



OREGON MEDICAL BOARD

NEW LICENSEE HANDBOOK

Mission Statement:

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

Statement of Purpose:

Recognizing that to practice medicine is not a natural right of any person but is a privilege granted by legislative authority, it is necessary in the interests of the health, safety, and welfare of the people of this state to provide for the granting of that privilege and the regulation of its use, to the end that the public is protected from the practice of medicine by unauthorized or unqualified persons and from unprofessional conduct by persons licensed to practice under the Medical Practice Act, ORS 677

CONTACT INFORMATION

Oregon Medical Board

Portland, OR 97201-5847
1500 SW 1st Ave., Suite 620
www.oregon.gov/OMB

Email: info@omb.oregon.gov
Phone: 971-673-2700
Toll-free in Oregon: 1-877-254-6263
Fax: 971-673-2670

Office Hours: 8 a.m. – 5 p.m.
Licensing Call Center: 9 a.m. – 3 p.m.
Both Closed 12 p.m. – 1 p.m.

Health Professionals' Services Program:
Phone: 1-888-802-2843
www.uprisehealthmonitoring.com

ACCESS THE OMB AT [WWW.OREGON.GOV/OMB](http://www.oregon.gov/OMB)

The Board's website provides information on the Board and its various functions, including a description of the Board's licensing programs, fees, forms, the disciplinary process, and how to file a complaint. There are also links to the statutes, administrative rules, and Statements of Philosophy.

Submit applications, renewals and address changes through the site or by using the shortcut <http://omb.oregon.gov/login>.

You can verify a license on the Board's website or by using the shortcut <http://omb.oregon.gov/verify>. The verification will show the license status, professional education and training, and any disciplinary orders or malpractice claims.

THE BOARD & COMMITTEES

Board members provide a critical public service for patients and the medical profession. The fourteen-member Board oversees all agency functions and makes all final decisions on the regulation of the practice of medicine in Oregon.

Each member is appointed by the Governor and confirmed by the Oregon Senate. The Board is composed of seven MDs, two DOs, one DPM, one PA and three public members. They represent a wide range of specialties and practice locations. Current Board member bios are available at www.oregon.gov/OMB/Board.

The Board works through committees. Each committee reviews information in its subject area and makes recommendations to the full Board, which makes all final decisions.

- Investigative Committee considers all investigative and disciplinary matters.
- Administrative Affairs Committee reviews administrative rules and applicants for licensure.
- Acupuncture Advisory Committee reviews matters related to acupuncture.
- Emergency Medical Services Advisory Committee reviews requested changes to the scope of practice and other matters related to EMS providers.
- Editorial Committee reviews Board publications for content and accuracy.
- Legislative Advisory Committee develops and responds to legislative proposals.

<p align="center">Investigative Committee</p>	<p align="center">Administrative Affairs Committee</p>	<p align="center">Acupuncture Advisory Committee</p>
<p>5 physician Board members 1 public Board member <i>Meets monthly</i></p>	<p>3 physicians, 1 PA-C 2 public Board member <i>Meets quarterly</i></p>	<p>3 LAcS, 2 physicians 1 Board liaison <i>Meets biannually</i></p>
<p align="center">EMS Advisory Committee</p>	<p align="center">Editorial Committee</p>	<p align="center">Legislative Advisory Committee</p>
<p>3 EMSs, 2 MD/DOs <i>Meets quarterly</i></p>	<p>2 Board members <i>Reviews publications as needed</i></p>	<p>2 or 3 Board members <i>Meets at call of Chair</i></p>

HISTORY

In 1889, the Oregon Legislature created the Board of Medical Examiners to regulate the practice of medicine by medical doctors. Osteopathic physicians were soon added in 1907.

In the 1970s, physician assistants and acupuncturists became newly regulated health professions of the Board. Podiatric physicians then transitioned to the Board’s oversight in 1981. In 2008, the Board’s name changed to the Oregon Medical Board.

Since its beginnings over 125 years ago, the Board has gone from three Board members to now 14. In 1900, it was responsible for 627 licensees; by 2020, the number of licensees has grown to over 20,000. Despite these changes, the mission of the Board remains constant – to ensure the people of Oregon receive appropriate medical care from qualified professionals.

FUNDING

Even though it is a state agency, the Board does not receive any money from the general fund (tax dollars). Instead, the Board is completely self-supporting with all income generated from licensing, registration, other fees or fines, and data requests.

Every two years a budget is prepared and sent to the Governor for review and possible modification. The budget is then sent to the Legislature for consideration and approval.

ACTIVITIES & RESPONSIBILITIES

The Board's services are provided by its professional staff, which handles all Board activities via the administration, business, licensing, and investigations departments. The Board also works with the ***Health Professionals' Services Program*** that oversees the treatment and rehabilitation of licensees who suffer from substance abuse disorders and/or mental health disorders.

LICENSURE

LICENSES & CERTIFICATES

Your license and certificate of registration will be mailed to you at the mailing address you provide to the Board, upon initial licensure. Please ensure that the address is accurate and you are able to receive mail at that location. Keep the Board apprised of all address changes.

You are required by law to display your license in a prominent place in your office. If you have more than one office, you may make copies of your license. If you lose your certificate of registration, you may contact the Board to request a duplicate.

LICENSE STATUS

Oregon medical licenses have a “status.” The most common statuses are:

- Active – actively practicing in Oregon with current practice address in Oregon or within 100 miles of Oregon’s border
- Emeritus – retired licensee practicing in Oregon for no pay or any other type of compensation in return for their services
- Inactive – living but not practicing medicine in Oregon or licensees who are not practicing in Oregon but are practicing elsewhere.
- Locum Tenens – residing out of state and practices intermittently in Oregon
- Retired – fully-retired and not practicing in any state in any capacity, whether paid, volunteer, or writing prescriptions
- Telemedicine, Telemonitoring or Teleradiology – physicians located out-of-state who provide care to Oregon patients

To change your license status, please contact the Board. You may be required to submit a reactivation application. More details are available at www.oregon.gov/omb/licensing, “Reactivate a License.”

Limited Licenses are granted to licensed professionals in a training program (e.g. postgraduate, resident, fellow, visiting professor, and medical faculty).

LICENSE FEES

Licensing fees vary by profession and license status. For example, an emeritus license has a reduced registration fee. All current licensing fees are available at www.oregon.gov/OMB/licensing/Pages/Fees.aspx.

ADDRESS REQUIREMENTS

Most license statuses require an Oregon practice address; a practice address must be a physical location, not a P.O. Box. You may have as many practice addresses as needed. If you request active status but do not provide an Oregon practice address within six months, your license will be changed to inactive status.

Note: Licensees with inactive status may *not* practice medicine in Oregon.

Changes in practice address or other contact information must be reported to the Board within 30 days of the change. Failure to do so is a violation of the Medical Practice Act. Addresses can be updated at <http://omb.oregon.gov/login>. Be sure to update your practice address and mailing address if both have changed.

Note: A licensee's practice address and mailing address are public records.

MAINTAINING LICENSURE (RENEWAL & CME)

Oregon Medical Board licensees are licensed for a one- or two-year period. To maintain licensure, you must renew your license before the registration period ends. With few exceptions, physician and PA license renewal is October-December of odd-numbered years. Acupuncture license renewal is April-June of even-numbered years. Late renewals are subject to additional fees.

Licensees must show continuing competence in one of two ways. First, licensees may engage in maintenance of certification by a Board-recognized specialty board (i.e. ABMS, AOA-BOS, ABPM, ABPS, NCCPA, or NCCAOM). Alternatively, licensees may obtain 30 hours (15 hours for acupuncturists) of continuing medical education (CME) each year. CME must be relevant to the licensee's practice area. Additional details and exceptions are available in OAR 847-008-0070.

New licensees must obtain CME in pain management as described in OAR 847-008-0075. More information on CME is available at www.oregon.gov/OMB/Topics-of-Interest/Pages/Continuing-Education.aspx.

RE-ENTRY TO PRACTICE

Applicants re-entering practice after more than two years of clinical inactivity collaborate with the Board to establish a re-entry plan. This non-disciplinary Consent Agreement for Re-Entry to Practice may include terms such as mentorship by another licensee and continuing education. Consent Agreements end upon successful completion. See www.oregon.gov/omb/licensing/Pages/Re-Entry-to-Practice.aspx for more details.

INVESTIGATIONS & DISCIPLINE

INVESTIGATION PROCESS

The Board receives hundreds of inquiries and complaints each year from patients, families, health professionals, healthcare institutions, insurance companies, governmental agencies, and medical associations. Each complaint gets an initial investigation to determine if there is an allegation of a violation of the Medical Practice Act. If not, the complaint is closed without further investigation or referred to other agencies. Cases alleging a violation of the Medical Practice Act are fully investigated.

OMB MAY Investigate	OMB <i>Usually</i> MAY NOT Investigate
Quality of care; inappropriate or substandard care	Complaints about providers not licensed by the Board
Impaired licensee	General billing issues
Inappropriate prescribing	Complaints that a licensee's staff was rude
Inappropriate relationship with patient or patient family member	Complaints about medical <i>facilities</i>
Inappropriate boundaries by a licensee	Complaints about Independent Medical Examinations (IME)
Criminal activity (also report to law enforcement)	Complaints about insurance companies or health plans

In an investigation, information and documentation is collected from the licensee, hospitals, pharmacies, and/or any other person or entity with relevant information. All information is reviewed by the Board's Chief Investigator, Medical Director and Executive Director and then forwarded to the Investigative Committee for review and direction.

If the Investigative Committee determines that the information ***does not support a violation of the Medical Practice Act***, the case is forwarded to the full Board for review and a decision regarding case closure. Sometimes, the Board sends a confidential Letter of Concern to the licensee highlighting concerns that were raised during the investigation but did not rise to the level of requiring disciplinary action.

If the Investigative Committee determines the information ***supports a possible violation of the Medical Practice Act***, it may request further evaluation of a licensee's practice, review by an independent consultant, and/or an interview of the licensee. Once the investigation is complete, the Board will decide whether the evidence supports a violation of the Medical Practice Act and disciplinary action is warranted. If so, the Board will issue a Complaint and Notice of Proposed Disciplinary Action outlining the specific allegations. The Board and its investigative staff are assisted by an Assistant Attorney General assigned to the Board. The licensee then has 21 days to request a hearing. The licensee may also enter into settlement discussions with the Board in an effort to find a mutually acceptable resolution at this time. The vast majority of disciplinary orders are reached through agreements between the Board and the licensee.

See ***Anatomy of Complaint*** on the next page or visit the Board's website at www.oregon.gov/omb/Investigations/Documents/anatomy-of-complaint.pdf for further information about each step.

REMEDIAL ACTIONS

The Board issues Corrective Action Agreements to licensees with issues amenable to remediation. These non-disciplinary actions are not reportable to the national data banks unless they relate to the delivery of health care or contain a negative finding.

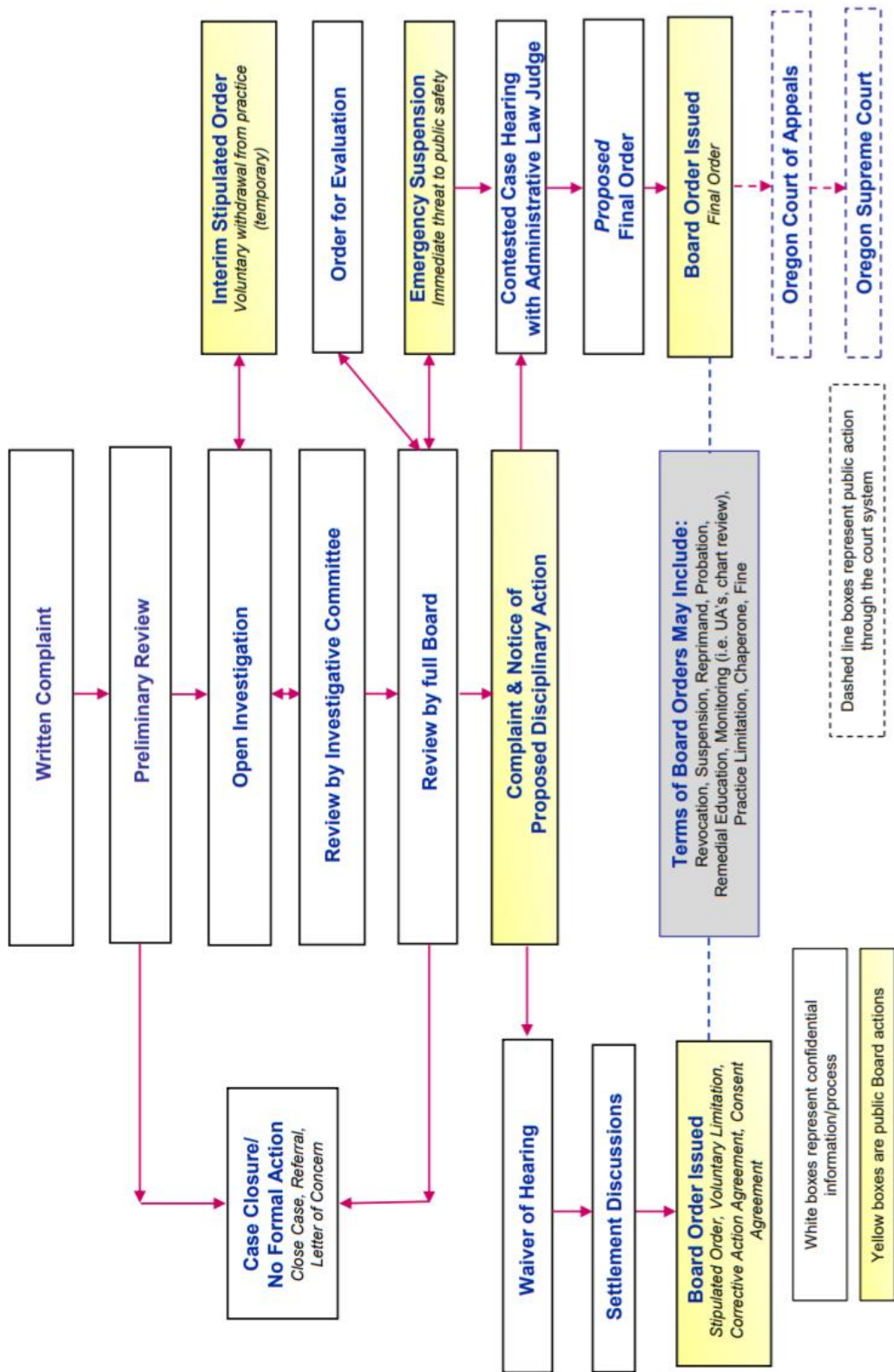
DISCIPLINARY SANCTIONS

Disciplinary sanctions imposed by the Board may include:

- Educational program or coursework
- Requirement for a practice mentor
- Chaperone requirement
- License limitation(s) (*activities restricted*)
- Referral to the Health Professionals' Services Program (HPSP)
- Fines (*maximum of \$10,000 per violation*)
- Assessment of hearing costs
- Probation
- Suspension of license for a period of time determined by the Board
- Denial or revocation of license

If a licensee disagrees with the action taken by the Board, the decision may be appealed to the Oregon Court of Appeals and the Oregon Supreme Court.

ANATOMY OF A COMPLAINT



REPORTING REQUIREMENTS

REPORTS TO THE BOARD

Impaired/ Incompetent Licensees: The Medical Practice Act (ORS 677.415) requires licensees to report within 10 days any information that another licensee is or may be:

- Medically incompetent
- Guilty of unprofessional or dishonorable conduct
- Unable to safely practice

Adverse Actions or Crimes: Licensees must report any adverse actions taken against them by another licensing board, government agency, or healthcare organization or facility. In addition, licensees must report any criminal conviction or felony arrest. These reports must be made to the Board within 10 days. (ORS 676.150)

Failure to report may result in investigation and discipline.

OTHER REPORTING REQUIREMENTS

Child Abuse: Report any reasonable belief that a child has been abused, including assault, physical abuse, neglect, sexual abuse or exploitation, threats of harm, and mental abuse, to the local office of Oregon Department of Health Services (DHS) Child Protective Services or a law enforcement agency. (ORS 419B.005-419B.050) www.oregon.gov/DHS/CHILDREN/CHILD-ABUSE

Seniors & People with Disabilities: Report any reasonable belief that a person 65 years or older or an adult with a disability has suffered abuse to Oregon DHS, county program, or law enforcement. (ORS 124.050-124.095, 430.735-430.765) Abuse includes physical injury that does not appear to be accidental, neglect, abandonment, or willful infliction of pain or injury. www.oregon.gov/DHS/ABUSE

Violence: Report to law enforcement a reasonable suspicion of a non-accidental serious injury or an injury caused by a weapon. (ORS 146.710-146.780)

Toy-Related Injury or Death: Report to the Oregon Health Authority. (ORS 677.491)

At-Risk Drivers: Report any patient whose persistent or episodic cognitive or functional impairment may affect the person's ability to safely operate a motor vehicle to the Department of Transportation. (ORS 807.710)

Vaccinations: Report adverse reactions to the Vaccine Adverse Event Reporting System (VAERS). For more information, contact the Oregon Immunization Program at 971-673-0300 or 800- 422-6012 or <https://vaers.hhs.gov/reportevent.html>.

PUBLIC HEALTH REPORTING

Oregon law¹ requires public health reporting to enable follow-up for patients, help identify outbreaks, and provide a better understanding of morbidity patterns. HIPAA does not prohibit reporting to public health authorities for the purpose of preventing or controlling disease. Reports should be made to the patient's local health department² or a state epidemiologist at 971-673-1111.

Report Immediately – day or night:

Anthrax	Marine Intoxication	SARS
Botulism	Measles (Rubella)	Smallpox (Variola)
Cholera	Plague	Tularamia
Diphtheria	Poliomyelitis	Yellow Fever
Hemorrhagic Fever	Rabies (Human)	Outbreaks and Uncommon Illnesses
Influenza (Novel)	Rubella	

Report Within 24 Hours (including weekends/holidays):

<i>Haemophilus Influenza</i>	<i>Neisseria Meningitides</i>	Pesticide Poisoning
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Report Within One Business Day:

Amebic Infections	Cryptosporidiosis	Hepatitis B	Leptospirosis
Animal Bites	Cryptococcosis	Hepatitis C	Listeriosis
Arthropod-Borne Disease	Cyclosporiasis	Hepatitis D (delta)	Lyme disease
Brucellosis	Enterobacteriaceae	Hepatitis E	Malaria
Campylobacteriosis	<i>E. coli</i> (Shiga-toxigenic)	HIV/AIDS	Mumps
Chancroid	Giardiasis	HUS	Nontuberculosis Mycobacterial Inf.
Chlamydiosis	Gonorrhea	Influenza Death	Pertussis
Coccidioidomycosis	<i>Grimontia</i>	Lead Poisoning	PID (acute, non-gonococcal)
Creutzfeldt-Jakob	Hantavirus	Legionellosis	
	Hepatitis A		
Psittacosis	<i>Salmonella</i>	<i>Taenia</i> Infection	Tuberculosis
Q Fever	Shigellosis	Tetanus	Vibrosis
<i>Rickettsia</i>	Syphilis	Trichinosis	Yersiniosis

1. ORS 409.050; ORS 433.004; OAR 333-018-0000 - OAR 333-018-0015.
2. <http://public.health.oregon.gov/ProviderPartnerResources/LocalHealthDepartmentResources>.

Acute and Communicable Disease Prevention

800 NE Oregon St, Suite 772

Portland, OR 97232

971-673-1111 Fax: 971-673-1100

<http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease>

REGULATING MEDICAL PRACTICE IN OREGON

OREGON REVISED STATUTES (APPENDIX A)

In Oregon, physicians, PAs and acupuncturists are governed by the Medical Practice Act (Oregon Revised Statutes (ORS) Chapter 677). These laws are enacted by the State Legislature, which delegates enforcement to the Board. The Medical Practice Act is available at www.oregonlegislature.gov/bills_laws/ors/ors677.html.

ORS chapter 677 is the Medical Practice Act and includes:

- Definition of the practice of medicine
- Administration of controlled substances for pain
- Informed consent requirements
- Qualifications for licensure
- Practice of medicine across state lines (*telemedicine*)
- Grounds for suspending or revoking a license
- Disciplinary and investigatory procedures

In addition, ORS 676.110-676.556 impacts licensees' practice in several ways (https://www.oregonlegislature.gov/bills_laws/ors/ors676.html), including:

- **Doctor Title Law** (ORS 676.110) specifies how health care professionals may present themselves to the public
- **Health Professionals' Services Program** (ORS 676.185-676.200) establishes the impaired health professional program
- **Liability cap for donated services** (ORS 676.340 - ORS 676.345)

OREGON ADMINISTRATIVE RULES (APPENDIX B)

The Board establishes administrative rules to further define and regulate the practice of medicine and acupuncture. These Oregon Administrative Rules (OARs) are online at http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_847/847_tofc.html.

STATEMENTS OF PHILOSOPHY

Statements of Philosophy are adopted by the Board to express its philosophy and intentions regarding the practice of medicine in the state of Oregon. Statements of Philosophy reflect the diversity of issues addressed by the Board, issues of state and national concern. In discussing these matters, Board members review the work of medical experts, consider the policy statements of national medical associations, and request input from other state licensing boards and state professional associations. The Board also consults existing Oregon Revised Statutes and Oregon Administrative Rules.

New Statements of Philosophy are discussed and drafted as the particular topics of interest arise. When adopted, Statements of Philosophy are published in the quarterly *OMB Report* newsletter, and added to the Board's website at <http://omb.oregon.gov/philosophy>.

- Advertising
- Care of the Surgical Patient
- Chelation Therapy
- Cultural Competency
- Deep Brain Stimulation
- Electronic Health Records
- Ending the Patient-Physician Relationship
- Expedited Partner Therapy for Sexually Transmitted Disease
- Licensees with Mental Illness
- Medical Use of Lasers
- Mesotherapy and Injection Lipolysis
- Pain Management
- Professionalism
- Provider-Patient Relationship
- Re-Entry to Clinical Practice
- Responsibilities of Medical Directors of Medical Spas
- Scope of Practice
- Sexual Misconduct
- Social Media
- Supporting Licensees with Substance Abuse and Mental Health Disorders
- Telemedicine
- Use of Unlicensed Healthcare Personnel
- Use of Unlicensed Healthcare Personnel in Acupuncture

ADVERTISING

In 1975, the Federal Trade Commission (FTC), through a court decision, established that professional associations were subject to antitrust scrutiny in their attempts at regulating advertising. This has also pertained to any attempts by medical boards to establish rules governing advertising.

The FTC has stated that honest and fair advertising promotes safe and fair competition. Restraints on legitimate advertising are restraints against legitimate competition.

However, it is accepted that any false or deceptive representation or statement a physician makes to mislead consumers as perceived by the consumer, to the consumer's detriment, will be considered unacceptable. There must be a reasonable basis for any claims made as to safety and quality of care. All statements must be true and confirmable. Although testimonials are not prohibited, they must not be fraudulent or misleading. Photographs may not be used so as to distort actual results. Claims of medical supervision must represent actual physician involvement in the care provided.

If a physician represents him/herself as a specialist, he/she must be prepared to demonstrate training or expertise in a legitimate specialty. Successful completion of training recognized as a prerequisite for Board certification in a medical specialty or subspecialty by either the American Board of Medical Specialties (ABMS) or the Advisory Board for Osteopathic Specialists (ABOS) shall be considered adequate. Anything less shall put the burden of proof upon the physician to legitimize the claim.

If a physician advertises him/herself as being "Board Certified," he/she must indicate the full name of the certifying board. This statement must contain the term "Not recognized" if the certifying board is not recognized by the ABMS or by the Advisory Board of the American Osteopathic Association (AOA).

- Adopted October 2007

CARE OF THE SURGICAL PATIENT

The evaluation, diagnosis and care of the surgical patient are primarily the responsibility of the surgeon. The surgeon bears responsibility for ensuring the patient undergoes a pre-operative assessment appropriate to the procedure. The assessment shall include a review of the patient's chart and an independent diagnosis by the operating surgeon of the condition requiring surgery. The operating surgeon shall have a discussion with every patient regarding the diagnosis and nature of the surgery, advising the patient that there are risks involved. It is also the responsibility of the operating surgeon to re-evaluate the patient immediately prior to the procedure.

The attending surgeon retains primary responsibility for evaluation and management of the surgical patient pre, during, and post procedure. Pre-operative assessment should include a complete history and physical examination, as well as a clearly documented Procedure, Alternatives, Risks, and Questions (PARQ) conference. Post-operative care will be provided by the surgeon or designee with similar credentialing, certification, and scope of practice. It is the responsibility of the operating surgeon to assure safe and readily available post-operative care for each patient on whom he/she performs surgery.

It is not improper to involve other licensed health care professionals in post-operative care, so long as the operating surgeon maintains responsibility for such care. When non-physician, licensed health care professionals are involved in the care of the patient, the surgeon needs to ensure care is based on what is best for the patient and that the other provider practices within the lawful scope of his/her practice. If co-management is done on a routine basis for primarily financial reasons, it is unprofessional conduct and may be illegal.

Post-operative notes must reflect the findings encountered during the surgery. When identical procedures are done on a number of patients, individual notes should be done for each patient that reflects the specific findings and procedures of that operation.

- Adopted July 2010

CHELATION THERAPY

In fulfillment of the Oregon Medical Board's mission to protect the health, safety and wellbeing of Oregon citizens, the Board looks to the standard of care in determining whether a patient received appropriate medical care. In some cases, medical techniques for diagnosis and treatment of conditions vary greatly and may include alternative treatments. However, patient safety must always be the primary concern when employing any diagnostic or treatment technique.

Chelation therapy is a proven treatment for heavy metal poisoning, including lead poisoning. According to the Centers for Disease Control and Prevention, the U.S. Food and Drug Administration, the National Institutes of Health, the Institute of Medicine, the American Medical Association, the American Osteopathic Association, the American Academy of Family Physicians, and the American Heart Association, there is no scientific evidence that chelation therapy is an effective treatment for any medical condition other than heavy metal toxicity. In addition, the potential risks are serious, including toxicity, kidney damage, irregular heartbeat, bone damage, loss of vitamins and minerals or death. Relying on this treatment alone and avoiding or delaying evidence-based medical care for conditions other than heavy metal poisoning may pose serious health risks.

A provider who treats a patient with chelation therapy for any medical condition first must verify the toxic levels of heavy metals. Post-chelator challenge urinary metal testing does not meet the standard of care for diagnosis of heavy metal toxicity. Further, the American College of Medical Toxicology has concluded that post-chelator challenge urinary testing "has not been scientifically validated, has no demonstrated benefit, and may be harmful when applied in the assessment and treatment of patients in whom there is concern for metal poisoning."¹ The Board cautions providers to use chelation treatment only after a diagnosis of heavy metal toxicity, which includes a blood test or other accepted unprovoked test confirming the presence of heavy metals, and a careful determination that chelation therapy is appropriate for the particular patient.

The Board evaluates all diagnostic and treatment techniques using the standard of care and continues to consider the potential benefits and risks of chelation therapy.

¹American College of Medical Toxicology Position Statement on Post-Chelator Challenge Urinary Metal Testing. July 27, 2009.

- *Adopted October 2013*

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, and that we commit to addressing inequities.

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 in cultural competency continuing education 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.

- Adopted October 2013

- Amended, April 1, 2021

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)

DEEP BRAIN STIMULATION

Modern medical practice has evolved in ways that could not have been foreseen when the Oregon Medical Practice Act was written, in particular, the advancements in neurosurgical procedures over the past quarter century.

Oregon Revised Statute 677.190 includes “psychosurgery” among the list of conduct that is grounds for discipline. “Psychosurgery” is defined as “any operation designed to produce an irreversible lesion or destroy brain tissue for the primary purpose of altering the thoughts, emotions or behavior of a human being.” However, the term “does not include procedures...undertaken to cure well-defined disease states such as brain tumor, epileptic foci and certain chronic pain syndromes.” In addition, the Board recognizes that brain surgery for other purposes is also acceptable.

Deep brain stimulation is an accepted and promising, evidence-based surgical treatment and is not grounds for discipline when performed by a qualified physician who meets the standard of care.

As with all medical care in the State of Oregon, the Board seeks to ensure that neurosurgical procedures are performed in a manner that protects Oregonians and provides them with access to quality care.

- Adopted October 2013

ELECTRONIC HEALTH RECORDS

The passage of the federal Health Insurance Portability and Accountability Act (HIPAA) in 1996 spurred further federal regulation¹ mandating electronic medical record keeping in an effort to standardize insurance claims, make medical records more portable, and eliminate medical errors. Electronic health records (EHR) were expected to facilitate the availability of test and diagnostic information, reduce space requirements and transcription costs, and ideally increase the number of patients served each day. Charged with protecting the health, safety, and wellbeing of Oregon citizens, the Oregon Medical Board shares in these goals.

To the extent that EHR and “meaningful use”² has become the standard of care, it is the responsibility of the Medical Board to ensure that the standard of care is met and to assist licensees wherever possible. The Board recognizes that licensees will need to hone computer skills, become proficient in billing and coding, and in some cases utilize voice recognition software in order to generate EHR. As with other areas in the evolving field of health care, it will be incumbent on providers to build these skill sets and adapt to the new standard.

EHR has the potential to improve health care quality and patient satisfaction. However, the Board also understands that the documentation can seem limitless, and the patient care provider, the most expensive and time stressed link in health care, may become subject to the role of data entry.

In order to not interfere with the establishment of therapeutic and compassionate communication between provider and patient, it is imperative that software developers, health care organizations, and providers work to optimize EHR as a tool for providing efficient, patient-centered care while minimizing interference in traditional provider-patient interaction.

As electronic health records progress, the Oregon Medical Board is mindful of the need to balance the goals of health care efficiency, safety, and portability with those of an informative and readable record that can be created without undue complexity or burden on the increasingly stressed healthcare professionals.

¹ The Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009.

² www.healthit.gov/providers-professionals/meaningful-use-definition-objectives

- Adopted August 2015

ENDING THE PATIENT-PHYSICIAN RELATIONSHIP

The physician-patient relationship is established when the physician evaluates the patient, and a plan is established for the treatment/management of the patient's complaint(s). This relationship may be ended informally or formally, when the patient's problem is resolved. It may also be ended by mutual agreement when the agreed upon treatment plan has not succeeded and the patient is moving on to another provider. It also may be ended by the patient simply disappearing or by requesting a transfer of his/her records to another physician with or without a more formal notification of the original physician. In this situation the patient may have been seeking a second opinion on their own and may well reappear after receiving the results of the visit with the other physician.

The physician may end this relationship for reasons of changes in the physician's scope of practice, change of practice location, retirement, illness, and loss of a contract that includes a time and distance clause preventing continued practice in the area. In the latter situation, the physician may be denied a list of names and addresses of his patients to use for communicating that he/she is discontinuing practice in the area. The current American Medical Association (AMA) ethics document on discharging a patient recommends under such circumstances (in consultation with his/her attorney) the physician should provide a model patient termination letter to be given to the party withholding his/her patients' addresses, and request that the addresses and letter be merged for distribution to these patients.

When physician is ending the relationship for a reason other than those already described, the physician should give the patient adequate notice to allow time for the patient to establish a new relationship with another healthcare provider. This should be at least 30 days except under special circumstances. One special circumstance includes a potential lack of availability of appropriate other providers, which may well cause a significant problem in rural settings. In such a case, a longer period of time may be necessary. For patients who are significantly disruptive, threatening or considered dangerous for the physician or his/her staff, a much shorter window of time down to and including one day may be appropriate.

Notification should be accomplished in writing sent by Certified Mail with "Returned Receipt Requested" or by regular mail with "Address Service Requested" in the bottom left hand corner of the front of the envelope. It is desirable to provide in the letter to the patient and/or to the patient's responsible party some explanation of the reason for ending the doctor-patient relationship, but the decision to provide or not provide that explanation is up to the licensee.

The physician should, if possible indicate resources that might assist the patient in establishing a new physician, but the discharging physician does not have to refer the patient to a specific physician or group of physicians. The physician should make certain that the patient understands that his/her medical records will be sent to the patient's new health care provider, when the patient's signed permission to do so has been received from that healthcare provider.

¹ www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page

- Adopted July 2008

EXPEDITED PARTNER THERAPY FOR SEXUALLY TRANSMITTED DISEASE

The Oregon Medical Board (OMB or “Board”) recognizes that the adequate treatment of sexually transmitted chlamydia and gonorrhea infections has always been a difficult public health issue. When Chlamydia and gonorrhea are identified in a patient, the adequate treatment and prevention of recurrence in the patient often depends upon treatment of the patient’s partner or partners, who may not be available or agreeable for direct examination.

The OMB recognizes that it is a common practice for healthcare practitioners to provide antibiotics for the partner(s) without prior examination. This is known as Expedited Partner Therapy (EPT) and, as such, is encouraged by the Oregon Department of Human Services (DHS) Office of Family Health and the U.S. Centers for Disease Control and Prevention (CDC) in situations where a face-to-face examination of the partner by a physician is unlikely or impractical.

While this is not ideal in terms of the diagnosis and control of chlamydia and gonorrhea, the OMB recognizes that this is often the only reasonable way to access and treat the partner(s) and impact the personal and public health risks of continued, or additional, chlamydial and gonorrheal infections.

When using EPT, the OMB urges practitioners to use all reasonable efforts to assure that appropriate information and advice are made available to the absent, treated third party or parties.

The OMB emphasizes that the use of EPT for conditions other than sexually transmitted disease caused specifically by chlamydia or gonococcus would be considered unprofessional conduct that might lead to disciplinary action. This is based on the Board’s previous determination that physicians should not write prescriptions unless they have conducted an adequate encounter with the patient, and documented this encounter in the medical record.

- Adopted April 2007

LICENSEES WITH MENTAL ILLNESS

A responsibility and obligation of the Oregon Medical Board is the licensing and regulation of physicians and other health care professionals, in order to uphold the standards of the medical profession and to protect the public from the practice of medicine or acupuncture by an impaired licensee.

The Board recognizes that a licensee, like any other member of society, is susceptible to illnesses, including mental illness. It is also known that a licensee can have a mental illness or seek counseling and not be occupationally impaired. For example, this can occur with some depression and anxiety disorders, or with marital and family problems.

However, just as with a physical illness, a licensee's ability to practice medicine or acupuncture may be compromised by his or her mental illness. This can occur with organic mental disorders, some mood and psychotic disorders and various types of character problems. Under ORS 677.190, the Board is required to refuse to grant or renew licenses, or to suspend or revoke licenses to practice medicine or acupuncture, under certain conditions. One such condition is any mental illness affecting a licensee's ability to safely practice medicine or acupuncture.

In such cases, the Board takes appropriate licensing action based on such evidence as civil adjudication or voluntary commitment to an institution for treatment of mental diseases. Supporting evidence may also include findings from an examination conducted by three impartial psychiatrists retained by the Board.

Furthermore, ORS 677.225 requires automatic license suspension when the Board learns that a licensee has been committed by civil action or admitted on a voluntary basis to a treatment facility for longer than 25 consecutive days, for a mental illness that affects the ability of the licensee to safely practice medicine or acupuncture.

The Board supports the de-stigmatization of mental illnesses in licensees. This is exemplified by the questions on the initial application and registration (renewal) forms that ask about current disabilities from mental illness rather than focusing only on the presence of a mental diagnosis and treatment. Specifically, the questions focus on the presence of serious physical or mental illnesses or hospitalizations for either illness (physical or mental) within the past five years which impairs (or impaired) the licensee's ability to practice medicine safely and competently.

If the Board has reasonable cause to believe that any licensee is or may be unable to practice medicine with reasonable skill and safety to patients, the Board may direct and order an investigation. This may include a mental, physical or medical competency examination for the purpose of determining the fitness of the licensee to practice medicine with reasonable skill and safety to patients, as outlined by ORS 677.420.

No restrictions are placed upon a licensee if the licensee is not found to be impaired by his or her mental illness.

However, if the mental illness is found to impair the licensee's ability to practice medicine or acupuncture, then the Board may take disciplinary action as outlined by ORS 677.205. This may

include license limitation, probation, suspension, revocation or denial of license. All of these Board actions are reportable to the National Practitioner Data Bank (NPDB).

The Board recognizes the adverse consequences of stigmatizing mental illness, including interference with the licensee seeking treatment. The presence of current impairment from a mental illness is investigated rather than focusing on a potential mental disability. As a result, the Board can protect the public and ensure that a licensee who has a mental illness can practice safely, professionally and competently.

- Revised July 2005

MEDICAL USE OF LASERS

The U.S. Food and Drug Administration (FDA) regulates the sale of lasers under the Centers for Devices and Radiological Health. It is a device that only a licensed practitioner can purchase.

Destruction, incision, ablation or the revision of human tissue by use of a laser is surgery.

Complications from the medical use of lasers can include visual impairment, blindness, inflammation, burns, scarring, hypopigmentation and hyperpigmentation.

The Oregon Medical Board adopts the position that the medical use of lasers is the practice of medicine as defined by ORS 677.085:

“(3) Offer or undertake to perform any surgical operation upon any person.”

“(4) Offer or undertake to diagnose, cure or treat in any manner or by any means, methods, devices or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity, defect or abnormal physical or mental condition of any person.”

Physicians using lasers should be trained appropriately in the physics, safety and surgical techniques using lasers and intense pulsed light devices, as well as pre- and post-operative care. Any physician who delegates a procedure using lasers or intense pulsed light devices to a non-physician should also be qualified to do the procedure themselves by virtue of having received appropriate training in physics, safety and surgical techniques using lasers and intense pulsed light devices, as well as pre- and post-operative care.

Any allied health professional employed by a physician to perform a laser or intense pulsed light procedure should have received documented training and education in the safe and effective use of each system, and may carry out specifically designed laser procedures only under direct physician supervision, and following written guidelines and/or policies established by the specific site at which the laser procedure is performed.

The ultimate responsibility for performing any procedure lies with the physician. The supervising physician should be on-site, immediately available, and able to respond promptly to any questions or problems that may occur while the procedure is being performed.

The guiding principle for all physicians is to practice ethical medicine with the highest possible standards to ensure the best interest and welfare of the patients.

- Adopted January 2002

MESOTHERAPY AND INJECTION LIPOLYSIS

Background

Treatments most properly called “injection lipolysis” have been commonly associated with the term “mesotherapy” to reduce or eliminate unwanted local accumulations of fat. Various terms for treatments that purport to “dissolve” fat seem to be used interchangeably, although “mesotherapy” has gained prominence in the public vernacular.

Injection lipolysis is typically done with trade-named products such as Lipodissolve™ and Lipostabil™ or with proprietary formulations provided by compounding pharmacies. The one common ingredient in all injection lipolysis formulations is phosphatidylcholine (PPC).

In the United States, sodium deoxycholate (DC), a constituent of bile, is a second major ingredient used to keep the PPC soluble and in an injectable form without precipitating out of solution.

Phosphatidylcholine (PPC) and sodium deoxycholate (DC) are both phospholipids, emulsifiers, and surfactants. PPC is the most abundant phospholipid component of cell membranes, a precursor to acetylcholine, and a constituent of lipoproteins. DC is a constituent of bile. Both substances are naturally present in the human body.

In contrast to injections into the mesoderm, injection lipolysis treatments are delivered into the subcutaneous fat. In both cases, the depth of injection is critical to prevent damage to fascia. It has been hypothesized that treatment with PPC and DC reduces subcutaneous fat by adipocyte necrosis due to direct toxic or surfactant effects.

Phosphatidylcholine (PPC) and sodium deoxycholate (DC) are both approved by the U.S. Food and Drug Administration (FDA) for use as surfactants and drug carriers, among other applications, but neither is approved for subcutaneous injection. Lipodissolve™ and Lipostabil™ are not approved by the FDA.

Proprietary formulations of PPC/DC and other drugs have been manufactured by compounding pharmacies, yet such formulations lack standardization in terms of good manufacturing practices and sterility.

The FDA is well aware that injections to reduce fat deposits are performed, but the agency thus far has not exercised its enforcement power to restrict the use of compounded PPC/DC.

Safety and Efficacy of Injection Lipolysis

To date, reports on the safety and efficacy of injection lipolysis have been anecdotal. Any clinical study involving subcutaneous injection of these drugs requires FDA approval of an investigational new drug (IND) application plus IRB approval.

Reports of adverse events, including mycobacterium skin infections have been reported following the injection of compounded preparations for injection lipolysis.

Recommendations Regarding Injection Lipolysis

Patients must be informed that this procedure uses compounded drugs that are not approved by the FDA for injection.

The use of a PPC/DC combination is permitted in the context of a clinical trial operating under a FDA-approved IND (investigational new drug) study protocol.

Physicians may order individualized prescriptions from a compounding pharmacy designed for a specific patient for the purpose of injection lipolysis. “Bulk” purchases of the compounded drugs will not be possible. There is the risk of FDA investigation and sanctions involving compounded drugs that are not approved by the FDA.

Lipodissolve™ and Lipostabil™ are not approved by the FDA. It is illegal to import or use them.

- Adopted October 2007

PAIN MANAGEMENT

The Oregon Medical Board urges effective, skillful treatment of pain for all patients.

Acute Pain

For acute pain, current standards recommend a multimodal approach, possibly including multiple classes of medications and appropriate application of local or regional nerve blocking agents. If opioids are prescribed, it is recommended to use the lowest effective dose of a single agent for a duration of less than 3 days. For most patients, this should be less than 50 Morphine Equivalent Dose (MED). In cases of more severe acute pain, limit the prescription to less than 7 days. If there is a compelling reason to re-prescribe, it should be well documented. Co-prescribing of benzodiazepines with opioids is to be avoided absent a documented compelling reason.

- See: [Oregon Acute Opioid Prescribing Guidelines](#)

Chronic Pain

The Board recognizes the complexity and difficulty in appropriately treating chronic pain. Addressing pain has been complicated in the not-too-distant past by well-meaning efforts to liberalize treatment of pain, including increased prescribing of opioids. Unfortunately, this has contributed to the opioid overdose crisis. Fortunately, there are now consensus statements from recognized authorities on the current standard of care. Specifically, from the United States Centers for Disease Control and Prevention and from the Oregon Pain Management Commission.

- See: [Center for Disease Control \(CDC\) Guidelines for Prescribing Opioids for Chronic Pain](#), [Oregon Pain Management Commission](#), and [Oregon Pain Guidance Chronic Opioid Prescribing Guidelines](#)

When the Board receives a complaint about potential overprescribing of controlled substances, it looks not only to these guidelines, but to the opinions of local expert consultants. While it is beyond the scope of a Statement of Philosophy to advise exact parameters, practitioners would do well to note the following guidelines.

Diagnoses and the treatment plan should be clearly documented. The effectiveness of the treatment, particularly as it relates to the patient's functional status, should be regularly assessed and documented. Assessments should be ongoing, real-time, not boilerplate repetitions. These are complex patients who deserve attention.

Prescribers should not go it alone. Consultants in specialty areas including pain management and mental and behavioral health are strongly advised. Recommendations from consultants should be reviewed, documented and acted upon.

The amount of prescribed opioid should be limited. When newly treating chronic pain, there is rarely a reason to exceed 50 morphine equivalent dose (MED) of opioid, and almost never a reason to exceed 90 MED.

Polypharmacy with opioids co-prescribed with benzodiazepines, muscle relaxants, gabapentinoids, and hypnotics should be avoided. If required, the medical decision making should be documented and, due to the attendant risks, the need regularly reassessed.

The Board recognizes not all patients can be tapered to MED less than 90, but such patients deserve thorough assessment and documentation and periodic referral to appropriate specialists for co-management. As much as possible, patients should be transitioned to Medication-Assisted Treatment (MAT) – buprenorphine-based treatment. Agonist/antagonist opioid medications have a far safer profile and are often found to be equivalent if not superior to pure agonists in treating pain.

A Procedure, Alternatives, Risks, and Questions (PARQ) conference – a Material Risk Notification (MRN) – is essential. It needs to be documented. A signed agreement with the patient – a “pain contract” – is likewise essential. These should be readdressed and updated periodically, at least annually.

- Examples: [Material Risk Notification](#) and [Patient Treatment Agreements](#)

Prescribers should regularly check the Oregon PDMP (Physician Drug Monitoring Program) for possible multiple prescribers. It is strongly encouraged that licensees who are prescribing chronic opioids have mechanisms for office staff to perform and document the results of these checks at every refill.

Periodic urine drug screens are essential. Board consultants generally recommend a urine drug screen (UDS) be done annually, at minimum. Any patient on chronic long-term opioids needs to be assessed for compliance, regardless of the degree of trust the prescriber may have. Even patients with a long history of compliance may find their prescriptions being diverted by others. Prescribers need to appropriately address and attempt to remediate any discrepancies discovered when checking the PDMP or a urine drug screen.

Patients on chronic methadone can develop dangerous prolongation of the QT interval in their cardiac conduction. An annual electrocardiogram (EKG) has been considered standard.

Terminal Illness

The Board believes that physicians should make every effort to relieve the pain and suffering of their terminally ill patients. Patients nearing the end of their lives should receive sufficient opioid dosages to produce comfort. The physician should acknowledge that the natural dying process usually involves declining blood pressures, decreasing respirations and altered levels of consciousness. Opioids should not be withheld on the basis of physiologic parameters when patients continue to experience pain.

Some physicians express concerns that the use of opioids in these patients may hasten death through pneumonia or respiratory depression. For these reasons, at times physicians may have limited the use of opioids in dying patients out of fear that they may be investigated for inappropriate prescribing or allegations of euthanasia.

The Board is concerned that such fear on the part of physicians may result in inadequate pain control and unnecessary suffering in terminally ill patients. The Board encourages physicians to employ skillful and compassionate pain control for patients near the end of life and believes that relief from suffering remains the physician's primary obligation to these patients

Evolving Standards

Finally, the Board knows the expectations of care can and do shift over time as the understanding of these complex situations shifts. While the Board makes every effort to update statements such as this, the final adjudication of an investigation of potential overprescribing will rest upon the recognized standards at the time.

- Adopted January 1993

- Amended April 1999

- Amended July 2004

- Amended April 2011

- Amended January 2013

- Amended April 2016

- Amended July 1, 2021

Under ORS 677.190(24) the Oregon Medical Board may suspend or revoke a license to practice medicine for prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping.

PROFESSIONALISM

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. It fulfills its mission by, among other activities, investigating and, if necessary, imposing disciplinary action upon physicians who do not uphold the standards of professionalism.

Professionalism comprises those attributes and behaviors that serve to maintain patients' interests above the physician's self-interest.

Professionalism means the continuing pursuit of excellence (see definition below), and includes the following qualities:

Altruism is the essence of professionalism. Altruism refers to unselfish regard for and devotion to the welfare of others and is a key element of professionalism. Self-interest or the interests of other parties should not interfere with the care of one's patients and their families.

Accountability and Responsibility are required at many levels – individual patients, society and the profession. First, there must be accountability to one's patients and to their families. There must also be accountability to society for addressing the health needs of the public and to ensure that the public's needs are addressed.

One must also be accountable to the profession to ensure that the ethical precepts of practice are upheld. Inherent in responsibility is reliability in completing assigned duties or fulfilling commitments. There must also be a willingness to accept responsibility for errors.

Duty: Acceptance of a Commitment to Service. This commitment entails being available and responsive when "on call," accepting personal inconvenience in order to meet the needs of one's patients, enduring unavoidable risks to oneself when a patient's welfare is at stake, and advocating the best possible care regardless of the patient's ability to pay.

Excellence entails a conscientious effort to exceed ordinary expectations and to make a commitment to life-long learning. Commitment to excellence is an acknowledged goal for all physicians. A key to excellence is the pursuit of, and commitment to, providing the highest quality of health care through lifelong learning and education. One must seek to learn from errors and aspire to excellence through self-evaluation and acceptance of the critiques of others.

Honesty and Integrity are the consistent regard for the highest standards of behavior and the refusal to violate one's personal and professional codes. Honesty and integrity imply being fair, being truthful, keeping one's word, meeting commitments, and being forthright in interactions with patients, peers and in all professional work, whether through documentation, personal communication, presentations, research, or other aspects of interaction. Honesty and integrity require awareness of situations that may result in conflict of interest or that result in personal gain at the expense of the best interest of the patient.

Respect for Others is central to professionalism. This respect extends to all spheres of contact, including but not limited to patients, families, other physicians and professional colleagues. One

must treat all persons with respect and regard for their individual worth and dignity. One must listen attentively and respond humanely to the concerns of patients and family members.

Appropriate empathy for and relief of pain, discomfort, and anxiety should be part of the daily practice of medicine. One must be fair and nondiscriminatory and be aware of emotional, personal, family, and cultural influences on patient well-being and patients' rights and choices of medical care. It is also a professional obligation to respect appropriate patient confidentiality.

Signs of Unprofessionalism

It is sometimes by looking at what is unprofessional behavior, that the physician can obtain greater understanding of the meaning of professionalism. The Board has seen these signs of unprofessionalism:

Abuse of Power: Physicians are generally accorded great respect by their patients. When used well, this power can accomplish enormous good. When abused, it causes the opposite. Examples of abuse of power are:

- Crossing sexual boundaries
- Breaching confidentiality
- Proselytizing a point of view in order to change a patient's mind

Arrogance: For a physician, arrogance is an offensive display of superiority and self-importance, which prevents the establishment of empathetic relationships. Examples of arrogance are:

- Failing to listen to others
- Abusing the social position of physicians
- Failing to make appropriate referrals
- Safeguarding physician interests above the patient

Greed: When money rather than patient care becomes the guiding force in a physician's practice. Examples of greed are:

- Doing procedures that have no medical indication
- Billing fraud
- Not providing medical documentation for services

Misrepresentation: In the context of unprofessional behavior, misrepresentation consists of lying (consciously telling an untruth) and fraud (conscious misrepresentation of material facts with the intent to mislead). Examples of misrepresentation are:

- Misrepresenting educational history
- Not filling out licensing and other applications for renewal truthfully
- Faking research
- Inflating credentials

- Altering charts
- Giving expert testimony that is not truthful

Impairment: This occurs when a physician is no longer able to give the patient the needed proper care. Examples are:

- Being under the influence of alcohol and/or drugs while on duty
- Having untreated physical or mental health problems
- Overworking, which may lead to the inability to concentrate

Lack of Conscientiousness: This occurs when a physician does not fulfill his/her responsibilities to patients, colleagues and society. Examples are:

- Charting poorly
- Abandoning patients
- Not returning phone calls or pages
- Not responding appropriately or refusing referrals without a good reason
- Not providing patient records in a timely manner
- Supervising trainees inadequately
- Self-medicating without documentation
- Not keeping up with the skills and knowledge advances in the scope of practice

Conflict of Interest: When the physician puts his/her interests above that of the patient and society, it is a conflict of interest. Here are a few examples:

- Ordering diagnostic procedures or treatment from businesses where the physician has an interest
- Receiving expensive gifts and/or money from drug dispensing companies, which causes undue influence

- Adopted May 2005

PROVIDER-PATIENT RELATIONSHIP

An Oregon provider has medical, legal, and ethical obligations to his or her patients. In light of these obligations, it is the philosophy of the Oregon Medical Board that:

1. Regardless of whether an act or failure to act is determined entirely by a provider, or is the result of a contractual or other relationship with a health care entity, the relationship between a provider and a patient must be based on trust, and must be considered inviolable. Included among the elements of such a relationship of trust are:
 - Open and honest communication between the provider and patient, including disclosure of all information necessary for the patient to be an informed participant in their care.
 - Commitment of the provider to fundamentally serve as an advocate for the patient's interest, without regard to secondary interests, whether personal, financial, or institutional and in avoidance of any conflict of interest with that of the patient.
 - Provision by the provider of that care which is necessary and appropriate for the condition of the patient, following community standards and best practices.
 - Avoidance of the creation or encouragement of any inappropriate relationships outside that of the therapeutic relationship, whether personal, financial, political, sexual, or other.¹
 - Respect for, and careful guardianship of, any intimate details of the patient's life, which may be shared with the provider.
 - Dedication by the provider to continually maintain professional knowledge and skills.
 - Respect for the autonomy of the patient.
 - Respect for the privacy and dignity of the patient.
 - Compassion for the patient and their family.
2. Any act or failure to act by a provider that violates the trust upon which the relationship is based jeopardizes the relationship and may place the provider at risk of being found in violation of the Medical Practice Act (ORS Chapter 677).
3. The philosophies expressed herein apply to all licensees regulated by the Oregon Medical Board, as well as those who make decisions, which affect Oregon consumers, including health plan medical directors and other providers employed by or contracting with such plans.

- Adopted 1998

- Amended July 10, 2020

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 1.1.1 Patient-Physician Relationships; 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: 1.5 Personal Relationships with Patients.

- ORS 677.190(1)(a) and ORS 677.188(4)(a)

RE-ENTRY TO CLINICAL PRACTICE

The Oregon Medical Board (“OMB” or “Board”) has the mission to protect the health, safety, and wellbeing of the citizens of Oregon and must protect the public from the practice of medicine by unqualified, incompetent or impaired physicians. Consistent with this directive, the Board has adopted a policy regarding provider re-entry to clinical practice following a period of clinical inactivity.

In general, the Board requires any licensed physician with more than a 24-month hiatus from practice to design a re-entry plan that includes an assessment and possible supplemental training or mentorship. Requirements for assessment and supplemental training vary depending on individual circumstances. Factors the Board uses in determining the appropriate plan include the number of years in practice before the physician’s hiatus, the number of years out of practice, the type of licensure requested, and the physician’s intended practice and specialty.

Competency assessments include the Special Purpose Examination (SPEX), Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX), self-assessment exercises, computer-based simulations and direct evaluation by a board-approved clinician. Assessments should be standardized and validated.

Following the initial evaluation, a detailed re-entry plan is constructed, which may consist of mentoring, supplemental training, passing the SPEX or COMVEX exam, or other activities pertinent to the clinician’s needs. Supplemental training should focus on the intended area of practice and cover a broad scope, including areas such as managing and assessing information. The duration of participation in a re-entry program is dependent upon individual circumstances, and completion requires a letter from the program verifying fitness to return to clinical practice. In cases where clinicians are found sufficiently competent during an initial assessment, supplemental training may be deemed unnecessary. The re-entry program is not a mechanism for switching specialties.

Providers who are re-entering clinical practice after a prolonged absence may also be required to restrict the scope or volume of practice, work with a mentor, or participate in regular re-assessment of competency. Mentors participating in physician re-entry programs must be board certified, have no public record and be Board approved. Decisions to allow physician re-entry will be significantly influenced by mentor opinion and achievement of goals established at the outset of the mentorship.

Currently, there are national discussions about standardization of re-entry programs. Common objectives of a standardized re-entry program include helping providers return to practice, assuring licensure boards of competency, promoting quality care, enhancing physician supply, and re-assessment of competency at the completion of the program. The Board supports initiatives to standardize re-entry programs and establish accreditation. Furthermore, the Board recognizes that re-entry programs may be expensive and that much of the financial burden will be borne by the clinician seeking re-entry. In some circumstances, admission to a re-entry program will be influenced by State need for clinicians in that specialty.

The Oregon Medical Board is firmly invested in ensuring provider competency to deliver safe health care to Oregonians, and every effort will be made to maintain balance between provider supply and the demand for safe, competent health care.

- Adopted April 2011

RESPONSIBILITIES OF MEDICAL DIRECTORS OF MEDICAL SPAS

The Oregon Medical Board is charged with protecting the health, safety and wellbeing of Oregonians through the regulation of the practice of medicine. As the practice of medicine in medical spas expands, it is incumbent upon licensees providing services in these settings to be aware of their responsibilities. In particular, a licensee who serves as a medical director of a medical spa or similar facility must clearly understand the duties and responsibilities of the role.

Medical directors must view medical spa patients as *their patients*, not just clients of the facility. Medical spa patients must be treated the same as a patient in any other medical facility. This includes performing an evaluation to establish the appropriate diagnosis and treatment, obtaining informed consent prior to treatment, and maintaining proper documentation and patient confidentiality.

Before personally performing or delegating any procedure to medical spa personnel, the medical director must consider the type of procedure and its risks. In addition, the medical director must ensure that the staff member has the appropriate education and training to perform the procedure. Proper delegation also includes effective supervision through oversight, direction, evaluation and guidance. The medical director may not delegate the diagnosis of a medical condition or development of a treatment plan to a staff member who is not licensed to provide independent medical judgment.

Medical directors authorized to prescribe scheduled medications must be aware that only they can order, own, possess or have access to those medications within their medical spa.

The medical director is responsible for the medical procedures performed at the spa and will be held to the same standard of care as though the procedure were performed in a medical facility. Above all, patient safety is the top priority, and medical directors should act in the best interest and welfare of their patients at all times.

- Adopted October 2015

SCOPE OF PRACTICE

The Oregon Legislature has given the Oregon Medical Board the power to exercise general supervision over the practice of medicine and podiatry within the state. Increasingly health professionals, some licensed by this Board and some by other agencies, are seeking to extend the scope of their practice and authority.

While the ultimate decision on scope of practice issues generally rests with the Legislature, the Board assists lawmakers by providing complete and accurate information upon which to base decisions. The following factors are considered when the Board reviews scope of practice questions:

- Public safety must be the primary focus;
- The patient should receive the same level of care and informed consent regardless of who provides the care;
- Fully qualified providers must perform procedures, whether those providers are physicians or other health care professionals.

With extensive years of medical training, physicians have broad authority and considerable latitude in the scope of their medical practice. Health care providers with less formal education need a clearly defined scope of practice in keeping with Oregon statutes.

When considering scope of practice changes for professions or individuals under its own jurisdiction, the Board considers the following:

- **Education:** Has the provider received education from an approved institution with national standards and what is the core education in terms of residency, post-graduate education and continuing education courses?
- **Experience:** What experience has the practitioner had recently relative to the proposed expansion in scope of practice?
- **Level of Supervision:** When health care professionals work under supervision, the Board expects the supervisor to be identified in advance and to be skilled in the procedure he/she is supervising. The supervisor must also assume responsibility for delegation of duties.
- **Back-up Assistance Available:** Before undertaking a scope of practice change, a functional back-up system must be identified in advance, with the availability of review similar to hospital peer review.
- **Demonstration of Skill Level:** In assessing ability, the Board looks for proficiency demonstrated under supervision, documented by an unbiased third party. There needs to be verified outcomes following an appropriate number of procedures over a given period of time.

Prior to the addition of a diagnostic or therapeutic technique to a health practitioner's scope of practice under any jurisdiction, the Board believes that the following questions should be answered in addition to the above outlined standards:

- What is the current standard of practice and is the skill being added appropriate to the professional background?
- What background is sufficient to prepare the professional to perform a given procedure safely?
- Does the individual have adequate experience to understand appropriate indications and handling of complications?

The citizens of Oregon expect and deserve the same high quality care for the same medical service rendered irrespective of the background, training, skill and knowledge of the health care provider. It is on this basis that the Oregon Medical Board carefully reviews questions of expanded scope of practice for health care providers.

-Adopted July 1999

SEXUAL MISCONDUCT

The Oregon Medical Board recognizes that the practice of medicine entails a unique relationship between the medical professional and the patient. The patient's trust and confidence in a provider's professional status grants power and influence to the physician, physician assistant, or acupuncturist.

Licensees are expected to maintain a professional manner and to avoid behaviors that may be misunderstood by or considered offensive by the patient. Licensees should take proactive steps to eliminate misunderstandings through clear, appropriate, and professional communication.

Recommended proactive practices:

1. Provide a professional explanation about each component of examinations, procedures, tests, and other aspects of patient care.
2. Communicate actions in advance, such as physical touch during an exam.
3. Have a chaperone present during sensitive examinations and procedures and anytime when requested by the patient.
4. Be cognizant of sexual or romantic feelings toward a patient or patient representative, and transfer the patient to another health care provider.
5. Be alert to a patient's or patient representative's sexual or romantic feelings; the licensee is responsible for ensuring that the boundaries of the professional relationship are maintained.
6. Exercise extreme caution in electronic communications due to the high potential for misunderstanding. The Oregon Medical Board's Statement of Philosophy on Social Media provides additional guidelines.

Sexual or romantic contact or a suggestion of any sort within a professional relationship, or any such contact outside of the provider-patient relationship is unethical and constitutes unprofessional conduct. "Contact" includes any interaction, whether verbal, physical, or over electronic means.

- Adopted 1995

- Amended October 3, 2019

"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."

- Oregon Administrative Rule 847-010-0073(3)(b)(G)

SOCIAL MEDIA

The Oregon Medical Board regulates the practice of medicine to protect the health, safety, and wellbeing of Oregon patients. As medical practice has evolved, so has the method of communication among practitioners, patients, and family. Colleagues, administrators, and patients increasingly expect healthcare professionals to stay connected, and online social networking has become a resource for healthcare professionals to share information and to form meaningful professional relationships.

The Board recognizes the benefits of social media and supports its responsible use. However, healthcare professionals are bound by ethical and professional obligations that extend beyond the exam room, and social media creates new challenges. Among the primary obligations to consider when engaging in social media are confidentiality, boundaries, and overall professionalism.

Confidentiality

Healthcare professionals have an obligation to protect patient privacy and confidentiality in all environments. Identifiable patient information – even seemingly minor details of a case or patient interaction – must never be posted online. Healthcare professionals must never discuss a patient’s medical treatment or answer a patient’s health-related question through personal social media. E-mail must be secure if used to communicate medical information to patients. Healthcare professionals must use discretion and consider all information posted online to be public.

Boundaries

Healthcare professionals must maintain appropriate boundaries in the physician-patient relationship at all times. Electronic media may blur the boundaries of the physician-patient relationship and heighten the potential for boundary violations.¹ As a result, healthcare professionals should consider separating personal and professional social media accounts and exercise caution if considering interacting with patients or their families online through personal social networking sites. Healthcare professionals should feel comfortable ignoring or declining requests to connect from current or past patients through a personal social media account. It is the professional’s responsibility to maintain appropriate boundaries, not the patient’s.

Professionalism

Online actions and content directly reflect on professionalism. Therefore, healthcare professionals must understand that their online activity may negatively impact their reputations and careers as well as undermine the public’s overall trust in the profession. Healthcare professionals should not make negative statements about other healthcare providers and should use caution when responding to the negative comments of others on social media. When conflicted about posting online content, healthcare professionals should err on the side of caution and refrain. Further, if healthcare professionals write online about their professional experiences, they must be honest about their credentials and reveal any conflicts of interest.

Healthcare professionals are required at all times to follow the Medical Practice Act, rules established by the Board, and professional standards of care. These obligations apply regardless of the medium of communication.

¹The definition of sexual misconduct in OAR 847-010-0073(3)(b)(G) includes sexually explicit communication via electronic methods such as text message, e-mail, video, or social media.

– Adopted January 2016

SUPPORTING LICENSEES WITH SUBSTANCE ABUSE AND MENTAL HEALTH DISORDERS

The foremost mission of the Oregon Medical Board (Board) is the protection of Oregon’s citizens from the practice of medicine by unqualified, incompetent or impaired medical providers. Secondly, the Board supports its licensees in remaining in or returning to the safe practice of medicine. The Board participates in the Health Professionals’ Services Program (HPSP), a rehabilitation and monitoring program for licensees with substance abuse or mental health disorders. HPSP was established in July 2010 as a statewide, confidential resource; it is the successor to the Health Professionals Program (HPP), which was in place for the preceding 20 years.

Licensees who participate in treatment and monitoring are very often successful in returning to safe and productive practice. Experience in Oregon and nationally indicates that anything short of this standard of comprehensive monitoring leads to a markedly higher failure rate.

The Board encourages licensees to attend to any substance use or mental health diagnosis and has adopted the following referral policy regarding the HPSP monitoring program.

Self-referral: Licensees may participate in HPSP through a “self-referral” if there has been no impact on patient care and no impairment in the workplace or in the licensee’s ability to practice. Voluntary HPSP participants require no further action relative to licensure, and they will not be reported to the Board so long as they successfully engage in the program.

Board referral: Licensees may be referred to HPSP by the Board through an investigation or through the license application process when the licensee has a substance use or mental health diagnosis that does or may impair the ability to practice safely. Licensees who have been impaired in the workplace or while scheduled to work (including on call) are referred to HPSP through the investigative and disciplinary process.¹ If the Board believes a licensee is not safe to practice without monitoring through HPSP, and if the licensee chooses not to participate in or comply with the terms of the HPSP agreement, the licensee will be subject to denial of licensure or discipline, up to and including suspension or revocation of licensure.²

The Board recognizes that self-referral is vastly superior to disciplinary action. Early identification and treatment – prior to impairment – is the obvious preference. All licensees and their organizations are encouraged to promote early intervention. When the Board refers a licensee to HPSP through the disciplinary process, it is often possible for the licensee to return to practice as soon as they are successfully participating in the program and they have been deemed safe to practice by an appropriate health care provider.

The Board strives to assure licensees with a substance use or mental health diagnosis that their future success is one of the Board’s goals. Substance use or mental health conditions do not have to destroy a professional’s career, personal life, or professional standing. With proper treatment and follow-up, licensees can continue the successful practice of their medical profession.

¹ State law requires that all impaired licensees be reported to the Board (ORS 676.150).

² Medical Practice Act violations are enumerated in ORS 677.190.

-Adopted 2007

-Revised October 2010

-Revised April 2020

TELEMEDICINE

The Oregon Medical Board supports a consistent standard of care and scope of practice for 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, through means of electronic communication, information technology, or other means of interaction between a licensee at one location and a patient in another location.

Telemedicine generally involves using secure videoconferencing or similar technology to replicate the interaction of an in-person encounter. The practice of medicine 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. Providers practicing via telemedicine on patients located in Oregon must be licensed in Oregon.

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, beyond that authorized by law. 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 licensee is expected to maintain an appropriate provider-patient relationship. At each telemedicine encounter, the 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.
- For treatment and consultation recommendations, a licensee is expected to 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.
- A licensee is expected to provide for an acceptable 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.
- When it is apparent that referral to an acute care facility or Emergency Department for treatment is necessary for the safety of the patient, a licensee is expected to immediately provide an emergency care plan, generally including a formal written protocol appropriate to the services being rendered, directly to the patient.
- A licensee is expected to 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.

- When using online services to provide care via telemedicine, a licensee is expected to be transparent in:
 - Specific services provided;
 - Contact information for licensee;
 - Licensure and qualifications;
 - Fees for services and how payment is to be made;
 - Financial interests, other than fees charged, in any information, products, or services provided by a licensee¹;
 - 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.
- Online services used by licensees to provide care via telemedicine should 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.
- Online services must have accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity. When providing links to other sites, licensees should be aware of the implied endorsement of the information, services or products offered from such sites.

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.

- Adopted January 2012

- Amended October 2, 2020

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 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)

USE OF UNLICENSED HEALTHCARE PERSONNEL

With ever-increasing demands on the time and resources of physicians, the role of unregulated healthcare personnel is expanding. As a result, high quality patient care depends on the contributions of a wide variety of personnel, including medical assistants. When establishing expectations and limitations for medical assistants in a medical office, the OMB advises that patient safety should be the primary factor.

The physician is responsible for ensuring that the medical assistant is qualified and competent to perform any delegated services. It is within the physician's judgment to determine that the medical assistant's education, training and experience is sufficient to ensure competence in performing the service at the appropriate standard of care. Performance of delegated services is held to the same standard of care applied to the supervising physician, and the physician is ultimately accountable for the actions of his or her supervised personnel.

Unlicensed healthcare personnel must be adequately supervised by a licensed physician. Examples of supervision include verifying the correct medication and dosage prior to administration of medicine by a medical assistant and being physically present in the facility when services are performed by a medical assistant.

The physician may not allow any unlicensed healthcare personnel to practice medicine as defined by the Oregon Medical Practice Act. Unlicensed healthcare personnel may not provide independent medical judgment. Therefore, medical assistants should not provide assessments, interpretations, or diagnoses and should not perform invasive procedures.

Physicians should exercise caution when employing a person who has education and training as a healthcare professional but is working as an unlicensed medical assistant. In this situation, it may be tempting for the physician to delegate (or the medical assistant to perform) duties beyond the scope of unlicensed healthcare personnel.

Medical assistants and other unlicensed healthcare personnel must maintain patient confidentiality to the same standards required of physicians. Medical assistants must be clearly identified by title when performing duties. This can be accomplished through wearing a name tag with the designation of "medical assistant" and clearly introducing oneself as a "medical assistant" in oral communications with patients and other professionals.

In order to fulfill its mission to protect the health, safety and wellbeing of Oregonians, the OMB asks physicians to follow these guidelines and to be mindful of patient safety when delegating services to other healthcare personnel.

-Adopted October 2012

USE OF UNLICENSED HEALTHCARE PERSONNEL IN ACUPUNCTURE

In providing safe, effective, and efficient care, an Oregon-licensed acupuncturist may be assisted by unlicensed healthcare personnel. Acupuncturists must use caution when employing unlicensed personnel, including ensuring adequate training and appropriate supervision and avoiding delegation of the practice of acupuncture.

An acupuncturist may not allow unlicensed healthcare personnel to practice acupuncture as defined in ORS 677.757. Unlicensed healthcare personnel may not diagnose, provide point location or needle insertion, perform manipulation, render advice to patients, or perform other procedures requiring a similar degree of judgment or skill.

Unlicensed healthcare personnel may perform administrative, clerical, and supportive services under adequate supervision by a licensed acupuncturist. Supportive services may include, but are not limited to, the operation of an e-stim machine after the acupuncturist has placed needles, attached leads, and set frequency. Operation in this context includes turning on the machine, adjusting intensity for patient comfort, turning off the machine, and unclipping the machine from needles so long as the unlicensed healthcare personnel is trained to do so. Unlicensed healthcare personnel may also remove needles after receiving appropriate training and supervision from a licensed acupuncturist.

Unlicensed healthcare personnel should clearly identify themselves to patients. This should include clear identification on badges as well as direct communication with patients.

In order to fulfill its mission to protect the health, safety, and wellbeing of Oregonians, the Oregon Medical Board asks Oregon-licensed acupuncturists to follow these guidelines and to be mindful of patient safety when using the assistance of unlicensed healthcare personnel.

- Adopted July 1, 2021

The Oregon Medical Board holds licensees to recognized standards of ethics of the medical profession, including the Oregon Association of Acupuncturists' Code of Ethics: Rule 2.3 Staff, and the National Certification Commission for Acupuncture and Oriental Medicine's 2016 Code of Ethics.

See ORS 677.190(1)(a) and ORS 677.188(4)(a)

PRESCRIBING

Familiarize yourself with state and federal laws relevant to your prescribing practices. The Board's rules on controlled substances are in [OAR chapter 847 division 15](#). Additional guidelines include:

- Do not prescribe for yourself, family, or friends except in limited circumstances and with appropriate documentation.
- Keep prescription pads in a safe, secure place – not in the open.
- Never sign a blank prescription, even for non-controlled medications.
- Do not pre-print your DEA number on your prescription pads.
- Write out all numbers in a prescription, such as “twenty (20).”
- Do not refill a prescription for another doctor's patient without confirming with that doctor.
- Avoid being hired by a clinic or group for your ability to prescribe controlled drugs.
- Prescribing long-term methadone for treatment of addiction is prohibited outside of a federally approved methadone maintenance program.

All Healthcare Professionals with an Oregon DEA number are required to register for the Oregon Prescription Drug Monitoring Program (PDMP). Effective July, 1 2018.

- PDMP login at <https://oregon.pmpaware.net/login>
- Select “Create an Account” and register

Oregon Opioid Prescribing Guidelines. Information regarding the prescription of opioids can be found at:

- <http://www.oregon.gov/omb/Topics-of-Interest/Pages/Pain-Management.aspx>

Pain management CME is required by the State of Oregon. This one-time requirement must be fulfilled by completing a one-hour course plus six more hours in pain management or the treatment of terminally ill and dying patients.

- The one hour course can be found at <http://www.oregon.gov/oha/HPA/CSI-PMC/Pages/index.aspx>
- The total seven hours must be completed in the first year of practice

Medication Assisted Treatment (MAT) for Opioid Addiction- Physician Assistants are now among the healthcare professionals who may provide MAT for opioid addiction. For more information about training and requirements go to:

- <https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/qualify-np-pa-waivers>

Oregon Board of Pharmacy
800 NE Oregon St., Suite 150
Portland, OR 97232-2162
971-673-0001
pharmacy.board@state.or.us
www.oregon.gov/pharmacy

Federal Drug Enforcement Agency
DEA Field Office
100 SW Main, Suite 500
Portland, OR 97204
503-721-6660
<https://www.dea.gov/index.shtml>

LICENSEE WELLNESS

Licensee health and wellness is a critical component in the Board's mission. The Board supports a proactive, broad approach to wellness and is part of the Physician/ PA Support and Professionalism Coalition to better understand the available resources and areas of greatest need. Wellness programs include:

Hazelden Treatment Program

1-866-831-5700

www.hazelden.org/web/go/hcp

Lane County Medical Society

541-686-0995

<https://lcmedsociety.site-ym.com/page/PWP>

Medical Society of Metropolitan Portland

503-764-5663

www.msmp.org/Physician-Wellness-Program

Oregon Health & Science University

503-494-1208

www.ohsu.edu/xd/education/schools/school-of-medicine/gme-cme/gme/resident-fellow-wellness-program/index.cfm

Oregon Wellness Program

541-242-2805

www.oregonwellnessprogram.org

PARTNER PROGRAMS

HEALTH PROFESSIONALS' SERVICES PROGRAM (HPSP)

Board licensees may participate in a statewide confidential monitoring program for licensed health professionals with a substance use disorder, a mental health disorder, or both types of disorders. In some cases, the Health Professionals' Services Program (HPSP) may be used as an alternative to disciplinary action for a licensee who is reported for a substance abuse and/or mental health disorder.

The Board may refer a licensee to HPSP or a licensee may self-refer. When the Board refers a licensee, HPSP will work with the board to ensure the licensee is monitored in accordance with his or her board agreement. When a licensee self-refers, HPSP will work with the licensee to develop an individualized monitoring agreement and will keep the licensee's enrollment **confidential** and without Board involvement as long as the licensee is in compliance with the HPSP monitoring agreement.

Licensees interested in more information or in self-referring to HPSP should contact the vendor administering the program, Uprise Health. Your call can remain confidential. Uprise Health can also provide a list of Board-approved independent third-party evaluators.

Uprise Health

Toll free: 888-802-2843

monitoring@uprisehealth.com

THE FOUNDATION FOR MEDICAL EXCELLENCE (TFME)

The Foundation for Medical Excellence (TFME) is a public, non-profit foundation whose mission is to assure that health care in the Pacific Northwest is of the highest quality. TFME focuses on problem areas identified by state medical boards, seeking solutions through education and research. TFME develops and presents a wide range of educational programs, provides consultative services, and sponsors in-depth research projects. TFME's board is composed of community leaders and health professionals.

The Foundation for Medical Excellence

1 SW Columbia St, Suite 860

Portland, Oregon 97258

Phone: 503-222-1960

www.tfme.org

OREGON POLST PROGRAM

The Physician Orders for Life-Sustaining Treatment (POLST) Program was first developed in Oregon in 1990 to ensure that a patient's wishes regarding use of life-sustaining treatments are more consistently honored. In 2009, the Oregon POLST Registry was established to increase accessibility to POLST orders statewide.

At the center of the program is the POLST form, a standardized set of medical orders based on a patient's wishes, signed by an Oregon licensed physician, nurse practitioner or physician assistant.

If a patient elects to complete a POLST form, the signing health care professional is responsible for submitting the form to the Registry (unless the patient opts out).

Oregon POLST
3181 SW Sam Jackson Park Rd.
Mail Code: UHN-86
Portland, Oregon 97239
Phone: 503-494-3965
Fax: 503-494-1260
polst@ohsu.edu
www.or.polst.org

RESOURCES

STATE & FEDERAL REGULATORY & HEALTH AGENCIES

**Oregon Health Authority,
Public Health**

800 NE Oregon Street

Portland, OR 97232

971-673-1222

www.public.health.oregon.gov

**Centers for Medicare & Medicaid
Services (CMS)**

701 5th Ave., Suite 1600

Seattle, WA 98104

206-615-2306

www.cms.gov

PROFESSIONAL MEDICAL ORGANIZATIONS

Oregon Medical Association*

11740 SW 68th Parkway, Suite 100

Portland, Oregon 97223

503-619-8000

www.theoma.org

**A list of Oregon's county and specialty medical societies is available through the OMA.*

Osteopathic Physicians & Surgeons of Oregon

4380 SW Macadam Ave, Suite 125

Portland, Oregon 97239

503-229-6776

www.opsso.org

Oregon Podiatric Medical Association

9900 SW Hall Blvd, Suite 100

Tigard, Oregon 97223

503-245-2420

www.opmatoday.com

**Oregon Association of Acupuncture &
Oriental Medicine**

PO Box 14615

Portland, Oregon 97293

www.oaaom.com

Oregon Society of Physician Assistants

PO Box 55214

Portland, Oregon 97214

503-650-5864

www.oregonpa.org

OREGON HOSPITALS

Adventist Medical Center

10123 SE Market, Portland 97216
503-257-2500

Asante Rogue Regional Medical Center

2825 E. Barnett Rd, Medford 97504
541-789-7000

Asante Three Rivers Medical Center

500 SW Ramsey Ave, Grants Pass 97527
541-472-7000

Asante Ashland Community Hospital

280 Maple St, Ashland 97520
541-201-4000

Bay Area Hospital

1775 Thompson Rd, Coos Bay 97420
541-269-8111

Blue Mountain Hospital

170 Ford Rd, John Day 97845
541-575-1311

Blue Mountain Recovery Center

2600 Westgate, Pendleton 97801
541-276-0991

Casey Eye Institute (OHSU)

33375 SW Terwilliger Blvd, Portland 97239
503-494-3000

Cedar Hills Hospital

10300 SW Eastridge, Portland 97225
503-944-5000

Columbia Memorial Hospital

2111 Exchange St, Astoria 97103
503-325-4321

Coquille Valley Hospital

940 E. 5th St, Coquille 97423
541-396-3101

Cottage Grove Community Med Center

1515 Village Dr, Cottage Grove 97424
541-767-5500

Curry General Hospital

94220 4th, Gold Beach 97444
541-247-3000

Doernbecher Children's Hospital (OHSU)

3181 SW Sam Jackson Rd, Portland 97201
503-494-8811

Genesis Recovery Center

600 South 2nd St, Central Point 97502
541-608-4000

Good Samaritan Regional Medical Center

3600 NW Samaritan Dr, Corvallis 97330
541-768-5111

Good Shepherd Medical Center

610 N.W. 11th St, Hermiston 97838
541-667-3400

Grande Ronde Hospital

506 4th St, La Grande 97850
541-963-3138

Harney District Hospital

557 W. Washington St, Burns 97720
541-573-7281

Holy Rosary Medical Center

351 SW 9th St, Ontario 97914
541-881-7287

Kaiser Sunnyside Medical Center

10180 SE Sunnyside Dr, Clackamas 97015
503-652-2880

Lake District Hospital

700 S. J St, Lakeview 97630
541-947-2114

Legacy Emanuel Children's Hospital

2801 N. Gantenbein Ave, Portland 97227
503-413-2500

Legacy Good Samaritan Medical Center

1015 NW 22nd Ave, Portland 97210
503-413-7711

Legacy Meridian Park Medical Center

19300 S.W. 65th, Tualatin 97062
503-692-1212

Legacy Mount Hood Medical Center

24800 SE Stark St, Gresham 97030
503-674-1122

Legacy Transplant Center
1040 NW 22nd Ave, Portland 97210
503-413-6555

Lower Umpqua Hospital
600 Ranch Road, Reedsport 97467
541-271-2171

McKenzie-Willamette Medical Center
1460 G St, Springfield 97477
541-726-4400

Mercy Medical Center
2700 NW Stewart Pkwy, Roseburg 97471
541-673-0611

Mid-Columbia Medical Center
1700 E 19th St, The Dalles 97058
541-296-1111

Oregon Health & Science University Hospital
3181 SW Sam Jackson Rd, Portland 97239
503-494-8311

Oregon State Hospital
2600 Center St NE, Salem 97301
503-945-2800

Peace Harbor Hospital (*PeaceHealth*)
400 9th St, Florence 97439
541-997-8412

Pioneer Memorial Hospital, Prineville
1201 N. Elm, Prineville 97754
541-447-6254

Providence Hood River Memorial Hosp
810 12th St, Hood River 97031
541-386-3911

Providence Medford Medical Center
1111 Crater Lake Ave, Medford 97504
541-732-5000

Providence Milwaukie Hospital
10150 SE 32nd, Milwaukie 97222
503-513-8300

Providence Newberg Medical Center
1001 Providence Dr., Newberg 97132
503-537-1555

Providence Portland Medical Center
4805 NE Glisan, Portland 97213
503-215-1111

Providence Seaside Hospital
725 S Wahanna Rd, Seaside 97138
503-717-7000

Providence St. Vincent Medical Center
9205 SW Barnes Road, Portland 97225
503-216-1234

Providence Willamette Falls Med Center
1500 Division, Oregon City 97045
503-656-1631

Sacred Heart Medical Center - Riverbend
3333 Riverbend Dr, Springfield 97477
541-222-7300

Sacred Heart Medical Center - University
1255 Hilyard St, Eugene 97401
541-686-7300

Salem Hospital
890 Oak St SE, Salem 97301
503-561-5200

Samaritan Albany General Hospital
1046 6th Ave SW, Albany 97321
541-812-4000

Samaritan Lebanon Community Hospital
525 N Santiam Hwy, Lebanon 97355
541-258-2101

Samaritan North Lincoln Hospital
3043 NE 28th St, Lincoln City, 97367
541-994-3661

Samaritan Pacific Communities Hospital
930 SW Abbey St, Newport 97365
541-265-2244

Santiam Memorial Hospital
515 N 3rd Ave., Stayton 97383
503-769-3441

Shriners Hospital for Children
3101 SW Sam Jackson Rd, Portland 97201
503-241-5090

Silverton Hospital
342 Fairview, Silverton 97381
503-873-1680

Sky Lakes Medical Center
2865 Daggett, Klamath Falls 97603
541-882-6311

Southern Coos Hospital & Health Center
900 11th St SE, Bandon 97411
541-347-2426

St. Alphonsus Medical Center
3325 Pocahontas Rd, Baker City 97814
541-523-6461

St. Alphonsus Medical Center – Ontario
351 SW 9th St., Ontario 97914
541-881-7000

St. Anthony Hospital
1601 SE Court Ave., Pendleton 97801
541-276-5121

St. Charles Health System - Bend
2500 NE Neff Rd, Bend 97701
541-382-4321

St. Charles Health System - Madras
470 NE A St, Madras 97741
541-475-3882

St. Charles Health System - Prineville
1201 N. Elm, Prineville 97754
541-447-6254

St. Charles Health System - Redmond
1253 N. Canal Blvd., Redmond 97756
541-548-8131

Sutter Coast Hospital
800 Washington St., Brookings 97415
541-469-9611

Tillamook Regional Medical Center
1000 Third, Tillamook 97141
503-842-4444

Tuality Healthcare
335 SE 8th Ave, Hillsboro 97123
503-681-1111

VA Medical Center
3710 SW Veterans Hosp Rd, Portland 97207
503-220-8262

VA Roseburg Healthcare Systems
913 NW Garden Valley, Roseburg 97471
541-440-1000

Vibra Specialty Hospital
10300 SW Hancock, Portland 97220
503- 257-5500

Wallowa Memorial Hospital
601 Medical Parkway, Enterprise 97828
541-426-3111

West Valley Hospital
525 SE Washington, Dallas 97338
503-623-8301

Willamette Valley Medical Center
2700 SE Stratus, McMinnville 97128
503-472-6131