order pursuant to OAR 858-010-0020(4).
  - **Suspension of License**- During the specified duration of suspension, a licensee may not practice psychology.
  - **Probation of License**- A licensee is placed on probation for a specified period of time and must comply with the terms and conditions of the probation.
  - **Supervised Practice (or additional supervision)**- Supervision by a Board-approved licensed psychologist for specified duration and frequency. Periodic reports from supervisor should be required. Supervision generally terminates after a specified minimum period of time with written recommendation from the supervisor and Board approval.
  - **Monitored Practice**- Monitoring is utilized when respondent's ability to function independently is in doubt or when fiscal improprieties have occurred, as a result of a deficiency in knowledge or skills, or as a result of questionable judgment.
  - **Limitation or Restriction on License**- The Board may place license restrictions such as limitations on types of clients licensee may see, methods of therapy licensee may provide, or number of hours worked per week, depending on the unique situation of the case.
  - **Denial of Initial License**- Initial license is denied. The Board may specify that the licensee may reapply after a certain period of time, or never. If the document is silent as to reapplication, then the Board will not review a subsequent application for licensure until at least one year has elapsed from the date of previous denial pursuant to OAR 858-010-0020(4).

- **Civil Penalty**- The Board is authorized to impose a civil penalty up to $5,000, or up to $10,000 in cases where 1) the conduct had a serious detrimental effect on the health or safety of another person, 2) the person has a history of discipline for the same or similar conduct, 3) the conduct involved a willful or reckless disregard of the law, 4) the conduct was perpetrated against a minor, an elderly person or a person with a disability, or 5) it is unlicensed practice. Civil penalty authority is *per violation.*
- **Additional Continuing Education**- The Board may specify the terms of the education, including the length and subject matter (6 additional hours of ethics, for example). The Board may require that the person take and successfully complete additional graduate level coursework. The document should specify that education must be in addition to the continuing education required for license renewal.
- **Write Article or Essay**- The Board should specify the subject matter and length of the article or essay.
- **Evaluation Required**- Psychological or drug/alcohol evaluations are utilized when an offense calls into question the judgment and/or emotional/mental condition of the respondent (impairment), or where there has been a history of abuse of dependency of alcohol or controlled substances. The purpose of the evaluation is to determine whether the respondent is able to practice independently and safely, and whether ongoing therapy/treatment is recommended. When appropriate, respondent shall be barred from rendering psychological services under the terms of probation until they undergo an evaluation, the evaluator has recommended resumption of practice, and the Board has accepted and approved the evaluation.
- **Write Letter of Apology**- The Board may require that the respondent write a letter of apology to one or more individuals who were negatively affected by respondent's conduct.
- **Therapy Required**- The need for psychotherapy or alcohol/drug abuse treatment program may be determined pursuant to a psychological or drug/alcohol evaluation or as evident from the facts of the case. Alcohol and other drug abuse treatment shall be required in addition to other terms of probation in cases where the use of alcohol or other drugs by respondent has impaired the respondent's ability to safely provide psychological services to patients. The frequency of therapy shall be related to the offense involved and the extent to which the offense calls into question the judgment, motivation, and emotional/mental condition of the respondent. The Board may 1) condition that respondent shall abstain completely from drugs and alcohol; 2) require periodic reports from the therapist; and/or 3) require random biological fluid testing.

Complaint Process



The purpose of the investigation is to determine whether credible evidence exists of violations of rules or laws administered by the Board. Upon consideration of the investigator's report, the Board may vote

to dismiss, continue the investigation (which may include the issuance of a 30-day letter[1]), or to institute disciplinary action. An "NPDA" (Notice of Proposed Disciplinary Action, against a licensee or applicant) or an "NICP" (Notice of Intent to Impose Civil Penalty, in cases of unlicensed practice) is the Board's proposed action and the reasons for it. A "Final Order" or "Stipulated Order" is the final document. A final order may be the result of a contested case hearing, an agreement between the Board and the individual, or may be the result of a default if the respondent fails to request a contested case hearing within 30 days.

Disciplinary Guidelines

The Board has adopted the following recommended guidelines for disciplinary orders and conditions of probation for violations of regulations pertaining to the practice of psychology. The Board recognizes that an unusual individual case may necessitate a departure from these guidelines.

Step 1- Review the applicable laws, rules and ethical principles to determine whether a violation(s) occurred.

Step 2- Identify the conduct and locate it on the Sanction Grid (below).

Step 3- Determine the severity of the conduct (low or high) using any relevant aggravating or mitigating factors, including:

- Actual or potential harm to patient(s)
  - Existence of multiple victims
  - Particular vulnerability of patient
- Level of danger to the public
- History of similar conduct
- Complaint/Discipline history
- Other concurrent findings of unprofessional conduct
- The length of time the licensee has practiced without complaint or violations
- Efforts toward self-remediation or corrective action
- The length of time since the date of violation
- Evident remorse/acknowledgment of conduct
- Cooperation with investigation
- The deterrent effect of the penalty imposed

Step 4- Determine the sanction within the listed range on the Sanction Grid, again taking into consideration the aggravating and mitigating factors. It may be necessary to deviate from the guidelines in extreme or unusual cases. The Board may substitute or add alternative sanctions in order to fit the unique circumstances of the conduct.

[1] A “thirty-day letter notifies the respondent of the specific allegations of conduct that may constitute violations. A response is due within 30 days from the date of mailing, and is presented for the Board’s review.

SANCTION GRID

Violation	References	Sanction Range	
		Low Severity of Conduct	High Severity of Conduct
Abuse of alcohol/substance	ORS 675.070(2)(a)-(b); EP 2.06	Reprimand; evaluation required; therapy required (alcohol/drug abuse treatment program); up to 5 years supervised practice; up to 5 years suspension	2 to 5 years probation and/or suspension to revocation/denial of initial license
Allowing or Aiding Unlicensed Practice	ORS 675.070(2)(g); EP 2.05 & 9.07	2 to 5 years probation and/or suspension; $1,000 to $5,000 civil penalty	5 years probation to revocation/denial of initial license; $5,000 to $10,000 civil penalty
Boundary Violation	EP 2.01, 2.02, & 5.04	Reprimand; up to 5 years probation and/or suspension; $1,000 to $5,000 civil penalty; monitored practice and/or conditions in some cases; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation/denial of initial license; $5,000 to $10,000 civil penalty
Breach of Confidentiality	EP 4.01-4.07 & 6.02	Reprimand; up to 5 years probation and/or suspension; $1,000 to $5,000 civil penalty; additional continuing education and/or write article or essay	Revocation/denial of initial license; up to $10,000 civil penalty
Cheating on Licensure Exam/Falsification of Scores	ORS 675.070(2)(f); OAR 858-010-0030(6)(c)	1 to 5 years probation and/or suspension; $1,000 to $5,000 civil penalty	Revocation/denial of initial license; $5,000 to $10,000 civil penalty
Client Abandonment	EP 3.12 & 10.09	Reprimand; up to 5 years probation and/or suspension; up to $5,000 civil penalty; monitored practice and/or conditions in some cases; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation/denial of initial license; up to $10,000 civil penalty
Client Abuse or Harassment	EP 3.01-3.03	1 to 5 years probation and/or suspension; $1,000 to $5,000 civil penalty; monitored practice and/or conditions in some cases; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation/denial of initial license; $5,000 to $10,000 civil penalty

Violation	References	Sanction Range	
		Low Severity of Conduct	High Severity of Conduct
Client Exploitation	EP 3.08, 5.05, 5.06, 6.05, & 10.10	1 to 5 years probation and/or suspension; $1,000 to $5,000 civil penalty; monitored practice and/or conditions in some cases; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation/denial of initial license; $5,000 to $10,000 civil penalty
Conflict of Interest	EP 3.06	Reprimand; up to 5 years probation and/or suspension; up to $5,000 civil penalty; monitored practice and/or conditions in some cases; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation/denial of initial license; up to $10,000 civil penalty
Continuing Education Violation	OAR 858-040-0070	* See Appendix for CE Violation Sanction Grid	
Conviction of a Crime Substantially Related to the Practice of Psychology	ORS 675.070(2)(b)-(c); OAR 858-010-0020(5), 858-010-0034	Reprimand; up to 5 years probation; up to 5 years suspension; monitored practice and/or conditions in some cases	2 to 5 years probation and/or suspension to revocation/denial of initial license
Disciplinary Action Taken by Other Licensing Agency	ORS 675.070(6); OAR 858-010-0020(5)	(Refer to appropriate violation and apply corresponding sanction)	
Dual Relationship-Sexual	EP 3.05, 7.07, 10.05, 10.07, & 10.08	2 to 5 years probation and/or suspension; $5,000 to $10,000 civil penalty; monitored practice and/or conditions; additional continuing education and/or write article or essay	Revocation/denial of initial license; $10,000 civil penalty
Failure to Adequately Maintain Records/Document Services	OAR 858-010-0060; EP 6.01-6.03, & 6.06	Reprimand; up to 2 years probation and/or suspension; up to $5,000 civil penalty; monitored practice and/or conditions; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation/denial of initial license; up to $10,000 civil penalty

Violation	References	Sanction Range	
		Low Severity of Conduct	High Severity of Conduct
Failure to Avoid Harm	EP 3.04	Reprimand; 1 to 5 years probation and/or suspension; $1,000 to $5,000 civil penalty; monitored practice and/or conditions in some cases; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation/denial of initial license; $5,000 to $10,000 civil penalty
Failure to Comply with Board Order		1 to 5 years probation and/or suspension; $1,000 to $5,000 civil penalty; monitored practice and/or conditions in some cases; additional continuing education and/or write article or essay	5 years probation to revocation/denial of initial license; $5,000 to $10,000 civil penalty
Failure to Comply with Supervision Requirements	OAR 858-010-0036	Reprimand; up to 5 years probation and/or suspension; $1,000 to $5,000 civil penalty; monitored practice and/or conditions in some cases; additional continuing education and/or write article or essay	5 years probation to revocation/denial of initial license; up to $10,000 civil penalty
Failure to Consult	ORS 675.070(2)(d)(B); OAR 858-010-0055: EP B, 2.06, & 10.04	Reprimand; up to 2 years probation and/or suspension; up to $5,000 civil penalty; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension; up to $10,000 civil penalty
Failure to Obtain Informed Consent	EP 3.10, 8.02, 8.03, 9.03, & 10.01-10.03	Reprimand; up to 2 years probation and/or suspension; up to $5,000 civil penalty; monitored practice and/or conditions; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation/denial of initial license; up to $10,000 civil penalty
Failure to Provide/Transfer Information/Records in a Timely Manner	EP 3.09, 3.12, & 9.04	Reprimand; up to 2 years probation and/or suspension; up to $5,000 civil penalty; monitored practice and/or conditions; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation/denial of initial license; up to $10,000 civil penalty

Violation	References	Sanction Range	
		Low Severity of Conduct	High Severity of Conduct
Failure to Report	ORS 675.145 & 676.150; EP 1.05	Reprimand; $1,000 to $5,000 civil penalty; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension; up to $10,000 civil penalty
False, Misleading or Deceptive Statement on Application	ORS 675.070(2)(d) & (f); OAR 858-010-0020(6)	Reprimand; up to 2 years probation; up to $5,000 civil penalty *Note: Mandatory minimum civil penalty of $200 for each undisclosed arrest or conviction.*	2 to 5 years probation and/or suspension to revocation/denial of initial license; $5,000 to $10,000 civil penalty; additional continuing education and/or write article or essay
Fraudulent or Abusive Billing	ORS 675.070(2)(i); EP 6.04 & 6.07	1 to 5 years probation and/or suspension; $1,000 to $5,000 civil penalty; monitored practice and/or conditions; additional continuing education and/or write article or essay	Revocation/denial of initial license; $5,000 to $10,000 civil penalty
Fraudulent Testimony as an Expert	EP 5.01	1 to 5 years probation and/or suspension; $1,000 to $5,000 civil penalty; monitored practice and/or conditions in some cases; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation/denial of initial license; $5,000 to $10,000 civil penalty
Representation as a Psychologist without being licensed	ORS 675.020(1)(b); ORS 675.070(2)(g)	$500 to $5,000 civil penalty (per violation)	$5,000 to $10,000 civil penalty (per violation)
Improper/Inadequate Supervision or Delegation	EP 2.05, 3.09, 7.06, & 7.07	Reprimand; up to 2 years probation and/or suspension; up to $5,000 civil penalty; monitored practice and/or conditions; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation/denial of initial license; up to $10,000 civil penalty
Improper/ Unnecessary Testing or Violation of Test Security	ORS 675.070(2)(d)(B); OAR 858-010-0002; EP 9.02, 9.05, 9.06, & 9.08-9.11	Reprimand; up to 2 years probation and/or suspension; up to $5,000 civil penalty; monitored practice and/or conditions; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation/denial of initial license; up to $10,000 civil penalty

Violation	References	Sanction Range	
		Low Severity of Conduct	High Severity of Conduct
Inadequate Notice/Referrals	OAR 858-010-0060(3); EP 3.07, 3.11, 4.02, 10.09, & 10.10	Reprimand; up to 2 years probation and/or suspension; up to $5,000 civil penalty; monitored practice and/or conditions; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation/denial of initial license; up to $10,000 civil penalty
Inappropriate Advertising	EP 5.01-5.06	Reprimand; up to 2 years probation and/or suspension; $1,000 to $5,000 civil penalty	2 to 5 years probation and/or suspension; $5,000 to $10,000 civil penalty
Incompetence	EP 2.03, 2.06, 7.03	1 to 5 years probation and/or suspension; $1,000 to $5,000 civil penalty; monitored practice and/or conditions in some cases; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation/denial of initial license; $5,000 to $10,000 civil penalty
Misrepresentation of Title or Credentials	ORS 675.090(2); ORS 676.110; OAR 858-010-0036(4)(a); OAR 858-010-0037(2)(a); EP 5.01, 5.02	Reprimand; up to 5 years probation; up to 5 years suspension; up to $5000 civil penalty	Revocation/denial of initial license; up to $10,000 civil penalty
Multiple Relationship	EP 3.05, 10.02, & 10.06	Up to 5 years probation and/or suspension; $1,000 to $5,000 civil penalty; monitored practice and/or conditions; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension; $5,000 to $10,000 civil penalty
Negligence	ORS 675.070(2)(d); EP 2.06	Reprimand; 1 to 5 years probation and/or suspension; $1,000 to $5,000 civil penalty; monitored practice and/or conditions in some cases; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation/denial of initial license; $5,000 to $10,000 civil penalty
Practicing Without a Valid License (Unlicensed Practice)	ORS 675.020(a); 675.070(2)(e)	$500 to $5,000 civil penalty (per violation)	$5,000 to $10,000 civil penalty (per violation)

Violation	References	Sanction Range	
		Low Severity of Conduct	High Severity of Conduct
Psychological/Mental Impairment	ORS 675.070(2)(a)	Evaluation required; therapy required; up to 5 years supervised practice; up to 5 years suspension	2 to 5 years probation and/or suspension to revocation/denial of initial license
Testimony/Professional Opinion Without Adequate Foundation	EP 2.04, 9.01	Reprimand; up to 5 years probation and/or suspension; $1,000 to $5,000 civil penalty; monitored practice and/or conditions in some cases; additional continuing education and/or write article or essay	5 years probation to revocation/denial of initial license; up to $10,000 civil penalty
Unprofessional Conduct	ORS 675.070(2)(d); OAR 858-020-0045(5); all EPs	Reprimand; up to 5 years probation and/or suspension; $1,000 to $5,000 civil penalty; monitored practice and/or conditions in some cases; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation/denial of initial license; up to $10,000 civil penalty
Unrecognized/ Unacceptable Methodologies	EP 8.01 & 8.07-8.10	Reprimand; up to 5 years probation and/or suspension; up to $5,000 civil penalty; monitored practice and/or conditions in some cases; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation/denial of initial license; up to $10,000 civil penalty
Violation of Continuing Education Requirements (See Appendix)	OAR Ch. 858 Div. 40; EP 2.03	Reprimand; up to 2 years probation and/or suspension; up to $2,500 civil penalty; additional continuing education and/or write article or essay	2 to 5 years probation and/or suspension to revocation; up to $5,000 civil penalty

APPENDIX

CE Violation Sanction Grid (OAR 858-040-0070)

Violation	Sanction
Late response to CE Audit	
Up to 30 days late	$200
Up to 60 days late	$300
Failure to respond to CE Audit after 60 days late	$500; suspended license until licensee responds. Additional sanctions for any deficiencies (below).
Failure to complete or submit documentation for CE*	
1-10 hour deficiency	$250
11-20 hour deficiency	$500
21-30 hour deficiency	$750
31-40 hour deficiency	$1000
* Licensee must also make up the deficient hours in addition to the sanction within 30 days, and will be informed that the made-up hours may not be double counted towards the current reporting period. Subject to mandatory audit for the next reporting period.	
Failure to make up deficient hours	
Up to 90 Days	$250 additional
More than 90 Days	Min. 60 day suspension
* May be subject to other disciplinary action as well.	

Note: A late response to the CE Audit alone results in a delinquent fee which may be imposed without the issuance of a public notice or order. A civil penalty-only enforcement action for CE violation is not reportable to the National Practitioner Databank (NPDB).

ADMINSTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Discussion Item

Member Assigned: **Cramer**

Subject: **2024 Legislative Session Memo**

MEMORANDUM

TO:	Oregon Medical Board, Administrative Affairs Committee
SUBJECT:	2024 Legislative Session Information
DATE:	March 8, 2024

The 2024 Legislative Session ended on March 7, 2024. The following bills are relevant to the Oregon Medical Board (OMB), passed by both chambers, and have been signed by the Governor or awaiting the Governor's signature.

Each bill includes a link to the bill (click the bill number), a summary, and draft implementation plan, if applicable. **As a state agency, OMB does <u>not</u> take a position on bills.**

HB 4010: PA Name Change to Physician Associate
Changes "physician assistant" to "physician associate" throughout Oregon law. Not related to OMB, the bill also specifies that flavoring of a prescription drug is not compounding, exempts the Oregon State Hospital from certain hospital staffing requirements, and removes a professional disclosure statement requirement for licensed professional counselors or therapists. Bill takes effect on the 91st day after session (June 5, 2024).

Implementation Plan

Newsletter Article	Spring 2024 Edition
Update OMB website	June 2024
Update OMB documents, materials, procedures, etc.	Starting June 2024 and ongoing
Update OMB rules	First Review July 2024, Final Review October 2024
Update database	As part of building new system

SB 1552: Predetermination Process
Section 44 allows a person, prior to beginning an education, training, or apprenticeship program for a professional license to petition a licensing board for a determination as to whether a criminal conviction will prevent the person from receiving the license. Not related to OMB, the bill also makes changes to the education laws in Oregon. Section 44 becomes operative July 1, 2025, but a licensing board may choose to make this determination before the operative date.

Implementation Plan

Develop process	Summer-Fall 2024
New fee approval process	Follow DAS process
Rulemaking	First Review January 2025, Final Review April 2025, rules effective July 1, 2025
Create forms and materials	May-June 2025
Update OMB procedures	June 2025
Update database (if needed)	June 2025
Update OMB website	July 2025

SB 5701: OMB Appropriations
Adds additional funds appropriation for OMB to cover negotiated state employee compensation, increasing the agency budget for 2023-25 (section 517).

Implementation Plan

OMB will update budget as indicated.

HB 4122: Fingerprint Retention System
Directs the Oregon State Police (OSP) to establish a fingerprint retention system for participation in the Federal Bureau of Investigation's Rap Back system. Creates requirements for authorized agencies to participate in the program to receive continuous notification of a person's criminal history.

Implementation Plan

When available from OSP, OMB staff will review requirements for possible participation.

HB 4150: Overdose Notifications
Authorizes the Oregon Health Authority or a third party to provide electronic notification to a practitioner when the practitioner's patient has a fatal or nonfatal overdose within one year from the date on which a drug prescribed by the practitioner was dispensed to the patient. OHA may not provide the practitioner's information to a health professional regulatory board for disciplinary purposes. Bill takes effect on the 91st day after session (June 5, 2024).

Implementation Plan

Add information to OMB's PDMP webpage	June 2024
Newsletter Article	Summer 2024 Edition

HB 4081: EMS Updates
Establishes the Emergency Medical Services Program and Emergency Medical Services Advisory Board within the Oregon Health Authority. Directs OHA to designate emergency medical services regions within the state and designate emergency medical services centers for the provision of specific types of emergency care. Requires the program to establish and maintain an emergency medical services data system.

HB 4117: Public Meetings Law Opinions
Authorizes the Oregon Government Ethics Commission to issue an advisory opinion, staff advisory opinion, or written or oral staff advice on public meetings law to any actual or hypothetical circumstance.

ADMINSTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Discussion Item

Member Assigned: **Poulsen**

Subject: **2025 Legislative Concepts Memo**

MEMORANDUM

TO:	Oregon Medical Board
SUBJECT:	2025 Legislative Concept Development
DATE:	February 21, 2024

Oregon Medical Board staff compiled the following legislative concept ideas for the 2025 Legislative Session. Please note, the concept ideas are pending the Governor's Office approval.

1. **Removing MD/DO Volunteer Emeritus License**
   This Legislative Concept would repeal ORS 677.120 and the Volunteer Emeritus license for physicians and physician assistants.

   The Volunteer Emeritus license has been obviated in recent years; specifically, House Bill 4096 (2022) created an authorization for out-of-state physicians and PAs to practice in Oregon without a license for up to 30 days each calendar year. As a result, the Oregon Medical Board no longer needs to offer the Volunteer Emeritus license, which is more restrictive, costly, and cumbersome for physicians and PAs. At present, zero (0) licensees hold a Volunteer Emeritus license, and the agency can save costs if it can avoid developing this license type in the new agency database that is set to be deployed in 2025.

2. **Defining the Practice of Medicine to include all OMB Licensees**
   This Legislative Concept would add a new definition for the "practice of medicine" in ORS 677.010 in order to clarify that the Oregon Medical Board has authority over allopathic, osteopathic, podiatric, and Oriental medicine.

   Chapter 677 has expanded over time, but not all parts of the chapter were updated in a consistent or holistic manner. As a result, it is unclear whether all portions of the chapter apply to all OMB licensees. Adding a definition stating that the "practice of medicine" is "the practice of allopathic, osteopathic, podiatric, or Oriental medicine if the context in which 'medicine' is used does not authorize or require the person to practice outside the scope of the license issued to the physician, podiatric physician and surgeon, physician assistant, or acupuncturist under ORS 677" would provide cohesion to the chapter and clarify the OMB's authority to regulate all of its licensed professions.

3. **Health Professionals' Services Program (HPSP) Updates**
   This Legislative Concept is a placeholder for addressing potential structural changes to the statewide Impaired Professionals Program.

   In 2022, the Oregon State Board of Nursing voted to withdraw from HPSP. As a result, health licensing boards may need to consider alternative program structure and funding models. ORS 676.185 to 676.200 may need to be revised to restructure the program.

State Agency Legislative Concept Development Schedule – 2025 Session

Prior to April 30, 2024	• Agency develop concepts in conjunction with state and local agencies and others that could be affected by the statute or program change. • Submit concept, detailed explanation, and draft language to DAS.
May 1, 2024 to June 27, 2024	• CFO analysts and other key staff review concepts for policy and fiscal issues and contact agencies when questions arise. • Governor's Policy Advisors review requests, make recommendations. • DAS notifies agency of final action. • DAS sends approved concepts to Legislative Counsel for drafting on June 28, 2024.
July 1, 2024 to October 25, 2024	Legislative Counsel works on bill drafts, consulting with agencies as necessary. Placeholder language must be finalized by July 31, 2024.
14 calendar days from the date on the bill draft	Request revisions to first draft of legislative concepts. One revision opportunity per concept.
By November 13, 2024	Final concepts, fiscal impact estimates and "one-page" bill summaries due to DAS for final review and approval by the Governor's Office and DAS.
December 13, 2024	Last day to pre-session file bills for 2025 Legislative Session. With approval from Governor, DAS pre-session files agency concepts.

ADMINSTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Discussion Item

Member Assigned: **Eshraghi**

Subject: **Oregon Wellness Program Annual Report**

THE FOUNDATION FOR MEDICAL EXCELLENCE
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PH: (503) 222-1960 ● FX: (503) 619-0609 ● EMAIL: info@tfme.org ● WEB: www.tfme.org

Oregon Wellness Program
Annual Report for 2023 Activities
Presented to the Oregon Board of Medicine
January 31, 2024

The purpose of this document is to respond to the requirements of the agreement between The Foundation for Medical Excellence (TFME) and the Oregon Medical Board (OMB) concerning the Oregon Wellness Program (OWP).

Introduction and OWP Overview

The OWP is a key element of a board-based effort by the health care community and Oregon health care policy leaders to promote the wellbeing of health care professionals through education, coordinated counseling services, and research. The community believes that improved provider wellbeing has a direct link to retaining health care professionals and therefore improved public access to health care services.

In 2023, the OWP served 331 OMB clients and provided 1,680 hours of counseling. This compares to 220 OMB clients and 1,078 hours of counseling in the same 12 months of 2022. A dedicated team of 34 mental health professionals uphold the OWP's standards of confidential services offered within 3 working days of a client's request. In 2023, the OWP provided 3,437 hours of counseling to 642 clients, *a 62% increase in clients and 74% increase in sessions overall from the year prior.*

OWP leadership continues to attribute the increased OMB licensee utilization to two factors:

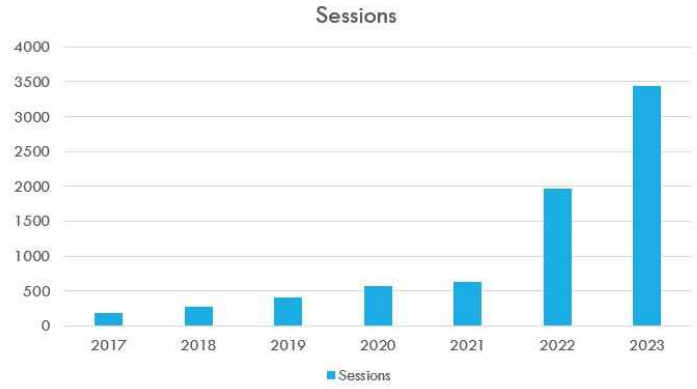
1. The impact of the pandemic continues to reverberate throughout the health care system, especially in terms of the staffing of key elements of the industry (hospitals, nursing homes, clinics). In many cases, there are more patients that need services than there is staff and/or space to accommodate them. Limited staff and space in many of Oregon's health care institutions generates even more pressure on our health care professionals to perform in an environment with scarce resources. Health care systems and clinics have responded by increasing compensation levels and hiring temporary staff. While more inpatient hospital beds and emergency room spaces are needed, their solutions are longer-term and, in the meantime, health care professionals remain under pressure to serve more patients in the same physical space.

2. Despite the aforementioned increase in demand for OWP services, the OWP mental health professionals have continued to meet the access needs of OMB, OSBN, and OBD licensees without an impact to OWP performance standards. We believe an increased awareness of the OWP amongst OMB licensees has been the result of collegial word-of mouth, and the program's incorporation of nurse professionals, dentists, dental hygienists, and dental therapists across the last two years.

Program Utilization

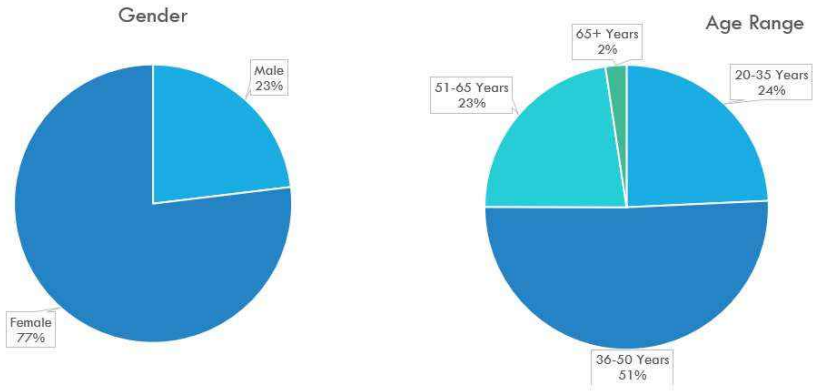
Between January and December 2023, OWP mental health care professionals provided 3,437 one-hour counseling sessions to 642 clients. As noted above, 1,680 of those sessions and 331 clients were OMB licensees. The first table below depicts program growth since the inception of OWP as a coordinated state-wide effort, and the second table shows the breakdown of clients by gender and age.

OWP GROWTH (2017-2023)



*Nurses became eligible to participate in June 2022

OWP CLIENT DEMOGRAPHICS – GENDER AND AGE



Barriers to Access and Care and Our Strategy to Increase Volumes

The primary "barrier" to program utilization is health care professional awareness of the program's availability and the program's strict adherence to client confidentiality. Increased program utilization in 2023 suggests OMB licensees are increasingly aware of the OWP and its standards. Additionally, the OWP temporarily contracted with a Portland-based professional marketing and communications team in 2022 and subsequently improved our web site and use of social media. We are considering engaging the firm once again to review our marketing and communications effort and ensure that we are maximizing program exposure to the licensees of the OMB, the OSBN, and the OBD.

Outcome Measures

The Oregon Wellness Program (OWP) is conducting a prospective longitudinal study to assess its impact on the professional quality of life of Oregon healthcare professionals. Although the results are preliminary, they are important. This section briefly summarizes those findings.

Participants: 306 Oregon healthcare professionals from various healthcare fields have completed surveys. These numbers allow that the final evaluations will be sufficient to verify the results.

Data Provided: Healthcare professional data on 1) professional demographics, 2) professional quality of life (using the ProQOL measure), 3) duration of OWP use, and 4) Adverse Childhood Experiences (ACEs) scores have all been collected. Demographics include specialty, duration of work, gender, age, etc. The ProQOL survey evaluates individual themes such as compassion fatigue, satisfaction, and burnout. The ACEs score, ranging from 0-10, assesses the level of childhood trauma, with higher scores indicating more trauma.

Demographics: The majority of study participants are registered nurses (65%), followed by advanced practice nurses (7%) and physicians (12%). Approximately 26% of all the participants are current OWP users, averaging around 8 visits per year.

Professional Quality of Life (ProQOL): While completed results will be available shortly, initial findings support the value of OWP use for decreased burnout, increased professional satisfaction, and decreased anxiety and depression.

Adverse Childhood Experience Scores (ACE): A unique chapter of the study includes an assessment of ACEs scores. National findings report that individuals with ACEs scores of 4 or more face significantly increased risks of serious health issues such as cardiovascular and lung diseases, depression, and a notably higher likelihood of attempted suicide. While 17.3% of the national population scores 4 or more on ACEs, nearly twice that number (32%) of Oregon's healthcare professionals score 4 or more. These findings underscore the critical need for programs like the OWP.

Summary: The ongoing analyses of data includes correlations between ProQOL and the number of OWP visits; comparison of burnout between OWP users and non-users; and correlation of

retrieved data from two time points, which to date align with the hypothesis that the OWP plays a crucial role in reducing burnout among healthcare professionals.

Program Financials (2023)

We have included copies of the latest TFME Statement of Financial Position and a display of OWP dedicated accounts. The reports are prepared by Susan Matlack Jones and Associates, LLC, a Portland Oregon firm that specializes in financial accounting for not-for-profit organizations.

Funding Request and Budget

The OWP respectfully request the commitment of $125,000 for the support of OMB licensee use of OWP services in 2024. These funds will only be utilized to support OMB licensees and will provide 520 hours of counseling services (520 sessions at $200/session plus 20% for administration including communications/billing/insurance/accounting).

If 2024 OMB utilization of the OWP matches the increased demand in services at the same rate it did in 2022-2023 (50% increase in client numbers, 56% increase in sessions), OMB licensees will likely require 2,621 one-hour sessions of care.

There is a significant funding gap between what the OMB can provide via licensing fees and the potential cost of caring for OMB licensees. In the past, the OWP has successfully met that funding challenge through contributions from health systems and foundation gifts (Legacy, OHSU, Providence, Asante, Virginia Garcia, MODA/EOCCO, CareOregon, Permanente Dental Associates and PacificSource have all contributed). IF the OMB licensees utilize OWP services at the rate noted above, the total funding needed would exceed $600,000 (2,621 sessions X $200/session + 20% administrative costs = $629,040). Administrative costs will not increase at the same rate as program utilization but if one only calculates clinical costs, the budget will approach $524,200. The OWP leadership understands that the OMB cannot sustain the program based on license fees and that maintaining program stability is difficult and unlikely if it must depend on gifts from health care organizations that are financially stressed.

Accordingly, the organizations that represent Oregon's health care professionals (Oregon Medical Association, Oregon Nurses Association and Oregon Dental Association) are actively seeking Oregon Legislature investment in the provision of OWP services to our health care professional community. The results of their efforts during the upcoming Legislative session will be known by April 2024.

The Foundation for Medical Excellence
Statement of Financial Position
12/31/2023

Prepared by Susan Matlack Jones & Associates
From TFME Records/For TFME Use Only
Unaudited

	12/31/2023	12/31/2022	Change
Assets:			
Northwest Bank Checking	301,720	143,689	158,031
Paypal Account	20,668	9,570	11,098
Northwest Bank History of Medicine	46,461	46,322	139
Beneficial Interest in Assets Held by Oregon	79,397	76,127	3,270
J Bloom Life Insurance Policy	23,486	23,486	-
Schwab/General Account	2,589,111	2,631,388	(42,277)
Prepaid Expenses	1,514	1,514	-
Fixed Assets	17,083	17,083	-
Accumulated Depreciation	(17,083)	(17,083)	-
Total Assets	3,062,356	2,932,096	130,261
Liabilities:			
Accounts Payable	56,639	46,714	9,924
Total Liabilities	56,639	46,714	9,924
Net Assets:			
Net Assets Without Donor Restrictions:			
Unrestricted and Available for Operations	1,983,279	1,993,231	(9,952)
Oregon Wellness General Fund	4,184	2,474	1,710
OWP - COMS	2,500	2,500	-
OWP - Oregon Board of Dentistry	32,000	-	32,000
OWP - OMB	(16,076)	5,573	(21,649)
OWP - OHSU	(21,029)	19,371	(40,400)
OWP - Legacy	67,650	77,950	(10,300)
OWP - Research	17,500	17,500	-
OWP - Providence	(92,600)	(45,000)	(47,600)
OWP - Asante	(12,700)	(3,500)	(9,200)
OWP - PacificSource	233	233	-
OWP - IPA	10,614	10,614	-
OWP - Virginia Garcia	2,000	2,000	-
OWP - St. Charles	5,200	11,200	(6,000)
OWP - Permanente Dental	(4,000)	(3,400)	(600)
OWP - EOCCO	21,400	21,600	(200)
OWP - OSBN	276,977	68,750	208,227
OWP - CareOregon	24,300	-	24,300
Total Net Assets Without Donor Restrictions	2,301,431	2,181,095	120,336
Net Assets With Donor Restrictions:			
Soul of Medicine	131,683	131,683	-
TFME Scholarship Fund	436,253	436,253	-
Org. Professional Charter Grant	16,416	16,416	-
History of Medicine	41,224	41,224	-
Permanently Restricted	78,710	78,710	-
Total Net Assets With Donor Restrictions	704,287	704,287	-
Total Net Assets	3,005,718	2,885,381	120,336
Total Liabilities and Net Assets	3,062,356	2,932,096	130,261

The Foundation for Medical Excellence
Statement of Activities - Oregon Wellness Program
12 Months Ending December 31, 2023

Prepared by Susan Matlack Jones & Associates
From TFME Records/For TFME Use Only
Unaudited

	YTD Total	General Oregon Wellness Fund 7100	Central OR Medical Society Fund 7110	Oregon Board of Dentistry Fund 7120	OMB Fund 7130	OHSU Fund 7140	Legacy Health Fund 7150	OWP Research Fund 7160	OWP Providence Fund 7170	OWP Asante Fund 7180	OWP PacificSource Fund 7190	OWP IPA Fund 7200	OWP Virginia Garcia Fund 7210	OWP St. Charles Fund 7220	OWP Permanente Dental Fund 7230	OWP EOCCO Fund 7240	OWP OSBN Fund 7250	COMP NW Fund 7260	CareOregon Fund 7270
Revenue:																			
Contributions	262,000	2,000	-	-	-	10,000	-	-	-	-	-	-	-	-	-	-	250,000	-	-
Program Income	655,000	-	-	40,000	170,000	-	75,000	-	-	10,000	-	-	-	-	10,000	-	250,000	-	100,000
Total Revenue	917,000	2,000	-	40,000	170,000	10,000	75,000	-	-	10,000	-	-	-	-	10,000	-	500,000	-	100,000
Expenses:																			
Salaries	26,667	-	-	-	10,667	-	-	-	-	-	-	-	-	-	-	-	16,000	-	-
Payroll Taxes	2,796	-	-	-	1,119	-	-	-	-	-	-	-	-	-	-	-	1,678	-	-
Contract Services	750,995	-	-	8,000	174,300	50,400	85,300	-	47,200	19,200	-	-	-	6,000	10,600	200	274,095	-	75,700
Computer Services	490	290	-	-	200	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Honoraria	400	-	-	-	-	-	-	-	400	-	-	-	-	-	-	-	-	-	-
Miscellaneous Expense	5,364	-	-	-	5,364	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Allocation of Shared Costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Expenses	786,711	290	-	8,000	191,649	50,400	85,300	-	47,600	19,200	-	-	-	6,000	10,600	200	291,773	-	75,700
Change in Net Assets	130,289	1,710	-	32,000	(21,649)	(40,400)	(10,300)	-	(47,600)	(9,200)	-	-	-	(6,000)	(600)	(200)	208,227	-	24,300
Beginning Funds	187,864	2,474	2,500	-	5,573	19,371	77,950	17,500	(45,000)	(3,500)	233	10,614	2,000	11,200	(3,400)	21,600	68,750	-	-
Ending Funds	318,152	4,184	2,500	32,000	(16,076)	(21,029)	67,650	17,500	(92,600)	(12,700)	233	10,614	2,000	5,200	(4,000)	21,400	276,977	-	24,300

Members of Oregon Legislative Leadership, **January 26, 2024**

The Oregon Medical Association (OMA), Oregon Nurses Association (ONA), Oregon Health Care Association (OHCA), and the Oregon Dental Association have come together to ask for your support in our $1M funding request for the Oregon Wellness Program (OWP).

In the nearly seven years since this program began serving physicians, physician assistants, dentists, dental hygienists, dental therapists, acupuncturists, advanced practices nurses, and nurses (RNs, CAN, LPNs), the number of free therapeutic sessions completed annually has increased by 1450 percent. The OWP now has 35 licensed mental health practitioners specially trained to counsel health professionals within 72 hours of the initial call for help. That kind of resource is invaluable not only to clinicians but all Oregonians who rely on them.

We have seen the powerful impact this program has had on the retention of Oregon's health care workforce. Working with the OWP's coalition, we have heard from numerous clinicians on the verge of quitting who were able to renew their passion for patient care and remain in their jobs. There have been several legislative hearings in recent sessions to discuss how to best retain and educate new health care professionals because the need is so great. The OWP is a crucial partner in those workforce goals. The cost of replacing clinicians can range from $40K to $100K each, so the amount of money saved when a health care organization retains staff far outweighs the $1M investment we're requesting.

The OWP is a successfully tested program that has grown beyond its existing funding sources, and we are working to prevent the very real likelihood that we will have to turn away clinicians when they take the brave step to seek the help they need. We believe Oregon can do better.

For these reasons, we are asking for your support in getting this nominal funding request through the 2024 legislative session.

Sincerely,

Bryan Boehringer
Oregon Medical Association CEO

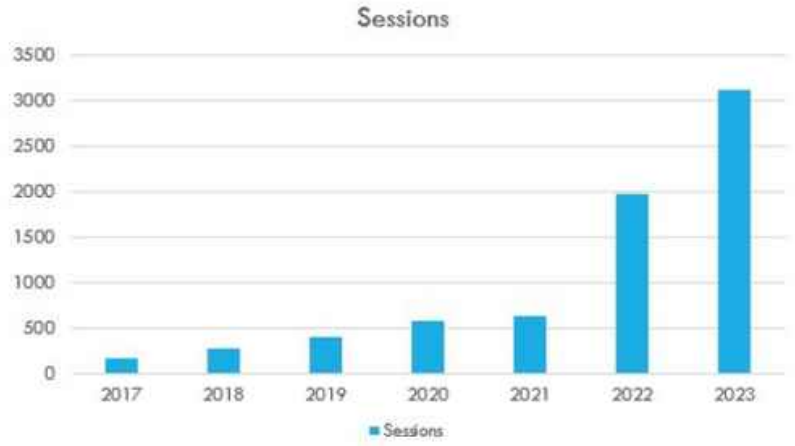
Cell: 503-805-9745
11740 SW 68th Pkwy,
Tigard, OR 97223
bryan@theoma.org
www.theoma.org

OREGON WELLNESS PROGRAM

Oregon's health care workforce needs your support

The OWP is an Urgent Mental Health Counseling Program Serving:

All of Oregon's **139,000** Licensed Physicians, Advanced Practice Nurses, Nurses (RN, CNA, LPN), Dentists, Dental Hygienists, Dental Therapists, Acupuncturists and Physician Assistants



With burnout, depression, and anxiety causing health care professionals to flee the field in extraordinary numbers, free and confidential mental health services have never been more urgently needed. Since 2017, the Oregon Wellness Program (OWP) has provided health care workers access to a team of specially trained and licensed mental health professionals, within 72 hours of first contact. These services help Oregon retain its health care workforce, but the need has outgrown existing funding sources. The OWP is asking for $1M in biennial state funding so they can continue to offer our health care professionals this critical service.

"Since the pandemic, it became clear to me that if I wanted to continue to provide care and remain in the dwindling healthcare workforce, I needed an outlet to cope with all the suffering we witness on a daily basis. The OWP provided anonymity which gave me the confidence to share freely. Within 24 hours of reaching out, I was scheduled with a therapist. I know that without the ease of accessibility, anonymity, and network of providers who understand healthcare specific issues I'd likely still be suffering in silence. I feel re-engaged in my work, and motivated to continue in my calling to help others now that I found help through the OWP."
Internal Medicine Doctor at an Oregon Hospital

For more information please contact:
Courtni Dresser, OMA, 503-380-9488
Christa North, OMA, 503-278-2130

OMA


oregon dental
ASSOCIATION


ONA
Oregon
Nurses
Association
Voice of Oregon Nurses Since 1904


OREGON
PEDIATRIC
SOCIETY


OCCAP
Oregon Council of
Child & Adolescent
Psychiatry


Oregon Chapter
American College of
Emergency Physicians


OPSO
OSTEOPATHIC PHYSICIANS
& SURGEONS OF OREGON


OSA
Oregon Society of Anesthesiologists


Oregon Psychiatric
Physicians Association


OREGON
ASSOCIATION OF
ORTHOPAEDIC SURGEONS


OSPA
Advancing Careers. Modernizing Healthcare.


OHCA
OREGON HEALTH
CARE ASSOCIATION


OREGON ACADEMY OF
FAMILY PHYSICIANS
MAKING HEALTH PRIMARY


OREGON
ACADEMY OF
OPHTHALMOLOGY
Eye Physicians & Surgeons


OMA
OREGON
MEDICAL
ASSOCIATION

ADMINSTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Discussion Item

Member Assigned: **Poulsen**

Subject: **OMB Vision Statement Draft**

MEMORANDUM

TO: Administrative Affairs Committee and Board

SUBJECT: OMB Vision Statement

DATE: February 28, 2024

Oregon Medical Board staff have developed a draft vision statement for the agency to capture what we hope for the citizens of Oregon and our licensees. The OMB vision statement will be incorporated into the agency's Strategic Plan and other guiding materials.

Does the AAC recommend adopting the draft vision statement?

ADMINSTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Discussion Item

Member Assigned: **Eshraghi**

Subject: **Oregon Podiatric Medical Association Letter Regarding HB 2817 FAQs**

1581 NW John Fremont St. #1
Bend, OR 97703
858.720.1695
www.opmatoday.com

March 1, 2024

Oregon Medical Board
1500 SW 1st Ave #620
Portland, OR 97201

Dear Ms. Ross,

We the membership at OPMA, with the support of the American Podiatric Medical Association, are writing to request changes to the FAQ for HB 2817.

We take issue primarily with #3, which reads:

3. Does this treatment include the underlying bone of the lower leg, proximal to the malleolar region?

Under the updated definition, when providing treatment of the soft tissue below the tibial tubercle, an Oregon licensed podiatrist may not include treatment of, or instrumentation of, the underlying bone of the lower leg, proximal to the malleolar region.

First of all, we think that is redundant to #2:

2. Does this treatment include treatment of ulcers on the human leg no further proximal than the tibial tubercle?

The updated definition of podiatry includes treatment of ulcers on the skin, skin-related structures, and subcutaneous masses on the human leg no further proximal than the tibial tubercle. **However, deeper ulcers, including those involving tendon, muscle, or bone** on the human leg, not directly attached to and governing the foot and ankle, **are outside of the scope of podiatrists.** **Treatment of tendons directly attached to and governing the foot and ankle is already within podiatrists' scope of practice as defined in ORS 677.010(15)(a)(A).*

Secondly, this phrase "may not include treatment of, or instrumentation of, the underlying bone" can easily be misconstrued, as we already had to clarify the rules back in 2020 for the use of pins placed in the tibia for ankle fracture and reconstruction and fear that hospitals will have difficulty reconciling this FAQ guidance. Perhaps an addition would include what is already allowed which is "The diagnosis or the medical, physical or **surgical treatment of ailments** of the human foot, ankle and tendons **directly attached to and governing the function of the foot and ankle.**" I do feel that if you add this last clarification, that it

should include whatever guidance that is already in place for the placement of pins in the bone for external fixation as well as language that supports us continuing to be able to treat ankle fractures in the tibia and fibula which has been the case since 1999.

In our humble opinion, leaving out #3 would be the easiest option.

Thanks,

Dusty

Michael J. "Dusty" McCourt, DPM
President, Oregon Podiatric Medical Association
Board Certified, Foot, Rearfoot/Ankle and Reconstructive Surgery
Fellow, American College of Foot and Ankle Surgeons
Diplomate, American Board of Foot and Ankle Surgery

HB 2817: Updating Podiatry Practice in Oregon
Frequently Asked Questions

In 2023, the Oregon Legislature passed HB 2817 that explicitly includes "the treatment of the skin, skin-related structures and subcutaneous masses, and wounds involving skin, skin-related structures and subcutaneous masses, on the human leg no further proximal than the tibial tubercle" within the podiatry scope of practice in Oregon starting January 1, 2024.

The Oregon Medical Board updated the division 80 podiatric rules to implement this change. The frequently asked questions are informational only, please refer to ORS 677.805 to 677.840 and podiatric medicine rules regarding DPM scope of practice in Oregon.

1. What was added to the DPM scope of practice?
The definition of podiatry in ORS 677.010(15) was updated to include the treatment of the skin, skin-related structures and subcutaneous masses, and wounds involving skin, skin-related structures and subcutaneous masses, on the human leg no further proximal than the tibial tubercle.

2. Does this treatment include treatment of ulcers on the human leg no further proximal than the tibial tubercle?
The updated definition of podiatry includes treatment of ulcers on the skin, skin-related structures, and subcutaneous masses on the human leg no further proximal than the tibial tubercle. However, deeper ulcers, including those involving tendon, muscle, or bone on the human leg, not directly attached to and governing the foot and ankle, are outside of the scope of podiatrists.
**Treatment of tendons directly attached to and governing the foot and ankle, were already within the definition of podiatry in ORS 677.010(15)(a)(A).*

3. Does this treatment include the underlying bone of the lower leg, proximal to the malleolar region?
Under the updated definition, when providing treatment of the soft tissue below the tibial tubercle, an Oregon licensed podiatrist may not include treatment of, or instrumentation of, the underlying bone of the lower leg, proximal to the malleolar region.

ORS 677.010(15) as amended by HB 2817 (2023)
(a) "Podiatry" means:
(A) The diagnosis or the medical, physical or surgical treatment of ailments of the human foot, ankle and tendons directly attached to and governing the function of the foot and ankle, and treatment involving the use of a general or spinal anesthetic if that treatment is performed in a hospital licensed under ORS 441.025 or in an ambulatory surgical center licensed by the Oregon Health Authority and is under the supervision of or in collaboration with a podiatric physician and surgeon;
(B) Assisting in the performance of surgery, as provided in ORS 677.814; and
(C) The treatment of skin, skin-related structures and subcutaneous masses, and wounds involving skin, skin-related structures and subcutaneous masses, on the human leg no further proximal than the tibial tubercle.
(b) "Podiatry" does not include administering general or spinal anesthetics or the amputation of the entire foot.

4. Is additional education or training needed for DPMs to treat skin, skin-related structures and subcutaneous masses and wounds?
There are no additional requirements for an Oregon licensed DPM to treat skin, skin-related structures and subcutaneous masses and wounds. However, as provided in OAR 847-080-0042, DPMs practice within their individual education, training, and experience.

DPMs are held to the standard and duty of care. Each podiatric physician must use that degree of care, skill and diligence that is used by ordinarily careful podiatric physicians in the same or similar circumstances and in the same or similar community.

5. Does this addition to the definition of podiatry change the threshold for when a DPM refers a patient to another physician?
No. DPMs are still expected to refer patients when indications are beyond the DPM scope of practice as defined in ORS 677.010 or their education, training, and experience. The law change does not change the threshold for DPMs to work with referral sources to provide appropriate patient care.

6. What process did the Oregon Medical Boad utilize to implement HB 2817?
On August 23, 2023, the Oregon Medical Board hosted a workgroup to receive comments on implementing HB 2817. The workgroup included persons with subject matter expertise who would likely be affected by the proposed rules. The workgroup included Board members, DPMs, MD/DO physicians, and representatives of professional associations. The process was designed to include a diversity of opinions and viewpoints. Workgroup minutes and materials are available online. The HB 2817 workgroup meeting was open to the public and any member of the public could attend the meeting and participate during the designated comment period.

In October 2023, the Oregon Medical Board initiated a rulemaking to implement HB 2817 and clarify that podiatric physicians and surgeons practice podiatry as defined in ORS 677.010, within the duty of care, and within their individual education, training, and experience. The Board held a public hearing and accepted written comments that were reviewed by the Board prior to final adoption of the rules, OAR 847-080-0001 and 847-080-0042.

We know there may be additional questions, please contact elizabeth.ross@omb.oregon.gov.

Relevant Oregon Podiatric Statutes

677.010 Definitions for chapter. As used in this chapter, subject to the exemptions in ORS 677.060 and unless the context requires otherwise:

(14) “Podiatric physician and surgeon” means a physician licensed under ORS 677.805 to 677.840 to practice podiatry.

(15)(a) “Podiatry” means:

(A) The diagnosis or the medical, physical or surgical treatment of ailments of the human foot, ankle and tendons directly attached to and governing the function of the foot and ankle, and treatment involving the use of a general or spinal anesthetic if that treatment is performed in a hospital licensed under ORS 441.025 or in an ambulatory surgical center licensed by the Oregon Health Authority and is under the supervision of or in collaboration with a podiatric physician and surgeon;

(B) Assisting in the performance of surgery, as provided in ORS 677.814; and

(C) The treatment of skin, skin-related structures and subcutaneous masses, and wounds involving skin, skin-related structures and subcutaneous masses, on the human leg no further proximal than the tibial tubercle.

(b) “Podiatry” does not include administering general or spinal anesthetics or the amputation of the entire foot.

ADMINISTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Informational Items

Member Assigned: **Cramer**

Subject: **OMB-Submitted Resolutions to the 2024 Federation of State Medical Boards Annual Meeting**

MEMORANDUM

TO: Administrative Affairs Committee
SUBJECT: Resolutions to the Federation of State Medical Boards (FSMB)
DATE: February 22, 2024

The Federation of State Medical Boards (FSMB) is accepting proposed resolutions from U.S. medical boards to be considered at its annual meeting in April 2024. The deadline for submission was February 16, 2024.

Oregon Medical Board staff worked with Chris Poulsen, DO, Board Chair, and Erin Cramer, PA-C, immediate past chair, to submit the enclosed resolutions.

1. **FSMB should explore various pathways to licensure for International Medical Graduates (IMGs).**

2. **FSMB should review Medical Directors making Necessity Determinations**.

Federation of State Medical Boards
House of Delegates Meeting
April XX, 2024

Subject: Pathways to Licensure for International Medical Graduates (IMGs)

Introduced by: Oregon Medical Board

Approved:

Whereas, State medical boards are responsible for ensuring access to safe, quality medical care; and

Whereas, Many states generally require international medical graduates to obtain three years of US-accredited residency prior to qualifying for a full, unlimited license; and

Whereas, International medical graduates have obtained education, training, and experience that may be substantially similar to that received in the United States; and

Whereas, Some international medical graduates may have been successfully practicing for years prior to an effort to immigrate to the United States; and

Whereas, Residency programs do not have capacity to accommodate the number of applicants for postgraduate training; and

Whereas, International medical graduates are statistically less likely to match into a residency program, and even less likely to match with each year that passes after graduating from medical school; and

Whereas, Requiring international medical graduates to obtain a three-year residency poses a barrier to entry for internationally trained physicians; and

Whereas, States have developed a variety of new license types to facilitate pathways to licensure for international medical graduates, but these licensure types often restrict the practice location, specialty, and independence of the physician; and

Whereas, In November 2023, the FSMB published a Key Issues Chart, "International Medical Graduates GME Requirements: Board-by-Board Overview" and a table, "Licensure of International Medical Graduates" summarizing the differences among state medical boards' regulations; and

Whereas, There is a need for a consistent approach to licensure for international medical graduates among states; and

Whereas, The U.S. Department of Health and Human Services projects a shortage of nearly 140,000 physicians by 2033; and

Whereas, State lawmakers, regional health systems, and rural communities are seeking to introduce new legislation that would impose regulatory changes on state medical boards; and

Whereas, Health care disparities are exacerbated when vulnerable communities do not have access to medical care; and

Whereas, International medical graduates may be able to provide care to bolster the medical workforce; and

Whereas, International medical graduates diversify the medical workforce and address cultural and linguistic barriers to health care;

Therefore, be it hereby

Resolved: that the FSMB work with the Accreditation Council on Graduate Education (ACGME) and other stakeholders to evaluate alternate licensure models for International Medical Graduates and provide guidance for state medical boards and policy makers considering alternate pathways for licensure.

Federation of State Medical Boards
House of Delegates Meeting
April XX, 2024

Subject: Medical Directors of Heath Insurers Making Medical Necessity Determinations

Introduced by: Oregon Medical Board

Approved:

Whereas, State medical boards are responsible for protecting the health, safety, and wellbeing of patients within their states by ensuring they have equitable access to quality care; and

Whereas, An estimated one-third of Americans have medical debt, and communities of color and families below the poverty level are disproportionately impacted by medical debt; and

Whereas, Patients may delay or defer care due to the inability to pay for medical services, which disproportionately affects disadvantaged communities and can exacerbate disparities in health outcomes; and

Whereas, More than 65% of Americans have private health insurance according to the U.S. Census Bureau's Report, "Health Insurance Coverage in the United States: 2022;" and

Whereas, Health insurers employ medical directors to make medical necessity determinations; and

Whereas, A medical director's medical necessity determinations are *de facto* determinations of whether patients will have access to needed treatments and medical services; and

Whereas, A medical director's role is not clearly within the definition of "practicing medicine" in state Medical Practice Acts, and state medical boards may not have authority to review their decision making in medical necessity determinations; and

Whereas, Medical directors are not required to meet standard qualifications or criteria by a particular government or regulatory authority, and medical directors are not required to specialize in the type of care they review; and

Whereas, There is a lack of transparency regarding each medical director's education, training, experience, and standing; and

Whereas, Medical directors may have a history of discipline by a state medical board, employer, or government agency or other malpractice or conduct reported to the National Practitioner Data Bank; and

Whereas, Peer-to-peer discussions between the treating physician and the medical director are administratively burdensome and contribute to physician burnout; and

Whereas, State medical boards aim to reduce causes of burnout in order support and retain a thriving workforce who can provide quality medical care for patients;

Therefore, be it hereby

Resolved: that the FSMB will research the current regulatory oversight for Medical Directors of health insurance companies; and be it further

Resolved: that the FSMB will publish a report articulating the impact of health insurance Medical Directors on patient care and providing recommendations to improve the quality of medical necessity determinations.

ADMINISTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Informational Items

Member Assigned: **Eshraghi**

Subject: **2023 Public Outreach**

MEMORANDUM

TO: Administrative Affairs Committee and Board

SUBJECT: 2023 Public Outreach

DATE: February 28, 2024

The Oregon Medical Board's commitment to public education extends beyond informational materials, physician profiles, and providing public records. The Board offers in-person presentations to health care related audiences, which allows direct and open communication in an intimate setting about the topics that affect our licensees and the public.

In 2023, the OMB participated in the following outreach activities:

Outreach 2023			
Facility/Group	**Topic**	**Presenter**	**Date**
OHSU MD Program - Transition to Residency	OMB Overview	Krishnaswami	01/23/23
OHSU PA Program - 2nd Year Students	Physician Assistant Regulations - Overview	Krishnaswami	01/25/23
Evergreen Family Medicine	Pain Management Adjudication	Farris	03/20/23
Aviva Health	Professionalism	Farris	04/05/23
ASTHO's Opioid Preparedness National Partner Convening	What to do about acute disruptions of patient opioid prescriptions	Farris	05/17/23
OAMSS Annual Spring Conference	2023 Rule Changes	Ross	05/19/23
Pacific University Lecture - Intro	OMB Overview / PA Modernization Act	Krishnaswami	08/01/23
National University of Natural Medicine	OMB Overview / LAc Specific	Krishnaswami	08/02/23
Pacific University Lecture - Graduate	OMB Overview / PA Modernization Act	Krishnaswami	08/10/23
OHSU Pain Intersession Class	Pain Management Adjudication	Farris	08/10/23
2023 CPCCO Substance Use Disorder Summit	Pain Management Adjudication	Farris	10/10/23
Oregon Rural Health Conference	Offering a Medical Chaperone Table Display	Ross	10/13/23
AIM Certified Medical Board Licensing Specialist Program	Overview of Physician Licensing	Krishnaswami	11/21/23
OHSU Pain Intersession Class	Pain Management Adjudication	Farris	12/11/23

In 2024, OMB staff have already presented an overview of licensing and investigations to OHSU medical students, participated in a Continuing Legal Education (CLE) event for the Oregon State Bar Health Law Section regarding the Boards statutory powers, trends, and focus on licensee wellness, and discussed mandatory reporting with providers at Aviva Health. Staff are also scheduled to participate in the Providence Health & Services annual professional staff leadership retreat to discuss the reportability responsibilities of peers, employers, and the hospital.

ADMINISTRATIVE AFFAIRS COMMITTEE
MARCH 13, 2024
VIDEOCONFERENCE

Informational Items

Member Assigned: **Mageehon**

Subject: **New Licensure Count**

New Licensure Count

November 22, 2023 — February 20, 2024

The following information is provided for insight regarding the number of new full licenses granted on a quarterly basis. For comparison, new licenses granted during the same quarter in the previous year are provided.